

Regulatory Management of Chemically Dependent Healthcare Practitioners

**A Forum Convened by the Citizen Advocacy Center
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These Proceedings are not a verbatim transcript, but they are faithful to the substance of each faculty member's remarks and the questions and comments from the audience. A link to the PowerPoint presentations from the Forum can be found on the CAC Web site at www.cacenter.org/cac/meetings.

Opening Remarks:

David Swankin, President CAC

When CAC planned today's program, we hoped it would attract a varied group of people. We are pleased to report that the forum attendees come from 20 states, the District of Columbia, and Canada. They represent at least eleven types of licensing boards. In addition to treatment programs and licensing boards, the attendees come from regulatory umbrella agencies, associations of regulatory boards, consumer advocacy organizations, academia, and so on.

Our call to this forum explained that occupational and professional regulatory boards exercise the police powers of the state to protect the public health safety and welfare by restricting practice by individuals who do not possess minimal competence. It is more and more common for these boards to offer impaired practitioners treatment for addiction and other impairments as an alternative to discipline. These programs rest on the rationale that they can provide a path to recovery for impaired licensees, that they can help to retain them in the workforce, and with proper monitoring they can help avert harm to the public while the licensees receives help. This is a sound, rationale based on worthy objectives, yet it is essential to recognize that chemically dependent licensees can present a danger to the public. As worthwhile as these programs can be, they must be developed and carried out in ways that ensure they are sufficiently accountable to the public and inspire public confidence and support. This is especially important given that patients typically do not know if a licensee is enrolled in one of these programs and given some recent highly critical external audits of some of the programs.

CAC has been looking at impairment programs for more than a decade. We convened three Forums on this topic, beginning in 1998. The Forums were co-sponsored by a large number of diverse organizations: Administrators in Medicine, American Pharmaceutical Association (now the American Pharmacists' Association), American Society of Addiction Medicine, Center for Medical Consumers, Citizens' Coalition for Nursing Home Reform, Federation of State Boards of Physical Therapy, Health Professions

Network, the Joint Commission, National Association of Addiction Treatment Providers, National Association of Alcoholism and Drug Abuse Counselors, National Association of Boards of Examiners in Long Term Care, National Association of Boards of Pharmacy, National Board for Certification in Occupational Therapy, National Board for Certified Counselors, National Council of State Boards of Nursing, and the National Organization for Competency Assurance.

The Proceedings of the first of the three Forums posed this question:

Why among all these organizations was it the Citizen Advocacy Center, a support program for public members on professional licensing boards and healthcare institutional governing boards, that set the ball in motion to organize these forums? CAC's programs include an annual meeting at which public members and others discuss significant and timely public policy questions. It was the public members of boards of nursing and medicine at our annual meetings in the late 1980ies who first raised our awareness of the issues associated with regulatory programs for impaired professionals. The public members were concerned about regulatory board responsibility. They raised a number of questions and concerns about the programs their boards were establishing or had established. Their questions went something like this:

- The board is responsible for knowing whether licensees are able to practice safely and competently. How can we cede that responsibility to a peer assistance program run by a professional association?
- Are professionals who have harmed patients escaping discipline by turning themselves in to a protected treatment program?
- What happens if a patient is harmed by a professional whose chemical dependency is unknown to the board because his or her confidentiality is protected?
- How do we know the treatment program works?
- Don't these patients have a right to know if their healthcare practitioner has a history of substance abuse?
- Why do we give a second chance to physicians and other healthcare professionals when we don't shelter others who are in a position to do harm, such as airline pilots and truck drivers?

Aware that these issues were on the minds of public members and more and more boards were considering the creation of impairment programs, we prepared a resource brief which raises some of the central public policy issues. The resource brief was published by the Council on Licensure, Enforcement and Regulation (CLEAR). We thought it was time to bring regulators, policymakers and

treatment providers together to take a hard look at how to structure a regulatory program so as to strike the right balance, as we said in the resource brief, between consumer protection and compassion.

Now, eleven years later, we thought it was time to revisit the issue of regulatory management. One reason is that there have recently been a number of critical reports based on audits of impairment program operations.

Today's meeting is organized into four sections. The first is a consumer perspective. The next is a legislative perspective, followed by two case studies of board oversight. The closing section is entitled Parameters of Program Accountability. Throughout the day, there will be ample opportunity for you to ask questions and make comments.

Part I – Consumer Perspectives:

What Do Consumers Have and Right To Expect?

Arthur Levin, Center for Medical Consumers

Good morning. My name is Arthur and I am *not* an alcoholic. That said, the partner I live with is in recovery and this September will celebrate 22 years of sobriety. So, I am personally familiar with the world of chemical dependency, its consequences, and what it means for a person to be in sustained recovery. I am telling you this because I don't want you to think that I lack an understanding of chemical dependency or compassion for those who battle with it throughout their lives.

Consumers Take a Physician-Centric View

While the subject of today's meeting is the regulatory management of chemically dependent healthcare professionals, I think the public – the consumer – sees impairment with a physician-centric view. I believe there are a number of historical and pragmatic reasons why and I want to explore some of them briefly. So I ask the kind indulgence and forgiveness of all those non-physician health care professionals in the room who work every day at the sharp end of health care. I acknowledge and respect the critical role of nurses, physician assistants, pharmacists, dentists, and all other therapists who make sure their patients receive high quality, safe care. I recognize that impairment because of chemical dependency can be destructive to that noble purpose without favor to any specific profession. To further assure you, let me say that I believe an impaired chemically dependent non-physician health professional can potentially wreak as much havoc on patients as anyone else.

I would suggest that is not unreasonable to assert that despite years of good faith effort to tear down the traditional hierarchies, some things have yet to change substantially, especially the culture of physicians. For the most part, MDs see themselves as the captain of the ship -- although I'm not sure that they buy into the tradition of going down

with the ship when it sinks. They see the role of other professions as primarily helpers or extenders.

Obviously, I paint this picture with too broad a brush. There are exceptions, but more likely than not, this is the reality of health care practice. The public's view, which may or may not be misguided, is that it is the doctor's skill and knowledge that primarily determine whether a medical outcome is good or not. It's the surgeon, not the surgical team. Everyone in this room knows this isn't true. I am talking about what I think is the public perception. For that reason, it is most likely the image of an impaired physician, with life and death in her or his hands, that strikes the most fear into the heart of the average patient.

Another reason for the focus on physicians is perhaps the unintended consequence of every state's scope of practice laws. It is usually only a physician who, among all health professions, is licensed by the state to perform invasive, risky interventions in unsupervised private practice under the cover of the opaqueness of their unlicensed and sacrosanct office. Those of you old enough to remember when Medicare was enacted will recall that there was language in the bill saying that nothing in this legislation shall interfere in the private practice of medicine. That is really a sacrosanct, continuing tradition.

This is a concern that takes on new levels of criticality at more and more invasive procedures migrate from licensed inpatient facilities such as hospitals to licensed outpatient facilities such as ambulatory surgery centers to unlicensed physician office-based practice. Someone has called the present trend as the "wild west of office-based surgery." No colleagues, no peer review, no procedures in place to help detect impairment or other issues of competence.

Most of the other health care professions are prevented from engaging in these kinds of invasive practices unless, at the very least, they are under the direct supervision of a physician. Dentists would be one major exception because they practice in an office environment.

Another distinctive feature of physicians is their relationship to the setting in which they practice their profession. The vast majority are independent contractors, or in the parlance of hospital-based medicine, attendings. The majority of other healthcare professionals are employed by an entity, whether it is a hospital, a clinic, or physician practice. While the number of salaried doctors is said to be growing, particularly as new full-time salaried specialties such as interventionists and hospitalists take hold. And younger doctors entering the profession are said to want more predictable private lives that full-time salaried positions can offer. Still, the majority of facility-based practice is still not in the employer-employee relationship. The result is that these contractors are rarely disciplined by the facility they work in. There are a number of reasons for this, not the least of which is that attendings control the primary source of hospital revenue – the admission of insured patients.

There is Tension between Professionalism and Regulation

The political reality is that among all the healthcare professional trade associations active within the Beltway, or in the capitals of fifty states, the AMA and the state medical societies likely wield the most influence. As a result, they are often able to shape regulation in ways that may be beneficial to their own self-interest but which could prove harmful to the public health. This reveals what I would characterize as a visceral tension between the self-regulatory model of professionalism and the traditional role and responsibility of government for protecting the public from harm through the exercise of regulatory oversight.

There is even tension in the very definition of professionalism. Elliott Freidson, a sociologist, in his classic 1970 study of healthcare, entitled *The Profession of Medicine*, defined a profession as “a work group that reserves to itself the authority to judge the quality of its own work.” He posited that society ceded this authority to a profession because of three beliefs. The first was altruism – that professionals will work in the best interests of those they serve rather than in their own interest. The second is self-regulation – that professionals will police one another. The third is that professionals possess some special expertise -- they are in command of a special body of technical knowledge not readily accessible to non-professionals.

I think many would agree there is overwhelming evidence that professional self-regulation has been less than a rousing success in the past. But, is the solution to reinvigorate the professional ethic, or is it to adopt a model of oversight that calls for more proactive involvement by the regulatory authority? This is and has always been a tug of war and is likely to be one for the foreseeable future.

The social contract that Freidson identifies, that government cedes to the professions the ability to self-regulate, is at the core of the discussion today about concerns we have surrounding impairment or diversion programs. Let’s explore the tension a little. In a 2006 article in the *Journal of Occupational Medicine*, a series of authors writing on behalf of the Council on Ethical and Judicial Affairs of the American Medical Association had this to say:

Traditionally problems of alcoholism, substance abuse and related mental health concerns among physicians have received more sustained attention than other conditions. Unfortunately, these concerns are often expressed in terms of discipline to ensure the safety of patients rather than in terms of treatment for the affected physicians.

There is the tension. Statements such as these, which appear to advocate putting the wellbeing of the regulated licensee first and the wellbeing and safety of the public second, are obviously disturbing to me, and I would guess to all consumer advocates. I think they actually call into question the very soul of professionalism. While this reference is specific to physicians, I would suspect that others in the healthcare professions may have expressed similar sentiments about this tension.

How Might We Improve the Process?

In any event, I think the tension is a good starting point for the discussion today. I now want to pose some concerns and questions I have about how we might improve the process.

First, the concern about the primary responsibilities and appropriate roles of licensing and disciplinary boards across the professions should be revisited periodically through public debate. For example, what are the origins and foundations of the view that a state regulatory agency, with responsibility for licensing, disciplining or both, has any responsibility for ensuring the wellbeing of the professionals it regulates? It seems to me that this view of agency responsibility towards the regulated is the policy foundation for the creation and continued existence of diversion or impairment programs for healthcare professionals. The question is: Is this policy or principle justified? If the answer is yes, I would ask: Where is the evidence that it is justified?

Secondly, I would suggest that boards have an obligation to make it clear to the public they serve that their efforts to deal with chemical dependency among health professionals are at best capturing only the tip of the iceberg. I continue to be disappointed in the small number of professionals that pass through diversion treatment programs when compared to even the most conservative estimates of impairment among the health professions – somewhere in the five to ten percent range. Given this, the numbers of professionals who have been through a diversion program are really miniscule. While this may not be sufficient reason to abandon such programs, it cries out for further study. Where have all the other impaired professionals gone? We need to know what happens to all those others in the five to ten percent who don't come in out of the cold into these programs.

Thirdly, I would argue from a consumer advocate point of view that boards should be required to conduct routine audits and in-depth evaluations of the programs they have sanctioned. The results of these audits and evaluations should be publicly reported. Boards should be required to post on their public Web sites the details of their relevant diversion and impairment programs. They should at a minimum make it clear who runs the program, what treatment it offers, what kind of monitoring, and other details of its functioning. What are the follow-up procedures and requirements to track people when they leave the program? The information should also include the details of enrollment, completion and drop out rates, as well as relapse experience. I believe that creating a requirement for full transparency on the part of these programs can help boards and state governments be held accountable for their programs' integrity.

I would also argue that the contracts boards enter into with medical societies or other entities to manage programs should have a relatively short sunset period. That would allow the results of audit and evaluation to be used in deciding whether a program should continue to be sanctioned. I think in New York the contract runs for ten years, which I think is far too long. In New York, it seems to be routine to continue to re-credential the one diversion program run by the medical society.

What about confidentiality? The small number of professionals who enter these programs suggests to me that the guarantee of confidentiality is simply not sufficient to bring a great number of impaired professionals in out of the cold. This reality makes me question the widely-held belief that the confidentiality guarantee offered to health professionals, including withholding that information from the relevant board, is necessarily justifiable. What does this confidentiality mind-set do to the argument that boards need to be more involved in the process? How can boards be more proactive if they are basically kept out of the loop? Are there other incentives to be added for entering treatment that would boost the numbers of healthcare professionals who come into these programs? For example, is there anything to be learned from interventions in civilian life within families and in other settings that persuade people to enter treatment? Is being more proactive possible within the authority boards presently have, or would legislatures need to give boards additional authority?

Should licensed chemical dependency treatment programs be required to provide some sort of notice to the professional oversight board when a professional enters treatment? I know about the confidentiality of the relationship between a health care practitioner and his or her patient. But, we do have examples where something trumps this confidentiality guarantee. One is suspected child abuse. Given that precedent, is there reason to consider trumping the confidentiality promise in the case of chemical dependency? If we were to agree that this would be worthwhile to explore, the quid quo pro might be that the board can possess the information but it cannot publicly disclose it.

Should boards be permitted to use such information to initiate an investigation if the circumstances warrant? There might be a case where the conduct was so gross, that an intervention is required. Should boards be permitted to use such information in an ongoing investigation? Suppose the board gets information that a professional has entered a treatment program, is it fair to use that information in the investigation?

Boards could be much more proactive. They could require drug and alcohol testing of all applicants for a license to discover who is in trouble before they enter practice. Boards ask a lot of questions in order to ascertain the applicant's moral character and fitness. Wouldn't this be another laboratory-based way of doing the same thing? Do we consider a license to practice medicine a privilege or an entitlement?

Is there any reason why boards and other oversight agencies should not require routine chemical dependency testing of all practitioners who are involved in a case of alleged or suspected negligence and incompetence? We do this routinely in the transportation world. Should this kind of testing be considered only when an error occurs? Should it be reserved only for those errors that result in patient harm? When there is a transportation-related accident, one of the things you read in a newspaper account is the result of an alcohol or drug test. In the transportation world, such testing is considered necessary for determining what happened and, if appropriate, fixing blame. Why the exceptionalism for health professionals?

Alternatively, rather than focus on health professionals who get in trouble or are newly applying for a license, should we routinely look at all professionals, particularly those engaged in high-risk practices, and subject them to routine drug and alcohol testing? Is the reliance on professionalism enough, or do we need to bring laboratory science to this situation?

Should boards be working with educators to try to identify students who are or are highly likely to become chemically dependent? Do we know whether assistance programs exist in medical schools and residency programs? Is there any teaching that occurs related to chemical dependency and the risks that are special to health professionals? Could a more proactive approach to alcohol and drug screening of students and residents help mitigate the problem? As a member of the ACLU, I have issues related to routinely screening people, but I am raising these questions as things for you to consider.

We all know that state laws require professionals to report a colleague's dependency problem, but we also know that a lot of observed misconduct is not reported. What happens to people who fail to report? My guess is very few, if any, healthcare professionals are disciplined for failure to report observed misconduct. Does dependency have to cause patient harm before it is taken seriously? What do we expect of health professionals and their ability to self-regulate? Self-regulation involves reporting observed misconduct.

Finally, does it make any sense at all for chemically dependent healthcare professionals to be allowed to continue to practice while they may still be active users, even though in treatment? Or, does such a policy do a real disservice to the doctrine of informed consent? How do I, as a patient, make an informed consent to be cared for by a healthcare professional who the state has guaranteed by virtue of the license on the wall is fully competent to practice his or her profession when there are factors known to others, but not to me, that say otherwise?

I conclude by remarking on some interesting contrasts in our society regarding chemical dependency. In the sports world, better performance through chemistry is front-page news. The debate rages over appropriate punishment for miscreant sports heroes. No one draws this attention more than San Francisco's own Barry Bonds. Little in the world of sports is withheld from public view, except by the players themselves, who always deny that they have even used a banned substance. Part of the debate rages around the records set by sports stars while using. Should they be marked with an asterisk or some other notation that gives the public fair notice of the circumstances at the time they achieved that record? I wonder if the same could be said about chemically dependent healthcare professionals. Should there be some public notice? Perhaps there should be an asterisk next to their names to indicate to patients that their performance may or may not be affected by their dependency.

Question: I can't remember one case coming to my medical board during the past ten years where the physician agreed that he or she had harmed any patient while impaired. I can't remember any case, although there may have been a few, where there were

complaints that the physician harmed a patient. We have no documentation showing patient harm, but, what you are suggesting is an asterisk by their names indicating that they could possibly harm someone. I'm a public member who wants to police as much as appropriate and I am not opposed to what you have said, but I'd like to hear your response.

Levin: You ask a reasonable question. Unfortunately, the connection between impairment and harm is a retrospective judgment. After the harm occurs, one looks back and asks whether the impairment was a factor. In some sectors, the abiding principle is a desire to be proactive and prospective about preventing harm rather than retrospective after harm has occurred. The notion is that there is sufficient evidence that being drunk or stoned impairs one's ability to think in certain ways and to perform manual tasks, such as driving a truck. We accept the fact that driving while impaired is dangerous. We have a lot of data to tell us that because we spend a lot more time and money studying traffic accidents, or railroad or airplane accidents, than we do studying errors or negligent behavior in healthcare. We do not have a National Transportation Safety Board in healthcare. No one comes in after a terrible event to do a thorough forensic analysis of what happened the way we do when a plane crashes.

Although we don't have data related to healthcare, there is data in other fields, and I think it is rational to say that if impairment affects the judgment and motor skills of a truck driver or airline pilot, it is likely to have the same effect on a physician or nurse or dentist or another health care professional. We need to collect more evidence and be on firmer ground.

Comment: I am the incoming medical director for a state physician health program. I want to emphasize that in addition to monitoring physicians, a big part of our mission is education. We teach medical students and residents about occupational hazards, including the potential for a substance use disorder. When medical students are accepted, schools do background checks and if they find a student with a history of DUI or other substance-related offense, they are automatically referred to the physician health program for evaluation. We engage in primary and secondary prevention because we believe it reduces the risk.

My other comment is that the Joint Commission evaluates sentinel events. If there is a bad outcome in a hospital, that agency does a root cause analysis and tries to prevent the same problem from occurring in other hospitals, whether it is an individual or a team error.

Levin: I think it is encouraging and meaningful that you are proactive with your state's educational institutions, but I wonder how true that is in other states. On the sentinel event program, remember that it is a voluntary program that captures very small numbers. In New York State, the hospital incident reporting program collects many thousand fold more sentinel events (defined the same way the Joint Commission defines them) than the Joint Commission's national data base captures. So, the Joint Commission is dealing with a very limited sample from those hospitals that choose to voluntarily report.

Comment: I am a past president of the Federation of State Physician Health Programs and I agree that the public has a right to hold boards that have oversight over physician health programs accountable. We are all for transparency and audits. I agree with you that “snitch” laws are rarely prosecuted, if ever. I agree that physicians’ record of self-regulation is lacking. In addition, I think in many cases, altruism isn’t the dominant motivation of many practices.

However, unfortunately, back in 1973 when the AMA started to pay attention to sick physicians, the word “impaired” was used. What I am asking for is evidence that having the illness of chemical dependency is equal to impairment. Physician health programs across the country know that the potential for impairment exists, and there have to be mechanisms in place to guard against it. We should be reporting fully to the boards that have oversight over us. But, impairment occurs late in the illness. Impairment is detectable in family life and other arenas long before it is detectable in the work place.

Doctoring under the influence is unacceptable. Even one instance of patient harm is unacceptable. We have evidence based on 1,077 consecutive physicians across seventeen physician health programs, ranging from five to eleven years of followup, that shows only one documented case of patient harm, and that was a prescription error.

One of the things physician health programs can do that medical boards cannot do is early detection, referral and assessment. The other thing I disagree with you about is the importance of confidentiality.

Levin: I think you raise an important point involving the use of the word impairment. Does dependency equal impairment and does impairment equal harm? You cite evidence that it may not. Whether that evidence is sufficient to make the case is something that needs to be discussed.

I don’t know how the word impairment got into the conversation about chemical dependency, but we certainly have evidence from other situations that performing under the influence has the potential to harm both the individual and others around him or her. I think we need more research.

I agree that early intervention is preferable to waiting for harm to occur. I applaud and encourage efforts to intervene as early as possible to identify the problem and decide whether this person should continue to be a licensed professional.

Comment: I am a patient advocate from California. I am also a survivor of a doctor who injured me in 2002 while he was battling an addiction to alcohol. This doctor battled the addiction for more than 20 years, unbeknownst to me. I found out that he was in a diversion program because he failed. He was in diversion twice. I sat at a board hearing where a psychologist and an alcoholism expert said he should not be treating patients. But, the board decided to allow him to continue to practice. Had I known he was in a diversion program or battled an addiction to alcohol, I would never have chosen him.

My question is when a patient like me files a complaint with the board about a doctor who could possibly be an addict, why does it take two years to investigate the complaint? I filed a complaint in December 2005. It did not become an accusation against the doctor until February, 2007. More than 100 other patients filed complaints with the board about the same doctor. The majority of the complaints were dismissed.

As of this past May, the doctor has lost his license. He didn't lose his license because of chemical dependency; he lost his license because he lied to the board. I believe doctors who are found to have chemical dependency should be suspended from practice. They should get help and when recovered, re-enter practice.

Comment: I am the Executive Director of North Carolina Caring Dental Professionals, which is a monitoring, assistance and advocacy program for impaired dentists established by the Board of Dental Examiners, the School of Dentistry at Chapel Hill, and the Dental Society. I agree with much of what you said this morning and I am very sorry for what happened to the previous speaker. Assistance programs are sometimes unable to serve the community because of the way state laws are written. The term "impairment" is defined in North Carolina law differently than we in the treatment world define it.

In North Carolina, we have a 98% recovery rate. We have a very strict monitoring program involving a lengthy contract of a minimum of five years. They cease practice once identified. Everyone is sent to professionals' programs for three months of treatment. We have mandatory drug screens. We visit the dental school and present to the students about the assistance program.

I think assistance programs play an important role in the recovery of impaired professionals and I agree the programs need some regulation. Dentists are difficult to identify and to monitor because they are independent practitioners in small practices.

Comment: I am a patient advocate with Colorado Citizens for Accountability. I lost my only child to a medical error committed by a doctor who I believe has a mental illness, but is still practicing. Colorado's physician health program is very cutting-edge. They stop physicians from practicing once identified. It has a patient safety committee on which I serve. They want to know the consumers' perspective. It would be helpful to have a best practices model for the states to follow.

A Case Study of Flawed Regulatory Management

Julianne D'Angelo Fellmeth, Administrative Director, Center for Public Interest Law, University of San Diego School of Law

Good morning. I am not a physician, and I have no formal clinical training or expertise in substance abuse detection, rehabilitation, or prevention. I am not here to tell you whether addiction is a disease, or that it can be treated, or that X treatment has a Y percent success rate.

I have a different background. I am an attorney, a law professor, and a consumer advocate. My organization — the Center for Public Interest Law (CPIL) at the University of San Diego School of Law — has been monitoring occupational licensing agencies in California for 29 years. I myself have been doing this for 23 years, during which time I have attended almost every meeting of the Medical Board of California (MBC) and meetings of most of the other healing arts boards.

I was given a unique opportunity to actually audit the diversion program of the Medical Board of California. Here is the way that came about.

In 2002, the Medical Board's enforcement program was the subject of a multi-day exposé in a California newspaper. That caught the attention of the state legislature which decided to create what we call an "Enforcement Monitor" position. The Monitor was given a two-year term and assigned to audit both the Board's enforcement program and its diversion program for substance-abusing physicians which, despite three failed audits in the 1980s, had inexplicably gone 18 years with no external audit.

The statute gave the Monitor fairly extensive investigative authority, and it required the Medical Board and the Attorney General's Office to cooperate with the Monitor — by turning over documents and files that are otherwise confidential, by participating in interviews, etc.

In 2003, after a competitive bidding process, I was appointed by the Director of Consumer Affairs as the Medical Board Enforcement Monitor. I was the Monitor, but I had a team of folks to assist me, including Tom Papageorge, one of the state's most respected veteran consumer protection prosecutors; and Ben Frank, a management consultant from Sacramento who is very experienced in evaluating government enforcement and diversion programs.

We published two reports — an *Initial Report* in November 2004 and a *Final Report* in November 2005. Both of those reports are available on CPIL's Web site [www.cpil.org] and on the Medical Board's Web Site — and you have been given the *Initial Report's* chapter on the Diversion Program as a reading for this conference.

Obviously, MBC's Diversion Program is the one I know most about. I know that you are not all from medical boards. You are from boards regulating all sorts of health care practitioners who — if they are impaired — can cause just as much harm as a substance-abusing physician. But the program I audited was a medical board's program — so I will probably use the terms "medical board" and "physician" a lot. You should just tune that out and substitute "nurse" or "physical therapist" or whatever is appropriate for you.

What was our methodology? What did we do to study this program?

We looked at the program's statutes, regulations, and procedure manuals. We read the three prior audits of the program that had been performed by state auditors. We reviewed

all of the program's data and its annual reports. We reviewed the program's paper files, and we compared the information in its paper files with the information in its electronic files.

We also interviewed all of the program staff, other Medical Board staff and prosecutors from the Attorney General's Office (about 90 in all), and the members of the "Liaison Committee to the Diversion Program," which was an outside committee of private addiction medicine specialists created to help advise the Medical Board on how to run this program.

The key thing we did was to analyze — in great detail — the participant files on 60 different program participants (and that comprised about one-quarter of the Program's participants at that time — a statistically significant sample). These files contain a lot of confidential information that hardly anyone else has ever seen — from the participant's intake interview form, to drug test results, to quarterly reports filed by group meeting facilitators and worksite monitors.

We reviewed these records in detail such that we were able to piece together the chronology of any participant's participation in the program — how he had been admitted, whether (and when) he relapsed, the program's response to the relapse, the amount of time that response took, etc.

None of us disagree that health care practitioners suffer from substance abuse. We all have compassion for those who are afflicted with it, and we all agree that we should do everything we can to encourage substance-abusing practitioners to seek help and to recover — that's obviously better than letting them continue to practice and risking harm to patients.

The concepts that proponents of impairment programs emphasize sound great and are really not debatable. Who can disagree with getting help for impaired doctors? Treatment? Recovery? Wellness? Better doctors = better patients? More health care?

No one disagrees with those concepts. But translating those concepts into a "nuts-and-bolts" on-the-ground program that truly protects patients and is effective in assisting doctors recover is an extraordinarily difficult task. I am going to hit you with a lot of nuts and bolts here today — because, in my experience looking at these programs, I have found that few people understand the importance of the nuts and bolts, and few people appreciate the need to have programs like this subject to the test of an external audit.

It's the nuts and bolts — as confirmed by an external auditor — that determine whether a program is in fact protecting patients from substance-abusing health care practitioners who retain a full and unrestricted license to practice, or whether it is simply protecting substance-abusing practitioners and allowing them to maintain both their licenses and their addictions.

Overview of the Medical Board's Diversion Program

Impairment programs vary greatly in structure and in size from state to state and from board to board — so I will give you a brief overview of MBC's Diversion Program so you can put it in context and be able to compare it to the program you know best.

1. MBC's program was created in 1980 — it was one of the first programs of its kind in the country.
2. From the day it was created to the day it died, it was one of the few in the country that was administered in-house by MBC employees (at least the case management aspects of the program were administered in-house; it did outsource some of its functions — such as drug testing and the facilitation of group meetings — to the private sector). The vast majority of medical boards outsource the administration of their impairment programs to private vendors; some even outsource it to local medical societies — but not in California.
3. Size? At any given time, there were usually no more than 250-275 doctors in the program. During the latter years of the program, over 100,000 doctors were licensed in California. You can do the math: This program was not attracting even the very tip of the iceberg of statistically-likely impaired doctors.
4. It was a monitoring program — not a treatment program. It evaluated the needs of participants and set forth a rehabilitative plan that might include treatment — including inpatient detoxification, medical and psychiatric evaluation, and psychotherapy. It would put all those requirements in a contract and monitor the participant's compliance with the terms and conditions of the contract.
5. It was a confidential program. For the vast majority of the years it existed, the program offered confidential participation to all participants in the program, such that a participant's patients could not find out he was in the program. This confidentiality was deemed necessary in order to attract doctors into the program.
6. There were three ways to get into the program:
 - (1) “voluntary self-referrals” — throughout its history, the program insisted that about 50% of its participants were self-referrals. We found that this was not technically true. I would estimate that no more than 10-15% of participants were true self-referrals; the rest — although they were initially classified as self-referrals — self-enrolled in the program in order to beat something they knew was going to come to the attention of the Medical Board sooner or later, such as a DUI arrest or conviction, or a hospital disciplinary action by their employer, or a complaint by their spouse or a patient. The participation of voluntary self-referrals was absolutely confidential from both patients and from the enforcement program of the Board.

(2) “board-referred participants” — these are people who came to the attention of the board’s enforcement program by way of a complaint or report. The enforcement program investigated the complaint or report, and determined that the cause of the complaint or report was substance abuse. If the practitioner had not hurt a patient (yet), the enforcement program could refer that doctor into the diversion program “in lieu of” taking discipline. So these people were known to the enforcement program, but their participation was kept secret from their patients.

(3) “board-ordered participants” — these are doctors who were the subject of a Board disciplinary action, such as “license revoked, revocation stayed, ten years’ probation,” and one term of probation was mandatory participation in the diversion program.” That board order was technically a public record — and the board posted on its Web site the fact that a disciplinary action had been taken. But prior to 2004, the Board did not list all the terms and conditions of probation on its Web site, and it did not post the full text of disciplinary orders on its Web site (the way it does now) — so the general public was not aware of the doctor’s participation in the program even though it had been ordered by the board.

7. Once a doctor was in the program, he signed a contract in which he agreed to participate in the program for five years. He agreed to abstain from all use of alcohol and/or unapproved drugs. He also agreed to cease practice if the program told him to. He also agreed to enter treatment if the program told him to; and he agreed that noncompliance with any term or condition of the contract is a breach. That may mean termination from the program, and that may mean referral to the board’s enforcement program.

8. The Program advertised and required compliance with various “monitoring mechanisms” that it used to monitor a participant’s compliance with the contract. The main monitoring mechanisms were:

(1) “random drug testing” — participants were tested four times per month for the first two years of participation. If all tests were clean and the doctor was in compliance with other terms of the contract, drug testing could taper off to two times per month during the latter years of participation.

(2) required attendance at group therapy meetings — participants had to attend group meetings with other impaired health care practitioners twice a week during the first two years of participation. After two years, attendance at these meetings could be reduced to once per week if the participant was in compliance with all terms of the contract.

(3) if the participant was permitted to work, he had to secure a “worksite monitor” who would report to the program on a quarterly basis.

(4) if the participant was permitted to work and had hospital privileges, he also had to secure a “hospital monitor” who was approved by the program and who would report to the program on a quarterly basis.

There were other monitoring mechanisms, but these were the major ones.

Findings

You have all heard the argument as to why a diversion program is superior to an enforcement program if the problem is substance abuse — and that is because a diversion program is allegedly actively monitoring the participant and can theoretically act much more quickly than an enforcement program to intervene, remove the physician from practice, and protect the public if that physician relapses or demonstrates pre-relapse behavior.

But the validity of that argument depends wholly on the existence and the adequacy of those monitoring mechanisms. If they don’t work, for whatever reason, then relapses by participants go undetected and that physician continues to practice medicine with no intervention by the program and no notice to patients that the physician has a serious problem. There is no way for patients to protect themselves from that physician — who, according to your Web sites — retains a clean and clear and unrestricted license to practice medicine.

Finding #1 was a three-headed monster. It involved the confluence of three interrelated failures:

(1) every one of the major monitoring mechanisms was failing;

(2) the program had an insufficient number of internal quality controls to ensure that those failures were detected by staff of the program and corrected, and

(3) the program had been so chronically and pervasively understaffed that its staff could not correct those failures even if they knew about them.

Let’s break that down.

(A) Failure of Monitoring Mechanisms.

Let’s talk about the failure of the monitoring mechanisms — the most important of which is drug testing, because that is the major objective measure of a participant’s compliance with his Diversion Program agreement.

(1) Drug Testing. The program said that it required participants to submit to random, observed urine testing. Participants were required to be tested four times a month during the first two years of their participation, and participants knew of this rate of testing.

A random schedule of testing dates for each participant was prepared by program staff at Sacramento headquarters, and circulated to specimen collectors all over the state. Theoretically, testing could occur on any day — on a weekday, weekend day, Christmas Day, or Super Bowl Sunday. Testing was supposed to occur on the random date generated by a computer, and the whole process was supposed to be monitored by several levels of diversion program staff.

What we found, however, was that in most cases (60% of the time), testing did not occur on those randomly generated dates. Instead, if it occurred at all, it occurred with frequency on dates that could be anticipated by the participant.

In many cases, testing did not occur as frequently as program policy required because the folks who were supposed to collect these urine specimens routinely ignored or overrode the random schedule to suit their own convenience. They skipped collections, and they failed to make up for skipped collections. They unilaterally and disproportionately moved collections from weekend days (when they were supposed to occur) to Tuesdays and Thursdays. They didn't explain these changes to anyone, and nobody required them to.

And when the specimen collectors weren't manipulating the dates of testing, the participants themselves were. When called for a test, they would claim to be “on vacation” or “in surgery,” and the program had no enforceable rules to deal with that kind of situation. The program purported to deem a “missed test” as a “failed test,” but in reality there were no consequences for that kind of noncompliance.

In many cases that we analyzed, participants — including participants who were newly-admitted into the program and generally allowed to practice, and participants who had just been released from inpatient treatment — were not tested for extended periods of time ranging from one month to four months. And nobody knew this but the participant.

In many cases we saw, test results — including positive results that indicate relapse into substance abuse — were not promptly communicated by the laboratory that conducted the test to the program. They were not accurately recorded in the program's paper file on each participant. They were not accurately recorded in the program's computerized records on each participant. There were errors and gaps and inconsistencies in the program's recordkeeping on these physicians — recordkeeping that must be there, accurate, available, and relied upon to make a quick decision in the event of a relapse.

In short, the program did not test as often as it was supposed to, and — when it did test — it was on days that the participant could anticipate. The drug testing requirement was easy to game. Doctors are not stupid, and they quickly learned that they were least likely to be tested on weekends, and more likely to be tested on Tuesdays and Thursdays. They also learned that if they were tested four times by the tenth of the month, the odds were that they would not be tested for another 20 days.

Three quick notes about drug testing:

(a) Some of our boards in California allow unobserved drug testing. What is the point of that? That simply invites contamination or substitution. And if you don't believe me, just Google the term "drug testing" and look at all the companies with names like "urineluck.com" and "passyourdrugtest.com". If you don't require observed testing, you might as well not require it at all.

(b) And let's step back and think about the "random" drug testing requirement for a minute — does that really ensure abstinence? That's what the contract requires, and that's what the board expects. But does "random" drug testing two or three or four times a month really ensure abstinence? No.

Many experts say that if you really want to ensure abstinence, you would test every 24-48 hours, depending on the drug of choice. And such testing need not be random; it could be scheduled. And, depending on the drug of choice, you may need to mix in some "elite" tests that test for more and different kinds of drugs than the normal urine drug screen does.

According to experts I have talked to, impairment program participants — and especially those who are permitted to practice — should be drug-tested continuously. This means that there should be no opportunity for a participant to drink alcohol or use drugs without that use being detected. That's the only way to ensure abstinence. But the Medical Board of California never even considered that option.

(c) And one last note about MBC's drug testing. For some reason, the program was using a lab in Utah. Although its policy manual said specimen collectors should immediately overnight mail all specimens to the lab, MBC found — two years after my audit was completed — that it was still taking an average of 4 days to get the sample to the lab and another 3 days for the program to receive the results. If you are dealing with a doctor who is tested on Day 1 and you don't get the results until Day 7 or 8, how is your program protecting all the patients that doctor treated between Days 1 and 8? It is not.

Think about your own program and its drug testing requirement. If your program requires random drug testing, do you know:

How is the random date set?

Who sets it?

Who can override it?

Are all tests actually conducted on the random date?

How does the licensee know "today's my day"?

How many hours elapse between notice of the test and the actual test?

Where and how is the test conducted? In observed fashion in a sanitary

laboratory-type setting, so that chain of custody of the sample can be

preserved? Or in the restroom of a Denny's or a McDonald's, like some of the MBC program's were?

How quickly does the sample get to the lab?

How long does the lab take to test the sample and return the result to you or your private vendor?

If that test is positive, how quickly does it does it notify you?

Who exactly does the lab notify? How?

What if that person is on vacation? Then who does the lab notify?

Does it notify your program after one relapse? Two? Six?

What does your program do in response to one relapse? Two? Six? Where is that written down?

Do you know the answers to these questions?

And even if you think you do, how do you know those answers are true?

So, that's one example of a "nuts and bolts" monitoring mechanism — arguably the most important one — gone awry. Let's discuss another.

(2) Group Meeting Attendance

As I mentioned, the program required participants to attend group meetings of substance-abusing health care practitioners twice a week during the first two years of participation. These meetings were supposed to be therapy sessions where a trained therapist conducts the sessions and observes the behavior of participants. Yet nothing in any statute or regulation or policy manual required the group facilitators to be licensed in California and legally qualified to provide therapy.

There was also little or no consistent tracking of meeting attendance by participants. Although program staff were supposed to be attending these meetings regularly in order to observe both participants and facilitators, there was little or no reporting by program staff on whether they were in fact attending them.

(3) Worksite Monitors

Sounds good, right? An impaired physician who is in the program, is in recovery, and who is deemed capable of working safely, is allowed to practice a certain number of hours per week, but only if he has a "worksite monitor" — someone (presumably a physician) who is non-impaired and can watch ("shadow") the participant while he or she is practicing medicine. Sounds great!

But the Medical Board never established any criteria for those people. No criteria saying the monitor had to be a physician. No guidelines forbidding someone who the participant hires and fires from being his worksite monitor. No criteria whatsoever saying that the monitor has to lay eyes on the participant X times per month, and/or talk to the participant Y times per month, and/or pop in unannounced. Nothing.

And worksite monitors were supposed to file quarterly reports to the program — some did; most did not. There was no standard format for the report; some were adequate and some consisted of one sentence. And we saw in many cases where the program increased the number of hours that a participant could work per week even though his worksite monitor had never filed a report.

This problem was identified in all three of the audits prior to mine — yet the program and the Board did nothing.

(4) Hospital Monitors

As to “hospital monitors,” the program insisted that participants who were allowed to practice medicine and who did practice medicine in hospitals had to have a “hospital monitor.” The program purported to work closely with the “well-being committee” in any hospital in which a program participant was practicing medicine — the committee of physicians that oversees physician conduct in that hospital. The program consistently insisted that hospital well-being committees were informed of and were in fact “partners” with the diversion program in monitoring a participant who practiced in a hospital.

But — again — the program never established any criteria for or qualifications of a “hospital monitor.” None. And we found out well after our project was over that, far from being a “partner” with the diversion program in overseeing practicing participants, well-being committees generally did nothing to monitor participants during the 27 years the program existed.

Much later, when the Board was considering abolishing the program, it was warned by hospital administrators that all well-being committee members would quit if they had to take any role in monitoring substance-abusing participants. That doesn’t sound like being a “partner” to me. Yet that is what the program had been saying for 27 years.

(B) No Internal Controls to Detect Failure of Monitoring Mechanisms

So the program’s major monitoring mechanisms were all failing. They were not consistently and adequately monitoring participant behavior.

The second aspect of our first finding was that nobody on the Diversion Program staff even knew that any of these problems were occurring, because the program lacked sufficient internal quality controls to alert staff to the failure of its monitoring mechanisms.

As to drug testing, for example, the Board was told — and we were told — that the program devoted a full-time employee to monitor the integrity of all aspects of the drug testing program. But when we interviewed her, she told us she devoted only two hours per month to overseeing drug testing. All she had time to do was generate the random schedule and send it out.

Nobody checked whether tests were actually administered on the random date. Nobody checked — even spot-checked — to see whether participants were being tested as often as they were required to be. There was no system — automated or manual or otherwise — to check whether the test results had been received and had been posted to the correct participant file.

(C) Chronic Understaffing of the Program

Even if those internal controls were there (and they were not), the third aspect of our first finding was that the program lacked sufficient staff to act on these problems and correct them. For its entire existence, the program had been chronically understaffed at all levels — management, administrative, analytical, clerical.

The program was funded solely by licensing fees paid by all physicians. Diversion program participants paid nothing toward the overhead of the program. Yes, they had to pay for their own drug tests and group meetings, but they paid nothing toward the program overhead. So staffing was minimal — there were approximately ten paid staff to monitor 275 doctors all over the state of California (which is the size of 13 east coast states).

The caseloads of the program's "case managers" — which were supposed to be at a maximum of 50 — soared to over 80 in some parts of the state, which is far too many. Did the program seek more funding so it could hire more staff? No — it decreased the case managers' monitoring activities in those areas, so participants in those areas were subject to even less monitoring.

Diversion program staff were so overloaded that they had no choice but to simply assume that all tests were conducted as scheduled, that all participants were tested as often as required, that all samples were accurately tested, and that all lab results were correctly returned to the program.

All they could do was to react — in hindsight — to positive drug tests. If they got no positive test results, they assumed everything was okay. Very frequently, however, everything was not okay. Very frequently, those assumptions were false in an uncomfortably large number of cases that we saw. Staff did not check, and the program had no internal controls to alert them.

These are very serious problems with the whole premise and indeed promise of the diversion program — the promise that these physicians with serious addiction problems were being adequately monitored to protect the public. In many cases, they were not — exposing patients to grave risk.

And patients were not the only ones who were at risk. As I mentioned, we read the files of 60 participants. In one of them, a participant was ordered by the Board to participate in diversion as a condition of probation. He was not tested at all for the first three months of his participation. The diversion program thought probation was testing him.

Probation thought diversion was testing him. Instead, nobody was testing him, and nobody knew that except the participant.

One night, the diversion program received a telephone call from an emergency room attending physician letting them know that the participant had been brought into the ER, passed out due to acute intoxication. That physician almost died because of the failure of the program's urine testing system. And that physician — at the time of his relapse — had a full and unrestricted license to practice medicine; and he was, in fact, permitted by the diversion program to practice medicine.

Finding #2: Neither the board nor the program established any enforceable rules or expectations for participants and staff.

The Diversion Program's statutes were skeletal at best. They set forth few enforceable rules, standards, or expectations for either the program or its participants. Its regulations were no better — they were mere regurgitations of the statutes. None of the monitoring mechanisms that I described — not the urine testing, not the worksite monitoring, not the group meeting attendance — were even mentioned in, much less governed by, any statute or regulation.

All of the monitoring mechanisms were contained in an unenforceable procedure manual that was rarely scrutinized by the Board (which was statutorily responsible for overseeing this program) or even the Diversion Committee that the Board set up during the latter years of the program's existence.

The program had no rules or expectations regarding consequences for relapse – no “three strikes and you're out” rule or anything approaching that. It had no standards for termination from the program. It had no rules to address what we called the “bites of the apple” problem — the repeated entry, failure, re-entry, failure, re-re-entry, and failure of doctors who were simply not able or willing to comply.

All of the prior audits pointed to these “missing standards” and directed the board to adopt them, but it never did.

Finding #3: The Board never took ownership of the program.

Contrary to the statutes, the Medical Board never took ownership of this program. As I mentioned, the Medical Board's diversion program was one of only four in the nation to be housed directly within a state medical board — subject to its direct supervision and oversight. Every other medical board, other than those four, contracts out the administration of its impaired physician program to the private sector.

One must assume that the purpose of this in-house structure was to enable the Medical Board to comprehensively oversee and supervise the program and its protection of the public. However, that did not happen. Instead, back in 1982 — a year after the program was created, the Board and the state's largest trade association of physicians, the

California Medical Association, decided to create an external “Liaison Committee to the Diversion Program” — a group of volunteer professionals (mostly addiction medicine specialists) whose careers focus on substance abuse detection, treatment, and rehabilitation, which would assist Board members (which usually did not include an addiction medicine specialist) and program staff (who were not doctors and certainly not addiction medicine specialists) in running this program.

While there may be certainly be a role for a group of volunteer professionals with this kind of expertise, it is clearly not to take over all of the policy decisionmaking concerning the diversion program. But that is, in effect, exactly what happened. The Medical Board — about a year after the program was created — simply punted the administration of the entire program to this committee of outside private addiction medicine doctors who were not members of the board.

About five years before the program was abolished, the Medical Board established a standing Committee on the Diversion Program, which met quarterly to discuss Diversion-related issues. The Board was trying to ensure that some board members had some idea how this program was supposed to work. However, that committee remained at the mercy of program staff in terms of the information that it received. And at no time did staff ever apprise that committee of any of the very serious problems that we found.

If you are a board member, ask yourself if you suffer from the same problem. Do you understand how your program works? When you ask the staff of your program a question, do you get a straightforward and acceptable answer?

Finding # 4: Isolation of the diversion program from the rest of the board

We found that the diversion program was completely isolated from the rest of the Medical Board. Its management had not been consolidated into enforcement management or into the management of the Board as a whole. The entire operation of Diversion had been walled off from the rest of the Board.

Clearly, the identity of self-referrals was to be kept confidential from the Board’s enforcement program. But that does not justify the complete isolation of this program from the rest of the Board’s management. Recall that the participation of the other two kinds of participants — board-referred and board-ordered participants — was already known to enforcement. However, there was little communication between Diversion and Probation — which should have been alerted immediately if a Board-ordered participant relapsed. And there was little communication between Diversion and Enforcement — which should have been notified if a board-referred participant relapsed.

This isolation contributed to the breakdowns that I have described — breakdowns that posed a risk not only to the public, but to the participants in the program, and which were not communicated to Medical Board management so that they might address these problems.

Finding #5: no evidence of long-term effectiveness

Finally, the Medical Board — for 27 years — spent well over \$1 million per year on this program, yet it had no idea whether it was effective in helping physicians recover from addiction.

This program did no postgraduate tracking of any of its participants, whether they terminated successfully or unsuccessfully. It did no tracking in any way. So it had no information on whether its physician participants are successfully practicing medicine today, or whether they have relapsed into drug and alcohol abuse, or whether they have died from it.

To my knowledge, no program does any tracking of that type.

Our 2004 Recommendations:

Despite all these problems, we did not recommend that the Board abolish the Diversion Program in our *Initial Report*. Instead, we made a series of sequential recommendations.

First, we recommended that the Medical Board reevaluate the whole “diversion” concept and whether it is feasible and consistent with the Board’s public protection mandate.

When the diversion program was created in 1980, the Board’s statute said that its highest priority, when exercising its disciplinary jurisdiction, was “physician rehabilitation” — so this program fit within that mandate. However, state law changed in 1990. In 1990, public protection became the Board’s highest priority. The statute also said that when public protection conflicts with some other interest sought to be promoted (including physician rehabilitation), public protection is paramount. That is state law. So we suggested that the Board reevaluate whether the diversion concept is consistent with that “new” mandate.

Second, we suggested that the Board reevaluate the location of the program: Should it continue to be located within the Medical Board?

It became very clear to us that the low participation rate (and the low rate of true self-referrals) meant that physicians were coming to this program as a last resort — after they had failed other programs, and after they had become the subject of a complaint or report or hospital disciplinary action.

Physicians generally didn’t want to come to a program that was part of the medical board — because they knew they were going to relapse (which is an expected and anticipated aspect of recovery), and the very last person they wanted to know that is someone from the Medical Board.

Third, if the Board wanted to keep this program in any way, shape or form, we suggested that sweeping and comprehensive reforms in a number of areas is required. Merely

increasing staff is inadequate. Obviously, an increase in staffing was necessary, but that alone would not do the trick. The program must install and staff internal control mechanisms to assure the Board, program participants, and the public that the program's monitoring mechanisms are effective in detecting relapse into drug or alcohol use.

The restructuring must include a consistent and respected program response to relapse, and the Board must figure out a way to address the "bites of the apple" problem that allowed physicians to repeatedly re-enter the program. The restructuring must also include the long-overdue adoption by the Board of meaningful criteria for acceptance, denial, and termination from the Diversion Program.

Fourth, we recommended that the Board address a number of other issues that had long been ignored:

(1) whether Program participation should be an entitlement for any and all impaired physicians in California, or whether its participation should be capped at a level that can be meaningfully monitored by the existing staff;

(2) how to adequately fund the program — the report made a number of recommendations in that regard;

(3) the Board must ensure that the management of the Diversion Program is effectively integrated into the management of the Board as a whole so that Diversion staff are knowledgeable of enforcement procedures, especially as those apply to participants who have been ordered into the program by the Board as a term of probation, or referred into the program in lieu of discipline; and

(4) finally, we recommended that if the program was retained, it should be subject to an external audit every five years. Under no circumstances should 18 years pass between external audits of this program.

Aftermath of 2004 Initial Report

As a result of the Initial Report, the legislature — in 2005 — imposed a June 30, 2008 sunset date on the program, and it required the Bureau of State Audits (BSA) to go back in and re-audit the Program during 2007. So, the legislature — in 2005 — gave the Board one last chance and two more years to address the problems that we and prior auditors had found. During that two-year period, the Board pumped a half a million dollars in additional resources into the program to improve it. During that time period, the program's budget increased from \$1.2 million annually to \$1.7 million.

Despite that, the Program then flunked BSA's 2007 audit. BSA confirmed what we found, and BSA confirmed that much of what we had found was still occurring 2.5 years later. A couple of the BSA findings:

(1) Two and one-half years after our audit, BSA found that drug tests were still being disproportionately moved from weekend days onto Tuesdays.

(2) BSA did a survey of some participants. Here is what one said about the program's random drug testing in 2007: "Mine wasn't very random. I was able to 'game it' for several years and I almost 'graduated' while still using."

(3) And even though the program had a policy that anybody who tested positive would be immediately removed from practice, BSA found that the program didn't do that. BSA tested a sample of 31 positive tests — of those 31, twelve were practicing medicine. Only three of those twelve doctors were immediately removed from work. Five others were removed from work within 2-14 days. Four of them were not removed at all. How does this protect patients? It does not.

Those are just a few of BSA's findings. You can read BSA's entire report at www.bsa.ca.gov.

After five failed audits in 27 years (and that was five out of five; not five out of ten or five out of twenty), and confronted with the testimony of some patients who had been injured by doctors while they were participating in the diversion program, the Medical Board unanimously decided in July 2007 not to seek an extension of the sunset date on the program.

As a result, the Board's program went out of business on July 1, 2008.

The Board was simply unwilling to continue parading around a program that was not capable of fulfilling its or the public's expectations, and whose existence threatened patients. In the Board's view, it was irresponsible to continue such a program. No program was better than a flawed and ineffective program in this area of grave patient risk. So it abolished the program.

There are several messages here. First, I am not here to tell you that this program never helped a physician in 27 years. It did. But our analysis of 60 program participant files revealed that it only helped that slim sliver of a minority who truly wanted to recover. It did not help those who did not want to be helped, and it did not monitor them adequately to protect patients. All it did for those physicians was to shield their participation from their patients and enable them to maintain both their licenses and their addictions, because it did not consistently or adequately monitor them while they were in the program.

A second message is that no one truly knows how an impairment program is operating, and no one knows whether an impairment program is operating effectively to protect the public, without an independent external audit to test the assertions of program staff.

Here in California, a new law enacted last year now requires an audit of the private vendor that administers the diversion programs at the boards regulating nurses, pharmacists, dentists, and other health care practitioners.

I hope that you subject your program to the test of an audit. If it's as good as you think it is, there is nothing to be afraid of.

Question: I am with the Maximus Assistance Program in California. During the last part of your presentation, you mentioned that relapse is expected. Are you saying there is documentation that every participant in a diversion program will relapse? Terrance Gorsky's nationally-known research indicates that two-thirds of chemically dependent people will relapse, but one-third will not.

Fellmeth: I don't know the answer to that question. I have read enough studies to know that relapse is expected. The sixty cases we looked at included the twenty most recent intakes into the program, the twenty most recent relapses while in the program, and twenty folks who had been in the program for five to seven years and were on the verge of graduating successfully. Of the twenty near-graduates, I do not recall any who had not relapsed at least once. My point in raising this is that the physicians who enter the diversion program are largely people who had flunked out of other programs. They had already tried and failed. They didn't want to go the medical board's program as a first resort because they knew they would relapse and the last person they want to know that is someone affiliated with the medical board. They are not sure how good a fire wall there is between the diversion program and enforcement.

Question: I think one of the reasons we are here is to create a model for the best possible program. You spoke about questions to ask about a program and items that should be in policy, operations and rules for a program. Could you send us a list of those questions and information about the audit process you utilized? You also mentioned quarterly reports of varying quality and length. It would be useful to have a model quarterly report.

Fellmeth: I am happy to post these remarks¹. If you are looking for a best practices suggestion from me, Patty Harris will speak later about legislation passed last year in California. Testimony was presented in connection with that legislation with which I tend to agree. The testimony was given by a person who runs a rehabilitation facility that stands to benefit from the abolition of the diversion program. His feeling is that participants should be continuously drug-tested. Not random, not once or twice a month, but continuously. There should be no opportunity for undetected use of alcohol or drugs. This might cost a little more, but it is the only way to ensure abstinence, which is what the program is after. Continuous drug testing combined with an agreement to surrender one's license for a year if there is a relapse. What happens after that is up to the practitioner – group meetings? AA? Testing? Psychotherapy? As Art suggested earlier, I am not sure that all of these personal decisions are really within the province of a regulatory board.

¹ This information can be found in the methodology section of the Enforcement Monitor Report at the "Major Publications" link at www.cpil.org.

Question: Since the diversion program has closed its doors, is there evidence that the public is better protected?

Fellmeth: My answer is that the public is no longer fooled into thinking that there is a program that is protecting them from substance-abusing physicians. Now, if the board receives a complaint or a report that indicates substance abuse, the board investigates and takes public disciplinary action as appropriate. The length of time this takes depends on the physician. If the physician knows her or she has a serious problem, the physician will stipulate. The terms of probation will include required drug testing.

The board is also moving in the direction of wellness -- preventing problems before they occur. They want to ensure that medical school students get education and training on wellness and preventing the burnout that so often accompanies medical practice. The board is working through hospital well-being committees to try to prevent problems before they come about rather than monitoring the behavior of physicians on a case-by-case basis in this huge, huge state.

Comment: I am one of the patients who testified before the Medical Board of California in 2007 when the diversion program was abolished. At that time, we told the medical board to either contract with an independent provider or law enforcement to oversee the diversion program, or completely abolish it.

In my case, my doctor was enrolled in the diversion program twice, but failed miserably. His own office manager was his work site monitor. This doctor tested positive many times for alcohol and his monitor lied about the physician attending AA meetings. During the time he was in diversion, he was arrested in a DUI accident while on his way to see a patient in the hospital. His license was not revoked that time. It took almost seven years for his license to be revoked, and not for patient care, but for lying to the board.

Question: I am a voluntary coordinator with North Carolina Caring Dental Professionals. In North Carolina, we require our participants to attend not only the required AA meetings and NA meetings, which can be as many as three or four a week, we also require professionals group meetings. Although many people are resistant to AA, they tend to “see the light” and understand that recovery is about building relationships. Why would it not be legal to require someone to attend AA or NA?

Fellmeth: There is a problem with a state requiring people to attend AA or NA because those programs have religious overtones and the U.S. Courts of Appeals have held that it is illegal for a state to require a doctor or nurse to attend AA or NA meetings if that person objects. The state has to offer an alternative.

The California medical board had requirements like the ones you describe in North Carolina. The problem is that attendance at those meetings is anonymous. The physician referred to by the previous commenter had his office manager approved as his work site

manager and the physician required her to attend the AA meetings and sign his name as if he were attending.

Comment: In North Carolina, the monitors attend the meetings with the program participant.

Comment: I am the medical director of the Oregon Health Professionals Program and past-president of the Federation of State Physician Health Programs. I appreciate your presentation and I think you have pointed out many flaws that are possible in a diversion program. I often say that if you have seen one physician health program, you have seen *one* physician health program. Each of us in this room has a concept of what we are talking about, and probably none are the same.

One of my big concerns is that the California program did not have medical direction. It has volunteer physicians overseeing it. The qualifications of personnel are very important.

I think we need a common language. In developing its own guidelines, the federation emphasized the concept of prevention: primary prevention, secondary prevention and tertiary prevention. Primary prevention in physician health is education, physician well-being committees, early intervention, stress relief, and so on. California is emphasizing this. Secondary prevention is the physician health programs. Somebody is in trouble, but there is not yet a complaint at the medical board. There is not necessarily patient harm. Tertiary prevention, to me, occurs after there has been patient harm and a complaint. I see California having tertiary prevention now. What has been lost is secondary prevention.

My understanding is that when the diversion program closed down, any participant with two years of sobriety was discharged, those with three years of sobriety were considered to have successfully completed the program. Anyone with less than two years sobriety was referred elsewhere. There is no longer any monitoring of people who would have been monitored for three years if the program had remained in operation. I don't believe this is public protection. We need to develop a seamless system from primary to secondary to tertiary prevention.

Fellmeth: I'm not from the medical board; I work for the University of San Diego School of Law. I wouldn't say there is no monitoring and I wouldn't say that the board waits until there is patient harm to impose monitoring. The board still receives DUI arrests, DUI convictions, and complaints about substance abuse from spouses, hospitals, patients, and others. The board still investigates those cases and either takes public disciplinary action or enters into a stipulation requiring drug testing. The board is working to beef up its oversight of potentially substance abusing physicians. But, at this point, having been stung for so many years by an under-performing program and five failed audits, the board does not want to be in the business of overseeing the behavior of individual physicians any more.

Comment: I am a member of the Medical Board of California (its secretary) and a member of the board of the Federation of State Medical Boards. It is hard to sit here and listen to our failings. I got on the board when the Enforcement Monitor's report was issued. We talked about the diversion program at every meeting. It was a system that didn't work, so we closed the door. But, the legislation being discussed by the next speaker may provide a framework for a better program.

Fellmeth: Senate Bill 1441 which was passed in 2008, requires the executive officers of all health care boards to form a committee to fashion standards in areas where the medical board's program lacked standards, such as drug testing, worksite monitors, hospital monitors, group meeting attendance, termination from the program, and appropriate response to relapse. Standards in these areas were lacking at the medical board and other health care board diversion programs, or they are inconsistent from board to board. The idea is to come up with consistent uniform standards that will be used by all the health care boards in California.

Comment: There is a bill in the legislative process, AB 526 by Assembly Member Fuente and sponsored by the California Medical Association, which would re-establish a program for physicians that would be strictly a monitoring program. It would not be run by the medical board, nor would it report to the medical board unless it found a problem.

Fellmeth: There are thousands of companies in California – for profit and nonprofit – that provide monitoring, testing, and rehabilitation services. Those are all available to health care practitioners. It is not clear to me why the State of California, through a regulatory board, has to be intimately involved in someone's personal recovery, especially when that is not always measurable short of 24 hour monitoring and continuous testing.

Question: I was on a diversion evaluation committee for California's physician diversion program for eight years. Please address the use of a temporary restraining order to prevent physicians, nurses, and others who are a threat to public health and safety from practicing in the state. Why is this tool used so rarely?

Fellmeth: Temporary restraining orders are very difficult to get. They have to be obtained from Superior Court where judges generally have little experience deciding occupational licensing matters. In 1990, my organization helped draft a bill creating an alternative mechanism which is very similar to a temporary restraining order. It is called an interim suspension order (ISO). In 1990 it was created for the medical board and because of its success it is now used by other boards. An ISO suspends a practitioner's license pending the conclusion of a disciplinary action, which could take two years. It is still very difficult to get. The AG's office and the affected board need evidence of active use and preferably active use while practicing, but it is hard to get professionals to testify against one another. If the evidence is there, the professional will usually stipulate to a suspension because they don't want to go through a public proceeding. If the evidence is not there, they can't get it.

Question: I have been the medical director for the Missouri Physician's Health Program for nearly twenty-five years. I am a board-certified psychiatrist certified in addiction medicine. I have a fulltime program coordinator. Our program operates under the state medical association, not in any way beholden to the legislature, the board of healing arts, or any other entity except the medical association. The association has instructed us that if we ever confront a conflict between the medical association and something we think is appropriate for us to do, we are to tell the medical association to leave us alone. Therefore, we have a free hand to do what we consider necessary and appropriate.

The Joint Commission that does external audits at hospitals and some out-patient facilities. Do you yourself, or do you know of an entity that does such audits of physician health programs?

Fellmeth: I don't know of organizations that do this for a fee. In California, there was a competitive bidding process and I submitted a proposal and was chosen. We have state auditors who can audit state programs, but as I understand it, yours is not a state program funded through physician licensing fees, but you do receive referrals from the Missouri Board of Healing Arts under a memorandum of understanding and you report back to them if there are problems.

Levin: Returning to the question about whether patients are any safer now in California. This is a legitimate question, but we also have to take seriously, from a consumer standpoint, what the state's fiduciary, moral, and ethical responsibility is to consumers. A license on the wall, rightly or not, is taken by ordinary patients to mean that the state is doing something to protect them from harm by ensuring that this is a competent, unimpaired practitioner. If it doesn't mean that, why bother to license? So the state does have a responsibility when it discovers that its own program fails to adequately measure the ability of doctors to perform high quality safe patient care because of impairment.

Part II – Legislative Perspectives:

Creating Standards and Audits for Impaired Practitioner Programs

Patricia Harris, Acting Chief Deputy Director, State of California Department of Consumer Affairs

The Department of Consumer Affairs is the umbrella agency for about forty regulatory agencies. I have been with the department for thirty-five years and with the Board of Pharmacy for twenty-five. I was there when the pharmacy board's diversion program started.

Senate Bill 1441, which was mentioned by the previous speaker, became effective in January, 2009. It created a Substance Abuse Coordination Committee of which I am the chair. The committee is comprised of eighteen executive officers from the Department of

Consumer Affairs plus the executive officers of the Boards of Chiropractic Examiners and Osteopathic Medicine, and the medical director of the Department of Drug and Alcohol Programs. It is unprecedented in California to have a committee of twenty-one executive officers developing standards.

The committee is charged with developing sixteen standards that all regulatory boards are to use in relation to programs for licensees who are abusing drugs or alcohol. The standards will apply whether or not a board has a formal diversion program.

The medical board had the first program in California, created in 1980. Six other boards followed. Diversion programs were created through statutes. Typically they divert a licensee from enforcement into a confidential program. If the licensee successfully completes the program, no information is provided to the public.

Background

When the medical board started its program in 1980, it was an in-house program administered by civil service employees. Drug diversion evaluation committees throughout California developed and approved the contracts for treatment, monitoring and rehabilitation of the licensees.

The dental board was the next to start a program in 1982. Board of Registered Nursing and Board of Pharmacy had legislation pending in 1983. The nursing board followed the medical board model. The pharmacy board had a public member who ran treatment programs, so its legislation called for the board to contract with an employee assistance program.

When I was at the pharmacy board, legislators raised concerns about public protection. They didn't want pharmacists to be able to hide behind the diversion program. The pharmacy board called its program the pharmacist's *recovery* program. The board investigated all its cases rather than referring them from enforcement. Pharmacists could also access the program voluntarily. As with the medical board, many self-referrals were what we call "board informals." They knew the board was investigating them, so they enrolled into the program. If a pharmacist who had entered the program voluntarily left the program and the vendor determined there was a potential for public harm, the vendor notified the board and it initiated action.

The vendor was focused on rehabilitation and being sure the licensee was complying with his or her contract, so if a case reached the point where discipline was called for, the vendor was concerned about being punitive. So, many of the orders were "revocation stayed" or some type of suspension. Nine out of ten times, the pharmacist did cease practice voluntarily while in treatment. Many were concerned about retaining their licenses so they didn't want to return to practice until the issue was resolved. So, the board gave them credit for taking themselves out of practice and mandated that they enter the recovery program where the board could monitor them.

The other programs created subsequently were osteopathic medicine in 1989, physician assistants in 1990, and physical therapists in 1991. Healing arts boards that do not have recovery programs but instead deal with their substance abusing licensees through enforcement are: acupuncture, behavioral sciences, chiropractic, occupational therapy, optometry, podiatry, psychology, respiratory care, speech-language pathology & audiology, veterinary medicine, vocational nursing, and psychiatric technicians. The medical board now belongs to this group. As Julie said, the medical program underwent a lot of scrutiny that highlighted ongoing problems so the board voted not to seek legislation to continue the program.

SB 1441 and the Substance Abuse Coordination Committee (SACC)

In 2008, the Senate Business, Professions and Economic Development Committee held hearings to review all the health board substance abuse programs. The chair of the committee, Denator Ridley-Thomas authored SB 1441 which created the Substance Abuse Coordination Committee (SACC) and identified sixteen standards for the committee to develop.

Committee meetings are subject to the Bagley-Keene Open Meetings Act. The committee formed a working group of staff from the boards which is drafting the standards. Based on comments from the public and discussions with interested parties, the working group re-works the language in time for the next SACC meeting.

The first six standards have been drafted and reviewed by the committee. The committee has some concerns that will be communicated back to the working group, but today I will talk about the June 2 version. The Department Web site has an analysis of the standards, the comments that were received and the work group recommendations.

Draft Standard # 1

Per the instructions in SB 1441, Standard # 1 shall contain specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee; specific requirements for a clinical diagnostic evaluation of the licensee, including but not limited to, required qualifications for the providers evaluating the licensee.

The June 2 draft Standard says that if a board determines that a clinical diagnostic evaluation is necessary in order to evaluate whether practice restrictions or other actions are warranted, the following minimum standards shall apply:

The clinical diagnostic evaluation shall be conducted by a licensed practitioner who:

- Holds a valid unrestricted license to do so,
- Has three years experience providing evaluation of health professionals with substance abuse disorders, and
- Is approved by the board.

The clinical diagnostic evaluation shall be conducted in accordance with acceptable professional standards for conducting abuse clinical diagnostic evaluations. The report shall include:

- Whether the licensee has a substance abuse problem,
- In the evaluator's opinion whether the licensee is a threat to him or herself or others, and
- In the evaluator's opinion recommendations for substance abuse treatment, practice restrictions, and other recommendations related to licensing, rehabilitation and safe practice

The evaluator may not have a financial relationship, personal relationship or business relationship with the licensee. The evaluator shall provide an objective, unbiased and independent evaluation. If the evaluator determines during the evaluation process that a licensee is a threat to him or herself or to others, the evaluator shall notify the board within twenty-four hours of subject determination. For all evaluations, a final written report shall be provided to the board no later than thirty days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation and it is not to exceed ninety days.

Draft Standard # 2

Per the instructions in SB 1441, Standard # 2 shall contain specific requirements for the temporary removal of the licensee from practice to enable the licensee to undergo the clinical diagnostic evaluation, any treatment recommended by the evaluator and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

The June 2 draft Standard says the board shall determine on a case-by-case basis whether the licensee shall be temporarily removed from practice to undergo the clinical diagnostic evaluation and any treatment recommended by the evaluator. The board may utilize any statutory provisions or other authority for temporary removal of the licensee.

Specific requirements for temporary removal of the licensee from practice shall be determined on a case-by-case basis by the board using the following criteria:

- The license type,
- The licensee's history,
- Documented length of sobriety,
- Time that has elapsed since substance use,
- Scope and pattern of use,
- Treatment history,
- Licensee's medical history and current medical condition,
- Nature, duration and severity of the substance abuse, and
- The threat to him or herself or the public.

These same criteria shall be used by the board to determine whether to permit a licensee to return to practice on a part-time or full-time basis.

Draft Standard # 3

Per the instructions in SB 1441, Standard # 3 shall contain specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status and condition.

The June 2 draft Standard says that if the licensee has an employer, he or she shall provide the name, physical address and telephone number of all employers and shall give specific written consent that the licensee authorizes the board and the employers to communicate regarding the licensee's work status, performance, and monitoring.

Draft Standard # 4

Per the instructions in SB 1441, Standard # 4 shall govern all aspects of required testing, including, but not limited to:

- Frequency of testing,
- Randomicity,
- Method of notice to the licensee,
- Number of hours between the provision of notice and the test,
- Standards for specimen collectors,
- Procedures used by specimen collectors,
- The permissible locations of testing,
- Whether the collection process must be observed by the collector,
- Backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing,
- Requirements for the laboratory that analyzes the specimens, and
- Required maximum timeframe from the test to the receipt of the result of the test.

The June 2 draft Standard says that licensees shall be tested no less than eighteen times per year for the first three years of continual abstinence. After the first three years, licensees shall be tested no less than twelve times per year.

The scheduling of tests shall be done on a random basis, preferably by a computer program or as directed by the board. Licensees shall be required to make daily contact to determine if testing is required. Licensees shall be required to test on the day of notification as directed by the board.

Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation (DOT). Specimen collectors shall adhere to the current U.S. Department of Transportation specimen collection guidelines. Testing locations

shall comply with the urine specimen collection guidelines published by the U.S. Department of Transportation regardless of the type of test to be administered.

Collection of specimens shall be observed. Prior to vacation or absence, alternative locations must be approved by the board.

Laboratories shall be certified by the National Laboratory Certification Program or the equivalent in other countries. A collection site must submit a specimen to the laboratory within one business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven days of receipt of the specimen. The appropriate board will be notified of non-negative test results within one business day and will be notified of negative test results within seven business days.

Draft Standard # 5

Per the instructions in SB 1441, Standard # 5 shall govern all aspects of group meeting attendance requirements including, but not limited to:

- Required qualifications for group meeting facilitators,
- Frequency of required meeting attendance, and
- Methods of documenting and reporting attendance or nonattendance by licensees.

The June 2 draft Standard says that if the board determines that a licensee must attend group meetings or support groups (including AA and NA), the following standards shall apply. When determining the frequency of group meeting attendance, consideration shall be given to the following:

- The licensee's history,
- The documented length of sobriety time that has elapsed since substance abuse,
- The recommendation of the clinical evaluator,
- The scope and pattern of use,
- The licensee's treatment history, and
- The nature, duration and severity of substance abuse.

The licensee shall be required to submit to the board at least once a month documentation of attendance at the group meetings, signed or initialed by a representative of the meeting organizer.

If the board determines the licensee must attend a group meeting facilitated by an individual who reports directly or indirectly to the board, in addition to the requirements above, the following standards shall also apply:

- The meeting facilitator must have a minimum of three years experience in the treatment and rehabilitation of substance abuse,

- The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee.
- The documents showing attendance must be signed by the group meeting facilitator and must include the licensee's name, the group name, the date and location of the meeting, and the licensee's level of participation and progress in treatment,
- The facilitator shall report any unexcused absences within two business days.

Draft Standard # 6

Per the instructions in SB 1441, Standard # 6 shall be used to determine whether inpatient, outpatient, or other type of treatment is necessary.

The June 2 draft Standard says that in determining whether inpatient, outpatient, or other type of treatment is necessary, the board shall consider the following criteria:

- Recommendation of the clinical diagnostic evaluation pursuant to Standard # 1,
- The license type,
- The licensee's history,
- Documented length of sobriety time that has elapsed since substance abuse,
- Scope and pattern of substance use,
- Licensee's treatment history,
- Licensee's medical history and current medical condition,
- Major duration and severity of substance abuse, and
- Threat to him or herself or the public.

At its July meeting the SACC will consider these draft standards. Meanwhile, there are ten additional standards called for in SB 1441:

Standard # 7 will deal with worksite monitoring requirements and standards, including but not limited to:

- Required qualifications of worksite monitors,
- Require methods of monitoring by worksite monitors, and
- Required reporting by worksite monitors.

Standard # 8 will deal with procedures to be followed when a licensee tests positive for a banned substance.

Standard # 9 will deal with procedures to be followed when a licensee is confirmed to have ingested a banned substance.

Standard # 10 will deal with specific consequences for major and minor violations.

Standard # 11 will deal with criteria a licensee must meet in order to petition for return to practice on a full-time basis.

Standard # 12 will deal with criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

Standard # 13 will govern when a board uses a private-sector vendor to provide diversion services and will include:

- Standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation,
- Standards for the vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors,
- Standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services, and
- Standards for a licensee's termination from the program and referral to enforcement.

Standard # 14 deals with the extent to which licensee participation in a diversion program shall be kept confidential from the public when a board uses a private-sector vendor to provide diversion services.

Standard # 15 deals with a schedule for external independent audits of a private-sector vendor's performance adhering to the standards adopted by the committee.

Standard # 16 deals with measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

The SACC is scheduled to present these uniform standards to the legislative committee by January, 2010. Each board will begin compliance with the standards after that date, either by statute, regulations, or guidelines.

Question: In relation to the requirement for observed screening, our program uses First Lab which tells us that because of the new standards for observed screening, they will no longer provide the service us. Are you experiencing a problem obtaining observed screenings?

Harris: This has not been a problem in California.

Comment: We have observed screening for men and women in North Carolina, but we do not use First Lab.

Question: Have you had someone familiar with DOT collection standards look at whether you will be able to use observed collections on the first round? The DOT regulations were designed to give the benefit of the doubt to the general population being screened. It was set up as a deterrent program, not a clinical program. My understanding

is that observed collections were allowed if there was a dilute or a problem with the initial collection. Quest doesn't do observed collections, so it is a problem to find collection sites in Oregon. Also DOT standards require that a medical review officer review the tests.

Comment: I was the director of the DOT Workplace Drug Testing Program and Policy Office during the writing of the DOT regulations. The framework for DOT drug testing regulations is extraordinarily different from the framework of drug testing in the context of diversion or treatment or post-rehabilitation monitoring. Many of the standards established under the DOT rules, such as chain of custody documentation, collection procedures, laboratory certification, standardization of the use of cut-offs, etc., are valuable in a post-rehabilitation or diversion program.

However, I caution you on two things. One is that the DOT program was only targeted at illicit drug use. So, for example, your one standard says laboratories must be certified by the National Laboratory Certification Program of the Department of Health and Human Services. That program only certifies quality controls and inspects laboratories for their procedures related to the testing for heroin, cocaine, amphetamine, methamphetamine, etc. None of the prescription drugs ranging from the phentolols to the opioids or synthetic opioids are part of that program.

With regard to the comment about direct observation collections, it is true that the DOT recently had to undergo a court challenge that was decided last week. DOT recently attempted to make direct observation procedures more invasive by requiring a disrobement in front of a same-gender observer. They also attempted to make direct observation mandatory for all collections where the person has returned to duty after treatment.

Based on my knowledge of state laws, I think it may be difficult in some states to impose direct observation for urine collection where there has not been a documented attempt to defraud, cheat, or otherwise manipulate a previous collection.

Also, I think would be valuable to your programs to have a physician trained in the medical review and interpretation of test results to look for things such as fluctuations in specific gravity levels, ph measurements, and the quantitative result of prohibited substances in relationship to prescribed or other authorized use.

My final comment is that while I agree that urine drug testing has been the gold standard for forensic or workplace testing, I think it is time for these programs to consider other alternatives. Particularly, I was struck by Ms. Fellmeth's comment about doing continuous testing. Also, you might consider other types of specimen matrixes that have longer windows of detection, such as hair testing, and use them in conjunction with a urine drug test.

Question: I have not heard of any program model that is not board-run. Why is it, after the cancellation of the California medical board program, that we keep re-inventing the same bad wheel? Why are not other alternatives being considered?

Harris: We have eighteen different boards running programs. Some don't have any type of diversion and treat substance abuse under enforcement. The six that do offer diversion will be audited when the standards are developed to determine whether it is viable to continue with them. Some of the boards that have programs truly believe that the programs provide public protection.

Question: In draft standard # 6, you say the board will take into consideration the clinical diagnostic evaluation in addition to several other factors. From my experience, all of the additional factors are part of the diagnostic evaluation. So, in what scenario would a board ignore a clinical diagnostic evaluation recommendation and make its own decision?

Harris: I am not sure they would.

Comment: In response to an earlier commenter, all board programs have not failed. California's program failed. The unfortunate side effect of a dialogue such as this that it concentrates so much on the failure of one program that it implicates all other programs. There are more than one hundred alternative to discipline and monitoring programs in this country, most of which are good, successful, competent, reliable, safe, and public-protecting programs.

Question: I will confine my remarks to California. If one program failed in California, why are other boards pursuing the same model?

Harris: Boards definitely make an effort to fulfill their mandate to protect the public. The legislature didn't ask us to abandon the programs. They asked for standards and programs audits.

Question: I am the medical director of the licensed professional program and clinical diagnostic evaluation program at the Betty Ford Center. I am a clinician and a patient advocate. After thirty-five years of family medicine, my patients now are primarily healthcare and other licensed professionals. I am always concerned about a forum like this because I see people settling into their battlements. After discussion with many of my colleagues here, I don't think we are at cross-purposes at all. I find the history of the injured patients who spoke up shameful and I am embarrassed by stories like that. We'll do everything we can to keep a bad physician from practicing medicine. We will do everything we can to treat sick physicians.

Sometimes our clinical diagnostic evaluations are questioned by a regulatory board. Sometimes, the board may think someone should not go back to work when we think he or she is safe, or vice versa. We have been at odds on a few occasions, but most the time our recommendations are taken. Unlike Mr. Levin, who mentioned that he isn't an

alcoholic, I am an alcoholic in recovery. I know that I owe my life to a process that allowed me to get help early in my disease process. Without that opportunity, physicians like me will just go underground and the disease will smolder in malignant denial, shame, hopelessness, despair, until it has progressed so far it risks causing a horrible adverse patient outcome.

I want to emphasize that you do great work – all of you patient advocates. The California diversion board was broken and needed to be fixed. I'm not sure we should have thrown the baby out with bathwater. The VA system was fixed after they found from an audit that it wasn't working well. We need to have a process where the physician who has yet to be identified by bad outcome has the opportunity to get help. Once they are patients, they deserve treatment.

Comment: From the point of view of a member of the California medical board, we are a failed program looking for guidance from all of you to help us to build a new program. We have 120,000 physicians and only 250 of them participated in the program. How can we increase participation? What can we do to make our program work in the future?

Harris: We hope that the standards the committee is developing reflect the best practices for determining how best to assure that a licensee is practicing appropriately. We hope to learn from this discussion. Each board's program is different. Each profession faces different challenges. Access is different. It is expensive to go into a recovery program. Licensees pay fees for treatment, testing, probation monitoring, etc. Boards have to be actively involved and work with the vendor to ensure it is adhering to the board's expectations.

Why Legislators and the Public Question These Programs

Nancy Achin Audesse, President, Federation of State Medical Boards (FSMB) Research and Education Foundation

I have been asked to talk about three things: (1) what legislators know, want to know, and don't know about medical regulation in general and about impairment programs specifically, and (2) what we all need to do to have an impact, and (3) what the Federation of State Medical Boards' Foundation might do.

One of my favorite observations about politics is that "Politics is the air that the beast of government breathes." We cannot separate politics from governmental processes, whether it is regulatory, administrative, or anything else. Maybe we wouldn't want to even if we could. What we can do is improve the air quality. We can remove the pollutants of ignorance and self-interest and we can make the air that sustains the beast of government healthy and productive.

The first step in cleaning up the environment is to educate everyone on the dangers of the pollution. We need to make the case that we can accomplish our goals without incurring

unreasonable societal costs. How do we get legislators' support without unreasonable cost to them? We need to make achieving our goals the same as victories for them.

What Motivates Legislators?

For elected officials, success means: getting support from constituents and political supporters, getting positive media coverage, and most important, getting re-elected. We are not the only people who are trying to motivate and influence elected officials. We have to understand where they are getting information and what they are going to do with it. For the most part, when we talk about issues such as this, we need to remember that legislators know absolutely nothing about state medical boards, physician health programs, or anything even tangentially related -- unless and until there is a disaster in their district. Neither does the average citizen doesn't know anything about what we do.

How do we go about getting public support and understanding in order to gain legislative support? We need to engage the public. That is one more reason why CAC is important to what we do and why having public members on regulatory boards is so important. I think it says a lot that the California medical board has its public member here learning about the voice should be on these issues.

Who do legislators listen to? They listen to the constituents. That's what they were elected to do and that is how they get re-elected. A single fanatical (meant in a good way) voter in a district can really move an issue. We had a case when I was the Executive Director of the Massachusetts medical board in which parents lost a daughter through what they thought was neglect. The board determined that it was actually a systems problem, rather than individual physicians, but instead of abandoning these people, we worked together and drafted legislation that would help to address some of their concerns going forward. Sometimes people in government ignore angry citizen calls rather than viewing the situation as an opportunity to do better for people and for the future.

On the other side of the coin, some physicians have the support of their patients, no matter what the board concludes about their performance, and legislators experience that pressure also because those patients are making phone calls.

The other thing to know about legislators is that every morning they and their mothers do the same thing: they read the paper and look for their name. They don't care about the economy unless it means votes. They don't care what is happening in Iraq unless they are on that committee. Especially at the state level, they care whether their name is in the paper. Secondly, they care if something big happens in their district.

What do legislators do with information? They do a political analysis of how it will play in their districts and what it is going to cost them politically. If I were a legislator with the Betty Ford Clinic in my district, I would enthusiastically support treatment programs because one of them employs so many of my constituents.

The biggest challenge facing those who wish to raise the quality of our public discourse would be this: As the newspaper industry continues to suffer financially, the situation will only get worse because there is so much competition for a limited number of readers and advertising dollars. Only what sells gets covered.

I Googled the words “doctor” and “addicted” to see what would come up. There were no really meaningful scholarly debates. An article entitled “Arizona Medical Board Nabs another Drunk Doctor” sensationalizes the story as much as possible with the headline and graphics. This will affect your conversation with legislators.

“Drunk Doctor Gives Epidural” is another article. In this case, the board considered keeping the doctor out of practice for eighteen months. This story now lives forever on the Internet. I think this makes people believe the problems are even more prevalent than they really are. So, we need to think about capturing real numbers and talking with policy makers about real facts.

I read the other day that the number one syndicated TV show is “House,” the story of a dysfunctional, patient-despising, drug-popping doctor. The hottest new show about to come on is about an addicted nurse.

Another article found by Google refers to the California medical board as, “The notoriously secretive state board.” This will become a common assumption, but where is the documentation to show that the board is “notoriously secretive?” Granted, we should be discussing how much confidentiality surrounding a diversion program is appropriate, but pejorative statements without factual backup are not helpful to the debate. I don’t think that complete anonymity from regulators will ever have public support. The public doesn’t trust their state nursing or pharmacy or medical board to do a good job anyway, let alone without complete information.

Another factor that I think is driving much of the policy making is celebrity media making statements, such as the one made by Anderson Cooper in a story about a diversion program, “Nothing could have prepared me for what (injured patients) revealed.”

How Can Advocates Have an Impact?

The issue is not sensationalism. The real issue is how do we protect patients from dangerous doctors and dangerous situations? How do we get other professionals to report these people? We have to find fair, equitable, effective paths to solving this problem.

Another thing that interferes with having intelligent discussion of the topic is celebrity patients. These stories do often drive immediate and not always well-thought out legislative responses. Other than losing an election, what do politicians hate the most? Surprises. Officials need to be prepared with facts to lower the temperature of the discussion when there is a story about a celebrity patient.

Here's a possible approach to take: "Senator, by law, I am not allowed to give you details at this time, however, I want to tell you that I got a press inquiry from the big newspaper in your district. Here are some of the facts I can tell you. There has been an allegation about a drunk doctor injuring a patient. The hospital is aware of it. The board is going to deal with it. I can't give you the details of the case. I have, however, prepared some talking points for your staff about what a diversion program is, how we handle things, the number of physicians in your district, and other statistics. Is there anything else I can do to be helpful?" So, instead of being panic-stricken about a problem in your district that's going to upset the chairman of the health care committee, you have opened up a dialogue and demonstrated that there are facts that can drive the decisions.

Even in the absence of a big story in their district, you could say, "Lots of people are talking about the such and such case, would you like me to prepare some talking points for you about what medical regulation in this state? Use it as an opportunity to inform and drive the debate.

Another thing that will drive the political process is the Internet. I would hope we could help legislators by informing them which Web sites in our fields are reliable and valid.

Consider a Web site entitled "The Texas Medical Board: Now With Slightly Less Corruption." It claims the board is engaged in "witch hunts" and "sham peer review" and that it violates "due process." How credible is this? But people visit the site. How many of them click to the third page to see that another real concern of the author of the site is the birthrate among young Latina Catholics?

The biggest threat or opportunity, depending on how you look at it, to confidential physician health programs is the fairness and equity issue. People don't understand why so many people in occupations that have a potential to impact others do undergo rigorous testing, but this does not apply to physicians.

If I were going to apply the testing that transportation workers undergo to the health care professions, I would start with pre-employment testing. I would do post-accident testing after any adverse or sentinel event. I would conduct random testing and I would test when there is a "reasonable suspicion." As hard as it is to report a colleague, if patients are in danger, it must be done.

We are the experts and we do have some quality research. But, we aren't getting the message across because we are not putting it in a format that is useful for legislators to use. We can fund and support more research. We can identify best practices. We can approach legislators to improve statutory authority instead of having them approach us. We can debunk bad information. We must engage the public.

I actually think the California medical board deserves a lot of credit. I don't know that any program – state-run, not state-run – would come out smelling like a petunia with the

kind of scrutiny the California board experienced. We can all learn from their experience and admit that we can do better.

The FSMB Foundation's Plans

The FSMB Foundation is going to be issuing some RFPs to find out what does work, what are the best practices, so we can work with state medical boards and other groups to make those things happen. We will run anything we do regarding public input through CAC, so you can check the CAC Web site.

We will work with our corporate parent, the Federation of State Medical Boards to strengthen the role of public members. Doctors or nurses or other professionals saying that their colleagues with substance abuse problems should be in confidential diversion programs does not carry water with legislators. They want to hear from patients why it is a good idea. They want to hear from the public.

The Chairman of the Federation has just engaged the foundation to do research to develop specialized training opportunities for state medical board public members so they can go out and fight for this type of progressive change, fight for what patients need to be safe and fight for what is fair and reasonable. He is also supporting additional funding to support the work of public members of state medical boards so they can come to more meetings and get more scholarships and be the voice they should be for patient protection.

Question: The 36-year old love of my life died three days after elective surgery. Neither the doctor nor the hospital told me a cause of death. The doctor lied to me. He said the surgery was successful. How do I know it wasn't? What I learned after I hired my own pathologist and called in the coroner was that there were surgical errors. There was a perforation. Infection set in and he died of sepsis. The night before he died, the doctor claimed he had visited the patient at 2:00 am and told me the patient was progressing normally, so the doctor left the hospital. When the medical records were reviewed much later, it was clear that the patient was in organ failure.

Three years later, during a legal proceeding, I discovered that the doctor had an arrest record over a ten-year span, including felony possession of crack cocaine. This doctor is still practicing. I submitted two autopsy reports, coroner confirmation, arrest records, and a list of other patients who had been hurt by the same doctor. The medical board wouldn't even open an investigation. How can this be?

Achin-Audesse: I believe a complete investigation should occur after any significant adverse event, such as an unexpected death. I also think hospitals should have systems in place to identify the indicators of sepsis. This sounds like a matter that is bigger than just one doctor.

Part III – Board Oversight – Two Case Studies

Case Study: North Carolina

Kay McMullan, Associate Executive Director of Programs, North Carolina Board of Nursing

I am going to talk about the accountability of the North Carolina Board of Nursing's alternative program to our board and to the public. I believe we have an excellent program and I stand behind it 100%, but considering what has been said today and all that I have learned in the last few months, I am sure we all have many opportunities for improvement, whether our programs are board-operated, committee-operated, or free-standing contracted programs.

We are an independent board of nursing. At the end of December 2008, we had 110,000 nurses employed in the state and about 130,000 nurses licensed in the state.

Background of the Program

In 1993, our board decided to start an alternative program for chemical dependency. Why? The chief nurse administrators across the state urged the board to do something about chemically dependent nurses. Also, the North Carolina Nurse's Association had a peer assistance program, but they needed funding and they only addressed the needs of Registered Nurses, ignoring Licensed Practical Nurses. Plus, other states were creating alternative programs at that time.

The board looked at different types of programs and decided it wanted a board-run program. The reason was that our priority is public protection. If, at the same time, the board can be an advocate for chemically dependent nurses and give them an opportunity to deal with the disease, that's fine, but we are not therapists, we are not your friends, we are regulators.

The board created an advisory committee consisting of an addictionologist, a recovering nurse who has been through the program, representatives of the law enforcement agency, the treatment program, and an employee assistance program, a nurse administrator and a board liaison. The advisory committee meets annually and makes recommendations to the board. The staff presents to the committee our statistics, our evaluations, our concerns and our questions. The advisory committee makes recommendations based on their expertise in the area of chemical dependency.

What Makes our Program Distinct?

Overall, we do the same things every other program does – screenings, 12-step meetings, and so on. There are some things that make us different. First, when a licensee signs our contract, he or she admits to having violated the nursing practice act. This gives the

board the authority to demand that they immediately surrender their license for one year if they relapse or otherwise violate the contract.

Also, we tell participants that privacy is maintained, but confidentiality is not assured. We do not have a statute granting total confidentiality, and our board did not seek one. To show the contrast, last week I contacted another program about a nurse who wanted to move to North Carolina who admitted she'd been ordered by her board to enter the rehabilitation program, but had relapsed repeatedly and then let her license expire. The other board's license validation system showed nothing; the National Council of State Boards of Nursing data base showed no action against the license. The state said it had to have signed permission from the licensee to release any information about her.

For participants in our alternative program, the North Carolina board puts an entry into the data base that interested persons should call the board for licensure verification. It does not say there has been any discipline, but it does say to call the board for verification.

All of our contracts are the same. Everyone who enters the program has his or her license held in abeyance for a minimum of three months to allow them to become grounded in recovery. After that, they petition the re-entry committee to return to practice. The re-entry committee consists of three people from a pool of registered nurses who are in recovery, treatment center staff, and members of the advisory committee. An addictionologist comes in and conducts education sessions for this group to teach them what to look for in determining whether someone is ready to re-enter practice. The licensee also has to submit an evaluation from an addictionologist and information to confirm that they have gone through treatment and that their counselors think they are doing well, that they are in after care, they are going to 12-step meetings, and they have a sponsor. If we determine they are safe to re-enter practice, they sign another contract and we start monitoring. If we determine they are not ready to re-enter practice, we tell them to return in 3 or 6 months and produce additional documentation.

Participants have to work in a licensed nursing position for three years without any relapse to successfully complete the program. I share this with you because I am aware of a program in another state that does not require nurses to return to licensed practice at all. I believe we need to monitor these nurses in a licensed position so they can have controls in place.

Like all other programs, we prohibit licensed substances in the first year, require a worksite monitor, etc. We drop some requirements after a year's time. We continue receiving reports and do screenings. We have parameters for dilute specimens. I'm delighted to see recommendations to have observed screens.

Our guidelines for relapse say that if they call us within 24 hours and they see their sponsor and their counselor, we will consider keeping them in the program. If they have been in the program and working two years, if we let them stay in, we re-impose all the restrictions that were in place when they signed the contract and they need to be clean for

three more years. Some programs I have heard of allow as many relapses as a nurse wants, but we are stricter.

Measuring Success

When we began the program, the board contracted with a professor at one of the UNC schools to write an evaluation. We send satisfaction surveys to employers at three months and eighteen months. We also survey participants after a year in the program and one year after than have completed the program. That's the only follow up we have after they complete. I see an opportunity for improvement here.

There are many ways to measure the success of an alternative program. Somebody this morning said they have a 98% success rate. You have to know how they are measuring that. Since 1994, we have had only 716 nurses sign the contract. These are very low numbers. At the end of December 2008, we had 151 participants. So, we could have had 565 successfully complete the program. In fact, we've had 133 successfully complete the program. That's a 24% success rate of those who signed the contract, stayed in and completed the program. That's pretty low, isn't it? Many people sign the contract and enter the program because they think that's the easy way out because their license will be held in abeyance for three months rather than a year.

Another way to look at the success rate is to consider that of the 133 who completed the program, we know of only 16 who have relapsed or died. Looking at it that way, we can say we have had an 88% success rate. That sounds better, doesn't it?

Accountability

As to our accountability to the board, we have a board liaison to the advisory committee and the executive director to the board receives monthly activity reports from us. The board gets a quarterly report telling them which contracts have been terminated, with a summary of that participant's record. Annually, they get survey results, advisory committee recommendations, and our statistics.

For the accountability to the public, when we receive a complaint, we immediately call the licensee to say, "We have a complaint involving you and drugs. Are you interested in the board's alternative program?" If they are, we can get them out of practice and into the program immediately and protect the public. If they decline, we send the complaint to investigations which usually takes care of the case in six months or less.

Another thing that makes us accountable to the public is the fact that when the contract is signed, we immediately put it on the verification system so if you call to verify Jane Doe, you will be told to call the board. We will probably respond that we need to get back to the caller. Then we call the licensee and tell him or her that a potential employer has inquired, that we were not aware the nurse was seeking employment there, and that we will inform the potential employer that the licensee is in the program. The licensee is supposed to inform the board before seeking employment.

Also, we have initial and continuous contact with the employers of program participants, so we know if anything is going on. The employer sends us reports and we can call them at any time. Under our contract with First Lab, we have the ability to order screens any time we want. If a participant doesn't call today, they are immediately screened tomorrow.

As a regulatory agency, we have direct access to controlled substance prescription summaries and criminal records. Before we lift a licensee's restrictions, we review his or her prescription history and look for any records of criminal charges and convictions. This access is one of the reasons we believe being a board-operated program gives us advantages over a contracted program. If our review finds problems, we immediately terminate the contract and accept the voluntary surrender of the license for a minimum of a year. If they return after a year with evidence of recovery, we put them in our chemical dependency discipline program. The executive director has direct oversight of the program staff so she ensures that we carry out our duties.

Transparency is the word of the day. We try to be transparent. A local TV station called and said they'd called several other regulatory agencies to ask about their alternative programs and didn't get any answers. We answered them and had a segment about our program on a local TV station.

Our board is always alert to opportunities for improvement. David Swankin and Mark Yessian of CAC recently did an outside audit of the structure of our program and they will report to the board in late autumn.

Case Study: Washington State

Jean Sullivan, Executive Director, Washington Health Professional Services

I direct a multi-disciplinary program. In the State of Washington, we have three programs for practitioners whose practice has been impaired as a result of substance use or abuse. These are the Washington Physicians' Health Program which works with physicians, physician assistants, veterinarians, dentists, and podiatrists. Another program for pharmacists is a subsidiary of the Washington Pharmacy Association. The third, Washington Health Professional Services, is part of the Department of Health but does not belong to any board or commission. We are free-standing.

I don't think it matters where a program is housed, or whether it is a contracted-out program or an in-house program. All of the same components have to be in place. There has to be accountability, a clear outline of tasks and expectations, a statement of the consequences of not doing those tasks, and an articulation of successful completion.

The Key is Monitoring

Our job at all three programs is to partner with the boards in public protection. Our sole reason for existence stems from the regulatory mandate to protect the public. We are not in the treatment business. We are not in the advocacy business. We are not in the intervention business. Our job is monitoring. Our job is to write a structured, supportive monitoring program for health professionals whose practice has been or potentially will be impaired as a result of a substance use disorder.

Most programs have the same components:

- abstinence,
- random urine drug screen testing,
- prescribed medication tracking, treatment,
- on-going recovery,
- practice restrictions, and
- practice site monitoring.

Let me say something about each of these components. I'm a believer that random drug screen testing should be done by a third-party administrator. I think in-house drug screen testing loses randomness and objectivity.

If a participant in our program has something prescribed for them, we expect to hear from the prescriber immediately what has been prescribed, why and for how long. If someone is positive on a drug screen and we cannot find any information from a prescriber, the licensee is in trouble.

The treatment and ongoing recovery portions of the contract are similar to other programs. There are a few states that do not call for professional peer support groups, but I think they are a vital and essential part of a good monitoring program. First, they provide another set of eyes. Some programs own the professional peer support groups and pay their staff to facilitate those groups. Others have community-based support groups whose facilitators are paid by the group members.

Practice restrictions control when a participant works, where they work, whether they have access to controlled substances, monitoring. The most important part of the entire contract is practice monitoring. We have language in our contract that says if the participant takes a position without informing the program and the employer doesn't know the participant is in the program, the licensee will be discharged from the program and lose the right to return to the program, which means his or her license will be suspended for minimum of two years.

Accountability

I can talk about accountability in three different ways. One is to talk about the wonderful man who audits us every year. All he cares about is whether we are doing what we say we do. We have the documentation to show that we are doing what we say we do.

The second way we are accountable is through the arrangement we made a few years ago with the twenty-three boards we work with that when there is a relapse, the licensee starts the program over again, beginning with treatment.

The third way we are accountable is that we take people out of practice within 24 hours of a complaint, but the licensees who go through the disciplinary process continue to practice for nine to twelve months while their case is investigated.

In most states, if the practitioner is chemically dependent and diverted controlled substances from the practice setting, their license will be disciplined, but neither revoked nor suspended. They will be allowed to practice under conditions. Who is likely to do a better job monitoring that practitioner?

Of the very few studies that address outcomes, the one done at the National Council of State Boards of Nursing revealed two important things. One thing is that the alternative to discipline programs identified relapse quickly. The second thing we learned from that study is that more than 80% of the practitioners in the alternative to discipline programs returned to practice, which is important in a time when there are shortages of educated, competent health care practitioners. In the traditional license-discipline states, 24% returned to practice.

Question: What do you think that California or any other state could learn from the established models that exist outside of California?

Sullivan: In the 29 years since these programs came into being, we have learned from our mistakes. I think it is not a good idea for any state to try to create a program in a vacuum without soliciting the wisdom of the existing programs. What we have learned is certainly portable and those of us from established programs talk to one another regularly about how to approach various situations or problems.

Comment: Thank you for representing the program point of view. I agree it is good to look at how we can improve our programs and what measures we need to put into place. I am the chair for the National Council of State Boards of Nursing new chemical dependency committee. Committee members are from diverse backgrounds; we have attorneys and nurses who run programs and a board of nursing member. The National Council started this committee in the spring of 2008 to look at both discipline and alternative programs and to come up with evidence-based practices, so it is very much in line with what I think I am hearing today. We really need to get at what are best practices. We do a lot of similar things in our programs, but we need to find the research that will support the things we are doing. There is a research gap as well as a treatment

gap. The treatment gap is still one of the most glaring concerns for all of us because we only treat about 10 % of the people we could be treating. We need to focus on education and prevention, teaching people how to identify and refer health care providers so we can help them get well and prove that through monitoring programs.

Comment: I am the executive officer for the physical therapy board of California. I want to point out that the medical board program has received the most scrutiny and publicity. The physical therapy board has what is called a diversion program, but it has never diverted anyone from discipline. We use it as a monitoring program. Even for those who enter the program voluntarily, if we get a complaint, they go into the discipline system and on probation if they keep their licenses. Participation in the diversion program is mandatory. There are other boards in California that do not have diversion programs and have only the enforcement option. So, it is important to look at each separate board in California.

Question: I thought that some people advocate having different kinds of programs for different kinds of professionals. But, if one were to limit to monitoring, is there any rationale for having a different program for different disciplines?

Sullivan: That is a matter of opinion. I have come to the conclusion that physicians probably do well in the physician programs, but I think just about everyone else can be monitored in a similar way. It is important that the monitor be a clinician with an understanding of the disease and the practice settings of a variety of different professionals. Basically, recovery is recovery is recovery. By and large, most disciplines need the same kinds of tools and structure for recovery.

Part IV – Parameters of Program Accountability

Board Oversight of Chemical Dependency Program Structure and Operations

Mark Yessian, Former Regional Inspector General for Evaluation and Inspections, Boston Region, Office of the Inspector General, U.S. Department of Health and Human Services

My aim is to pull together some of today's discussions and present a working template of accountability for alternative to discipline programs. I hope to address things at a level that is general enough to be relevant in all your settings but detailed enough to suggest tools you can use for self-assessment and third-party reviews.

I am drawing on the better than 10 years experience that CAC has had exploring these issues, on the kind of audits that Julie Fellmeth and others talked about. I also draw on work CAC did recently reviewing the North Carolina Board of Nursing's alternative program which gave us a real-world test of the concepts in the template.

I approach this topic as an evaluator – an auditor – with no real attitude or preconceptions about these programs. For most of my professional life, I ran a program in the Inspector General’s Office of the U.S. Department of Health and Human Services where we did reviews and audits, mainly of Medicare, Medicaid and Food and Drug Administration performance, but also for the better part of 25 years, I was very involved in looking at licensure boards, mainly medical boards. So, I know the universe you operate in.

The Case for Accountability

One case for accountability is what I call “limit the danger from sudden exposure.” State licensure boards typically operate in the bureaucratic backwaters of state government. But, in a moment they can be on the front page, naked to the world, facing hard questions about how the program is really run. If you have an alternative to discipline program that is highly accountable, you will look a lot better than otherwise.

A more important rationale for accountability is the “enhance the prospects for an effective program” rationale. A highly accountable program will be one that enhances the likelihood of reaching its objectives.

What are the program components that enhance accountability? Think of these as the architecture or structure or design of a program. These are the framework of laws, regulations, policies, and other things that guide the program. I distinguish the architecture from the practice or operation of a program. A program can have an architecture that would pass the test of being highly accountable, but the implementation of the program may be far from its design. It is helpful to think of this on a continuum from lower levels of accountability to higher levels, because no program is likely to be perfect. I am talking about programs run under public auspices, either by the board or under contract with a vendor, so I am talking about accountability in a public context.

The six structural elements I will talk about are program governance, operations, feedback, evaluation, internal quality control, and public awareness.

Governance: The program is established in law and has a clearly stated mission in accord with the board’s public protection mission. The governing licensure board provides ongoing, overall direction to the program.

It is important to have a mission statement that makes it very clear that of the two goals of an alternative to discipline program, the goal of public protection always trumps the goal of rehabilitation when there is a conflict. Also, the mission should be something everyone in the program embraces and is guided by.

Whether a program is run by the board or contracted out, the board needs to be engaged with the program. This doesn’t mean being involved in all the operational details, but the board must be informed enough to be assured that the program is carried out as intended and be able to provide a steering function.

Program Operations: The program is grounded in an explicitly stated and transparent set of operational rules concerning entry to the program, monitoring of program participants, criteria for graduation, and other key matters. The operational rules afford sufficient internal safety valves to protect the public while facilitating the recovery objectives of the program.

This is the guts of the program. I won't go into all the particulars of how a program is run; I want to emphasize that from an accountability perspective, it is vital that the program's operating procedures on matters concerning monitoring, criteria for graduation, etc. be clearly set forth and be transparent.

Ideally, rules and procedures are adopted by the board itself and they are transparent, up-to-date, and reviewed from time to time. As to the content of rules and procedures, we have heard calls today for best practices. In my government work, we were regularly attacked for using the term "best practices" because we usually couldn't produce conclusive data to support the assertion, so we referred to "promising approaches." Because it is hard to prove that something is a best practice is all the more reason for the programs' rules and procedures to be in the public realm where there can be open discussion of the merits of one approach over another. Should a license be suspended immediately? How many relapses should be allowed before termination? At what point should the board be informed of a lapse? How frequent should testing be?

Program Feedback: The governing licensure board and the program itself remain adequately informed about the performance of individual participants in the program and about the overall performance of the program. They share information as necessary with boards in other states to protect the public from licensees who drop out of the program.

Whether I am a board member in a steering role, or a member of the public, or someone with the media, I want to know what is *really* happening with the program. There need to be processes in place to keep all these stakeholders adequately informed of the results of the program.

It is in this area where I think there are real opportunities for enhancing the accountability of most if not every program. I will talk about two elements: information management systems and ways to get regular, reliable feedback from people associated with the program.

An essential part of information management is *comparisons*. It is usually impossible to get anything meaningful from data about program results unless they are presented in some comparative way. Ideally, the comparison would be with some national standard or with the experience in other states that are doing similar things.

One way it is possible to do valid comparisons is by documenting changes in your own program over time. This is why it is important to present data cumulatively over the life

of the program and also to present it in a way that makes it possible to see the movement of variables.

What kind of data is useful? The minimum essentials include characteristics of participants: age, gender, places of employment, nature of employment, previous dependency, previous disciplinary actions, and so on.

A second category is entry into the program: how many participants, through what referral route, time between referral and entry into the program, and so on.

How many people drop out of the program; what are the reasons; what are the characteristics of the group that dropped out.

How many reinstatements are there? What are the reasons? What are their characteristics?

How many graduate? How long does it take them to graduate? Is this number getting better or worse over time? What happens to graduates after they leave the program?

Surveys, focus groups, and interviews with participants in the program, employers, and others can be informative, although the data may be considered softer than other statistics.

Program Evaluation: The program has sufficient mechanisms in place to assess efficiency and effectiveness and to conduct continuous quality improvements.

Evaluation goes a step beyond the monitoring and feedback mechanisms I just talked about. Each program should want readily available metrics to be able to tell people something about its success.

What are the most convincing and compelling data for people like me who don't have an opinion about these programs, and even more importantly, for people who have a negative opinion? What do you need to present a case to the legislature, the media, and others to show that your program is valuable?

On success measures, a good yardstick is the number that tells you what proportion of participants who successfully completed the program during its existence. The big statistic is the one that tells how many participants remain recovered after graduation.

The physician health program study by McClellan and DuPont, et. al. is a very good study. It says some very favorable things about physician health programs, but what sticks most in my mind is that there are good results *so long as monitoring is going on*. The study found many participants felt the main motivator to remain abstinent was the knowledge that they were being monitored. What happens after the monitoring stops?

Is there any way of doing periodic followup tracking to determine whether people are still in recovery two or three years after graduation? If this is not addressed, there is a big gap in the accountability chain.

Internal Quality Control: The program has a system of internal quality controls sufficient to ensure the accuracy, integrity, and timeliness of program activities.

In terms of continuous quality improvement, continuous, data-driven evaluation should be built into every board program, including the alternative to discipline program. For example, data will tell how quickly licensees who are referred to the program actually sign up to participate and how long it takes them to do so. Some may decide to take their chances with discipline and only after the investigation appears to be going poorly from their point of view, decide to enter the program.

This data tells you whether the program is working the way the architecture intended. Are the tests taking place as they should be, is the system being “gamed,” and so on? A highly accountable program would have look-back mechanisms built into it. These could include random checking of case files, double checking what the contractor is doing.

Public Awareness: The program facilitates public awareness of the mission, approaches, and results of the program

There may be some confidentiality protections built into the program, but the existence of the program is not confidential. I believe there should be a priority effort to make the purposes of the program, the protocols, the rules, and operations totally transparent. If you have confidence in your program and want to assert that you are fully accountable, the parameters of the program should be out there for everyone to look at.

There is no reason why all the information about the program shouldn't be easily accessible on a licensure board Web site. This should include the comparative data talked about earlier. Being transparent conveys that you have nothing to hide and it may disarm some critics.

Another benefit from making the program and its procedures and results transparent on the Web site could be to expand the reach of the program to include a larger percentage of licensees with chemical dependency. Many licensees must visit the Web site and probably look under something like license renewal. If information about the impairment program is prominently posted, maybe they'll notice it and remember it in the future if they or a colleague needs help.

Question: Thank you for a superb presentation. Even though I think we run a good program, there are many things I have written down today that I will take a look at when I get home. On your sixth point, I have no philosophical problem with public awareness, but I have some practical concerns. What about plaintiff attorneys? We have been involved in three lawsuits over 20 years where plaintiff attorneys have tried extremely hard to get their hands on our policy and procedures. We are protected under peer

review, we think. My problem is that I don't know how to promote public awareness without putting the program into unanticipated jeopardy in terms of showing what someone may consider dirty laundry.

Yessian: I understand the dilemma, and it happens in other medical realms. But, looking at this from an accountability vantage point, you are not being highly accountable in a public sense if your policies and procedures are not transparent. Maybe there is a legislative solution that could give you some element of protection. To operate under peer review confidentiality, you are asking for a lot of trust from the public and others.

Comment: I have been a public member of two medical boards and am a sociologist in my professional life. I'd like to make two points. It is interesting to see the variety in approaches from state to state. One point that I think is especially important is that an evaluation of how well each of the boards and each of the programs is functioning has to be done by someone outside the organization. An independent evaluation is the only way you can assure yourselves you are really protecting the public.

My second point has to do with confidentiality. How much should the medical board know? Whether a program is board-run, medical society-run, or contracted out, medical boards need to have some information about who is in the program. Even those people who are voluntarily in the program usually were pushed by a spouse or colleagues. When a medical board receives a complaint – even one that appears to be minor -- the board needs to know whether the named practitioner is in the program and being monitored, because that knowledge would affect the priority attached to that complaint. I believe that everyone in the program should be known by name to someone associated with the board.

Comment: I run the health professionals program at Hazelton in Oregon. I don't serve the state. My job is not to protect the public, but to advocate for the patient and to rehabilitate him or her.

Confidentiality is the number one concern of the doctors I see enter treatment. They want to minimize how badly they are hurt as a result of coming to treatment. This is by far the number one barrier stopping them from seeking treatment. It impacts not only the practitioner, but his or her employer and family because they will all have the same concerns about reporting the individual and getting them help. Further, successful treatment depends on the patient being honest and open, which isn't possible without confidentiality.

Comment: Confidentiality does not mean we are hiding doctors. In Washington State, when a board receives a complaint, the board contacts us to see if the person is in the program. We say we will get back to the board and then approach the voluntary client and ask permission to reveal his or her name to the board. We almost invariably get that permission.

Confidentiality is a contentious and critical issue. There is data to suggest confidentiality is important because of the stigma associated with addiction. The U.S. Congress enacted a statute some years ago providing for extra confidentiality for chemical dependency patients, even more than the usual doctor-patient relationship.

Yessian: This issue of confidentiality is appropriate for public discussion and debate because there has to be buy-in. If you can't convince the people who govern the programs and the larger political establishment, then programs based on confidentiality aren't going to be viable.

Comment: It makes me nervous that we are conflating treatment and oversight. I fully appreciate what the folks who treat addiction have said. But treatment is not the same thing as the responsibility of the state which grants a license to a professional to make sure the licensee follows the rules and practices safely. The tension mentioned earlier in the day between the treatment community and the oversight community may speak in favor of a treatment program that is entirely outside the board, but it does not obviate the responsibility of the board to make sure the professionals they license are competent to practice according to the rules and laws of the state.

Is this an irreconcilable tension? We are hearing from one group that confidentiality is essential to treatment. We are hearing from the public advocates that confidentiality is inconsistent in some circumstances with public protection. In the doctrine and spirit of informed consent, the public deserves to know about the person from whom they are accepting treatment. They assume from the license on the wall that the state has taken the steps necessary to make sure the person is competent to practice, but no information is revealed about chemical dependency or, for that matter, any other factor that may affect the practitioner's competence.

Comment: On confidentiality, I think you get nowhere in the discussion unless you separate confidentiality from the public and confidentiality from the board. The board gives out the license. Citizens depend on the board to determine whether a person is qualified to practice. Alternative to discipline programs do not have that authority. They may offer advice, but they don't give out the license. If the board gives out the license, the board has to have a way to know who is in the program. As Mark said, the public doesn't buy into the claim that, "We do a good job. Trust us." Boards can't just trust the situation either. They must have evidence on which to base trust. It is worthy of debate whether to keep participation in a program confidential from the public. But, it's a much harder one to make a case that this information should be kept confidential from the board. This notion that the physician, nurse, pharmacist, dentist, or other professional hates the idea that the board's going to know, that's too bad, because the board has to know.

Comment: This has been a wonderful forum and we have learned a lot. There is room for improvement in every situation. In my experience, alternative programs must be part of a board's program if you want to get licensees out of practice as quickly as possible. No matter how good it is, the enforcement program can't act swiftly because of due process requirements. I work with a board and none of the diversion program

participants are confidential from me. When names come up, we have mechanisms in place, including authority to suspend from practice immediately upon entry into the program.

Yessian: I agree that there clearly is tension surrounding confidentiality and other aspects of alternative to discipline programs. Perhaps one area where we should be able to get pretty clear consensus and maybe even some national standards is on information management systems for a program. However one views controversial aspects, it seems clear that everyone should want to have as a common frame of reference a set of metrics that is used by individual programs to compare their own progress over time. Developing such a set of metrics should be doable without consuming a lot of resources.

Comment: The topic of confidentiality has been researched in the context of the Joint Commission, peer review, and federal alcohol and drug confidentiality. Whenever the government has examined this, the conclusion has been that there has to be confidentiality for people to get into alcohol and drug treatment.

There is confusion about the definition of “voluntary admission.” Physician programs use this term to mean the individual is not under a legal mandate. Participants that are confidential are accountable to other mechanisms. They are open to complaints; they are going through peer review; they have the same quality assurance as every other physician. The programs are not protecting them from accountability for their medical practice.

When there is a public order forcing a physician into treatment, he or she loses board certification, third-party payer privileges, and Medicare and Medicaid certification. The loss is so great that their colleagues in the hospital are not going to want to refer a high paying surgeon to a program if they believe that will result in a public sanction that will remove them from insurance panels.

Comment: I am a pharmacy practitioner and also the coordinator for the American Pharmacists’ Association Addiction Practitioner Interest Group. We heard a vivid description of a systems failure that, in my view, was due to a lack of buy-in and support from the agency that put the system into place in the first place. Regardless of whether we are nurses, physical therapists, pharmacists, physicians, or public members, we as board members have to ensure that the board as an entity buys-in to the value of that program and gives it the necessary resources to do its job.

Also, we are very concerned about the lack of education of health care providers about addiction as a disease and the very real possibility for health care professionals to be affected by that disease some time in their life. The American Pharmacists’ Association feels this can be addressed by exposing students to a course on addiction and addiction recovery early in their education.

Comment: I work with Maximus. I believe case managers should be clinicians with chemical dependency expertise. We do teach about chemical dependency in schools throughout California.

Comment: I run a program for doctors, nurses, pharmacists, dentists, dental hygienists, attorneys, and judges in Idaho. The only thing our legislature wants to hear about is public safety. Based on my own experience in recovery, I concur with what has been said about the importance of monitoring.

Comment: I am the director of addictions at a clinic in Houston, Texas. I have worked with about seventeen addiction programs and find it an interesting thing that the health care professionals who come into the clinic have complex problems. Our goal is to get them into an assistance program. We have to be able to give them some assurance we are looking out for their best interests. The last thing we want to do as a treatment provider is send someone back to work before they are ready. I have been impressed with the physician assistance programs and feel very good about sending impaired professionals back to them.

Comment: If there were some way to develop a set of metrics for evaluating and documenting program operations, I hope it can be structured for use between programs as well as to evaluate programs over time.

I hope that the tension between confidentiality and public awareness and between public safety and rehabilitation are not irresolvable. I hope we can find some way to reconcile this tension.

I would like to have the opportunity to attend another conference that would address what seems to me to be the salient block to reaching full consensus and that is confidentiality vs. public awareness.

Swankin: When I opened this forum, I recalled the earlier forums we convened a decade ago. We made great progress at those forums in every area except one: the area of regulatory management --the relationship between these programs and the boards. The question of confidentiality is integral to this. I am not as pessimistic as to think that this is a tension that cannot be managed, but in eleven years, we have not made a lot of progress, which is why we convened this meeting and will continue to address this issue.