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Eliminating the California Diversion Program

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Forward

About two years ago, the California Medical Board, which licenses its physicians, decided to end its diversion program for substance-abusing physicians. That unanimous decision was set in motion by an extremely revealing 2004 audit of that program. I was part of the auditing team.

While I am a not a physician and have no formal clinical training or expertise in substance abuse protection, prevention or rehabilitation, I am an attorney, law professor and consumer advocate. My organization, the Center for Public Interest Law, based at the University of San Diego School of Law, has been monitoring occupational licensing agencies in California for 29 years. For the past 23 years, I have attended almost every medical board meeting.

How it began

In 2002, the California Medical Board's enforcement program got into trouble. The issue was the subject of a multi-day expose in a California newspaper that caught the attention of the state legislature. It decided to create an enforcement monitor to audit both the board's enforcement program and its diversion program for substance-abusing physicians, (Despite three failed audits in the 1980s, it had been 18 years since the last independent external audit.) The statute gave the monitor fairly extensive investigative authority, requiring the medical board and the attorney general's office to turn over otherwise confidential documents and files.

In 2003, after a competitive bidding process, I was appointed as the enforcement monitor. My team included a veteran public protection prosecutor as well as a management consultant with considerable experience in auditing government regulatory programs and diversion programs. We published an initial report in November 2004 and a final report in November 2005. Both are available at www.cpil.org,

We accomplished the task by first looking at the program's statutes, regulations, policies and procedure manual. We read the three prior state audits, reviewed all of the program's data and its annual report and

also reviewed the program's paper file and compared that information to that in its electronic file. In addition, we interviewed the program and enforcement program staff, prosecutors from the attorney general's office and members of the liaison committee to the diversion program, which was an outside committee of private addiction medicine specialists that advised the medical board on running this program.

However, the key thing we did was analyze in great detail the files of 60 different participants in the program, at that time about one-quarter of the program's population. These files contained a wealth of information, ranging from the participant's intake interview form and drug test results to reports filed by the participant's work site monitor, group meeting facilitator and work site monitors. We were able to chronologically piece together the participant's entire participation in the program including how he or she was admitted, whether they relapsed, the program's response to the relapse, how long it took the program to respond to the relapse, and so on.

I think we can agree that we should do everything we can to encourage substance-abusing healthcare practitioners to get help to seek recovery. But translating that idea into a nuts-and-bolts program that protects patients and is effective in assisting healthcare practitioners to recover from substance abuse is an extraordinarily difficult task. Few people understand the importance of the details and the need to have those details subject to the test of an external independent auditor. It is, after all, the independent auditor that determines whether a program is protecting patients from substance-abusing practitioners who have retained a full and unrestricted license to practice. The program also may be simply protecting those practitioners and allowing them to maintain both their license and their addiction.

The California program

Impairment programs vary greatly in structure and in size from state to state and from board to board. From the day our medical board's program was created in 1980 to the day it died, it was one of the few programs in which the case management aspect was administered in-house by medical board employees. While it outsourced some functions like drug testing and facilitation of group meetings to the private sector, the program was run in-house, differing in that way from medical board diversion programs in the rest of the country.

At any given time, there were only 250 to 275 physicians in this program even though, during its later years, there were more than 100,000 licensed physicians in California. This program was not even attracting the very tip of the iceberg of statistically-likely impaired physicians. It was a monitoring as opposed to a treatment program that evaluated the needs of participants. It set forth a rehabilitative plan that might include treatment such as inpatient detoxification, medical and psychiatric evaluation and psychotherapy.

All treatment and monitoring requirements were put into a contract requiring the licensee to sign the contract and monitor the participant's compliance with terms and conditions of that contract. For the vast majority of the years that it existed, the program offered confidential participation to all participants; this aspect was deemed necessary in order to attract physicians.

The program could be accessed in three ways.

- The physicians could be self-referred participants; the program, in fact, insisted that more than 50% of participants were self-referral. We found this was not true; only about 10 or 15 percent were voluntary self-referrals. Although they were initially classified as such, if you looked further, you'd find that the physicians volunteered to be in the program only in order to beat something that was coming to the attention of the board, such as a DUI arrest or conviction. The benefit of being classified as a self-referral was that it was absolutely confidential, both from patients and from the board enforcement program.
- The physicians could be board-referred participants. They came to the attention of the medical board's enforcement program by way of a complaint or report. The enforcement program investigated it, determined that the cause was likely substance abuse; and if the physician had not yet injured a patient, the enforcement program had the ability to refer that person into the program in lieu of taking disciplinary action against that doctor. These people were known to the enforcement program, but their participation was not available to their patients.
- The physicians could be board-ordered participants, doctors who were the subject of public board disciplinary action such as having a license revoked or receiving ten years probation on terms and conditions, one of which was mandatory participation in the diversion program. This order is technically a public record, and the board posted on its website that a disciplinary action had been taken, but prior to 2004, it didn't list all the terms and conditions of probation nor did it post a full text of its disciplinary orders the way it does now. So, the general public was still not aware of the doctors' participation in the program even though it had been ordered by the board.

How it worked

Once in the program, the physician signed a contract agreeing to participate for five years, abstain from all use of alcohol or unapproved drugs, cease practice if the program told him to and get treatment if the program required it. The physician also agreed that noncompliance with any program term and condition or request was grounds for termination from the program as well as referral to enforcement. The program advertised and required various monitoring mechanisms. The major ones were random drug testing. The first two years of participation, doctors were required to be tested four times a month. That requirement could taper off to two times a month after the first two years if tests were clean and doctors were compliant with the contract.

Attendance was required at group therapy meetings. During the first two years, doctors had to attend two meetings per week and that again that could taper off. If the physician was permitted to work, he had to secure a work-site monitor who would report to the program on a quarterly basis. If the physician also had hospital privileges, he had to secure an approved hospital monitor who would report to the program.

We have heard the argument that a diversion program might be superior to enforcement if the problem is substance abuse; actively monitoring participant behavior can protect the public much more quickly than enforcement if that physician relapses or demonstrates pre-relapse behavior. But the validity of that argument depends entirely on the existence and the adequacy of those monitoring mechanisms. If those mechanisms do not work for whatever reason, then that physician continues to practice medicine with no intervention 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 the board's website - maintains a clear and clean and unrestricted license to practice.

Finding No. 1: Monitoring programs

Finding No. 1 goes straight to the heart of the program - the monitoring mechanisms. Every one of the major monitoring mechanisms was failing; the program had an insufficient number of internal quality controls to ensure that failures of those monitoring mechanisms could be detected and the program was chronically understaffed.

The most important failure of the monitoring mechanisms is drug testing because it is the major objective measure of whether a participant is complying with that contract. The program required participants to submit to random observed urine testing. Participants were required to be tested four times a month during the first two years, and the participants knew of this frequency of testing rate. Every month, a random schedule of testing dates was prepared by headquarters in Sacramento for each participant and distributed to specimen collectors across the state. Theoretically, testing could occur on any day. It was supposed to occur on random dates generated by the computer and the process was supposed to be monitored by several levels of diversion program staff.

What we found, however, was that in more than 60% of cases, testing did not occur on those randomly generated dates. Instead, if it occurred at all, it occurred on dates that participants could anticipate. In many cases, testing did not occur as frequently as the program policy required because the folks who were supposed to conduct testing and collect specimens routinely ignored or overrode that random testing schedule to suit their own convenience. They unilaterally moved collections off weekend days to Tuesdays and Thursdays and didn't explain these changes to anyone.

When specimen collectors were not manipulating testing days, participants did so. When called for a test, the doctor would claim to be on vacation or in surgery, and the program had no enforceable rule to deal with this kind of excuse. In many cases that we analyzed, participants were not tested at all for extended periods of time ranging from one to four months, and nobody knew this except the participants. In other cases, we saw test results - including positive results that indicated relapse into substance abuse – that were not promptly communicated by the lab to the program. They were not accurately recorded in the program's paper file or in its electronic files.

There were also errors, gaps and inconsistencies in the program's record-keeping. As I'm certain you agree, record-keeping absolutely must be there, must be available and must be relied upon in the advance of a relapse. In short, the drug testing requirement was easy to avoid. Doctors quickly learned that they were least likely to be tested on weekends and most likely to be tested on Tuesdays and Thursdays. If they got four drug tests by the 10th of the month, the odds were they were not going to be tested for another 20 days and they would adjust their behavior accordingly.

This program also required participants to attend group meetings of substance-abusing healthcare practitioners twice a week during the first two years. 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 these group facilitators to be licensed in California and qualified to provide therapy. There was also little or no consistent tracking of meeting attendance either by participants or by program staff.

Two more examples of monitoring mechanisms that failed were worksite monitors and hospital monitors. An impaired physician who is in the program, but in recovery and deemed capable of safe practice, is allowed to practice if he gets a worksite monitor. If that person has hospital privileges and is permitted to practice in the hospital, the participant additionally had to get a hospital monitor. But the medical board never established any criteria stipulating that this person even had to be a physician. There were no guidelines forbidding someone who the participant hires and fires from being approved as the worksite monitor or hospital monitor. There were no criteria saying that the monitor has to lay eyes on the participant X times per month or speak on the phone with the participant Y times per month or pop in unannounced. These monitors were supposed to report to the board on a quarterly basis; most did not. There was no standard report format, and although some reports were adequate, others consisted of one sentence. We saw in many cases that the program increased the number of hours that a doctor was allowed to work per week, even though that doctor's hospital monitor or worksite monitor had never filed a report. This problem was also identified in all three audits prior to mine. The board never did anything about it.

The program's major monitoring mechanisms were all failing. They were not consistently and adequately monitoring participant behavior.

The second aspect of this finding was that there was no internal control to detect failure of these monitoring mechanisms. Nobody even knew these problems were occurring because the program lacked sufficient internal quality control to alert staff to the failure of the mechanisms. The board said the program devoted a full-time employee to monitoring the integrity of the drug-testing program, but the employee told us that she only had two hours a month to devote to that task. All she had time to do was to generate a random schedule and send it out. Nobody checked whether the tests were actually administered on the dates and nobody spot-checked to see whether participants were being tested as often as required. There was no system, automated or manual or otherwise, to check whether test results had even been received and posted to the correct participant file.

The third aspect of our first finding concerned board staffing. Even if those internal controls existed, the program lacked sufficient staff to act on and correct problems. It was chronically understaffed at all levels; management, analytical, administrative and clerical.

The program was funded solely by physician licensing fees and paid by all physicians. Diversion program participants, although they paid for their drug test and group meetings, paid nothing towards the overhead. So staffing was minimal. Ten paid staff members to monitor behavior of 275 physicians are insufficient. Diversion program staffs were so overloaded that they had to assume tests were conducted on the right dates, participants were tested as often as required and that all samples were accurately tested. All staff could do was react to positive drug tests. If they did not get a positive drug test, the staff simply assumed everything was okay. Very frequently those assumptions were false. In an uncomfortably large number of cases, staff did not check and the program had no internal controls to alert them.

The false promise that physicians with serious addiction problems were being adequately monitored to protect the public, exposed patients – and physicians - to grave risk.
One participant was ordered by the board to participate in the diversion program as a condition of probation. He was not tested for the first three months of his participation. The diversion program thought that the probation unit was testing him and probation thought diversion was testing him. The program

received telephone calls from an ER- attending physician letting them know that this participant had passed out due to acute intoxication. As a result, that physician almost died because of the failure of this program's testing system.

Finding No. 2 – Rules and regulations

There was also a complete absence of any enforceable rules or regulations. The diversion program's statutes are skeletal at best. Its regulations are no better. None of the monitoring mechanisms were even mentioned in any statute or regulation, much less governed by them. The mechanisms were instead contained in an unenforceable policy manual that was rarely scrutinized by the medical board. The program had no rules regarding consequence for relapse. It had no standards for termination from the program. All prior audits pointed to these missing standards and directed the board to adopt them, but the board never did.

Finding No. 3: No program ownership

Contrary to the statutes, which required the medical board to be responsible for overseeing this program, the board never took ownership. One must assume that the purpose of in-house functioning is to enable the medical board to comprehensively oversee and supervise the program, but it didn't happen. Instead, in 1982, a year after this program was created, the board and California's largest trade associations of doctors, the California Medical Association, decided to create an external liaison committee to the diversion program. This group's careers focused on substance abuse detections, treatment and rehabilitation, and its function was to assist board members, many of whom were not addiction specialists, and the program staff, who were not even doctors, in running the program. However, the group was making all policy decisions. The medical board simply punted oversight of this program to this group of private doctors who were not board members. About five years before the program was abolished, the board created a standing committee of board members that met quarterly to discuss diversion- related issues. So, the board tried to ensure that at least some members of the board had an idea how this program was supposed to work, but even that committee remained at the mercy of program staff in terms of receiving information.

Finding No. 4: Isolation

The program was isolated from rest of the medical board. It was shunted off to a corner of the compound where the board had its offices and nobody ever went in there except program staff. The justification was that nobody was supposed to know who was in the diversion program, but that does not justify complete isolation from board management. This isolation contributed to program breakdowns.

Finding No. 5: No tracking

For 27 years, the board spent more than $1 million a year on this program, but it never had any idea whether it was effective in helping physicians recover from addiction. The program did no post-graduate tracking whatsoever of any of its graduates. The board had no idea whether those doctors are practicing safely today, have relapsed into substance abuse or have died from it.

Recommendations

Despite all of these problems, we did not recommend that the board abolish the program in our initial report. Instead, we made a series of sequential recommendations.

- We recommended that the board re-evaluate the diversion concept and whether it was consistent with the board's public protection mandate. When this program was created in 1980, California

law said that the highest priority for the medical board in exercising its disciplinary jurisdiction was physicians' rehabilitation, so this program fit nicely within state law. But in 1990, the law changed. California law said that public protection is the medical board's highest priority, and if public protection is inconsistent with some other interest, such as physician rehabilitation, public protection is paramount. We recommended that the medical board revisit this entire concept to determine whether it was consistent with its public protection mandate.

- We recommended that the board re-evaluate the location of the program. It seems very clear that the low participation rate and the low number of true self referrals meant that physicians were coming to this program as their last resort. They did not want to come to a program that was housed in the medical board because they already knew they were going to relapse. It's an expected part of the recovery process, and the last person that the physicians wanted to know about that was somebody who worked at the medical board.
- We said that if the board decided that diversion is consistent with public protection and decided to keep the program, the board should engage in major comprehensive reforms. Merely increasing the staffing was not going to do it. The board also needed to install internal control mechanisms to ensure that the program's monitoring mechanisms are effective in detecting relapse into drug or alcohol use. We said that the program had to formulate rules governing consequences for relapse. Restructuring had to include the long overdue adoption of meaningful criteria for acceptance into the program, denial of acceptance into the program and termination from the program.
- We also recommended that if the board should decide to keep this program, it had to address whether program participation should be an entitlement for any and all impaired physicians in California or whether the participation should be kept at a level that could be meaningfully monitored by program staff.
- Clearly, the program was not adequately funded. We said the board had to ensure that the management of the diversion program was integrated into the management of the board.
- We recommended that the program be subjective to an external audit every five years.

The aftermath

As a result of this report, the legislature, in a 2005 bill, imposed a June 30, 2008, sunset date on the program. That same bill required the Bureau of State Audit (BSA), to re-audit the program in 2007 to make sure it had addressed all the deficiencies that we and prior auditors had found. In essence, the legislature gave the board one last chance and two more years to address these problems. During that two-year period, the board pumped an additional $500,000 into resources and staffing. Despite that, the program flunked BSA's 2007 audit. BSA confirmed that much of that we found 2 1/2 years earlier was still happening.

It found, incredibly, that drug tests were still being moved off weekend days. And even though the program had a policy that anybody who tested positive and who was allowed to work would be immediately removed from work, BSA found that the program did not do that. It tested a sample of 31 positive tests and of those 31 doctors, 12 were practicing medicine.

After five failed audits in 27 years, the medical board unanimously decided in July 2007, not to seek an extension of that sunset date. As a result, the boards program went out of business on July 1, 2008.

Having analyzed 60 program files in detail, I can tell you that the program only helped those who wanted to be helped.

The board's decision to abolish its diversion program struck a nerve across the country. Many other boards are taking a new look at the diversion programs. In California, a new law requires an audit of the private vendor that runs the diversion program of our seven healthcare boards that have them.

On July 21, 2009, the *Los Angeles Times* published a devastating series of stories about the diversion program at our board of registered nursing. It was positively frightening. In conclusion, all diversion programs should be subjected to an audit. If they are as good as some believe, there is nothing to fear. If they are not, responsible regulators need to take decisive of action.

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Since 1983, Professor D'Angelo Fellmeth has taken an active role in California's regulation of business, professions and trades. She has actively participated in the California's Legislative Sunset Review of the State Occupational Licensing Board including the Medical Board, the Dental Board, the Board of Optometry, Contractor State Licensing Board, Board of Accounting and many other occupational licensing agencies. Since 1987, she has participated in three extensive enforcement monitor projects investigating enforcement programs at California agencies regulating attorney, construction, contractors and physicians.

On November 1, 2005, she completed a two-year term as the medical board enforcement program monitor pursuant to California's Business and Professional Code Section 2220. In that capacity, she published two extensive reports, the initial report of the Medical Board Enforcement Program Monitor and final report of the Medical Board Enforcement Program Monitor, both of which are available on CIPA's website at www.cpil.org .

Her reports have prompted the medical board to adopt dozens of reforms including an overhaul of its investigative process and the abolishment of its diversity program for substance-abusing physicians.