STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA
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DIVERSION ADVISORY COUNCIL TELECONFERENCE MEETING

July 10, 2007

Medical Board of California
Executive Conference Room
1424 Howe Avenue, Suite 92
Sacramento, CA 95825

Action may be taken on any item listed on the agenda.

Additional meeting locations:

University of California San Diego
140 Arbor Drive, Room 331
San Diego, CA 92103

Kaiser Permanente
Chemical Dependency Recovery Program
1201 Filmore Street
San Francisco, CA 94115

AGENDA

7:00 p.m. – 8:00 p.m.
(or until completion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE
If a quorum of the Board is present, members of the Board who are not members of the Council may be attend only as observers.

1. Call to Order/Roll Call

2. Review of Proposed Regulation Language for Guidelines for Determining when to Order a Clinical Competency Examination

3. Discussion of Whether to Modify the Criteria for Termination from the Diversion Program (Enforcement Monitor Recommendation #5)

4. Discussion of the Establishment of a Mechanism for Termination and Revocation of a License for Continuously Repeating Participants (Enforcement Monitor's Recommendation #6)

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

5. Public Comment on Items not on the Agenda

6. Adjournment

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Rhonda Baldo at (916) 263-2600 or sending a written request to Ms. Baldo at the Medical Board of California, 1420 Howe Avenue, Suite 14, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.
Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the Chair may apportion available time among those who wish to speak. ********** ***For additional information, contact the Diversion Program at (916) 263-2600.***

Agenda Item 2A

Proposed Draft Language for Guidelines for Determining When to Order a Clinical Competency Examination

(a) Prior to recommending that the program manager order any clinical competency examination under subsection (b), the Diversion Evaluation Committee or committee case consultant shall rule out a physical or psychiatric cause for the physician's perceived inability to practice medicine safely and may conduct a re-evaluation interview of the physician.

(b) Upon completion of the above review, the program manager may order a physician to undergo a clinical competency examination if:
   (1) The physician has not practiced medicine for at least one year; or
   (2) There is reasonable cause to believe that the physician is unable to practice medicine with reasonable skill and safety to patients. Reasonable cause must be demonstrated by written documentation containing a specific factual description of objective observations and/or clinical evaluations, describing repeated incidents raising concerns about the physician's ability to practice medicine safely. The objective observations shall be those of the physician's committee case consultant, program case manager, group facilitator, worksite and hospital monitor(s), or well-being committee(s).

Legal Counsel Revisions to Proposed Draft Language for Guidelines for Determining When to Order a Clinical Competency Examination.

(a) The program manager may order a physician to undergo a clinical competency examination if :

(1) The physician has not practiced medicine for one year or more; or

(2) There is reasonable cause to believe that the physician is unable to practice medicine with reasonable skill and safety to patients. For purposes of this section, reasonable cause shall be demonstrated by one or more clinical evaluations or by written documentation prepared by the physician's committee case consultant, program case manager, group facilitator, worksite or hospital monitor(s), or well-being committee(s), that contains specific factual descriptions of objective observations of repeated incidents that raise concerns about the physician's ability to practice medicine safely.

(b) Prior to ordering a clinical competency examination pursuant to subsection (a)(2), the diversion evaluation committee or physician's committee case consultant shall rule out a physical or psychiatric cause for the physician's perceived or observed inability to practice medicine safely and may conduct a re-evaluation interview of the physician.

Recommendation	Plan	Status	Due Date
Issue #1			
Should Diversion Program participation be capped within a fixed budget as noted in the Enforcement Monitor's Recommendation #60: The Division of Medical Quality must determine whether Program participation should be an "entitlement" for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Diversion Program.	To study and analyze the diversion programs in other states and make a recommendation to the Diversion Committee on the feasibility of this proposal.	At this time there are no concerns about excessive caseloads. Diversion Case Manager staff has been agumented to handle current workload and future increases to keep caseloads at a manageable level.	Ongoing
Issue #2			
Should the Diversion Program charge participants who are practicing medicine participation fees to cover part of the overhead of the Program?	Revisit this issue in 2007 in the meantime the DPM will poll other states' diversion programs to determine if they charge a fee and how much, and if this has a negative affect on participation.	At this time there are no concerns since Diversion funding is adequate to cover staffing and programatic costs. The Committee may want to revisit the issue of participants paying a nominal fee for participation.	None
Issue #3			
Review duty statements for appropriate designation of roles and responsibilities of the group facilitators. Are the group facilitators serving as therapists and if so, are they subject to the reporting laws and requirements?	To review and update the guidelines and Contract for Group Facilitators, out lining their responsibilities to the program.	The Group Facilitators met and agreed upon new Contract language and the guidelines that support the Contract. Present to the Diversion Committee.	Completed
Issue #4			
Develop meaningful worksite monitor and hospital monitor standards, criteria and requirements.	Review current worksite/hospital monitor responsibilities and develop updated criteria and requirements; develop training for case managers in this area.	Draft document was approved by the Diversion Committee July 27, 2006.	Completed

Recommendation	Plan	Status	Due Date
Issue #5			
Consider the establishment of consistent criteria for termination from the Diversion Program.	Review criteria and make recommendations for amending CCR, Section 1357.5 - Causes for Termination from the Program - for more specific language on the subject.	This issue may be reviewed by the Diversion Advisory Counsel with recommendations being made to the Diversion Committee	Apr-07
Issue #6			
Consider the establishment of a mechanism for termination and revocation of license for continuously repeating participants. i.e. Use of Penal code, Section 1000 type of mechanism, where a repeating participant might sign a stipulated surrender of the license so that upon non-compliance the document is used for termination and revocation of license or develop standards for filing a petition to revoke probation and the license of a Board-ordered participant after "X" number of relapses.	Review criteria and make recommendations for amending CCR, Section 1357.5 - Causes for Termination from the Program - for more specific language on the subject. Also, review CCR, Section 1357.1 -Criteria for Admission, and possible regulation changes.	This issue may be reviewed by the Diversion Advisory Counsel with recommendations being made to the Diversion Committee	Apr-07
Issue #7			
Review and evaluate the role, purpose, and structure of the Liaison Committee	Liaison Committee as it has existed since 1982 was abolished by the DMQ in Feb-06. A Diversion Advisory Council was approved to replace the Liaison Committee. Council Membership will be appointed at the April 07 DMQ meeting.	Diversion Advisory Council structure and membership approved by DMQ at Feb 07 meeting. Council Member to be appointed at April 07 DMQ Meeting	Apr-07
Issue #8			
Review the DEC Relapse Referral Matrix for update and adoption as policy to guide the DECs.	Discussion with DEC members and Group Facilitators/Casemanagers to restructure the Relapse Matrix was held. More discussion will be held at the next DEC annual meeting to finalize the Matrix.	Under review by the DEC work group.	None
Issue #9			
Develop greater level of reporting communication between Diversion and Enforcement regarding Board-ordered and/or Board-referred participants in lieu of enforcement.	All Case Managers were moved to Enforcement field offices. Diversion Program Manager meets regularly with Enforcement Managers on matters of mutual concern.	Ongoing	Ongoing

Issue #10			
Update the Quarterly Quality Review reporting form to obtain the most important information required by the Committee for oversight purposes. i.e. Expand information on relapses, releases, include information on the number of urine collections and the number of monthly reports filed by the collectors.	To seek input from the Committee on what information should be included on the report that will assist them in their oversight responsibilities; revise the report format; expand on the data for relapses and releases.	A new format is underway-using suggestion from the Diversion Committee.	Apr-07
Issue #11			
Develop criteria/regulations for "evaluating physicians" who perform initial "multidisciplinary physical/mental examinations" on participants as they enter the Program.	Proposed standards were sent to various organizations and individuals. Responses were received and suggestions were incorperated into the suggested standards for Evaluators.	Proposed Criteria/Standards for Diversion Participant Evaluators were approved Nov-06.	None
Issue #12			
Develop criteria/regulations for a competency exam requirement for Diversion Program participants.	There are no current regulations for the Diversion Program established; but this requirement is addressed by the DEC.	On hold at this time due to no pressing need to develop this regulation. Will revisit in 2007.	None
Issue #13			
Consider a policy for mandatory "practice cessation" upon entry into the Diversion Program.	Continue the current "Policy" of case by case review by the DEC. Most physicians entering the program are sent to 120 days inpatient treatment. Once treatment is completed the participant cannot return to work without the permission of the DEC.	Issue to revisited in the future as needed.	None
Issue #14			
Consider if the Diversion Program is equipped to handle singly-diagnosed mentally ill physicians.	Continue the current "Policy" of case by case review by the Diversion Evaluation Committee (DEC) Provide ongoing training.	Ongoing	Ongoing
Issue # 15			
Develop and Update Policy and Procedure Manual	The Manual has bee updated, edits have been made and is currently awaiting approval of legal counsel.	Awaiting approval of legal counsel.	May-07

Compounding the failure of its monitoring mechanisms and understaffing problems described above, the Diversion Program is plagued by an almost complete lack of hard-and-fast, enforceable rules, standards, or expectations to which participants are held. The Diversion Program's decisionmaking is characterized by an unacceptable "case-by-case basis" mentality which promotes inconsistent decisionmaking and serves the interests of neither the participants nor the public.

a. The Diversion Program's statutes and regulations are skeletal at best, and set forth few enforceable rules, standards, or expectations for either the Program or its participants. The Diversion Program's statute was enacted in 1980 and has been rarely amended since then; DMQ's regulations implementing that statute are — for the most part — nonsubstantive restatements of the statute. None of the monitoring mechanisms described above — not the urine testing, nor the requirement that case managers regularly and personally observe both the group facilitators and the participants, nor the requirement of group meeting attendance, nor the worksite monitor requirements, nor the treating psychotherapy reporting — are mentioned in, much less governed by, statute or regulation. All of these monitoring mechanisms are contained in an unenforceable "procedure manual" that has rarely if ever been scrutinized by DMQ — which is statutorily responsible for administration of the Program — or even the Diversion Committee.

b. The *Diversion Program Manual* — which is unenforceable — sets forth no clear rules and no mechanisms to ensure standardized and consistent decisionmaking about potentially dangerous physicians. As described above, Diversion Program decisionmaking is excessively fragmented. If and when a relapse occurs — a relapse into drug or alcohol use by a physician who is practicing medicine with a full and unrestricted license and who may see dozens of patients each day, that event (which is detected by the Program days or even weeks after the test) sets in motion a complex and time-consuming chain of communications between various Program personnel (the CM, GF, the DEC consultant assigned to the participant, and perhaps the entire DEC which may be polled by telephone) and the participant, the lab, the participant's worksite monitor and/or hospital monitor, and the hospital well-being committee. As described above, these contributors to the ultimate Program decision are hampered by "records on each participant . . . scattered among three separate files" — participant files maintained at headquarters which lack critical documentation, a Diversion Tracking System that is used inconsistently by case managers and fails to capture all relevant information, and documentation of Program requirements that is either on location with the case managers or does not exist at all because it has not been submitted.

These individuals have no clear standards to guide their decisionmaking — a dynamic which can lead to inconsistent decisionmaking. The "rules" that are set forth in the *Diversion Program Manual* and purport to govern day-to-day operational procedures have been developed by prior staff with little or no input from the Division of Medical Quality, the Diversion Committee, or any of the Committee's predecessor task forces. Several of those "rules" are in fact "underground regulations" that should be adopted as regulations pursuant to the Administrative Procedure Act.

Each DEC operates in a vacuum; no standards exist to guide their consideration of individual participant matters to ensure that their recommendations are fair, consistent, and protective of the public interest. No DEC knows how another DEC has acted in a similar matter. No caselaw, precedent, or standards exist anywhere to guide them. In fact, no minutes of DEC meetings are ever taken.[464] The minutes of Liaison Committee meetings indicate an occasional concern that the various DECs are treating similar substantive issues differently, or procedurally functioning differently from each other. Under current law, the Program Administrator (not the DEC) is supposed to make final decisions and is thus in a position to impose consistency on various DEC recommendations — but the Program Administrator rarely if ever overrules a DEC recommendation.[465]

c. There is no consistently applied and enforceable rule regarding consequences for relapse. The Diversion Program's statute sets forth no consequences for relapse; instead, it directs the Division of Medical Quality to "establish criteria for the . . . termination of physicians" from the Program.[466] In turn, the Division has adopted a regulation authorizing the Program Administrator to terminate a physician's participation "for any of the following reasons: (a) [t]he physician has failed to comply with the diversion agreement, including but not limited to, failure to comply with the prescribed monitoring or treatment regimen, use of alcohol or other unauthorized drug; or refusal to stop practice when directed to do so . . . ."[467] This regulation is close to meaningless in practice. Participants relapse every day and are not terminated. Participants routinely fail to comply with their Diversion Program agreements in all sorts of ways — both significant and insignificant — and are not terminated. Of most critical importance, however, is the Division's failure to address the consequences for relapse. As noted above, relapse is expected during recovery, and it may not be reasonable to fashion a "one-strike-you're-out" policy. However, the Diversion Program has unilaterally fashioned (without input from DMQ) a "three-strikes-and-you-<u>may</u>-be-out" policy which is unenforceable.[468] Further, this "rule" is not consistently applied. In our review of twenty recent

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[464] Counsel to the Board have advised the Program not to take or retain "minutes" of DEC meetings which might be subpoenaed. Instead, the Program Administrator and analyst take notes on each case, which notes are then destroyed after staff implements the directives recorded in those notes.

[465] Interview with Diversion Program Administrator (July 26, 2004). Program staff note that the Program Administrator attends every DEC meeting and is in a position to inform one DEC how another DEC has treated a similar case. This may be true, but — for purposes of consistent decisionmaking across DECs and over time — it assumes that the Program Administrator serves for a lengthy tenure and has perfect memory. The Diversion Program has had two Administrators and one Acting Administrator in the past four years.

[466] Bus. & Prof. Code § 2350(a).

[467] 16 CAL. CODE REGS. § 1357.5.

[468] As noted above, both Diversion Program manuals include a "rule" stating that "a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program." *See supra* text at note 416 and note 416. This is one example of arguable "underground rulemaking" contained in the Diversion Program's policy and procedure manuals.

relapse cases, we found at least six cases in which the participants had relapsed at least four times before even being considered for termination, including the following examples:

- A participant was referred to the Diversion Program during mid-1998 pursuant to an SOU. The participant was permitted to remain in the Diversion Program following three relapses during November 1998 (collection tested positive for cocaine), December 1999 (collection tested positive for cocaine and alcohol), and December 2000 (self-reported using alcohol after missing work and group meetings). The participant subsequently relapsed a fourth time during April 2003 (collection tested positive for methamphetamine) and concurrently quit providing specimens and attending group meetings. The participant was not formally terminated from the Program until more than two months after the fourth relapse was detected.

- A participant was ordered into the Diversion Program during November 2000 as a condition of probation. At that time, the participant had already been involved with the Diversion Program for nearly two years. The participant missed several urine tests during the evaluation phase and also was noncompliant with Program requirements for a 2.5-year period following acceptance into the program (for example, the participant provided only two urine specimens over a 24-month period due to an inability to pay associated fees, failed to submit quarterly therapist reports, failed to submit semi-annual reports, and was out of compliance with continuing education requirements). Notwithstanding these continuing compliance deficiencies, during April 2003 the participant was authorized to return to work on a part-time basis. Following this, the participant continued to be out of compliance with Program requirements. In November 2003, the participant tested positive for cocaine, but was allowed to continue participating in the Program. In February 2004, the participant tested positive for Vicodin. Three months later, during May 2004, the participant was terminated from the Diversion Program. In total, this participant was involved with the Diversion Program for nearly six years and, as best we can determine, never achieved monitored sobriety for a sustained period or otherwise complied with Program participation requirements.

- A participant was referred to the Diversion Program during June 2001 pursuant to an SOU. The participant was permitted to remain in the Diversion Program after four relapses during October 2001 (tested positive for alcohol), February/March 2003 (tested positive for alcohol on two different occasions), December 2003 (tested positive for alcohol), and March 2004 (tested positive for alcohol). The participant also missed a scheduled collection during June 2001, was unavailable to be monitored for an extended period of time during mid-2003 due to participation in an unauthorized activity, and submitted a diluted specimen during January 2004. The participant was terminated from the Diversion Program one month after the fourth relapse was detected. The stated basis for the termination was the participant's failure to begin recommended inpatient treatment, suggesting that the participant otherwise would have been permitted to continue in the Program.

- A participant self-referred to the Diversion Program during November 2002. The participant relapsed during August/September 2003 (tested positive for Meperidine and Fentanyl), ceased taking Naltrexone without notifying the case manager, overmedicated a patient, was observed carrying unnecessary medications on his cart, missed urine collections and, after mid-October 2003, stopped attending group meetings. The participant was not formally terminated until early January 2004 (more than three months after he had stopped complying with Program requirements).

In 1982, the Auditor General detailed six cases in which participants egregiously violated the terms of their Diversion contracts but were not terminated from the Program; according to the Auditor General, "[t]hese deficiencies result from a lack of established standards and guidelines for terminating participants. In particular, the Board has not clarified the requirement that a physician be terminated from the program when that physician is deemed too great a risk to public health, safety, or welfare, especially when the physician is either under the influence of alcohol or drugs or mentally or physically disabled while caring for patients."[469] In 1985, the Auditor General detailed three matters where the participant repeatedly violated significant terms and conditions of the contract and should have been suspended from the practice of medicine and/or terminated from the Program but was not; the Auditor General concluded that the Medical Board must "[s]pecify for the program manager of the diversion program the kinds of noncompliance that warrant suspension or termination," and "develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly."[470]

Over 20 years later, DMQ has still failed to establish meaningful and enforceable standards for the handling of relapse by Diversion Program participants and for termination from the Program — apparently preferring to delegate to DECs and the Program Administrator a "case-by-case" approach. The Monitor appreciates the difficulty of fashioning a "one-size-fits-all" rule regarding relapse, but it seems patently unfair to both physicians and consumers that chronic relapsers who repeatedly and egregiously violate the terms of their Diversion contracts remain in the Program while other physicians genuinely seeking help are denied admission because of resource constraints and the Program's unwillingness to terminate the chronic relapsers.

d. The Diversion Program's statutes permit repeat offenders "too many bites of the apple." Related to the concern expressed above about DMQ's failure to establish meaningful standards for relapse and termination from the Program is another dynamic that we found in our review of Diversion Program files — and that remains unaddressed by statute, regulation, or policy. This dynamic involves a participant's repeated entry into, withdrawal or termination from, and

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[469] *See* 1982 Auditor General Report, *supra* note 427, at 43.

[470] *See* 1985 Auditor General Report, *supra* note 428, at 22–32.

reentry back into the Diversion Program. This "too many bites of the apple" syndrome works as follows:

Bite #1: A physician self-refers into the Diversion Program, then withdraws or is terminated for noncompliance. The Program can do nothing unless a DEC makes a finding that the physician constitutes a "threat to the public health or safety" under section 2350(j)(3).

Bite #2: MBC receives a complaint, a DUI arrest or conviction, or section 805 report against that same physician. Enforcement investigates the matter and diverts the physician into the Diversion Program under a statement of understanding (SOU) under section 2350(b). The physician is again in the Diversion Program; this time, his participation is known to enforcement but it is still concealed from the public because SOUs are not disclosed on MBC's Web site or in any other way. The physician withdraws or is terminated from noncompliance. This time, there is no "threat" assessment because the physician is in Diversion under an SOU, so he is referred to enforcement.

Bite #3: This time, enforcement likely files an accusation, which fact is disclosed on MBC's Web site. The physician stipulates to probation, including required participation in the Diversion Program. That term of probation is not included on MBC's Web site because of CAS limitations (see Chapters V and XIII). The physician withdraws or is terminated for noncompliance.

Bite #4: HQE files a petition to revoke probation (and possibly a petition for ISO if HQE can prove the physician is currently using drugs or alcohol). After hearing, the ALJ recommends revocation of the license. DMQ revokes, stays the revocation, and places him on probation — one term of which is (again) required participation in Diversion. The physician withdraws or is terminated for noncompliance.

Bite #5: This "bite" will be a repeat of Bite #4 unless DMQ finally revokes the license or the DEC and the Program Administrator refuses to admit him into the Diversion Program (both events are somewhat rare).

This is not a hypothetical issue. We have found a number of cases in which chronic relapsers who repeatedly enter and are repeatedly terminated from the Program are repeatedly readmitted to the Program. Two examples are illustrative:

- While undergoing inpatient substance abuse treatment in 1997, 1998, and 1999, a physician was ordered by the Board to participate in Diversion in July 1998; the physician was unsuccessfully terminated in June 1999. In September 1999, HQE filed an accusation and a petition

for ISO after the physician collapsed on duty as a result of abuse of Vicodin, Demerol, and Xanax. A partial ISO imposing therapy and practice restrictions (not a suspension) was granted on September 19, 1999. Following the filing of a supplemental accusation in November 2000, DMQ placed the physician's license on probation and ordered the physician to return to Diversion. In February 2002, a DEC denied admission to Diversion because of noncompliance during the evaluation phase; Probation was not notified of the DEC's decision, and assumed the physician was in the Diversion Program. In July 2003, HQE filed a petition to revoke probation (because the physician was not in Diversion), and the physician reapplied for admission to Diversion. This time, the DEC accepted the physician's application and admitted the physician into the Program. HQE's petition to revoke probation is pending.

- After undergoing inpatient treatment in 1997, 1998, and 1999, this physician was unsuccessfully terminated from the Diversion Program in April 2000. As the result of a complaint to enforcement, the physician was referred back into Diversion under an SOU in July 2000. The physician resumed practice without authorization and, in December 2000, the physician's application for admission into Diversion was denied. During September 2001, the participant was ordered into Diversion under the terms of a DMQ-approved stipulation. Although the physician relapsed on alcohol on July 17, 2003, the Program permitted the physician to continue practicing medicine. On July 28, 2003, the physician tested positive for Demerol, and was terminated from Diversion on August 8, 2003.

Nothing in the Diversion Program's statutes, regulations, or policy manual addresses this issue or prevents this waste of the Program's limited resources. In light of the Program's budget constraints, understaffing, and the significant absence of internal controls described above, it is unfair to subject the public to a repeat offender who is able to manipulate the system and remain licensed. That physician's space in the Diversion Program would be better used by someone more committed to recovery.

DMQ must shoulder its statutory duty and establish clear standards for several aspects of the Program. It is fair to say that DMQ has never meaningfully implemented the Legislature's directive to "establish criteria for the acceptance, denial, or termination of physicians" from the Diversion Program.[471] The Division has adopted some regulations, but they are merely restatements of the statute and/or commonsense, circular, and fairly nonsubstantive prescriptions.[472] The Division has never meaningfully implemented the Legislature's directive to "establish criteria for the selection

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[471] Bus. & Prof. Code § 2350(a).

[472] For example, a physician can be terminated from Diversion under section 1357.5, Title 16 of the California Code of Regulations, if he has done anything to warrant denial of his application for admission under section 1357.4, Title 16 of the California Code of Regulations.

of evaluating physicians and surgeons or psychologists who shall examine physicians and surgeons requesting diversion . . . ."[473] This leads the Monitor to the next major concern.

3. Contrary to statute, the Division of Medical Quality has never taken "ownership" of or responsibility for the Diversion Program.

As noted above, state law requires DMQ to administer the Diversion Program and oversee its functioning.[474] MBC's Diversion Program is one of only four in the nation to be housed directly within a state medical board — subject to its direct supervision and oversight. One must assume that the purpose of this in-house structure is to enable members of the Medical Board to affirmatively oversee the Diversion Program to ensure that the public is protected from impaired physicians. However, this has not happened. Instead, in 1982, the Division of Medical Quality effectively delegated its authority over the Diversion Program to the Liaison Committee — which has no statutory existence or authority — and to the staff of the Diversion Program, which in the past has interpreted Liaison Committee directives and recommendations as orders, and has implemented them without DMQ or Diversion Committee review.[475]

The Auditor General reports of the 1980s universally found that the Division has failed to adequately supervise and oversee the Diversion Program.[476] The 1985 report could not be more

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[473] Bus. & Prof. Code § 2350(h). *See supra* note 398. Instead, the Division punted this duty to the Liaison Committee, which presented some draft criteria to the Diversion Committee at its February 2001 meeting. The Chair of the Diversion Committee strongly objected to some of the exceptions to the requirements, and sent the criteria back to LCD for more work. The LCD did not come back with an amended version until the Committee's January 2002 meeting, when legal counsel objected to them and LCD withdrew them for "further work." These criteria have never again appeared on any agenda of the Diversion Committee or the Division of Medical Quality.

[474] Bus. & Prof. Code § 2346.

[475] In 1999 documents, the Liaison Committee noted that it had engaged in numerous activities and made many recommendations regarding the functioning of the Diversion Program over the prior five years. These activities include a report and recommendation on the Program's urine testing program (Oct.16, 1998); a recommendation on elements which should be included in the clinical evaluations of physicians applying for or participating in the Program (Feb. 25, 1998); a report specifying the role and responsibilities of the DEC member who is serving as a case consultant, plus two measures for identifying whether a case consultant is carrying out the intended function (Aug. 21, 1996); and the adoption of a policy in 1994 requiring group facilitators to maintain a current file on each participant. Liaison Committee to the Medical Board's Diversion Program, *Testimony before the Medical Board's Diversion Task Force* (Jan. 20, 1999) (on file at CPIL); *see also* Liaison Committee to the Medical Board's Diversion Program, *Agenda Packet for May 27, 1998 Meeting* (Agenda Item V.F. regarding Facilitator Records) (on file at CPIL). None of these recommendations were ever discussed, reviewed, or ratified by DMQ at any public meeting.

[476] *See* 1982 Auditor General Report, *supra* note 427, at 36 ("the board has not established policies governing frequency of contact with participants"), 40 ("the board has not established policies for approving and monitoring supervised, structured environments for Diversion Program participants"), 43 (the board has failed to establish "standards and guidelines for terminating participants"). *See also* 1986 Auditor General Report, supra note 430, at 21 ("[t]he Board of Medical Quality Assurance has improved some elements of its diversion program for physicians; however, further improvement is needed. . . . [T]he board still does not routinely monitor physicians in the diversion program

other state medical boards and California boards with licensee impairment programs. Neither of these threshold issues were directly addressed by MBC during 2005. However, the Board has created a mechanism — a new Diversion Committee — to consider the other policy issues raised by the Monitor and listed below. SB 231's July 1, 2008 sunset date on the Diversion Program should serve as an incentive for the Committee and DMQ to fully and finally resolve these significant and longstanding policy issues:

1. Whether Diversion Program participation should be an "entitlement" for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Program (Monitor's *Initial Report* Recommendation #60).

2. Whether the Diversion Program should charge participants who are practicing medicine participation fees to cover part of the overhead of the Program — as several other agencies do (Monitor's *Initial Report* Recommendation #60 and discussion at page 241, note 390).

3. Development of meaningful "worksite monitor" and "hospital monitor" standards, criteria, and requirements (*Initial Report* discussion at pages 267–69).

4. Development of meaningful consequences for relapse, including a review of the Relapse Referral Matrix contained in the *Diversion Program Manual.* The matrix should be restated and adopted as policy or regulations to provide consistent guidance to the DECs and Program staff (*Initial Report* Recommendation #58 and discussion at pages 245, 275–77).

5. Consideration of the establishment of consistent criteria for termination from the Diversion Program (for example, "three strikes and you're out") (*Initial Report* Recommendation #62 and discussion at pages 274–80).

6. Consideration of the establishment of a mechanism that not only terminates Diversion Program participation but also revokes the license of Board-ordered and Board-referred "repeated-bite-of-the-apple" participants who have been admitted to the Program, terminated for noncompliance, readmitted to the Program, terminated for noncompliance, etc. (*Initial Report* Recommendation #62 and discussion at pages 277–80).

    a. For example, use of a Penal Code section 1000-type mechanism where a repeat offender is required, upon his second or third admission to the Diversion Program, to sign a stipulated surrender of his license which is then filed while he is participating in Diversion. If he violates his contract, that stipulation is resurrected and not only is he terminated from the Program but his license is revoked without further proceedings.

b. As an alternative, MBC should develop standards for the filing of a petition to revoke probation and revoke the license of a Board-ordered participant after X number of relapses while in the Program. This would take more time and require additional procedures that are avoided in 6(a) above.

7. Review and evaluation of the appropriate role, purpose, and structure of the Liaison Committee to the Diversion Program (*Initial Report* Recommendation #59 and discussion at pages 280–81).

8. Protocols for the Diversion Program's communication with MBC's enforcement and probation programs on participants who are Board-ordered and/or Board-referred. There should be a greater level of communication between Diversion and enforcement on these participants, who are participating in Diversion in lieu of enforcement.

9. The categories of information that should be included in "quarterly quality review" (QQR) reports from Program staff to Diversion Committee members that would enable the Committee to responsibly oversee the functioning of the Program as required by law.

10. A review of the role and duty statements of the Program's group facilitators. Most GFs are licensed therapists of some sort, and they are functioning as therapists. The program must ensure that GF duty statements require appropriate licensure or certification, and that GFs comply with all laws regulating their practice.

11. Regulations establishing qualifications and criteria for "evaluating physicians" who perform initial multidisciplinary physical and mental examinations on participants as they enter the Program. Since 1981, DMQ has been required to adopt regulations codifying these criteria, but the current regulation (section 1357.3, Title 16 of the California Code of Regulations) is meaningless. This issue was delegated to the Liaison Committee in 2000, but that Committee has never presented alternative standards (*Initial Report* discussion at pages 279–80 and notes 398 and 473).

12. Regulations governing competency examinations for Diversion Program participants. This option was added in SB 1950 (Figueroa) in 2002, and the statute requires rulemaking by the Division of Medical Quality. The Diversion Committee delegated this issue to the Liaison Committee in 2003, which produced draft standards for the conduct of a competency exam allowing Diversion Program participants three chances to pass a basic clinical competency exam in May 2004. The Diversion Committee chair returned those draft standards to the Liaison Committee for more work, but no revised standards have ever been produced (*Initial Report* discussion at note 460).

13. Consideration whether there should be a mandatory "practice cessation" period for participants upon entry into the Diversion Program (as the Board of Registered Nursing requires). In practice, this happens in many cases because the physician immediately enters treatment upon entry into the Program. However, should it be a requirement? At least a presumption? (*Initial Report* Recommendation #62).

14. Whether MBC's Diversion Program is equipped — either now or in the future — to handle singly-diagnosed mentally ill physicians, as required by SB 1950 in 2002 (*Initial Report* discussion on page 253).

CALIFORNIA CODES
BUSINESS AND **PROFESSIONS CODE**
SECTION **2340**-2358

2340. It is the intent of the Legislature that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety.

2341. As used in this article:
(a) "Division" means the Division of Medical Quality of the Medical Board of California.
(b) "Committee" means a diversion evaluation committee created by this article.
(c) "Program manager" means the staff manager of the diversion program or his or her designee.

2342. One or more diversion evaluation committees is hereby created in the state to be established by the division. Each committee shall be composed of five persons appointed by the division.
Each committee shall have the following composition:
(a) Three physicians and surgeons licensed under this chapter. The division in making its appointments shall give consideration to recommendations of medical associations and local medical societies and shall consider, among others, where appropriate, the appointment of physicians and surgeons who have recovered from impairment or who specialize in psychiatry or who have knowledge and expertise in the management of impairment.
(b) Two members not licensed as a physician and surgeon.
Each person appointed to a committee shall have experience or knowledge in the evaluation or management of persons who are impaired due to alcohol or drug abuse, or due to physical or mental illness.

It shall require the affirmative vote of four members of the division to appoint a person to a committee. Each appointment shall be at the pleasure of the division for a term not to exceed four years. In its discretion the division may stagger the terms of the initial members appointed.

2343. (a) Each member of a committee shall receive per diem and expenses as provided in Section 103.
(b) The program manager shall account for all expenses and revenues of the diversion program and separately report this information to the board on a quarterly basis.

2344. A committee created under this article operates in an advisory role to the program manager. Three members of a committee, at least one of whom shall be a public member with expertise or experience with the treatment of substance abuse and addiction, shall constitute a quorum for the transaction of business at any meeting. Any recommendation requires the majority vote of the committee.

2345. Each committee shall elect from its membership a chairperson and a vice chairperson.

2346. The division shall administer the provisions of this article.

2350. (a) The division shall establish criteria for the acceptance, denial, or termination of physicians and surgeons in a diversion program. Only those physicians and surgeons who have voluntarily requested diversion treatment and supervision by a committee shall participate in a program.

(b) A physician and surgeon under current investigation by the division may request entry into the diversion program by contacting the Chief or Deputy Chief of Enforcement of the Medical Board of California. The Chief or Deputy Chief of Enforcement of the Medical Board of California shall refer the physician and surgeon who requests participation in the diversion program to a committee for evaluation of eligibility, even if the physician and surgeon is currently under investigation by the division, as long as the investigation is based primarily on mental illness or on the self-administration of drugs or alcohol under Section 2239, or the illegal possession, prescription, or nonviolent procurement of drugs for self-administration, and does not involve actual harm to the public or his or her patients. Prior to referring a physician and surgeon to the diversion program, the division may require any physician and surgeon who requests participation under those circumstances, or if there are other violations, to execute a statement of understanding in which the physician and surgeon agrees that violations of this chapter or other statutes that would otherwise be the basis for discipline may nevertheless be prosecuted should the physician and surgeon be terminated from the program for failure to comply with program requirements.

(c) Neither acceptance into nor participation in the diversion program shall preclude the division from investigating or continuing to investigate any physician and surgeon for any unprofessional conduct committed before, during, or after participation in the diversion program.

(d) Neither acceptance into nor participation in the diversion program shall preclude the division from taking disciplinary action or continuing to take disciplinary action against any physician and surgeon for any unprofessional conduct committed before, during, or after participation in the diversion program, except for conduct that

resulted in the physician and surgeon's referral to the diversion program.

(e) Any physician and surgeon terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the division for acts committed before, during, and after participation in the diversion program. The division shall not be precluded from taking disciplinary action for violations identified in the statement of understanding described in subdivision (b) if a physician and surgeon is terminated from the diversion program for failure to comply with program requirements. The termination of a physician and surgeon who has been referred to the diversion program pursuant to subdivision (b) shall be reported by the program manager to the division.

(f) Nothing in this section shall preclude a physician and surgeon who is not the subject of a current investigation from self-referring to the diversion program on a confidential basis. Subdivision (b) shall not apply to a physician and surgeon who applies for the diversion program in accordance with this subdivision.

(g) Any physician and surgeon who successfully completes the diversion program shall not be subject to any disciplinary actions by the board for any alleged violation that resulted in referral to the diversion program.

(1) Successful completion shall be determined by the program manager and shall include, at a minimum, three years during which the physician and surgeon has remained free from the use of drugs or alcohol and adopted a lifestyle to maintain a state of sobriety.

(2) Notwithstanding paragraph (1), with respect to mental illness, successful completion shall be determined by the program manager and shall instead include, at a minimum, three years of mental health stability and treatment compliance and adoption of a lifestyle designed to maintain a state of mental health stability.

(h) The division shall establish criteria for the selection of evaluating physicians and surgeons or psychologists who shall examine physicians and surgeons requesting diversion under a program. Any reports made under this article by the evaluating physician and surgeon or psychologist shall constitute an exception to Section 2263 and to Sections 994, 995, 1014, and 1015 of the Evidence **Code**.

(i) The division shall require biannual reports from each committee which shall include, but not be limited to, information concerning the number of cases accepted, denied, or terminated with compliance or noncompliance, and a cost analysis of the program. The Bureau of Medical Statistics may assist the committees in the preparation of the reports.

(j) Each physician and surgeon shall sign an agreement that diversion records may be used in disciplinary or criminal proceedings if the physician and surgeon is terminated from the diversion program and one of the following conditions exists:

(1) His or her participation in the diversion program is a condition of probation.

(2) He or she has a disciplinary action pending or was under investigation at the time of entering the diversion program.

(3) A diversion evaluation committee determines that he or she presents a threat to the public health or safety.

This agreement shall also authorize the diversion program to exchange information about the physician and surgeon's recovery with a hospital well-being committee or monitor and with the board's

licensing program, if appropriate, and to acknowledge, with the physician and surgeon's approval, that he or she is participating in the diversion program. Nothing in this section shall be construed to allow release of alcohol or drug treatment records in violation of federal or state law.

In addition, this agreement shall authorize the diversion program, upon recommendation by a diversion evaluation committee, to order the physician and surgeon to be examined by one or more physicians and surgeons designated by the diversion program to determine clinical competency. The failure of the physician and surgeon to comply with this order shall constitute grounds for suspension or revocation of his or her certificate. The board shall develop regulations that provide guidelines for determining when this examination should be ordered.

2351. The committee shall inform each physician and surgeon who requests participation in a program of the procedures followed in the program, of the rights and responsibilities of the physician and surgeon in the program, and of the possible results of noncompliance with the program.

2352. Each committee shall have the following duties and responsibilities:

(a) To evaluate those physicians and surgeons who request participation in the program according to the guidelines prescribed by the division and to make recommendations to the program manager.

(b) To review those treatment facilities to which physicians and surgeons in a diversion program may be referred and make recommendations to the program manager.

(c) To receive and review information concerning a physician and surgeon participating in the program.

(d) To call meetings as necessary to consider the requests of physicians and surgeons to participate in a diversion program, and to consider reports regarding physicians and surgeons participating in a program from an administrative physician and surgeon, from a physician and surgeon, or from others.

(e) To consider in the case of each physician and surgeon participating in a program whether he or she may with safety continue or resume the practice of medicine and make recommendations to the program manager.

(f) To make recommendations to the program manager regarding the terms and conditions of the diversion agreement for each physician and surgeon participating in the program, including treatment, supervision, and monitoring requirements.

2352.1. The program shall provide information to the division as it may prescribe to assist it in evaluating the program, directing the program's operation, or proposing changes to the program. The division shall hold a meeting open to the public, at least annually, for the purpose of reviewing the required data and evaluating the program's operation.

2353. Notwithstanding the provisions of Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government **Code**, relating to public meetings, a committee may convene in executive session to consider reports pertaining to any physician and surgeon requesting or participating in a diversion program. A committee shall only convene in executive session to the extent that it is necessary to protect the privacy of such a physician and surgeon.

2354. Each physician and surgeon who requests participation in a diversion program shall agree to cooperate with the treatment and monitoring program designated by the program manager. Any failure to complete successfully a treatment and monitoring program may result in the filing of an accusation for discipline which may include any acts giving rise to the original diversion.

2355. (a) After the program manager has determined that a physician and surgeon has been rehabilitated and the diversion program is completed, the program manager shall purge and destroy all treatment records pertaining to the physician's and surgeon's participation in a diversion program, except as otherwise provided in this section. Notwithstanding Section 156.1, the board shall retain any other information and records that it specifies by regulation.

(b) Except as otherwise provided by Section 2350, all board and committee records and records of proceedings pertaining to the treatment of a physician and surgeon in a program shall be kept confidential and are not subject to discovery or subpoena.

2356. The board shall provide for the representation and indemnification of any persons making reports to a committee or the board under this article in any action in accordance with Section 2317.

2358. This article shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute that is enacted before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

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Agenda Items 3 & 4

Impaired Physician Program

TITLE 16. Professional And Vocational Regulations
Division 13. Medical Board of California*
Chapter 2. Division of Medical Quality
Article 2. Impaired Physician Program

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Impaired Physician Program

§1357. Definitions.

As used in this article.

(a) "Program" means the impaired physician diversion program authorized pursuant to Article 14 (commencing with Section 2340) of the Medical Practice Act.

(b) "Committee" means a diversion evaluation committee

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Impaired Physician Program

§1357.1. Criteria for Admission.

An applicant shall meet the following criteria for admission to the program:

(a) The applicant shall be a licensed physician or be otherwise legally authorized to practice medicine in this state.
(b) The applicant is found to abuse dangerous drugs or alcoholic beverages, or suffer from mental or physical disability in a manner which may affect the physician's ability to practice medicine safety or competently.
(c) The applicant shall have voluntarily requested admission to the program.
(d) The applicant agrees to undertake any medical or psychiatric examinations ordered to evaluate the application for participation in the program
(e) The applicant cooperates with the program by providing medical information, disclosure authorizations and releases of liability as may be necessary for participation in the program.
(f) The applicant agrees in writing to cooperate with all elements of the diversion agreement.

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Impaired Physician Program

§1357.2. Procedure for Review of Applicants.

(a) Program staff and a committee, shall act as consultants to the program manager for the purpose of interviewing each applicant who requests admission to the program.
(b) The committee shall recommend such medical and psychiatric examinations as may be necessary to determine the applicant's eligibility for the program and request such other information, authorizations, and releases necessary for the program.
(c) The committee shall make a recommendation to the program manager whether the applicant should be admitted to the program.
(d) The program manager's decision on admission of an applicant to the program shall be final.

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§1357.3. Evaluating Physicians.

A physician selected by the program manager or his/her designee to conduct medical and psychiatric evaluations of an applicant shall be a licensed physician who is competent in his/her field of specialty.

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Impaired Physician Program

§1357.4. Causes for Denial of Admission.

The program manager may deny an applicant admission to the program for any of the following reasons:

(a) The applicant does not meet the requirements set forth in Section 1357.1.
(b) The applicant has been disciplined by another state medical licensing authority.
(c) Complaints or information have been received by the division which indicate that the applicant may have violated a provision of the Medical Practice Act or committed any other act that would be grounds for discipline, excluding Sections 822 and 2239 of the code.
(d) The committee recommends that the applicant will not substantially benefit from participation in the program or that the applicant's participation in the program creates too great a risk to the public health, safety or welfare.

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Impaired Physician Program

§1357.5. Causes for Termination from the Program.

The program manager may terminate a physician's participation in the program for any of the following reasons:

(a) The physician has failed to comply with the diversion agreement, including but not limited to, failure to comply with the prescribed monitoring or treatment regimen, use of alcohol or other unauthorized drug; or refusal to stop practice when directed to do so by the committee.

(b) Any cause for denial of an applicant in Section 1357.4.

(c) The physician has failed to comply with any of the requirements set forth in Section 1357.1.

(d) The committee recommends that the physician will not benefit from further participation in or has not substantially benefited from participation in the program or that the physician's continued participation in the program creates too great a risk to the public health, safety or welfare.

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§1357.6. Notification of Termination.

Whenever any physician who is self-referred is terminated from the program and has been determined to present a threat to the public health or safety, the program manager shall report such fact to the division, without the inclusion of any confidential information as defined in Section 1357.8.

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Impaired Physician Program

§1357.8. Confidentiality of Records.

(a) All board, division, committee and program records relating to a physician's application to the program or participation in the program shall be kept confidential pursuant to section 2355 of the code, including all information provided by the applicant, or by an examining physician, to the program manager, a medical consultant, members of the committee, or other employees of the division in connection with the program. Except as otherwise provided in section 1357.9, such records shall be purged when a physician's participation in the program is either completed or terminated.

(b) All other information or records received by the board prior to the acceptance of the applicant into the program, or which do not relate to the physician's application to the program, or which do not relate to the physician's participation in the program, shall not be maintained in a confidential manner as required by Section 2355 and may be utilized by the board in any disciplinary or criminal proceedings instituted against the physician.

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Impaired Physician Program

§1357.9. Retention of Diversion Program Participant Records.

The diversion program shall retain the following types of records concerning a participant:

(a) All intake reports and case analyses.
(b) All agreements and amendments thereto.
(c) All correspondence with the Enforcement Program.
(d) All committee letters.
(e) All file notes, laboratory and incident reports.
(f) Computerized records derived from any of the foregoing types of documents.

For Review July 10 by DAC

Diversion Program Regulations CCR Title 16 DRAFT (Pating/Snook 7/2/07)
(underlined = proposed amendments to regulations)

1357.4. Causes for Denial of Admission.

The program manager may deny an applicant admission to the program for any of the following reasons:
(a) The applicant does not meet the requirements set forth in Section 1357.1.

(b) The applicant has been disciplined by another state medical licensing authority.

(c) Complaints or information have been received by the division which indicate that the applicant may have violated a provision of the Medical Practice Act or committed any other act that would be grounds for discipline, excluding Sections 822 and 2239 of the code.

(d) The committee recommends that the applicant will not substantially benefit from participation in the program or that the applicant's participation in the program creates too great a risk to the public health, safety or welfare.

<u>(e) The committee determines that the applicant is unlikely to be successfully rehabilitated based upon documented evidence.</u>

<u>The Division shall adopt guidelines for denial of admission for applicants or referrals who have previously been in the program and review, update and approve them annually to assess effectiveness and consistency with current clinical monitoring standards.</u>

s 1357.5. Causes for Termination from the Program.

The program manager may terminate a physician's participation in the program for any of the following reasons:

(a) The physician has failed to comply with the diversion agreement, including but not limited to, failure to comply with the prescribed monitoring or treatment regimen, use of alcohol or other unauthorized drug; or refusal to stop practice when directed to do so by the committee.

(b) Any cause for denial of an applicant in Section 1357.4.

(c) The physician has failed to comply with any of the requirements set forth in

Section 1357.1.

(d) The committee recommends that the physician will not benefit from further participation in or has not substantially benefited from participation in the program or that the physician's continued participation in the program creates too great a risk to the public health, safety or welfare.

The Division shall adopt guidelines for termination from the program and review, update and approve them annually to assess effectiveness and consistency with current clinical monitoring standards.

Guidelines for Assessment for Admission and Termination from Diversion Program. DRAFT (Pating/Snook 7/2/07)

(Guidelines for Assessment following Positive Urine Test; or Alcohol/Drug Relapse – TO FOLLOW)

I. [Assessment trigger] Upon any change in program status, including but not limited to admission, annual review, positive urine toxicology test, reported use of alcohol or other unauthorized drug, or consideration for termination from the program, the program manager shall direct the case manager and case consultant or diversion evaluation committee to perform a documented monitoring assessment and request written recommendations..

(a) [Goal of assessment] In collaboration with the case consultant or diversion evaluation committee, the program manager shall determine in every instance if 1) the physician can be successfully rehabilitated and 2) the physician can benefit from participation in the program as described under regulations section 1357.4 (d).
(b) Physicians meeting these criteria shall be provided written recommendations by the program manager, after consultation with the case consultant and diversion evaluation committee.
(c) Physicians not meeting both these criteria shall be deemed ineligible for the program and may be denied admission or terminated.

II. Documented assessments by case consultants and diversion evaluation committees must be written and submitted to the program manager.

(a) [Assessment components] Assessments by the case consultant or diversion evaluation committee must include review of 1) current health status, including treatment, status and prognosis of any reported medical, psychiatric or substance abuse related impairment; 2) program and treatment compliance, including review of compliance with stipulations in the physician's diversion program agreement, 3) safety to practice, including ability to return to practice or record of safety if already returned to medical practice, and 4) status of license.
(b) [information reviewed] Case consultants and diversion evaluation committees may consider multiple sources of information in completing their assessment, including but not limited to medical records or conversations with treating provider; diversion program staff members, case managers or group leaders; diversion program monitoring and compliance records; urine toxicology reports and/or reports from Medical Review Officer; work-site monitor or physician wellbeing

committees; or another other relevant collateral information. Sources of information used shall be documented in the assessment report.

(c) [establish and document opinion] Case consultants and diversion evaluation committees shall establish and document an opinion regarding 1) current health status, 2) program and treatment compliance, 3) safety to practice and 4) status of license. These opinions should be provided to the program manager.

(d) [written recommendations] Case consultants and diversion evaluation committees shall document and provide the program manager with any written recommendations deemed necessary to improve the physician participant's 1) current health status, and/or 2) program and treatment compliance. These recommendations may include 1) specific health recommendations to improve compliance with recommended treatment; or medical or psychiatric evaluation for any identifiable or unresolved impairments, or 2) revised program or monitoring requirements, or 3) referral to the program managers for suspected unsafe practice.

(e) [removal from work for safety] Case consultants or diversion evaluation committees must notify the program manager of any physician deemed or suspected to be unsafe to practice. Upon receiving this notification, the program manager shall remove the physician from work until safety or competency concerns are resolved. If necessary, the program manager, in consultation with the case consultant or diversion evaluation committee, may direct the physician to undergo a competency examination.

III. [Criteria for Admission by DEC] Physician's considered for admission to the program shall receive a documented assessment by the diversion evaluation committee.

Physicians may be admitted to the program if they meet criteria specified in section 1375.1 Physicians may be denied admission to the program if they meet criteria specified in regulations Section 1375.4.

(a) In accordance with regulations Section 1357.4 (d) the diversion evaluation committee shall establish and document its opinion substantiating a participant's ability to benefit from participation in the program. This opinion shall be established based on consideration of 1) the physician's likelihood of response to treatment and 2) likelihood of compliance with program requirements as stipulated in the diversion agreement. This opinion may included consideration of any prior treatment history or prior involvement in a diversion monitoring program or complications arising from co-morbid conditions. [nb. Diversion is abstinence based, not harm-reduction]

(b) In accordance with regulations Section 1375.4 (d) the diversion evaluation committee shall establish and document its opinion substantiating a participant's ability to practice safely. This opinion

shall be established based on consideration of 1) prior work and safety history, 2) review of patient complaints or prior discipline, and 3) response to treatment. The diversion evaluation committee shall report any physician deemed or suspected to be unsafe to the program manager.

(c) In accordance with standard documented assessment guidelines, the diversion evaluation committees shall document and provide the program manager with written recommendations, which are deemed necessary to improve the physician participant's 1) current health status, and/or 2) program and treatment compliance. These recommendations may include 1) specific health recommendations to improve compliance with recommended treatment; or medical or psychiatric evaluation for any identifiable or unresolved impairments, or 2) revised program or monitoring requirements, or 3) removal from practice for suspected unsafe practice.

IV. [Criteria for recommending Termination by DEC] Physician's considered for termination from the program shall receive a documented assessment by the diversion evaluation committee. Assessment by case consultant only is insufficient for termination.

(a) [successful termination] Physician may be successfully terminated from the program if the diversion evaluation committee establishes and documents the following:

1) [disease remission or stable maintenance] The physician has been effectively treated and demonstrates likelihood of continued disease remission or stable response to maintenance-phase treatment.

i. Disease remission from alcohol or substance dependence is demonstrated by either 3 years of continuous abstinence from drugs or alcohol and compliance with an effective maintenance-phase treatment regimen.

ii. Stable remission from mental disorders is demonstrated by at least 18 months of stable response to maintenance-phase treatment and compliance with treatment recommendations.

2) [compliant with program] The physician has been satisfactorily compliant with all program requirements as stipulated in the diversion agreement.

3) The physician has safely returned to medical practice for at least 1 year.

4) The physician has an active license.

(b) [unsuccessful termination] Physicians may be terminated from the program as unsuccessful if the diversion evaluation committee establishes and documents any of the following: (nb. Need sentence to cross reference 1375.4 and 1375.5)

1) [untreatable or failed treatment] The physician has been deemed unlikely to achieve continued disease remission or has been unable to demonstrate a stable response to maintenance-phase treatment as demonstrated by repeated failure of treatment, recurrence of symptoms, or alcohol or drug relapse despite multiple clinical interventions.
2) [non-compliance] The physician is deemed non-compliant with program requirements as stipulated in the diversion agreement.
3) [unsafe] The physician is deemed unsafe to practice medicine following competency evaluation and remediation training and/or proctoring.
4) [no license] The physician voluntarily surrenders their license or their license is revoked.

(c) Physicians may be terminated from the program if it is deemed by the program manager, in consultation with the diversion evaluation committee, that the physician is unable to benefit from the program.

(d) [Referral to DMQ if unsuccessful] (nb. Optional-check with Frank) Physicians who are terminated from the program as unsuccessful should be referred to the Division of Medical Quality.

IV. [Urine test positive] Documented assessment by case consultant or diversion evaluation committee must occur following an MRO-reviewed positive urine toxicology test for alcohol or any unauthorized drug. {Nb. Need new comprehensive relapse procedures.}

(nb. Need a Sub-committee to handle review of Urine Positive Relapses and other reported Relapses)

V. [Unauthorized alcohol or drug use aka Relapse] Documented assessment by case consultant or diversion evaluation committee must occur following and reported unauthorized alcohol or drug use.