Hearing Date: April 14, 2008 Bill No: SB 1441

SENATE COMMITTEE ON BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT

Senator Mark Ridley-Thomas, Chair

Bill No: SB 1441 Author: Ridley-Thomas
As Amended: April 7, 2008 Fiscal: Yes

SUBJECT: Healing arts practitioners: alcohol and drug abuse.

SUMMARY: Specifies legislative intent that the Bureau of State Audits (BSA) conduct a thorough performance audit of board diversion programs to evaluate the effectiveness and efficiency of the programs and the providers chosen by Department of Consumer Affairs (DCA) to manage the programs, and to make recommendations regarding their continuation; establishes within the DCA the Diversion Coordination Committee (DCC) and the Licensee Drug and Alcohol Addiction Coordination Committee (LDAACC) to establish guidelines and recommendations relating to licentiates with alcohol and drug problems.

Existing law:

1) Establishes the DCA which oversees boards and bureaus which license and regulate businesses and professions, including doctors, nurses, dentists, engineers, architects, contractors, cosmetologists and automotive repair facilities, to name a few.

2) Requires the following boards to establish criteria for the acceptance, denial or termination of licentiates in a diversion program:

a) The Medical Board of California (MBC) to establish diversion evaluation committees to identify and rehabilitate physicians and surgeons with drug, alcohol abuse problems, or mental illness or physical illness that affects their competency to practice medicine.
b) The Osteopathic Medical Board of California for osteopathic physicians and surgeons.
c) The Board of Registered Nursing for registered nurses.
d) The Board of Dental Examiners of California for dentists.
e) The Board of Pharmacy to operate a recovery program for pharmacists or intern pharmacists.
f) The Physical Therapy Board of California for physical therapists.
g) The Veterinary Medical Board for veterinarians and registered veterinary technicians.
h) The Physician Assistant Committee for physician assistants.

3) Establishes the Attorney Diversion and Assistance Act within the State Bar of California to address the substance abuse and mental health problems of attorneys who voluntarily participate in the program.

4) Allows a board of a healing arts licensee to deny, suspend, or revoke a license for specified acts.

5) Creates the Health Quality Enforcement Section within the Department of Justice (DOJ) with the primary responsibility of investigating and prosecuting proceedings against licensees and applicants within the jurisdiction of the MBC and various other boards.

6) Requires that DOJ 's attorneys staff and the intake unit of specified regulatory boards to evaluate and screen complaints and develop uniform standards for their processing, and simultaneously assigns a complaint received by the MBC to an investigator and a deputy attorney general in the Health Quality Enforcement Section. Makes these provisions inoperative on July 1, 2008, and repeals them on January 1, 2009, unless a later enacted statute deletes or extends those dates.

This bill:

1) Specifies legislative intent that the Bureau of State Audits (BSA) conduct a thorough performance audit of the diversion programs created pursuant to this bill to evaluate the effectiveness and efficiency of the programs and the providers chosen by DCA to manage the programs, and to make recommendations regarding the continuation of the programs and any changes or reforms required to ensure that individuals participating in the programs are appropriately monitored, and the public is protected from health practitioners who are impaired due to alcohol or drug abuse or mental or physical illness.

2) Establishes within DCA the DCC to issue at an unspecified date a set of best practices and recommendations to govern those healing arts licensing boards' diversion programs or diversion evaluation committees.

3) Specifies the following for DCC:

a) To be comprised of the executive officers of those healing arts licensing boards within DCA that establish and maintain diversion programs or diversion evaluation committees.
b) For the Director of DCA to act as chair of DCC.
c) To meet periodically at the discretion of the director.
d) To issue at an unspecified date a set of best practices and recommendations to govern those healing arts licensing boards' diversion programs or diversion evaluation committees.

4) Requires the recommendations specified in item #3) to propose best practices, regulations, or changes in law, as are necessary, and shall include but

not be limited to addressing all of the following issues:

a) When a licensee is to be irrevocably terminated from the diversion program and referred for disciplinary action.
b) Periodic audits of the program.
c) Whether a licensee enrolled in the program who may pose a risk to patients may continue to practice while in the program without the knowledge or consent of patients.
d) How best to ensure that drug tests are random, accurate, and reliable, and that results for those tests are obtained quickly.
e) Whether there should be criteria for entry into the program, such as criteria that differentiate between licensees who the board has reason to believe pose a risk to patients and those where the risk is speculative.

5) Establishes within DCA the LDAACC to issue a set of best practices and recommendations to govern those healing arts licensing boards' within DCA that do not establish and maintain diversion programs or diversion evaluation committees.

6) Specifies the following for the LDAACC:

a) To be comprised of the executive officers of the healing arts licensing boards within DCA that do not establish and maintain diversion programs or diversion evaluation committees.
b) For the Director of DCA to act as chair of LDAACC.
c) For LDAACC to meet periodically at the discretion of the DCA.
d) To issue at an unspecified date a set of best practices and recommendations to govern those healing arts licensing boards' disciplinary programs as they relate to disciplinary matters relating to drug or alcohol addiction.

7) Requires the recommendations specified in item #6) to propose best practices, regulations, or changes in law, as are necessary, and to include recommendations addressing all of the following issues:

a) Criteria for placing a licensee on probation and related criteria for reporting and monitoring the probation.
b) Criteria for refusing a request for probation.
c) Criteria for imposition of discipline and the level of discipline.
d) Criteria for restoration of a license.

FISCAL EFFECT: Unknown. This bill has been keyed "fiscal" by Legislative Counsel.

COMMENTS:

1. **Purpose.** The Author is the sponsor of this measure. According to the Author, this bill is necessary to ensure that public safety remains the paramount mission of healing arts licensing boards when dealing with licentiates who are

suffering from drug or alcohol abuse or dependency problems. The Author cites high-profile cases, which have gained national attention, in highlighting the potential threat to public safety when health care providers with substance abuse problems are allowed to continue to see patients. For example, Dr. Brian West, a plastic surgeon, with a history of alcohol problems and drunk driving offenses, was allowed to perform surgery on a woman that resulted in dead stomach tissue and exposed intestines. In addition, the Author points out that no audit or review has been conducted on the other health care licensing boards that maintain and operate their own diversion programs for licensees that suffer from chemical dependency, or on the singular program which administers the diversion programs of these boards. The Author believes that public confidence can only be maintained if common and uniform standards are established to govern the different healthcare licensing boards' diversion programs.

2. **Background.** The Author indicates that the impetus for this bill is the repeated failures of the MBC's Physician Diversion Program (PDP), and the immediate and grave risks to the public posed by physicians who continue to practice medicine despite their chemical dependency. Background information provided by the Author, including newspaper articles, reveal that several physicians have been allowed to practice medicine and treat patients even after testing positive for alcohol or drugs. In recognition that patient safety cannot continue to be compromised, the MBC voted unanimously on July 26, 2007 to end the PDP, declaring in its motion that "in light of the MBC's primary mission of consumer protection and as the regulatory agency charged with the licensing of physicians and surgeons and enforcement of the Medical Practice Act, the MBC hereby determines it is inconsistent with the MBC's public protection mission and policies to operate a diversion program." This declaration prompted MBC to approve a Diversion Transition Plan (DTP) on November 2, 2007 to accommodate the 203 physicians already in the program. The DTP split the participants in two categories; those with at least three years of sobriety and those without. For those with at least three years of sobriety, participants will be evaluated by a Diversion Evaluation Committee (DEC), and if the DEC recommends and the DTP's administrator approves, the individual will be deemed to have successfully completed the program and discharged. For those with less than three years of sobriety, participants would receive a letter to "highly encourage" them to seek entrance into another monitoring or treatment program to assist them in maintaining sobriety. MBC has also articulated a policy in the DTP to deal with physicians who were referred into the diversion program from enforcement in lieu of discipline, and for physicians who were directed into the program as part of a disciplinary order.

3. **Physician Diversion Program (PDP)**. MBC's PDP was created in 1980 to rehabilitate doctors with mental illness and substance abuse problems without endangering public health and safety. Under this concept, physicians who abuse drugs and/or alcohol or who are mentally or physically ill may be "diverted" from the disciplinary track into a program that monitors their compliance with terms and conditions of a contract that is aimed at ensuring their recovery.

The PDP is a voluntary program and only those physicians and surgeons who

have voluntarily requested diversion treatment and supervision can participate in the program. A physician could enter the diversion program in any of the following ways: a) self-referral; b) referral by the Enforcement Unit of the MBC in lieu of discipline; or c) directed as part of a disciplinary order. Confidentiality is required for physicians and doctors that self-refer and may be granted to those who are referred by the MBC (doctors may avoid public discipline if there was no evidence of patient harm and they successfully complete the program). For those who are directed to the program as part of a disciplinary order, disciplinary actions are public records and the practice violation that triggered MBC's involvement would be reflected in the doctor's public file. Any physician and surgeon terminated from the PDP for failure to comply with program requirements is subject to a disciplinary action for acts committed before, after or during participation in the PDP, and a physician that successfully completes the PDP is not subject to any disciplinary action for any alleged violation that resulted in referral to the PDP. The PDP monitors participants' attendance at group meetings, facilitates random drug testing, and requires reports from work-site monitors and treatment providers. The PDP is set to sunset on June 30, 2008.

4. **Audits of the Physician Diversion Program**. The BSA has audited the PDP four times between 1982 and 2007. In 2005, a legislatively created enforcement monitor also audited the PDP. The enforcement monitor's audit indicated that "the Board's PDP is significantly flawed; its most important monitoring mechanisms are failing, it is chronically understaffed, and it exposes patients to unacceptable risks posed by physicians who abuse drugs and alcohol." The 2007 BSA audit concluded that "although the PDP has made many improvements since the release of the November 2005 report of the enforcement monitor, there are still some areas in which the program must improve in order to adequately protect the public. BSA points out the following: Although case managers appear to be contacting participants on a regular basis and participants appear to be attending group meetings and completing the required amount of drug tests, the PDP does not adequately ensure that it receives required monitoring reports from its participants' treatment providers and work-site monitors. In addition, although the PDP has reduced the amount of time it takes to admit new participants into the program and begin drug testing, it does not always respond to potential relapses in a timely and adequate manner. Specifically, the PDP has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a non-prescribed or prohibited drug. Further, of the drug tests scheduled in June and October 2006, 26% were not performed as randomly scheduled. Additionally, the PDP currently does not have an effective process for reconciling its scheduled drug tests with the actual drug tests performed and does not formally evaluate its collectors, group facilitators, and diversion evaluation committee members to determine whether they are meeting program standards. Finally, the BSA indicates that MBC has not provided consistently effective oversight.

5. **Other Health Provider Diversion Programs**. While MBC houses its diversion program, other boards outsource these functions. DCA currently manages a master contract with Maximus, a publicly traded corporation for six boards' and one committee's diversion programs: the Board of Registered

Nursing, the Dental Board of California, the Board of Pharmacy, the Physical Therapy Board of California, the Veterinary Medical Board of California, the Osteopathic Medical Board of California, and the Physician Assistant Committee. The individual boards oversee the programs, but services are provided by Maximus. The board's diversion programs follow the same general principles of MBC's PDP. Health practitioners with mental illnesses or substance abuse issues may be referred in lieu of discipline or self-refer into the programs and receive help with rehabilitation. After an initial evaluation, individuals accept a participation agreement and are regularly monitored in various ways, including random drug testing, to ensure compliance. Maximus provides the following services that MBC kept in-house: medical advisors, compliance monitors, case managers, urine testing system, reporting, and record maintenance. DCA's master contract standardizes certain tasks, such as designing and implementing a case management system, maintaining a 24-hour access line, and providing initial intake and in-person assessments, but the planning and execution of the programs are tailored to each board according to their needs and mandates. Each board specifies its own policies and procedures. Maximus generally has a less hands-on approach to managing the diversion programs than MBC attempted. Maximus reports that caseloads range from 100 to 200 per clinical case management team. Maximus also limits its in-person resources; for example, in the program design for the Board of Registered Nursing, Maximus specifies that they will conduct in-person reassessments by telephone unless otherwise requested by the Board. Also, the contractor performs unobserved, as well as observed, drug screening.

6. **Informational Hearings**. The Senate Business, Professions, and Economic Development Committee held informational hearings on the PDP issue on June 11, 2007 and March 10, 2008. The June 11, 2007 hearing focused on the findings of the 2007 BSA audit. The March 10, 2008 hearing examined how the MBC and the other healthcare licensing boards deal with licentiates with substance abuse and drug addiction problems.

7. **Similar Legislation.** SB 761 (Ridley-Thomas), which died in the Assembly Appropriations Committee, extends the sunset date of the PDP to July 1, 2010.

8. **Prior legislation**. SB 231 (Figueroa), Chapter 674, Statutes of 2005, had various provisions relating to the MBC and specifically established a January 1, 2009 sunset date for the PDP.

SUPPORT AND OPPOSITION:

Support: None on file as of April 10, 2008

Opposition: None on file as of April 10, 2008

Consultant: Rosielyn Pulmano