STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA– Diversion Program
1434 Howe Avenue, Suite 14, Sacramento, CA 95825
(916) 263-2600 Fax (916) 263-2607 www.mbc.ca.gov

DIVERSION COMMITTEE

MEMBERS OF THE COMMITTEE

Laurie C. Gregg, M.D., Chair
Cesar Aristeigueta, M.D.
Stephen Corday, M.D.
Shelton Duruisseau, M.D.
Janet Salomonson, M.D.

July 26, 2007

Embassy Suites
Tiburon/Sausalito Room
250 Gateway Blvd.
South San Francisco, CA 94010
(650) 589-3400

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

AGENDA

2:00 p.m. – 4:30 p.m.
(or until the conclusion 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 Committee may attend only as observers.

1. Call to Order/Roll Call

2. Approval of the April 26, 2007 Minutes

3. Bureau of State Audits' Recommendation Matrix Review

4. Diversion Program's Policies and Procedures Manual Approval

5. Diversion Advisory Council Update
   A. Proposed Regulation Language for Guidelines for Determining when to Order a Clinical Competency Examination (Enforcement Monitor Recommendation #12)
   B. Proposal to Modify the Regulatory Criteria for Admission to and Termination from the Diversion Program (Enforcement Monitor Recommendation #5)
      1. Re-entry into the Diversion Program

6. Proposed Regulation Language for Response to Relapses

7. Discussion of the Establishment of a Mechanism for Termination and Revocation of a License for Continuously Repeating Participants (Enforcement Monitor's Recommendation #6)
   A. Status of License after Termination from the Diversion Program

8. Quarterly Quality Review Report (New Format)
   A. Discussion of Enhancements to the Quarterly Quality Review Reports

9. Diversion Program Update
   A. DEC Member Re-Appointments
   B. Worksite Monitors – Conflict of Interest
   C. Status of New Vacation Policy
   D. Case Managers' Caseloads
   E. Financial Status Report per SB 231 (Business & Professions Code 2343 (b))
   F. Resolution of the remaining Enforcement Monitor's Recommendations

10. Collection System Manager's Report
   A. Report on Actions taken for June 1, 2007 – July 25, 2007 Positive Drug Tests
   B. Discussion on Collectors/Participants Collection Problems

11. Case File Review Report

12. Agenda Items for November 2007 Meeting

13. Public Comment on Items not on the Agenda

14. Adjournment

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.
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 before the Board, but the Chair may apportion available time among those who wish to speak. For additional information, call (916) 263-2600.
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 Teresa Schaeffer at (916) 263-2389 or sending a written request to Ms. Schaeffer at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.

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Diversion Committee

Sacramento Convention Center
Room 307
1400 J Street
Sacramento, CA 95814

April 26, 2007

MINUTES

Agenda Item 1 Call to Order

The Diversion Committee of the Medical Board of California (MBC) was called to order by Chair, Laurie Gregg, M.D., at 11:00 p.m. Notice had been sent to interested parties.

Members Present:

Laurie Gregg, M.D.
Richard Fantozzi, M.D.
Cesar Aristeiguieta, M.D.
Shelton Duruisseau, Ph.D.
Janet Salomonson, M.D.

Staff and Guests Present:

Frank Valine, Program Administrator
Dave Thornton, Executive Director
Kimberly Kirchmeyer, Deputy Director
Camille McGee, Associate Analyst
Julie D' Angelo Fellmeth, Center for Public Interest Law
Sandra Bressler, California Medical Association

Agenda Item 2 Approval of the January 13, 2006 and February 1, 2007 Minutes

It was m/Gregg, s/Duruisseau, c/all to approve the minutes from the January 13, 2006 and February 1, 2007 meetings.

Agenda Item 3 Diversion Program Update

A. Program Status

Mr. Valine provided an update of the Diversion Program. He stated there are three case managers and one case manager supervisor in Northern California with case loads of 28, 33, 34, and 3 participants

respectively. In Southern California there are three case managers and one case manager supervisor with caseloads of 39, 40, 45, and 9 respectively. These case loads do not include physicians that are in the intake process waiting to be scheduled for a Diversion Evaluation Committee (DEC). Mr. Valine reported that the Diversion Program has a new Group Facilitator, Doug Rolly, MFT.

B. Quarterly Quality Review Report

Mr. Valine reported that 20 physicians contacted the program during the third quarter reporting period. A total of 66 physicians have contacted the program thus far in fiscal year 2006/2007. Eleven of the 20 physicians were not practicing medicine at the time they contacted the program and 14 physicians began the evaluation process for formal participation by completing their initial interview. One physician was not interested after an intake interview and one was terminated during the evaluation process. Seven of the physicians were board-referrals and 13 were self-referrals.

Mr. Valine reported in this quarter an average of nine days elapsed from the time a physician contacted the program to when the intake interview with the case manager was performed. He also reported the time between the initial contact and the first urine test was an average of 5.5 days. A physician is immediately put into the random drug generator (RDG) system when they contact the program, and within days they begin testing as well as have a case manager assigned and attend group meetings.

Mr. Valine reported four physicians relapsed this quarter, two board-referrals and two self-referrals. Two of those that relapsed are in treatment. Mr. Valine reported when the Diversion Program terminates a physician that is a board-referral, enforcement receives a memo the same day stating that the physician is being terminated from the program. There were 23 releases from the program this quarter, 12 were successful and 11 were unsuccessful. Dr. Gregg requested all unsuccessful participants be referred to their hospital monitor.

C. Collection System Manager's Report

Approximately 2,498 urines were collected this quarter of which 250 were positive. Of the 250 positives, four were deemed relapses. Two of the relapses were terminated from the program and two were ordered to inpatient treatment. 219 of the 250 positives were for approved prescriptions, including Naltrexone. Negative dilutes tests were retested with no positives. Mr. Valine reported that a physician stops working whether or not it is a positive from an approved prescription or a deemed relapse.

D. Financial Status Report per 231 (Business & Professions Code 2343(b))

Mr. Valine discussed the program's budget and accounted for all expenses and revenue for the quarter.

E. Diversion Program Matrix Update

It was m/s/c to refer the Enforcement Monitor's Recommendation Matrix Items 5 and 6 to the Diversion Advisory Council (DAC) for review, discussion, and recommendations to the Committee.

F. DEC Appointments

It was m/Gregg, s/Fantozzi, c/all to approve Steven Oppenheim, M.D as a DEC Member.

G. Status of Diversion Audit

Mr. Valine reported on the status of the Diversion Audit by the Bureau of State Audits (BSA). Dr. Gregg reported she is looking forward to the audit report and BSA's recommendations to the program.

Agenda Item 4 Non-Statutory Diversion Advisory Council – Appointments

Dr. Gregg reported the DAC will be composed of seven members: two DEC members, two members from the California Society of Addition Medicine (CSAM), one member from the California Medical Association, one member from the California Psychiatric Association, and one member from the Medical Board. Mr. Thornton reported AB253 will officially put the DAC into statute, but the Committee can establish the DAC now. It was m/Aristeiguieta, s/Gregg, c/all to approve the following members for the DAC: Lee Snook, M.D. (CMA), Barry Rosen, M.D. (CMA-Alternate), David Pating, M.D. (CSAM), Stephanie Shaner, M.D. (CSAM), Marvin Firestone, M.D., J.D. (CPA), Thomas Ciesla, M.D. (CPA-Alternate), Bruce Kaldor, M.D. (DEC), Shannon Chavez, M.D. (DEC), and Laurie Gregg, M.D. (MBC).

Agenda Item 5 Develop and Approve Guidelines for Determining When a Competency Examination Should be Ordered

Dr. Gregg requested this agenda item be referred as a priority to the DAC for review and consideration. It was m/s/c to refer this matter to the DAC.

Agenda Item 6 Agenda Items for the next Committee Meeting

- Issues five and six of the Enforcement Monitor's Recommendation Matrix
- Issue 12 of the Enforcement Monitor's Recommendation Matrix

Agenda Item 7 Public Comment

Mr. Thornton suggested that there be timelines on the agenda items given to the DAC to let them know their priorities.

Agenda Item 8 Adjournment

Dr. Gregg adjourned the meeting at 12:00 p.m.

MEDICAL BOARD OF CALIFORNIA - DIVERSION PROGRAM
BUREAU OF STATE AUDITS' RECOMMENDATIONS

Rev. 7/16/07

No.	Recommendation	Goal	Status	How Implemented	Comments or Completion Date
1	To better monitor diversion program participants, program management should create mechanisms to ensure that group facilitators, therapists, and worksite monitors submit required reports, and that the participants submit required meeting verifications. When such documentation is not received, program management should have case managers make an effort to obtain this information.	8-1-07 for policies and procedures 11-1-07 for revisions to system	The policies and procedures have been drafted and will be completed by the due date. ISB will be reviewing the DTS and determining areas of improvement and reports that can assist with followup indicating what is missing from a participant's file	On 6/21-22 a meeting was held with all case managers and supervisors and their responsibilities were reviewed to ensure they were aware of the file requirements.	ISB is currently reviewing the DTS for automation of the reporting requirements. Enhancements have been identified.
2	The Diversion Program should institute a formal policy to increase or refuse to reduce the frequency of diversion and support group meetings and drug tests when a participant neglects to provide required documentation. In addition, the program's policy should include a provision to not lift or reduce work restrictions unless a participant is in full compliance with worksite monitoring requirements.	8-1-07 for policies and procedures 9-1-07 for meeting with all DEC members	The policies and procedures have been drafted and will be completed by the due date. These new policies and procedures indicate the criteria for changing a participant's requirements.		Formal policy will state that participant requirements will not be reduced if the requried reports are not in participants file. Participants, case managers and diversion evaluation committee (DEC) members will be made aware of policy. A checklist of completed reports will be provided to members of each DEC before a decision about reduction in participant requriements is made.
3	To eliminate uncertainty regarding individual participants' requirements, the program should process a formal amendment to a participant's diversion agreement if the program determines that a requirement should be changed for that physician.	8-1-07 for policies and procedures	Policy states that the case manager shall have the participant sign an amended agreement in a face to face meeting. Policy will state that a copy of the amended agreement will be given to the participant and sent to the worksite monitor and therpist	On 6/21-22, a meeting was held with the case managers and supervisors to ensure they are aware of the necessity for all changes to the agreement be in writing.	

MEDICAL BOARD OF CALIFORNIA - DIVERSION PROGRAM
BUREAU OF STATE AUDITS' RECOMMENDATIONS

No.	Recommendation	Goal	Status	How Implemented	Comments or Completion Date
	To ensure that worksite monitors provide unbiased and complete reports, the diversion program should do the following:				
4	• Ensure that each participant's worksite monitor is approved in advance and has no relationship with the participant that would impair his or her ability to render fair and unbiased monitoring reports.	By 7-25-07 case managers will meet with current worksite monitors without a conflict to go over the new monitor's policies and sign a new agreement. 8-1-07 for policies and procedures	Current worksite monitors are meeting with case managers to go over the new policies to ensure they are aware of all changes. All new monitors will meet with the case managers prior to being approved.		The Diversion Committee approved worksite monitor policy in July 2006. As of 7-2-07 all worksite monitors that had a conflict of interest were terminated and new monitors signed the new agreement.
5	• Ensure that the newly developed worksite monitor agreements containing conflict-of-interest language are approved by the medical board's executive office and signed by all worksite monitors.	See above item #4. 8-1-07 for policies and procedures	The new forms have language regarding conflict-of-interst. All current worksite monitors are signing the new forms. All new monitors will be required to sign the new form.		As of 7-2-07 all worksite monitors that had a conflict of interest were terminated and new monitors signed the new agreement

MEDICAL BOARD OF CALIFORNIA - DIVERSION PROGRAM
BUREAU OF STATE AUDITS' RECOMMENDATIONS

No.	Recommendation	Goal	Status	How Implemented	Comments or Completion Date
6	• Notify worksite monitors of any work restrictions imposed on the participant they are monitoring, and direct them to report on compliance with these requirements.	7-25-07 deadline to meet with worksite monitors to discuss participant's work restrictions and amendments. Revised quarterly reporting forms will be provided to the monitor at this time and used for the participant evaluation from 7-1 to 9-30-07. The new forms will be returned by 10-10-07.	Worksite monitor quarterly reporting forms will specifically ask about work restriction compliance. Policy will state that a copy of the participant's agreement will be given to worksite monitor each time it is amended	On 6/21-22, a meeting was held with the case managers and supervisors to ensure they are aware of the necessity to contact worksite monitors with changes to a participant's agreement.	
7	To ensure that participants receive program services on a timely basis, the diversion program should continue its efforts to achieve the goal of completing participants' first drug tests within seven days of their intake interview.	COMPLETED - but will always be monitored		This goal is listed in the policies and procedures and the collection systems manager is aware of this requirement.	6/1/07 -The average time reported in the last quarter was 5.5 days. Additionally, review of the auditor's report for 2007 indicates the goal is being met.

MEDICAL BOARD OF CALIFORNIA - DIVERSION PROGRAM
BUREAU OF STATE AUDITS' RECOMMENDATIONS

No.	Recommendation	Goal	Status	How Implemented	Comments or Completion Date
	To ensure timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:				
8	• Immediately remove practicing physicians from work upon receiving notice of a positive drug test.	Program administrator/Executive Director/Deputy Director currently reviewing all positives. Clear policy guidelines to be approved by diversion committee at July meeting	The policies and procedures will clearly outline the requirement to immediately pull the physician upon receipt of a positive drug test.	On 6/21-22, a meeting was held with the case managers and supervisors ensure they are aware of the need to remove physicians from paractice.	All positives will be reported in the quarterly review for the diversion committee. 6-25-07 letter to participants clarifying policy. All participants since that time have been immediately pulled from work.
9	• Provide sufficient justification when it determines that a positive drug test does not constitute a relapse.	8-1-07 for policies and procedures 9-1-07 for statewide DEC meeting	The policies and procedures will state that any positive that is not a relapse has to be documented with reasons why it was not a relapse.		Case manager will discuss the positive with the DEC (or case consultant if immediate need) who will make a recommendation which is approved by the Program Administrator. All actions taken will be documented in the participant's file.
10	• Have the reconstituted liaison committee [DAC] assess the need to have an MRO [medical review officer] evaluate disputed drug test results, and hire such an individual if it is determined that this action is needed.	7/07 Diversison Committee will assign Diversion Advisory Council (DAC) with task. 11/07 DAC recommendation to Diversion Committee			

MEDICAL BOARD OF CALIFORNIA - DIVERSION PROGRAM
BUREAU OF STATE AUDITS' RECOMMENDATIONS

No.	Recommendation	Goal	Status	How Implemented	Comments or Completion Date
	To ensure that it adequately oversees participants' random drug tests, the diversion program should do the following:				
11	• Change existing policy to require both the case manager and the group facilitator to approve all vacation requests prior to the rescheduling of any drug tests.	8-1-07 for policies and procedures	Although the policies and procedures have not been finalized, the Program has already begun to require both the group facilitator and the case manager to approve vacations.		
12	• Establish a control over the rescheduling of drug tests that prohibits the collection system manager from rescheduling drug tests without a properly approved vacation request and also prevents participants from submitting vacation requests directly to the collection system manager.	8-1-07 for policies and procedures		The collection systems manager has been advised that she cannot change dates due to vacation unless this has been discussed and cleared with the case manager.	7/1/07 Completed.
13	• Clarify the vacation request policy for participants, and incorporate the 14-day notice requirement for vacation requests into the participants' diversion agreements.	8-1-07 for policies and procedures	The participant agreement has been updated to include this language.		6-25-07 letter to participants clarifying policy. 7/1/07 Completed.
14	• Establish a more timely and effective reconciliation of scheduled drug tests to actual drug tests performed by comparing the calendar of randomly generated assigned dates to the lab results.	6-1-07 process began 8-1-07 for policies and procedures	The collection systems manager will make the comparison twice a month rather than at the end of the month.		6/1/07 Completed.
15	• Require a program manager to review the drug test reconciliation to ensure that it is complete and accurate.	7/1/2007	The program manager has begun to receive a report from the collection systems manager to review and ensure reconcilliation is being completed.		7/1/07 Completed.

MEDICAL BOARD OF CALIFORNIA - DIVERSION PROGRAM
BUREAU OF STATE AUDITS' RECOMMENDATIONS

No.	Recommendation	Goal	Status	How Implemented	Comments or Completion Date
	To ensure that it adequately oversees its collectors, group facilitators, and DEC members, the diversion program should do the following:				
16	• Document instances in which the collector moves drug test dates without receiving approval two weeks in advance, makes an error in the submission of a urine sample, or fails to file an incident report when required. In these instances, the collection system manager should contact the collector, determine the cause of the noncompliance and reiterate the need to follow program policy if necessary.	8-1-07 for policies and procedures	On 2/11/06 and 5/11/07, the Program held refresher/ training courses for collectors. Additionally, the first 30 days after a collector is hired will be closely monitored prior to having them sign on for the year.	The Program will conduct individual evaluations for current collectors and continue to do so yearly. The collectors must sign a contract containing terms and conditions to continue providing services for the upcoming year.	The Board has recently terminated 2 collectors because their service did not warrant continued service.
17	• Maintain updated files on group facilitators to ensure that they stay current with required licenses, certifications, and continuing education requirements.	8-1-07 for policies and procedures 11-1-07 updated files checked and complete		Board staff will conduct yearly evaluations of group facilitators to check on these items.	
18	• Formally evaluate collectors, group facilitators, and DEC members annually and take timely corrective action when these individuals do not fulfill their responsibilities.	8-1-07 for policies and procedures 11-1-07 for all completed evaluations	The Program has already begun this process of evaluating the different parties.	The Program will conduct individual evaluations for all parties and continue to do so yearly.	The policies and procedures as drafted identify the roles and responsibilities of all parties. Each person will have to review the policies and procedures. Failure to comply with their responsibility will lead to termination of the party.

MEDICAL BOARD OF CALIFORNIA - DIVERSION PROGRAM
BUREAU OF STATE AUDITS' RECOMMENDATIONS

Rev. 7/16/07

No.	Recommendation	Goal	Status	How Implemented	Comments or Completion Date
19	To effectively oversee the diversion program, the medical board should require the program to create a reporting process that allows the medical board to view each critical component of the program. To the extent that the diversion program lacks the data required to report on the performance of critical components of the program, the medical board should require program management to develop mechanisms to efficiently acquire such data so that both the medical board and program management can provide effective oversight	7/07 modify the quarterly review document 11/07 new quarterly review document used to report to the board	The Diversion Committee will modify the quarterly review report to better serve the goal of overseeing the program at the July meeting.		Once these reporting requirements are identified the Program Administrator will work with staff and ISB staff to develop reports.
20	To ensure that it adequately oversees the diversion program, the medical board should have its diversion committee review, clarify where necessary, and approve all policy statements contained in the program's policy manual. Any informal policies that the program is operating under, but that are not in the policy manual, should be reviewed and approved by the diversion committee. Finally, the diversion committee should ensure that any policy directive it approves is added promptly to the manual.	8/1/2007	The policies and procedures manual will be reviewed by the Diversion Committee at the July committee meeting. Once it is approved, it will be put in final draft and provided to all parties.		Any future enhancements requested by the committee/board will be made to the policy manual prior to the next meeting. The Diversion Committee Chair and the Program Administrator will be responsible for follow-up at the next meeting. Board staff will ensure any action item is reflected in the board summary and new or revised policy added promptly to the manual.
21	The Medical Board should ensure that areas of program improvement recommended by the enforcement monitor are completed within the next six months. If necessary, the diversion committee should meet for longer than one hour each quarter until this is accomplished	11/30/2007	The Diversion Committee will be discussing any outstanding enforcement monitor recommendations at the July meeting. Two of the items have been forwarded to the Diversion Advisory Council for input and that input should be provided to the committee in July as well.		Some of the items may require regulatory of statuatory changes. If so, the final process could take longer than 6 months.

MEDICAL BOARD OF CALIFORNIA - DIVERSION PROGRAM
BUREAU OF STATE AUDITS' RECOMMENDATIONS

No.	Recommendation	Goal	Status	How Implemented	Comments or Completion Date
22	The medical board should direct the program administrator to delegate some of his day-to-day tasks so that he can refocus his efforts on program development. To the extent that delegation alone is not sufficient to accomplish this goal, the medical board should reconsider its decision to have two case manager supervisors, rather than one case manager supervisor and one supervisor of other program staff.	11/30/2007	The Board will review this item in 6 months to determine if the Program Administrator has delegated duties and whether the hiring of another case supervisor has assisted in the workload.		A BCP has been requested to hire a supervisor for the administrative staff that will be able to assist in the day-to day tasks.

Medical Board of California

Diversion Program

Policies and Procedures

DIVERSION PROGRAM

The Diversion Program is a statewide program administered by the Medical Board that monitors physicians impaired by substance abuse and mental or physical illness. Established in 1979 by statute, it began operations in 1980. The statutes governing the Diversion Program are Business and Professions Code sections 2340 through 2358.

The primary mission of the Medical Board and the Diversion Program is protection of the public. The purpose of the program is to monitor physicians while they are assisted with rehabilitation from the disease of substance abuse or mental illness. With public protection as its goal, the Diversion Program has the authority to remove a participant physician from the practice of clinical medicine if there is a possibility that he/she is unsafe to practice.

Physicians may enter the program in one of two ways: self-referral or board referral. In the first instance, a physician elects to enter the program voluntarily. In the second instance, the board, as a condition of a disciplinary order or in lieu of one, requires a physician to participate in the program. Public protection is served as many of these participants enter monitoring and rehabilitation before there is harm to the public or unsafe medical practice. All physicians receive the same level of monitoring regardless of the manner of entry.

Participants are closely monitored while in the Diversion Program. A wide variety of monitoring components are used to ensure patient safety and provide strong support for the physician's recovery. Monitoring components include, but are not limited to:

- 5-year participation agreements;
- Diversion Evaluation Committee (DEC) meetings;
- Facilitated Diversion Group meetings;
- Case management;
- Random, observed body fluid testing;
- AA/NA or other 12-Step meetings;
- Inpatient/outpatient treatment;
- Worksite and hospital monitors;
- Ongoing psychotherapy, psychiatric and/or medical examinations;
- Antagonist medications;
- Continuing education in chemical dependency or mental health; and,
- Progress reports from therapists, monitors, and treating physicians.

The Diversion Program uses the DEC to determine appropriateness for participation, terms of participation and successful completion of or termination from the program. There are three DEC meetings in Northern California and four in the southern part of the state. Each committee consists of three physicians, including at least one psychiatrist, and two public members. All members are appointed by the Medical Board and have extensive experience in the treatment and recovery of substance abuse disorders and mental illness. DEC members also provide consultation to program staff regarding participants.

Staff has various responsibilities and functions within the program. The members of the Medical Board oversee the program. Within the Medical Board is a Diversion Committee who has primary oversight over the program.

Medical Board of California Staff

Program Manager is responsible for the entire administration of the program. By law, the manager is responsible for determining whether a participant may graduate or must be terminated from the program. (B&P Code section 2350 (g) (1))

Diversion Program Compliance Specialist I referred to as Case Managers are responsible for monitoring their assigned participants' compliance of their agreement. They must ensure that those assigned to them attend the mandatory meetings and monitor their laboratory test results. Any non-compliance is documented and reported. Case managers have the authority to remove participants from the practice of medicine and notify worksite and hospital monitors.

Diversion Program Compliance Specialist IIs supervise the work of the case managers. They assign participants to their case managers and monitor their progress and compliance. Their primary priority is dealing with crisis and relapse situations reported by the case managers.

Program Analysts provide analytical services to the Program Manager, DEC, and Diversion Committee. Their work frequently includes the writing of reports, attending DEC meetings and providing case analyses to the committee members and other informational data.

Collection Systems Manager schedules random drug screenings for participants with the assistance of the Random Drug Generation (RDG) system. The Collection Systems Manager also oversees the entire collection system including obtaining notification of positive tests and providing oversight of the collectors performing the drug screenings.

DEC Coordinator schedules participants for the meetings, prepares their agendas and provides support services to the Committees.

Other entities involved in the Program

Group Facilitators facilitate the Diversion Program group meetings using skills within the scope of their license or certificate and knowledge of various 12-step programs and other community-based, self-help groups. These meetings provide support for recovery and monitoring of participants. The group facilitators are not employees of the board, but provide their services under a contract agreement.

Diversion Evaluation Committee (DEC) is made up of three physicians and two non physician members. The DEC members must have experience of knowledge in the evaluation or management of persons who are impaired due to alcohol/drug abuse or physical/mental illness. The DEC reviews participants for: entrance into the Diversion Program and if approved, recommends requirements for the participant's agreement; determination of a relapse; ability to practice medicine safely; progress in recovery; unsuccessful termination from the program, and successful completion of the program. All recommendations from the DEC have to be approved by the Program Manager.

Therapists provide therapy to the participants who are required to receive psychotherapy. The therapist is required to provide reports to the case manager regarding the participant.

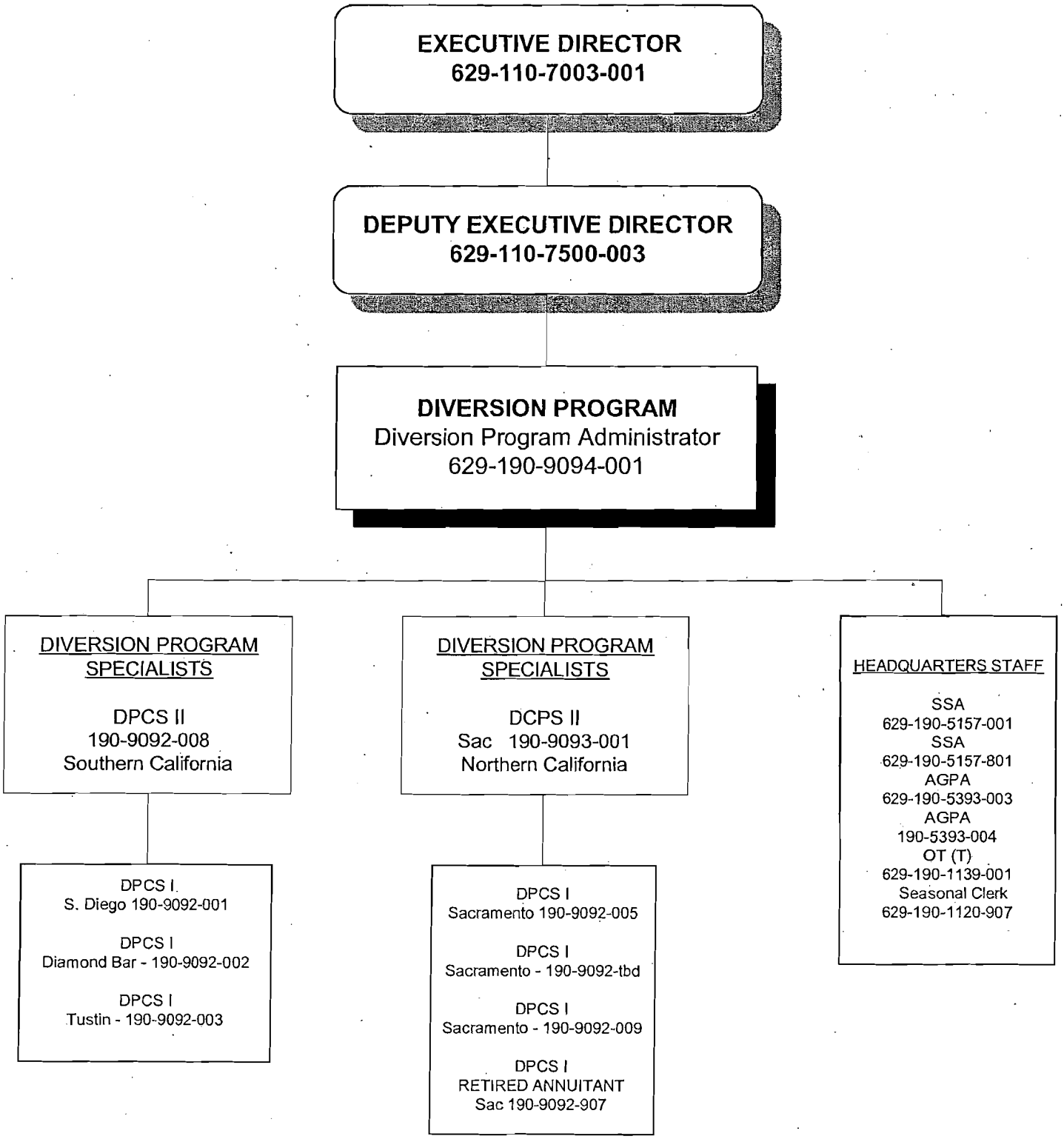
Diversion Program Case Management Teams: Participants are assigned a case management team that is comprised of a case manager, a DEC case consultant, a Diversion Program Compliance Specialist II, group facilitator, drug screening collection monitor, worksite/hospital monitor, therapist and/or primary care physician.

Collectors conduct the collection of urine samples from the participants. The collectors contact the participant and request that they appear for testing within six hours of the initial contact. The collectors follow guidelines to ensure the sample is provided to the lab in a secure manner. The collectors also must submit reports to the Collection System's Manger twice a month to indicate the testing performed or any incidents that occurred during the specified time frame.

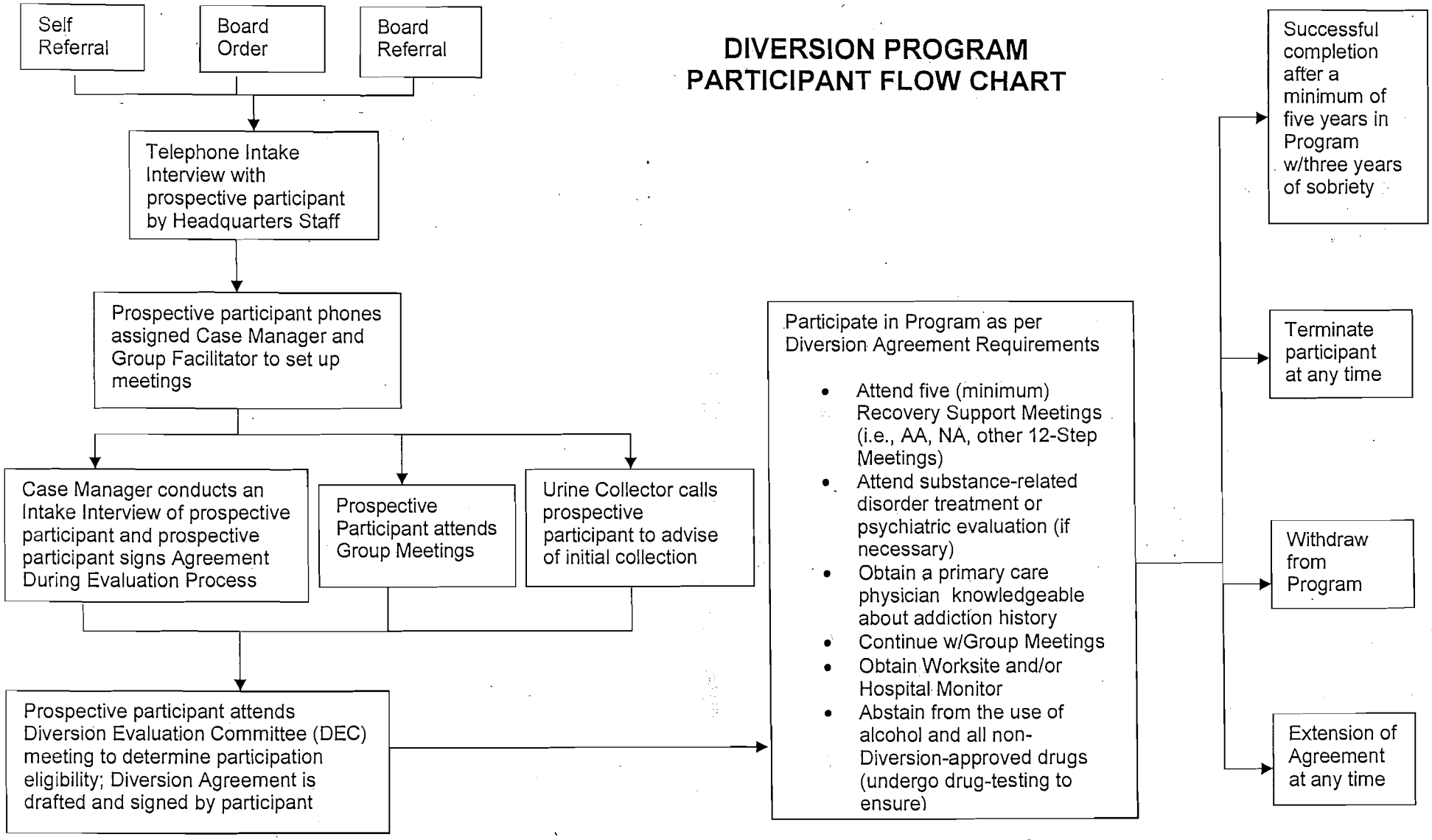
Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
Diversion Program
JUNE 2007

CURRENT



DIVERSION PROGRAM PARTICIPANT FLOW CHART



CHAPTER 1

CASE MANAGER DUTIES AND RESPONSIBILITIES

CHAPTER 1
CASE MANAGER DUTIES AND RESPONSIBILTIES

Role of the Diversion Program Compliance Specialist I

The Diversion Program Compliance Specialist I (case managers) role is that of a team leader. The case manager is responsible for:

- Public protection
- Assuring participants engage in treatment facility approved by the Diversion Evaluation Committee (DEC) and the Diversion Program, as necessary.
- Monitoring the participant's recovery progress.
- Coordinating relapse intervention.
- Monitoring compliance with the Diversion Agreement.
- Assuring the collection of random drug screenings.

Each participant has a case management team composed of a case manager, an assigned Diversion Evaluation Committee Case Consultant (CC), a Diversion Program Compliance Specialist II (DPCS II), a Group Facilitator (GF), the Diversion Program Administrator, drug screening collection monitors, worksite/hospital monitors, therapists and/or primary care physicians.

The case manager is assigned to a specific geographical area. As participants enter the Diversion Program they are assigned to the case manager based upon where the participant chooses to attend Diversion Program group meetings (group meetings). The DPCS II must approve any exceptions to this procedure. The case manager has knowledge of treatment resources compatible with the Diversion Program needs and the needs of the participant in his/her geographical area, California, and the nation. The case manager is thoroughly familiar with Alcoholics Anonymous and Narcotics Anonymous language, step work, and traditions, as well as the recovery oriented interpersonal interaction process (both group and individual).

Case Manager Responsibilities

The following is a list of activities for each case manager. Public safety is a case manager's top priority and the case manager shall organize their activities accordingly. The first two activities are of the **highest** priority.

- Check drug screening results **daily**.
- **Evaluate and resolve crisis and relapse situations** involving a public safety issue, including providing written documentation of incident to the DPCS II.
- Contact the Enforcement Program Probation Unit if a relapse or positive drug screening occurs for those referred through Enforcement.
- Contact worksite monitors when a participant is removed from work or restrictions have changed
- Update DTS on a **daily** basis with all applicable information.
- Monthly review of each participant file (including DTS file) to ensure therapist, work/site monitor, and group facilitator reports are current. Also ensure that attendance at meetings has been documented and appropriate fields updated.
- Maintain participant files.
- Contact new participants within two business days of the telephone intake to schedule intake interview and assessment within seven days.
- Contact the GF at least once weekly.

- Monthly attendance at each of the Diversion Program group meetings in the area assigned and document attendance in Diversion Tracking System (DTS) under "*Participant Contacts*".
- Contact worksite/hospital monitors, therapists, and treatment programs quarterly.
- Complete DEC meeting requests.
- Submit necessary documentation for DEC meetings.
- Attend DEC meetings.
- Complete administrative duties and documentation including: Travel claims, car mileage logs, activity reports, attendance reporting, filing of participant documentation, copying, etc.

Intake Interview

When a prospective participant contacts the Diversion Program Headquarters (Headquarters), a telephone intake interview is conducted by a Diversion Program analyst (analyst). The analyst notifies the prospective participant that he/she must contact the assigned case manager and GF immediately. Upon completion of the telephone intake interview, the analyst notifies the case manager and the GF via fax. The analyst also notifies the Collection Systems Manager so he/she can schedule the participant for random drug screening collections. The Collection Systems Manager must schedule a random drug screening within seven days of the intake interview.

If the case manager receives a call from the participant, he/she must return the call within two days. The case manager will email the intake packet to the prospective participant (if available). The case manager must complete a face-to-face intake interview with all new participants within seven days of the notification. (If the intake interview is not completed within seven days, the case manager must contact the DPCSII and ensure DTS and the participant's file is updated with the reason the interview was not completed.) On the date of the meeting with the participant, the case manager uses the following protocol:

1. The case manager meets the prospective participant at an agreed upon location. For distances of more than 60 miles, the case manager can have the prospective participant meet approximately half way.
2. Have the prospective participant complete the application and history of alcohol/drug use or mental illness. This information is contained in the "Case Manager Instructions" (also known as intake packet, Chapter 1, Attachment A).
3. Conduct the interview using the information completed by the prospective participant and the Intake Interview Guide Sheet contained in the intake packet.
4. Complete the "Agreement During Evaluation Process" (Chapter 1, Attachment B or C) during the evaluation, review it with the prospective participant and obtain his/her signature.
5. Confirm any prior treatment for alcohol/drug dependence. If prior treatment has been completed, obtain the prospective participant's signature on the "Authorization for Release" (Chapter 1, Attachment D). Following the interview, prepare a letter requesting treatment records, including a copy of the signed Authorization for Release, and mail it to the records office of the facility or to the therapist.

Note: *Mental health participants are required to provide any psychiatric evaluation (including MBC ordered), hospitalization discharge summaries and treatment therapist reports or assessments. Chemical dependency participants are required to provide any inpatient/outpatient treatment records, discharge summaries, evaluations or assessments.*

6. Provide the prospective participant with a copy of the Participant Information Packet.
7. Summarize the Diversion procedures and expectations.
8. Complete interview narrative using approved outline.

Note: At any time during the interview if the prospective participant appears to be under the influence or is a threat to himself/herself or others the case manager shall end the interview and contact the DPCSII for further instruction.

Upon completion of the interview contact the Collection Systems Manager located at Headquarters to 1) obtain information on when the first drug screening test will take place (if it has not) to ensure that the seven day goal from telephone intake to first drug screening is met and 2) assure the random drug screening collections have been set up. **A mandatory minimum of four drug screening collections monthly is required for all participants.**

The case manager will contact the GF to be assured the prospective participant is attending Diversion Group Meetings. The case manager summarizes the Intake Interview on the approved template and submits the original to Headquarters, with a copy to the GF. The case manager shall send the original application, original signed "Agreement During Evaluation Process" (Chapter 1, Attachment B or C), original history, and intake interview narrative to Headquarters within 7 business days of the intake interview.

Participant Monitoring

Each participant will sign a Diversion Agreement customized to their specific circumstances. The case manager is responsible for monitoring the participant's compliance with the Diversion Agreement. To accomplish this, the case manager has four primary tools: group meetings, worksite/hospital monitors, drug screenings (urine), and local therapists. Additionally, the case manager may utilize regular telephone and personal contact with the participant.

Critical and High Risk Situations

The basic difference between "critical situations" and "high risk situations" is:

1. A critical situation occurs when a participant is known or strongly suspected to be using drugs or alcohol. In the case of a participant with an emotional disorder, he/she would be manifesting the gross symptomology of his/her particular disorder.
2. A high-risk situation occurs when a participant is demonstrating attitudes and behavior that generate stress and anxiety that may cause the participant to seek relief through destructive compulsive behavior (e.g. drinking, drugs).

For critical situations, e.g. participants who have relapsed, psychotic episodes, and suicidal or homicidal ideations, the case manager must address the situation immediately. These situations, almost always, require personal contact with the participant to assess the threat to self and patient care. The participant shall be required to immediately stop the practice of medicine until he/she can be evaluated. This is often accomplished by requesting the participant to present himself/herself at a treatment facility for an admissions evaluation. The case manager shall involve the CC, GF, DPCS II, and other team members in decisions regarding a participant's treatment needs. The Case Manager must notify the worksite monitor.

For high risk situations the case manager is required to contact participants suspected of using, resisting recovery, or manifesting pre-relapse behavior. High-risk situations may require making

personal visits with the participant's therapists and/or GF; however, most situations can be addressed by telephone.

Drug Testing – Participant Failure to Appear

Each participant will submit to random drug testing each month. A collector will contact the participant to set up the time and place of the collection. The collector will phone the participant. The participant has six hours from the time of the call to present to the collector for the collection. If the participant is not available and the collector leaves a message for the participant, the participant must return the phone call within two hours of the telephone call to set up the time and place of the collection (the six hour time frame from the initial call still applies).

If the participant does not appear for the test or fails to contact the collector within the specified time, then the physician will be suspended from the practice of medicine. As soon as the participant fails to call or appear, the collector will immediately contact the collection system manager. The collection system manager will immediately contact the case manager. **The case manager must contact the DPCSII to discuss the failure to appear. The case manager must then contact the participant and inform him/her that he/she must cease the practice of medicine. The case manager also must contact the worksite monitor and tell him/her of the cessation of practice.** The participant cannot practice medicine until a thorough investigation of the incident has occurred and another drug testing with negative results has been taken.

Procedures Following Positive Drug Test

THE DIVERSION PROGRAM POLICY IS THAT THE CASE MANAGER SHALL IMMEDIATELY REMOVE ANY PHYSICIAN FROM PRACTICING MEDICINE UPON NOTIFICATION OF A POSITIVE DRUG SCREENING.

A minimum of four random drug screenings samples shall be taken monthly (unless the participant has an agreement/amendment signed prior to July 1, 2007 indicating otherwise). Additional random drug screenings may be added at any time. Biological fluid collections are observed and a chain of custody protocol is followed. Each day the case manager will **access** the current drug screening lab database to check drug test results. Once the case manager receives confirmed positive drug screening results, the case manager shall assess and identify the cause and/or source of the detected substance by following the verification protocol set forth below:

1. Verify the case number of the participant.
2. Contact the collector:
   a. Verify the date and time of the collection.
   b. Verify the time and method of transport of the drug screening sample to the lab.
   c. Verify the chain of custody number.
   d. Determine whether there were any unusual circumstances at the time of the collection.
   e. Determine whether the participant presented any unusual behavior at the time of the collection.
3. Contact the DPCS II (or the Program Administrator in his/her absence) to discuss **all** positive drug screening results.
4. **Advise the participant of the positive drug screening results and immediately remove participant from the practice of medicine pending completion of further investigation. At the same time, request an explanation (relapse**

autopsy) from the participant and tell the participant that if a split sample is requested it must be done within 2 business days.

5. Notify the worksite/hospital monitor of the action.
6. Confirm with the Collection Systems Manager that another collection has been scheduled.

Further Investigation

1. If the participant requests the split sample to be analyzed by another Lab, the case manager will verify the results.
2. Contact the current drug screening lab (Lab) for additional verification of the positive drug screening results (speak with a certifying scientist).
3. Contact a current worksite/hospital monitor.
4. Contact the participant's treating physician to review prescribed medications.
5. Contact the GF for consultation and an update on the participant's participation in group meetings.
6. Contact the case consultant and DPCS II to review the information gathered and discuss plan of action.
7. Document the positive drug screening result, using the approved **Relapse Checklist & File Note** template, including cause/source in the participant's file.
8. Update DTS, under the lab result field, explaining the positive result *(ex.: approved prescription, alcohol, specific drug, etc.).*

Each positive drug test must be evaluated to determine whether it is a relapse. Other factors, as outlined in the relapse section below, should be considered before a final determination of relapse is made. **All positives, negative and positive dilutes, and invalids must be documented by the case manager in the participant's file with a file note and in the relapse section of the DTS participant profile. Additionally, DTS must be updated with the specific name of the drug identified in the positive sample.**

Relapse

A positive drug test for a substance for which the participant has a pre-approved prescription shall not constitute a relapse.

A physician who has relapsed may not return to the practice of medicine until approved to do so.

A positive drug screening is only one indicator of a possible relapse. If a participant produces a positive drug screening result, the case manager shall consider the following criteria:

1. The participant's compliance with his/her Diversion Agreement (e.g. group attendance, 12-Step participation, therapy, etc...)
2. The content and affect of his/her participation in group meetings.
3. Worksite monitor's feedback.
4. Family feedback.
5. The participant's explanation of the positive results..
6. Drug screening history.
7. Drugs found in drug screening results.

The case manager will discuss these considerations with the CC, GF, and the DPCS II to determine if the positive drug screening constitutes a relapse. The case manager, if the participant's DEC is not scheduled within two weeks, shall poll via telephone the DEC members to review the incident and determine if a relapse occurred. If a DEC is scheduled within two weeks, then this issue shall be

considered by the DEC at that time. The DEC may use its discretion in determining whether a "positive drug screening" or a "self-report" of mood-altering drugs or prescription drugs is considered a relapse. **The case manager must completely document the events that lead to the determination of whether the incident was determined to be a relapse or not in both the participant's file and DTS.**

The DEC will also determine the appropriate action to take after a relapse. The DEC will either terminate the participant or amend the Diversion Agreement. See section "Termination/Decision after Relapse" below for additional information.

Management of Prescribed Controlled Substances

Participants who are taking prescribed controlled substances from Schedules II-V will not be allowed to practice medicine until they have provided a negative drug screening. The following protocol will be followed:

1. Prior to use, the participant must provide the case manager with a prescription and completed Prescribed Medication Documentation form completed by his/her treating physician. The case manager should remind the participant he/she will not be permitted to practice. The case manager must contact the worksite monitor.
2. In a medical emergency, the participant must provide this documentation to the case manager by the next working day. The case manager shall ensure he/she contacts the participant immediately upon notification of the emergency to ensure the participant is not practicing medicine. The case manager must also contact the worksite/hospital monitor to ensure they are aware the participant cannot practice medicine.
3. The participant's treating physician cannot be a friend, monitor, or current Diversion Program or group meeting participant. This applies to all participants whether or not they are taking controlled substance.
4. The participant disposes of remaining controlled substance under the supervision of the case manager or GF (this should be done in the presence of a witness).
5. When drug screenings are collected while taking controlled substance, the participant indicates the type and dosage on the accompanying lab slip.
6. The participant should discuss in group meetings, at least once a month, how the controlled substance management is working.
7. **The participant must provide one negative drug screening before returning to the practice of medicine.**

Diversion Program Response to "Negative-Dilute" Results

1. The case manager must notify the Collection System Manager to ensure he/she has requested the drug screening collector to obtain another sample from the participant for a re-test.
    a. If this is the participant's first negative-dilute, the case manager contacts the participant to review the result, inquire as to what behavior may have caused the result, explain how dilute drug screenings can be avoided, and inform the participant that future negative-dilute results may result in additional monthly drug screenings or suspension from the practice of medicine.
    b. If the participant had prior negative-dilute results, the case manager contacts the participant to review the result, inquire as to what

behavior caused the result, and discuss any action to be taken in response.

2. The case manager will continue to monitor the participant's drug screening results for signs of negative dilute patterns.
3. The case manager will contact the DPCS II when a negative dilute pattern is confirmed, evaluate the pattern, and develop a plan to respond to future negative-dilutes.
4. The case manager will complete a file note detailing all actions taken in response.

Monitoring Antagonist Medication

For participants required by the DEC to take the narcotic antagonist naltrexone or the alcohol antagonist disulfiram (antabuse), the following protocol will be used:

1. Prior to starting the antagonist medication, the participant must provide the case manager with a prescription for the medication completed by the participant's treating physician.
2. Unless an alternative arrangement exists, the administration of the antagonist medication is overseen by the GF at the group meetings. As part of the weekly telephone call to the case manager, the GF advises the case manager which participants took naltrexone or antabuse. The GF will include the same information on the weekly attendance reports.
3. The case manager should encourage the participant to see the prescribing treating physician every three to six months for liver function studies.
4. The case manager shall review annually with the DEC the need for a participant to continue with antagonist medication.
5. If a participant's drug test does not show a positive for the use of the antagonist, the case manager will contact the GF to discuss the incident. A participant not taking the antagonist as required will be considered out of compliance with his/her agreement.

Telephone Reporting to DPCSII

The case manager shall telephone the DPCS II for any of the following reasons:

1. A participant was a "no show" for drug screening collections or there were collection problems, which **may** result in a "positive" result.
2. A prospective participant has not contacted the case manager for an intake interview.
3. There are problems with group meetings or GF, e.g. group too large, participant complaints, etc.
4. He/she needs to request vacation or needs to discuss personnel issues.

Diversion Participants on Probation with the Medical Board

The case manager is required to immediately report any violations of probation to the Enforcement Program. The case manager works closely with the assigned probation officer to ensure compliance is maintained.

Diversion Group Meetings
The case manager attends each Diversion group meeting in his/her geographic area once per month to directly observe participants. Case manager protocol is as follows:

- Advise the GF at least two days in advance that he/she will be attending a meeting.
- Be on time for the group meeting.
- Dress professionally.
- Be attentive during the group meetings.
- Attend the entire group meeting and leave only when the group ends.
- Do not remove participants from group meeting early, nor keep them from being on time at the beginning of the group meeting.
- Work together as a team with the GF and support each other especially when diffusing difficult situations in group meetings.

The case manager must address any unusual participant behaviors observed at the group meeting with the GF, the DPCS II and other team members, as appropriate. If the case manager has concerns with the manner in which the GF conducts the meeting or with meeting facilities, he/she will address the issues with the GF and the DPCS II. If a plan of change is developed as a result of these discussions, the case manager documents the revised plan and sends a copy to the DPCS II for approval. The case manager is responsible for continued monitoring of the new plan.

The case manager must communicate by telephone with the GF on a weekly (or as needed) basis regarding participants who:

1. are "using" (immediately after group).
2. might be using (immediately after group).
3. are absent.
4. provided drug screening samples.
5. the GF has major concerns about/because of the following: a life crisis that threatens recovery (marital, family, financial, professional, physical) or a marked change in attitude and/or behavior suggesting a possible relapse.

The case manager must receive monthly attendance reports from the GF on each participant regarding group meeting attendance.
The attendance report will be placed into the participant's file and the information updated into DTS. If the attendance report is not received by the 15th of the each month, the case manager shall contact the GF.

Case Manager Responsibilities for Diversion Evaluation Committee Meetings
The case manager is expected to attend DEC meetings when a participant appears for or is discussed at an annual review before the committee. The case manager provides information and recommendations about the participant's recovery. Any exception to the case manager's regular attendance must be approved by the DPCS II. Case manager recommendations to the DEC are discussed with the participant prior to the DEC meeting.

When a participant is meeting with the DEC in person, it is the responsibility of the case manager to present and introduce the participant to the DEC members and attendees including headquarters staff.

Prior to the DEC meeting, the case manager shall submit a DEC Request to the DEC Coordinator. The DEC Request needs to be submitted six weeks in advance. This form is used to schedule a participant

for an appearance at the DEC The case manager is responsible for updating the DTS profile after receipt of the form to reflect the participant's correct addresses, work status, relapses, drug screenings and **all Diversion Agreement requirements**. Both the case manager and the GF must submit participant annual assessments. The case manager may want to collaborate with the GF; however, the case manager's annual assessment reflects the participant's **current** status relative to compliance with their Diversion Agreement. After the DEC agrees on a Diversion Agreement (Chapter 1, Attachment E) or changes to the Diversion Agreement, the Headquarters staff prepares the Diversion Agreement or amendment and sends it to the case manager. The case manager shall have the participant sign the Diversion Agreement or amendment by meeting face-to-face with the participant and providing a "New Participant" packet, reviewing the packet with the participant, and answering any questions. The Diversion Agreement can be sent to the GF for the participant's signature, and it is the case manager's responsibility to ensure the Diversion Agreement is signed and returned to Headquarters. The case manager is responsible for ensuring that DEC directions are implemented. The case manager will assure that new and revised copies of the DEC agreement are provided to the worksite monitors, hospital monitors, treating physicians and therapists involved in the participant's recovery.

Contacting the Case Consultant

The case manager shall contact the case consultant for those specific reasons set forth below. If the case consultant is not available, the case manager will contact the Diversion Evaluation Committee Chair. When possible, the case manager shall e-mail the case consultant (for documentation of the discussion). In cases where the participant has not been before the DEC, the case manager will contact the DPCS II for direction.

The case manager shall contact the case consultant if:

1. A participant has relapsed and/or is jeopardizing public safety. If this should come to light in the evening or weekend hours, the case manager may take immediate action and then contact the case consultant within **24-48 hours**.
2. Positive drug screening results - involve case consultant in discussion of intervention strategy.
3. The case manager determines treatment is necessary.
4. A participant refuses to comply with DEC direction. The case manager may make attempts to work through the participant's resistance prior to contacting the case consultant (The DPCS II is also contacted.)
5. The case manager concludes the participant should be brought to a DEC for further evaluation, motivation or change in the participant's Diversion Agreement.

Treatment Facility Admission

The following are reasons to request treatment for a participant:

1. If the participant is considered a danger to him/herself or patient safety due to use of prohibited drugs/alcohol and/or mental disorders.
2. Immediate intervention is necessary.

If a case manager determines treatment is necessary, he/she shall contact the GF and the case consultant (or if no case consultant is assigned, contact the DEC chair). **The case manager must contact the DPCSII (or the Program Administrator if the DPCSIII is unavailable) to review treatment options before referring any participant to treatment.** When a participant is asked to enter treatment or therapy, the participant will be provided with the names and telephone numbers of at least three treatment facilities. The participant makes the choice of the recommended treatment

facilities. It is the participant's responsibility to contact the treatment facility for entry. If the participant refuses to comply with the request to discontinue the practice of medicine and/or be admitted for treatment, the case manager shall immediately contact the DPCS II.

The team interaction (case manager, GF, case consultant and DPCSII) provides a treatment strategy that must be documented in writing by the case manager with a copy sent to the DPCS II. It is the responsibility of the case manager to document the facts and assure that the participant follows through with the strategy.

In critical situations the case manager can ask a participant to enter a treatment facility for admission evaluation without the case consultant's involvement after discussion with the GF and the DPCSII. However, the case consultant must be contacted within **24-48** hours after immediate action was taken without consultation.

To avoid a conflict of interest, the case manager or GF is not permitted to refer participants to a treatment facility in which they have a past or present financial interest, employment or prior work history (other than previous Diversion Program referrals).

Participant must not return to the practice of medicine until seen by the DEC for approval.

Worksite/Hospital Monitors

Each participant must have a worksite and (if applicable) hospital monitor. If the participant has hospital privileges, the case manager will notify the chairperson of the Well Being Committee in each hospital where he/she has privileges. The Well Being Committee chairperson will complete the "Well Being Committee Acknowledgment" form (Chapter 1, Attachment F) acknowledging the participant is enrolled in the Diversion Program and has a hospital monitor. The case manager will also provide the Well Being Committee chairperson with a letter (Chapter 1, Attachment G) explaining the Diversion Program and its process. The case manager confirms the participant has a Well Being Committee Acknowledgment form for each hospital where the participant practices medicine.

Prior to a participant returning to the practice of medicine, he/she must submit the name and qualifications of one or more licensed physician and surgeon or licensed allied health practitioner (e.g., podiatrist, physician assistant, physical therapist, pharmacist, licensed clinical social worker, psychiatric social worker, registered nurse, licensed vocational nurse, or dentist) whose licenses are valid and in good standing or the name of a contracted healthcare facility office manager who is not an employee of the participant nor in the supervisory chain of the participant. If the monitor has a California license, the case manager must check the CAS system to verify that the monitor has a valid California license, no open complaints, no complaints closed due to insufficient evidence within the past three (3) years, and no past or pending disciplinary action. The case manager approves all worksite/hospital monitors. The case manager will meet with the potential monitor and review the required responsibilities. The case manager shall provide the worksite/hospital monitor with a copy of the participant's Diversion Agreement and all amendments.

The worksite/hospital monitor shall have no prior or current business (including, but not limited to, any form of bartering), personal, or familial relationship with the participant, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Diversion Program. In addition, each individual must agree to serve as the worksite/hospital monitor.

The case manager shall provide the worksite/hospital monitor with an "Agreement to Monitor at the Worksite and/or Hospital" and the "Policy Guidelines for Worksite/Hospital Monitors" (Chapter 1, Attachment H and I) to review and sign the appropriate form acknowledging he/she will follow the guidelines and monitor the participant. All worksite/hospital monitor agreements shall be placed in the participant's file. The worksite/hospital monitor's responsibility is to observe the participant on a regular basis and to assess to the best of his/her ability whether the participant is impaired as a result of drugs, alcohol and/or mental disorder. The worksite/hospital monitor also provides a "Monitor Quarterly Report" (Chapter 1, Attachment J). This is a written report on a preprinted form regarding the progress of the participant and is intended to assess if there are any changes in the participant's attitude or behavior. This report must be submitted quarterly with both positive and negative changes. The monitor shall also notify the case manager if he/she feels a drug screening is needed and the case manager may collect a drug sample. There is also a cover letter for the worksite/hospital monitors paperwork located in the intake packet. The case manager shall document the worksite/hospital monitor interview with a file note.

It is the participant's responsibility to ensure the worksite/hospital monitor reports are submitted timely. If the worksite/hospital monitor reports are not received by the 10th day of the reporting period, the case manager shall contact the participant to obtain the worksite/hospital monitor reports.

For additional detailed information regarding worksite/hospital monitors, see "Worksite/Hospital Monitor Guidelines" (Chapter 1, Attachment I).

Monitoring Practice Restrictions

When a participant in the Diversion Program is required to stop or restrict his/her practice of medicine, the following procedures are to be used:

1. The case manager will notify the participant.
2. The case manager will notify and consult with the participant's worksite/hospital monitor, well being committee (if applicable), and DPCS II.
3. The case manager will discuss the participant with the GF who will observe the participant at group meetings to determine if the participant is complying with restrictions.
4. The case manager will monitor the participant's activity to ensure compliance.

Meeting Attendance Verification

Initially, every participant will submit a meeting attendance verification form for a minimum of one year (Chapter 1, Attachment K). Meeting attendance verification could be added at any time during the participant's participation. A participant with both continued compliance with his/her Diversion Agreement and sobriety may be considered for removal of the meeting attendance verification cards requirement. A participant must submit, in writing, a request for removal of the meeting attendance verification cards requirement. The case manager shall discuss the request at the DEC and the DEC will determine approval or denial.

It is the participant's responsibility to ensure the original meeting attendance verification is submitted monthly. If verification is not received, the case manager shall contact the participant to obtain verification. The case manager will update DTS verifying attendance monthly.

Psychiatric/Psychological Evaluations

When the DEC requests that a participant obtain a psychiatric and/or psychological evaluation, the case manager will send a letter to the evaluator briefly explaining the Diversion Program, specifying

the reason for the referral and outlining what is needed in the evaluation. It is the case manager's responsibility to communicate with the evaluator, briefly explaining the Diversion Program, specifying the reason for the evaluation, and stating what is needed in the evaluation report. If a psychiatric evaluation is required, then a psychotropic medication evaluation/ recommendation must be included in the report. The case manager has an outline available to use when communicating with the evaluator.

Treating Therapist

When the participant's Diversion Agreement requires psychotherapy, the case manager shall contact the therapist to explain the Diversion Program and ask the therapist to provide written quarterly reports (Chapter 1, Attachment L). It may be necessary for the case manager to contact the therapist by phone or in person to discuss the participant if a critical or high-risk situation occurs. The case manager shall document the therapist interview with a file note.

It is the participant's responsibility to ensure the therapist reports are submitted quarterly. If the therapist reports are not received by the 15th, the case manager shall contact the participant to obtain the therapist reports.

Monitoring Participants with a Single Diagnosis of Mental Illness

Each participant with either a confirmed diagnosis of mental illness, or a referral to the Diversion Program for evaluation of a mental health-related disorder, will begin the evaluation phase under an obligation to comply with all conditions of monitoring as set forth by the Diversion Program. The participant will continue under these set provisions with the knowledge and understanding that:

1. The case manager will schedule the participant to meet with a DEC to determine if participation in the Diversion Program is appropriate or would benefit the participant.
2. If the participant is deemed appropriate for the Diversion Program, the DEC will recommend individual monitoring provisions to provide greater benefit to the participant while still providing public safety. In making modifications, the DEC considers clinical assessments, other evaluative measures, and recommendations provided by Diversion Program Administrator, DPCS II, GF, and the case manager.

Provisions, Terms & Requirements During the Evaluation Phase:

1. The participant shall obtain a full psychiatric evaluation to confirm a mental illness diagnosis, and shall arrange for the written report to be provided to the Diversion Program. For some participants, this requirement will have been completed prior to contacting the Diversion Program.
2. If the participant's psychiatric evaluation or treating psychiatrist/psychotherapist recommends psychiatric treatment, such treatment shall be successfully continued until it is determined to be either completed or unnecessary. Prior to meeting with the DEC, the participant shall complete any recommended inpatient treatment. Participants in outpatient treatment may be scheduled to meet with the DEC while still participating in treatment.
3. The participant must initiate or continue attendance with the treating psychiatrist or psychotherapist, except while participating in inpatient treatment.
4. If the participant's treating psychiatrist has prescribed medication for the management of mental illness, the participant shall continue with the prescribed medication and shall arrange for the Diversion Program to receive quarterly written

reports on the participant's psychiatric medication management from the treating psychiatrist.

5. If Schedules II-V medications are prescribed, the participant shall not practice medicine.

Participant Absence Requests

Participants requesting to be excused from either group meetings and/or drug screenings must submit requests for vacation. (**All requests must be submitted in writing at least 14 days in advance.**) The participant completes a vacation request and submits it to the GF for approval. The GF signs and faxes the request to the case manager. The case manager approves/disapproves and documents the request in DTS. The case manager signs and faxes the approved/disapproved form to the Collection System Manager and back to the GF to notify the participant of approval/disapproval. A copy of the completed request is put in the participant's main file.

If the participant submits an absence request in less than 14 days, the absence request shall be directly submitted to and reviewed by the case manager. The case manager will determine the reason for the failure to submit the advance timely. **Only if there is an emergency (e.g. family death or illness) will a request be approved without a 14-day prior notice.** The case manager will determine whether the request should be approved or denied. A copy of the request, the reason for the untimely request, and approval or denial should be put in the participant's file.

Reduction of Diversion Group Meetings

Initially, participants will attend two group meetings per week. A participant with both continued compliance with his/her Diversion Agreement and sobriety may be considered for a reduction in group meetings after the first three years. A participant may submit in writing a request for group meeting reduction to the GF and case manager. The participant's request will be considered when their DEC next meets. The following criteria must be met to be considered for a reduction in meetings:

1. Semi-Annual reports are current.
2. Worksite/hospital monitor and therapist reports are up-to-date.
3. 30 continuing education units are completed.
4. Participant is in full compliance with his/her Diversion Agreement

No participant will be allowed to reduce the number of group meetings if he/she is not in compliance with his/her Diversion Agreement.

If the reduction of group meetings is approved, the procedures listed below should be followed to amend the participant's Diversion Agreement.

Diversion Agreement Changes

A participant may request a change in his/her Diversion Agreement by submitting a written request to his/her case manager. Requests for changes are documented by a file note and submitted to the DPCS II. No change to reduce the participant's requirements in a Diversion Agreement will be considered if the participant is not in full compliance with the requirements of the agreement, e.g. all required reports are received, sustained sobriety, meeting worksite requirements, etc.

All changes in a participant's Diversion Agreement must be discussed at the participant's DEC meeting or annual review meeting. The assigned headquarters analyst will prepare all approved changes as an amendment to the Diversion Agreement. The amendment will be provided to the case

manager who will obtain the participant's signature and then provide a copy to the GF, worksite monitor (if applicable), and the participant. The original will be returned to headquarters for the participant's master file.

Termination/Decision after Relapse

Each relapse will be evaluated to determine whether the participant should be terminated from the Program. The case manager will discuss each relapse with the DEC who will assess each case (either at a meeting or by the case manager telephone polling the DEC members if a DEC isn't scheduled within two weeks after issue giving rise to the relapse). The DEC will consider the participant's potential for successful recovery and whether or not the participant can practice medicine safely and then make a determination whether or not to terminate the participant. If the DEC allows the participant to continue in the Diversion Program with additional terms added to the participant's agreement, the case manager completes a file note and updates DTS. The file note will document the clinical circumstances for which the participant is approved to remain in the Diversion Program. If an amendment to the participant's Diversion Agreement is made, the case manager will follow the guidelines in the "Diversion Agreement" section in this chapter.

If the DEC makes a recommendation to terminate the participant, the case manager must receive final approval from the Diversion Program Administrator. The participant will be notified in person if he/she is present at the DEC or the case manager will notify the participant by telephone if he/she is not present at the DEC. The case manager will contact the GF, worksite monitor, and the well being committee of the termination. A letter is drafted and sent from the Diversion Program Administrator to the participant. If the participant is a board referral (either board-ordered or with a Statement of Understanding), the Program Administrator will notify the Enforcement Program. If the individual is a self referral and is determined not to be a risk to public safety no notification will be made. If he/she is determined to be a risk to public safety, the Diversion Program Administrator will notify the Enforcement Program. The case manager will ensure copies of all letters are in the participant's master file and that DTS is updated.

After Termination from the Diversion Program

In the event a participant does not complete the Diversion Program successfully, the Medical Board may elect to pursue the original case for which the participant was originally referred or open a new case if the participant was self-referred. In some cases, the participant's Diversion Program records may be provided to the Enforcement Program to aid in an investigation. The case manager must notify the Program Administrator to contact the Enforcement Program.

Case Manager Documentation

All original documents must be sent to Headquarters for a participant's master file. Each case manager will maintain a file folder for each of their participants in the Diversion Program. The file will contain copies of the following documents:

1. Diversion Program Application (Chapter 1, Attachment M)
2. Agreement During Evaluation Process
3. Diversion Agreement
4. Amendments to the Diversion Agreement
5. Intake Interview & subsequent DEC overviews
6. Positive drug screenings
7. Case manager relapse file note & checklist
8. Problem list

9. Medical Evaluation Summary
10. Psychiatric evaluations
11. Therapists reports
12. Annual Assessments
13. Treatment records
14. Case manager file notes for all Diversion Agreement changes
15. Worksite/hospital monitor signed agreement
16. Worksite/hospital monitor reports
17. Probation Order - if applicable
18. Continuing Education Units
19. Semi-annual reports
20. Meeting Attendance Verification (Chapter 1, Attachment K)
21. File Notes (All file notes are placed and maintained in the Headquarters master file)

In addition to the participant's file folder having the above information, DTS must be updated to reflect the receipt of reports, records, attendance reports, etc. on a daily basis.

Case Manager Monthly Activity Report (Chapter 1, Attachment N)

The case manager shall complete this report by the last working day of each month and submit it to the DPCS II no later than the 3rd working day of the following month. This report is self-explanatory. These reports are reviewed by the DPCS II. Questions or concerns about the case manager activities can be addressed with the DPCS II.

Case Manager Instructions
Participant Information
Intake Packet

Intake

Prospective Participant Letter
MBC Diversion Program (2 Pages)
Attendance at Diversion Meetings
Specimen Collection
Drugs with Potential Abuse/Addiction Risks (3 Pages)
To Family Members
The Family Disease
Q & A Regarding Diversion

Agreement

Reduction of Meetings
Semi-Annual Reports
Education Requirements
Requesting Successful Program Completion

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Dear Participant:

You have taken a big step in dealing with a personal problem that involves a significant part of your life and career. We commend you!

You will be scheduled for a future Diversion Evaluation Committee (DEC) meeting to be evaluated for participation in the Diversion Program. A staff member will call you to make an appointment.

We encourage you, if you are not already doing so, to attend the Diversion group meetings. You will find these meetings with fellow health professionals very supportive during your wait for the DEC meeting. The group facilitator is not a state employee. He or she has agreed to conduct the group meetings according to Diversion Program Policies and Procedures. The fee charged by the group facilitator is a business arrangement between the two of you. The fee can be adjusted according to your ability to pay.

We are enclosing some information about the Diversion Program that you may find helpful. Please share this with your family and/or close friends. The personal experience of prior participants has shown that recovery is much easier when the family and/or close friends are involved.

We strongly encourage your family and close friends to attend Al-Anon Family Group meetings or other support groups to assist them while being involved in your recovery. A list of meetings is available through the local Alcoholics Anonymous, Narcotics Anonymous or Cocaine Anonymous central office listed in the telephone book or through the local mental health association.

If you have further questions about the Diversion Program, we will be happy to answer them for you. The group facilitator can answer general questions about your recovery. When participants have had crises develop in their lives and need someone to talk to, we suggest they contact the group facilitator. Facilitators are available day or night and will provide you with or direct you to immediate help.

Your Case Manager can answer questions about your status in the Program and your appointment with the DEC.

Again, we think your involvement in Diversion will be most enlightening and commend you for the action you have taken.

Sincerely,

Frank L. Valine
Diversion Program Administrator

MEDICAL BOARD OF CALIFORNIA DIVERSION PROGRAM

DOCTORS HELPING OTHER DOCTORS

In the Diversion Program, each participant's recovery is guided by a concerned committee and a case consultant. The committees are composed primarily of physicians with expertise in treating addictions and mental disorders. Many committee members also have personal experience in recovery.

Participants attend facilitated meetings with fellow doctors who are recovering from substance abuse and mental disorders. Each participant is required to attend local self-help meetings, e.g. Alcoholics Anonymous, where the participant learns how to maintain lifelong recovery.

ADMINISTRATION OF THE DIVERSION PROGRAM

The California Diversion Program is administered by the Medical Board of California (MBC) and is funded from physicians' licensure fees. There are other programs statewide where participants might seek a supportive structure in rehabilitation. However, the California Diversion Program is unique because California state law specifically empowers the MBC to divert a physician from discipline who has a substance abuse or mental disorder. The Diversion Program also oversees the rehabilitation of self-referred doctors.

DIVERSION EVALUATION COMMITTEE (DEC)

Soon after applying for participation in the Diversion Program, each prospective participant is evaluated by a Diversion Evaluation Committee (DEC). The DEC establishes an individual rehabilitation plan (Diversion Agreement) for each participant in the Diversion Program. Diversion Agreements are usually five years and the participant must comply with the provisions of this agreement to continue in the Diversion Program. The Diversion Agreement may be changed by the DEC as events warrant.

The DEC determines if the participant needs temporary limitations on his license to practice medicine, ambulatory or institutional detoxification, a recovery house, psychiatric or medical evaluation, and Naltrexone or Antabuse. The DEC functions as an expert consultant. Each participant will be permanently designated a case consultant from the DEC.

MONITORING

Since the concept of permitting the participant to work is a cornerstone of the Diversion Program, all Diversion Agreements contain language which detail multi-tiered documented monitoring. This monitoring includes the following:

- Participants initially attend Diversion group meetings twice a week for the at least the first three (3) years. These meetings are organized statewide and professionally facilitated.
- Participants are required to attend self-help meetings.
- Each participant has a case manager who works closely with a team to confirm and document the participant's recovery process and to expedite the resolution of any crisis or non-compliance. The team may include: the group facilitator, the worksite/hospital monitor, the specimen collector, the DEC case consultant, and therapists.
- Participants have worksite/hospital monitors. These individuals are responsible for observing the participant in and about the work place. They agree to provide the Diversion Program with progress reports and to contact the case manager if they observe anything unusual or suspect a relapse.

- Participants are required to provide a minimum of four (4) random, observed drug testing specimens (urine) per month, upon request. Group facilitators, case managers and collectors may take additional specimens, as necessary. All specimens are sent to a central laboratory for testing using a comprehensive customized drug screen.
- Participants must inform the well being committee at each hospital where they have privileges that they are in the Diversion Program.
- If a participant practices medicine while under the influence of alcohol or other drugs or refuses to comply with the Diversion Agreement, the Diversion Program will suspend the participant from the practice of medicine.

WORKSITE/HOSPITAL MONITOR REQUIREMENTS

The participant must submit the name and qualifications of one or more licensed physicians and surgeons, licensed allied health practitioners (e.g. podiatrist, physician assistant, registered nurse, licensed vocational nurse, or dentist), or the name of a contracted healthcare facility office manager who is not an employee of the participant nor in the supervisory chain of the participant to the case manager. The case manager will determine if the potential monitor is qualified.

The worksite/hospital monitor shall have no prior or current business, including but not limited to any form of bartering, personal, or familial relationship with the participant, or other relationship that could reasonable be expected to compromise the ability of the monitor to render fair and unbiased reports to the Diversion Program. The individual must agree to serve as the worksite/hospital monitor.

CONFIDENTIALITY

A physician who is licensed to practice medicine in California may volunteer to participate in the Diversion Program. This allows self referrals to enter the Diversion Program and encourages early identification and intervention. Because of the confidentiality policy of the Diversion Program, the MBC Enforcement Program remains unaware of the participation of "self-referred" physicians unless there is a current complaint.

EXPERIENCE OF RECOVERY

An indication of the effectiveness of the Diversion Program is the number of participants who have completed the program successfully. To complete successfully, a chemically dependent participant must be substance free for at least three continuous years and maintain a lifestyle which supports ongoing recovery.

EDUCATION REQUIREMENTS

All participants are required to obtain a minimum of ten hours per year within the first three years for a total of 30 hours of substance abuse/mental health education. Prior to attending a continuing education event the participant must contact the case manager to ensure the course will qualify as substance abuse/mental health education. The education credits are required for Diversion Program successful completion and participants must provide verification to the case manager. The educational requirement is outlined below:

1. Online courses may be accepted for up to 10 of the 30 required continuing education hours.
2. The following are not acceptable:
    a. Correspondence school courses
    b. DUI driving school courses
    c. Aftercare programs
    d. Reading books on substance abuse
    e. Films or lectures provided by the facilitator at group meetings

Diversion Program staff will make efforts to inform participants of upcoming seminars, workshops, and symposiums dealing with substance abuse. Participants are also encouraged to explore Continuing Education resources.

ATTENDANCE AT DIVERSION GROUP MEETINGS

Attendance at Diversion group meetings is mandatory. Participants should consider these meetings a top priority, as regular attendance is directly related to the participant's Diversion Agreement and recovery. Most Diversion Agreements require the participant to attend two group meetings a week for at least three (3) years.

Participants are required to attend all meetings. Prior case manager authorization is required if the participant is unable to attend a group meeting. Participants requesting to be excused from group meetings must submit requests for vacation. **All requests must be submitted in writing at least 14 days in advance**. The request must be submitted to the group facilitator and will be approved by both the group facilitator and the case manager. The group facilitator will notify the participant of the approval/denial of the request. **Requests submitted without a 14-day notice will only be approved if there is an emergency (e.g. family death or illness).**

When unexpected absences occur, the participant is required to call the case manager and group facilitator and discuss the absence. Whenever possible, missed meetings are expected to be made up. If there is a difficulty with attendance, the participant will be contacted by the case manager and may be brought back to the DEC to explain the absences.

REDUCTION OF GROUP MEETINGS

Initially, participants are required to attend two Diversion group meetings a week. Upon a written request to his/her group facilitator and case manager, a participant may be considered for a reduction in group meetings after three years in the program. The request will be discussed at the next DEC meeting. The following criteria must be met to be considered for a reduction in meetings:

1. Semi-Annual reports are current
2. Worksite/hospital monitor reports and therapist reports are up-to-date
3. 30 continuing education units are completed
4. Recovery substantiates a meeting reduction.
5. Participant is in full compliance with all terms of his/her Diversion Agreement

No participant will be allowed to reduce the number of group meetings if he/she is not in compliance with his/her Diversion Agreement.

SEMI-ANNUAL REPORTS

Semi-annual reports are required on the sixth and twelfth month anniversary of the participant's first DEC meeting. These reports shall be sent to the case manager and include any changes in:

1. work status
2. home address or telephone number
3. office address(es) or telephone number(s)
4. worksite monitor(s)
5. hospital monitor(s)
6. therapist, physician, or psychiatrist
7. current medication

If there are no changes, the participant shall confirm the above items. The semi-annual report should reflect the participant's perception of the internal progress made over the past six months. These reports are one of the major ways the DEC learns of your progress.

We realize that it is not easy to express self-perception on paper. To assist participants, the DEC offers four areas to consider:

1. What is your personal recovery program?
2. How does the 12 Step program assist you in your personal recovery program?
3. How do you feel about yourself and the relationships you have?
4. What do you see as your greatest life-problem?

Participants are not restricted by the suggestions and are free to use their own topics.

DRUG SCREENING

Participants in the Diversion Program are subject to random biological fluid collection for drug screening. Local providers, working in conjunction with group facilitators and case managers, collect urine specimens for the Diversion Program.

A minimum of four random urine specimens is taken monthly. Additional random urine tests may be taken at any time. Biological fluid collections are observed and a chain of custody protocol is followed. It is the participant's responsibility to be available for biological fluid collections. Participants must provide the monitor with telephone and/or pager number where they can be contacted at all times. Participants must return the monitor's call within 2 hours and present themselves for biological fluid collection within 6 hours of the initial call. Failure to respond within the required time will be considered a missed drug test.

In response to a missed drug test, the Diversion Program may require any/all of the following:

1. ceasing the practice of medicine
2. increased frequency of random drug testing
3. increased attendance at Diversion group meetings
4. meeting with the DEC, which may include a termination recommendation

If a work-related emergency precludes a biological fluid collection, the participant must contact the collection monitor. The collection monitor will contact the case manager immediately. The case manager must confirm the work-related emergency with the participant's worksite/hospital monitor, head nurse or other approved individual designated by the participant, and an incident report will be transmitted to Diversion Program by the collection monitor.

Participants requesting to be excused from biological fluid collection must submit requests for vacation. **All requests must be submitted in writing at least 14 days in advance**. The request must be submitted to the group facilitator and will be approved by both the group facilitator and the case manager. The group facilitator will notify the participant of the approval/denial of the request. Requests submitted without a 14-day notice will only be approved **if there is an emergency (e.g. family death or illness).**

Participants are responsible for all fees associated with biological fluid collection and testing as set forth below:

- The standard cost for collection is $25. Other circumstances may increase the cost. The participant may make payment arrangements with his/her collection monitor.
- Laboratory fees are $35 per specimen with a $25 extra fee for EtG. Payment is required by check or money order at the time of collection. Payment will accompany the specimen to the laboratory.
- Case managers may require the participant to have special or additional screenings. The laboratory fees may range from $25 to $120 and may be in addition to the $25 for the usual screen. Additional charges must be paid at the time of collection.

ETHYL GLUCURONIDE (EtG) TESTING

EtG or ethyl glucuronide is a unique metabolite of alcohol. This unique enzyme stays in urine for up to 80 hours detecting ingested alcohol. This very sensitive enzyme can produce a positive alcohol reading reflecting exposure from alcohol containing foods, non-alcoholic beer or wine, or medicines. The Diversion Program utilizes both a drug panel and the EtG for urine specimen testing of all participants.

DRUGS WITH POTENTIAL FOR ABUSE/ADDICTION RISKS AND POSITIVE DRUG TESTS

It is extremely important the participant's primary care physician is aware of Diversion Program participation. In cases in which the participant's physician believes a Schedule II-V prescription drug is necessary, the participant will have to remove him/herself from the clinical practice of medicine. **The participant will not be allowed to work while taking a prescribed controlled substance from Schedules II-V and will not be allowed to return to work until the prescription is completed and a negative test is produced.**

To assist you in maintaining your life free of mind-altering drugs, included is a list of frequently prescribed psychoactive drugs and commonly used over-the-counter drugs with potential hazards to participants who are chemically dependent. This is not an all-inclusive list. Alternate solutions to drugs may require more time or effort, but will support the development of a drug-free lifestyle.

NARCOTICS & ANALGESICS

Codeine
- Tylenol #1,2,3,4
- Empirin # 1,2,3,4
- Phenaphen # 2,3,4

Dilaudid
Fentanyl-Sublimaze
Hydrocodone
- Hycodan, Tussiones, Vicodin

Lomotil
Meperidine
- Demerol or Mepergan

Methadone
Morphine
Nubain
Oxycodone
- Percodan, Tylox

Propoxyphene
- Darvon, Darvocet

Paregoric
Stadol
Talwin
Ultram

ANTIHISTAMINES

Benadryl
Dramamine
Pyribensamine

STIMULANTS

Amphetamines
- Dexedrine & Dexamyl
- Benzedrine, Biphetamine

Cylert
Fastin
Ionamin
Methamphetamine
- Desoxyn, Methedrine

Preludin, Prelu-2
Cocaine or any ACaines@
- Procaine (other than as a local anesthetic)

Ritalin
Tenuate
Redux

ALCOHOL

Liquid medicines denoted by the term AElixir@

VOLATILE INHALANTS

Amyl/Butyl Nitrate
Anesthetics
Nitrous Oxide

SEDATIVE HYPNOTICS, TRANQUILIZERS & ANTI-ANXIETY AGENTS

Ambien
Amytal
Ativan
Buspar
Carbrital
Centrax
Dalmane
Donnatal
Doral
Doriden
Equanil
Halcion
Librium
Meprobamate
Methaqualone
Miltown
Nembutal
Noctec or Chloral Hydrate
Noludar
Parest
Placidyl
Prazepam
Restoril
Seconal
Serax
Sodium Luminal
Sodium Phenobarbital
Sonata
Sopor
Tranxene
Valium
Veronal
Vistaril
Xanax
Zolpidem

OTC (over-the-counter)

Use of the following drugs may cause a positive urine test. This can almost always be avoided since there are cold and cough preparations on the market, which do not contain alcohol and/or antihistamine.

ANTIHISTAMINES
Dristan, Contac, etc.

CAFFEINE PREPARATIONS
NoDoz, Vivarin, etc.

COUGH MEDICINES CONTAINING ALCOHOL AND/OR ANTIHISTAMINES
Hycodan, Tussiones, Dimetane DC, Actifed C, Phenergen, Nyquil, Robitussin, etc.

DIET AIDS
Dexatrim, etc

MOUTHWASH CONTAINING ALCOHOL
Scope, Listerine, Nyquil, etc.

OTHER OTC DRUGS
Somines, Nytol

POPPY SEED FOODS/FOODS PREPARED WITH ALCOHOL

Diversion participants must avoid the use of foods containing poppy seeds, poppy seed paste, and foods prepared with alcohol. Ingestion of poppy seeds can result in morphine positive drug screens and foods prepared with alcohol may result in a positive test for alcohol. Please be advised that when a participant's drug screens are positive for morphine or alcohol, the consumption of these foods is an unacceptable explanation and participants are considered positive for drug/alcohol use.

REQUEST FOR SUCCESSFUL PROGRAM COMPLETION

It is the participant's responsibility to apply for successful completion. When ready, participants discuss successful program completion with their group facilitator, case manager, and worksite monitor. Participants shall submit a written request to the case manager.

The DEC will consider the following factors when determining successful program completion requests. The participant must have:

1. Complied with all terms of the Diversion Agreement.

2. Accrued three years of continuous sobriety, if chemically dependent.

3. Demonstrated a change in lifestyle that supports sobriety and recovery. This change in lifestyles may be demonstrated by commitment to a personal program of recovery, changes in work habits that support ongoing sobriety, and participation in Diversion group meetings.

4. Positive recommendations from the case manager, group facilitator, and worksite monitor about participant's readiness for successful completion.

5. Group facilitator and lab collection fees paid or arrangements made.

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To Family Members and Significant Others:

We would like to take this opportunity to provide you with information about the Diversion Program to which your family member or significant other has recently applied for participation. We have included a question and answer sheet about the Diversion Program. If your family member or significant other has a mental disorder, we suggest that you contact your local mental health association for information and support groups specific to the illness. Literature may also be obtained through local self-help support group associations.

We recommend that you educate yourself about chemical dependency and mental illness for two reasons: first, and most importantly, so that you can understand the impact of the illness on you, and secondly, so you can be supportive of your loved one's recovery in an informed manner. Support groups are available for families and significant others to assist in coping with and recovery from the effects of chemical dependency and mental illness. Al-Anon Family Groups, Codependents Anonymous and Emotions Anonymous are listed in the telephone directory.

If you have any questions about the Diversion Program, or if there is any way in which we can assist you, please call (916) 263-2600. Our staff will be happy to help you.

Sincerely,

Frank L. Valine
Diversion Program Manager

Attachments: The Family Disease
Questions and Answers About the Diversion Program

THE FAMILY DISEASE

We may live with a problem for a long time before we can identify its nature. Such is often the case with chemical dependency (alcoholism and/or other drug addiction). It is a disease that "breaks the rules," so to speak. In the case of most major illnesses, the physical symptoms tend to manifest themselves first, and the behavioral changes come about later. But with chemical dependency, the behavioral symptoms generally manifest themselves long before the physical changes occur. This leads to feelings of confusion in the family. Feelings of "something is wrong, but what?" (These same feelings exist in families where there is mental illness.)

In a culture that is, for the most part, uninformed as to the disease concept of alcoholism and other drug addiction, and where chemical dependency and mental illness are often a "moral issue," it is difficult to admit to such a problem existing in one's family. Perhaps this is especially so for families of doctors. But without this admission, the chance for family recovery is lost.

Alcoholism, drug addiction and mental illness are diseases. They are chronic, relapsing, progressive, and often fatal diseases. They are sometimes joked about and taken lightly. They are not to be underestimated. As with any other disease of such a serious nature, no one chooses to be alcoholic, drug addicted or mentally ill. It is not a matter of guilt or blame, even though those feelings often permeate the entire family. Although alcoholism and drug addiction are no one's fault, recovery from the disease is everyone's responsibility.

While the alcoholic or addict has been living with the problems of drinking or using, the spouse and other family members have been living with those problems, too. The chronic, progressive nature of the disease takes its toll on the whole family. In fact, we refer to chemical dependency as a "family disease." And we have a name for the resultant set of symptoms in family members: co-dependency.

We human beings are wonderfully adaptive creatures. We learn to survive under even the most adverse of conditions (physical or emotional). All members of a family in which there is chemical dependency or mental illness become part of a "supporting cast" to the disease. The roles become more and more rigid as more and more energy must be spent to keep things together. After a while, family members become, in a sense, "type cast." Fortunately, we have an enormous potential for change. What makes learning a new role so difficult is that one of the most rigid-commandments" in a family is "Thou shalt not ask for or accept help."

Recovery from these diseases requires accepting help even though it may not feel comfortable at first.

QUESTIONS AND ANSWERS ABOUT DIVERSION

WHAT IS THE DIVERSION PROGRAM?

The Diversion Program is a confidential program which provides a supportive structure for building a personal program of recovery from chemical dependency and/or mental illness. The Diversion Program also monitors a participant's progress, not only for the public safety, but also as documentation of recovery for the participant.

WHAT WILL THE DOCTOR BE EXPECTED TO DO WHILE IN THE DIVERSION PROGRAM?

While participants receive treatment programs tailored to their individual needs, there are general similarities in requirements. Some requirements are:

1. Participate in the program for 5 years.
2. Attend 3-7 Alcohol Anonymous (AA), Cocaine Anonymous (CA) or Narcotics Anonymous (NA) meetings each week (for those with substance abuse disorders) or attend therapy sessions (for those with mental health disorders).
3. Attend 1-2 Diversion group meetings each week.
4. Abstain from all drugs including alcohol.
5. Accumulate 30 hours of continuing education in the field of addiction or mental health.
6. Obtain worksite and hospital monitors.
7. Be evaluated by the Diversion Evaluation Committee periodically.
8. Be contacted by a case manager on a random basis.
9. Provide urine specimens on a random basis.
10. Not use prescribed medications unless approved by the program.

There may be additional and more specific requirements depending on the needs of an individual participant, such as inpatient treatment or counseling for a specific problem.

WHAT HELP IS AVAILABLE TO THE SPOUSE AND OTHER FAMILY MEMBERS?

Family members are very strongly encouraged to participate in family treatment programs, which may be offered in conjunction with primary addiction or mental health treatment. These disorders have a powerful impact on families. It is well known that education and support can be of great significant to family members and to the long-term well being of the family as a whole.

For the spouse of the chemically dependent person, we regularly refer to Al-Anon as the primary recovery resource. Adult children can benefit enormously from participation in an Adult Children of Alcoholics/Al-Anon Family group. For younger children, Alateen is a great source of comfort and support. Increasing numbers of communities have groups such as Alatot for very young children. Theses can be found in your local telephone directory.

For family members of the mentally ill person, local mental health organizations provide many support groups. These organizations can be contacted through your local mental health association.

AGREEMENT
DURING EVALUATION PROCESS
Self Referral

I, _____, M.D., am applying for admission to the Physician Diversion Program, a rehabilitation and monitoring program administered by the Division of Medical Quality of the Medical Board of California (MBC). I recognize and acknowledge that I may have a substance-related disorder or mental health-related disorder. I will be scheduled to meet with a Diversion Evaluation Committee for an evaluation of my particular circumstances, to determine if I am appropriate for, and may benefit from, the Diversion Program, and to finalize the treatment plan provisions of my Diversion Agreement. I understand the Diversion Program's first priority is protecting the public's safety.

I, _____, M.D., agree to comply with the terms and conditions outlined below, pending a decision on whether I will be accepted into the Diversion Program:

1) I agree to cease my practice of medicine if the Diversion Program determines that I am impaired. Impairment may be determined by:
   a) practicing while under the influence of alcohol or other drugs.
   b) submitting a biological fluid test which results in a positive drug screen or a pattern of negative dilute specimens.
   c) refusing to submit to biological fluid testing.
   d) attending diversion group while under the influence of alcohol or drugs.
   e) documented reports from a worksite/hospital monitor of unsafe practice performance.
   f) non-compliance with the terms and conditions set forth in this agreement.

2) I will enter a treatment program within _____ days as directed if it is determined by the Diversion Program that treatment is necessary in order for me to practice medicine safely. I understand that I am responsible for paying the cost of the treatment program.

3) I will attend one/two facilitated Diversion Group meetings per week as directed at the assigned location. If I am unable to attend, I will report the reason to the group facilitator and my Diversion Program case manager. I agree to stay current with group fees or make payment arrangements with the group facilitator. I will request Diversion Program approval prior to taking any time off from group. I will make up all missed Diversion group meetings within the following week by attending recovery support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous, with my case manager's approval.

4) I will attend _____ recovery support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous, per week, as directed.

5) I agree that while I am practicing medicine I will be under the monitoring of a worksite/hospital monitor.

6) If directed by the Diversion Program, I will undergo a substance-related disorder and/or psychiatric evaluation if I have not had treatment for my condition. I understand that I am responsible for paying the cost of the treatment program.

7) I will abstain from the use of alcohol and all psychoactive drugs except those prescribed for me by another physician and approved by the Diversion Program.

8) I will not practice medicine while taking prescribed controlled substances from Schedule II-V.

9) I will report by telephone to my Diversion Program case manager all personal use of prescription drugs and the name of the prescribing physician. I will obtain a copy of all prescriptions written for me prior to having them filled. These copies will be given to my case manager.

10) I will not self-prescribe any medications which require a prescription.

11) I will provide a minimum of four observed biological fluid samples per month, as requested. The laboratory results of these tests will be submitted to the Diversion Program. The urine test lab fee and collection fee will be paid at the time of the testing. All fees are my responsibility.

12) I will obey all federal, state and local laws and rules governing the practice of medicine in the State of California. I will immediately report by telephone to my Diversion Program case manager any arrest for or conviction of any offense.

13) I will immediately report by telephone to my Diversion Program case manager any relapse or use of alcohol or unauthorized drugs.

14) I understand and agree that my participation in the Diversion Program does not affect, alter, or curtail in any manner the MBC's authority to investigate and take disciplinary action against my license for any unprofessional conduct committed by me whether before, during, or after my participation in the Diversion Program.

15) Any expenses related to the requirements of the Diversion Program are my responsibility. I understand that any expenses incurred in my treatment (i.e., hospitalization, biological fluid analysis, doctor fees, meeting fees, etc.) are my responsibility. I understand that payment of fees is to be kept current or payment arrangements made.

16) I understand that the Diversion Program may amend this agreement during the evaluation process as circumstances warrant.

17) Other provisions -

I have read and discussed this document with the Diversion Program case manager. I understand and agree to the terms and conditions outlined above and I acknowledge receipt of a copy of this document.

_____ _____
Applicant Signature Date

_____ _____
Diversion Program Case Manager Date

_____ _____
Diversion Program Administrator Date

AGREEMENT
DURING EVALUATION PROCESS
Enforcement Referral

I, _____, M.D., am applying for admission to the Physician Diversion Program, a rehabilitation and monitoring program administered by the Division of Medical Quality of the Medical Board of California (MBC). I recognize that I may have a substance-related disorder or mental health-related disorder. I will be scheduled to meet with a Diversion Evaluation Committee (DEC) for an evaluation of my particular circumstances, to determine if I am appropriate for, and may benefit from, the Diversion Program, and to finalize the treatment plan provisions of my Diversion Agreement. I understand the Diversion Program's first priority is protecting the public's safety and welfare.

I understand that a complaint has been filed against me with the Medical Board and is being investigated. I also understand that **I will not** be allowed entrance into the Diversion Program until the investigation is completed and the Deputy Chief of Enforcement evaluates and has approved my request for participation.

While the complaint is being investigated, I agree to be evaluated by the DEC or its designee to determine if I have a substance-related disorder or mental health-related disorder and require treatment. I also agree to cooperate in the evaluation process and to comply with the terms and conditions set forth in this document. I understand that I will be closely monitored during the evaluation process to assure public protection.

I understand that if I am accepted into and successfully complete the Diversion Program, pursuant to Business and Professions Code section 2350, I will not be prosecuted administratively for violations that resulted in my referral to the Diversion Program.

I understand that if I am <u>not</u> accepted into the Diversion Program, or if I am terminated from the program for failure to comply with Diversion Program requirements, information from my diversion file (excluding alcohol or drug treatment records protected by federal or state law) may be provided to the Enforcement Program pursuant to Business and Professions Code section 2350(j)(2). I understand that I may be subject to disciplinary action by the Medical Board for acts committed before, during, and after referral to the Diversion Program.

AGREEMENT
DURING EVALUATION PROCESS
Enforcement Referral

I, _____, M.D., agree to comply with the terms and conditions outlined below, pending a decision on whether I will be accepted into the Diversion Program:

1) I agree to cease my practice of medicine if the Diversion Program determines that I am impaired. Impairment may be determined by:

   a) practicing while under the influence of alcohol or other drugs.
   b) submitting a biological fluid test which results in a positive drug screen or a pattern of negative dilute specimens.
   c) refusing to submit to biological fluid testing.
   d) attending diversion group while under the influence of alcohol or drugs.
   e) documented reports from my worksite/hospital monitor of unsafe practice performance.
   f) non-compliance with the terms and conditions set forth in this agreement.

2) I will enter a treatment program within _____ days as directed if it is determined by the Diversion Program that treatment is necessary in order for me to practice medicine safely. I understand that I am responsible for paying the cost of the treatment program.

3) I will attend one/two facilitated Diversion Group meetings per week as directed, at the assigned location. If I am unable to attend, I will report the reason to the group facilitator and my Diversion Program case manager. I agree to stay current with group fees or make payment arrangements with the group facilitator. I will request Diversion Program approval prior to taking any time off from group. I will make up all missed Diversion Group meetings within the following week by attending recovery support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous, with my case manager's approval.

4) I will attend _____ recovery support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous, per week as directed.

5) I agree that while I am practicing medicine I will be under the monitoring of a worksite/hospital monitor.

6) If directed by the Diversion Program, I will undergo a substance-related disorder and/or psychiatric evaluation if I have not had treatment for my condition. I understand that I am responsible for paying the cost of the treatment program.

7) I will abstain from the use of alcohol and all psychactive drugs except those prescribed for me by another physician and approved by the Diversion Program.

8) I will report by telephone to my Diversion Program case manager all personal use of prescription drugs and the name of the prescribing physician. I will obtain a copy of all prescriptions written for me prior to having them filled. These copies will be given to my case manager.

9) I will not practice medicine while taking prescribed controlled substances from Schedule II-V.

10) I will not self-prescribe any medications which require a prescription.

AGREEMENT
DURING EVALUATION PROCESS
Enforcement Referral

11) I will provide a minimum of four observed biological fluid samples per month, as requested. The laboratory results of these tests will be submitted to the Diversion Program. The urine test lab fee and collection fee will be paid at the time of the testing. All fees are my responsibility.

12) I will obey all federal, state and local laws and rules governing the practice of medicine in the State of California. I will immediately report by telephone to my Diversion Program case manager any arrest for or conviction of any offense.

13) I will immediately report by telephone to my Diversion Program case manager any relapse or use of alcohol or unauthorized drugs.

14) If I am being referred to the Diversion Program as a result of a Probation Order from the MBC, I understand that any violation of my probation terms, while in the Diversion Program, will be reported to the MBC Enforcement Program by the Diversion Program Administrator.

15) I understand and agree that my participation in the Diversion Program does not affect, alter, or curtail in any manner the MBC's authority to investigate and take disciplinary action against my license for any unprofessional conduct committed by me (except for the basis for which I am entering Diversion) whether before, during, or after my participation in the Diversion Program.

16) I understand that I am responsible for any expenses related to the requirements of the Diversion Program. I understand that any expenses incurred in my treatment (i.e., hospitalization, biological fluid analysis, doctor fees, meeting fees, etc.) are my responsibility. I understand that payment of fees is to be kept current or payment arrangements made.

17) I understand that I am responsible for the timely submission of the reports prepared by my therapist and worksite/hospital monitor as applicable and that the Diversion Program may contact me if these reports are not submitted on time.

18) I understand that the Diversion Program may amend this agreement during the evaluation process as circumstances warrant.

19) Other provisions -

I have read and discussed this document with the Diversion Program case manager. I understand and agree to the terms and conditions outlined above and acknowledge receipt of a copy of this document.

_____ _____
Applicant Signature Date

_____ _____
Diversion Program Case Manager Date

_____ _____
Diversion Program Administrator Date

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION TO AND WITH THE CALIFORNIA PHYSICIANS' DIVERSION PROGRAM

I, _____, M.D. birth date _____, hereby authorize and request the person or entity listed below to release and exchange information regarding myself to and with the Diversion Evaluation Committee (DEC) and/or its designee, the Diversion Program, located at 1420 Howe Avenue, Suite 14, Sacramento, CA., 95825.

Disclosure of this information is authorized for the purpose of assisting the DEC and/or the Diversion Program to design a recovery program for me and to assist in my rehabilitation efforts.

Request for disclosure of information is made from/to:

_____
Name

_____
Organization or Facility

_____
Address

_____
City State Zip Telephone

Disclosure will be limited to the following information:

_____ Diagnostic and Discharge Summary
_____ Physical Exam
_____ Psychiatric Examination
_____ Pertinent Laboratory Findings
_____ Psychological Tests
_____ Neurological Examination
_____ Requirements for Diversion Participation
_____ Attendance at Diversion Group Meetings
_____ Attendance at Therapy
_____ Progress Notes
_____ Verification of Participation
_____ Other _____
_____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon. If not earlier revoked, it shall terminate on _____, (date, event or condition not to exceed six (6) years) without express revocation.

_____ _____
Participant or Authorized Representative Date

_____
Witness (If signed by other than participant indicate relationship)

Further disclosure of alcohol/drug treatment and related information authorized by this consent is prohibited by Federal Law. Federal Regulations (42CFR Part 2) prohibits the making of any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Diversion Program participant information is disclosed from records whose confidentiality is protected by California State Law (Section 2355 of the Business and Professions Code). Any further disclosure requires specific written consent of the person to whom it pertains.

MEDICAL BOARD OF CALIFORNIA
PHYSICIAN'S DIVERSION PROGRAM
1420 Howe Avenue, Suite 14
Sacramento, CA 95825-3236
Telephone: (916) 263-2600
Toll Free: 1-866-728-9907
www.caldocinfo.ca.gov

PHYSICIAN'S DIVERSION PROGRAM AGREEMENT

This agreement consists of Part I and Part II

PART I

The Diversion Evaluation Committee (DEC), after evaluating my particular circumstances, has designed this Agreement to establish the terms and conditions of my participation in the Diversion Program (Program) for my recovery from a [substance-related and/or mental illness-related] disorder. All the conditions listed below are subject to modification by the DEC and the Program Administrator.

In a cooperative effort with the DEC, I, _____, M.D., agree I will:

1. Not practice medicine until _____ /approved by the DEC [or] Restrict practice to _____

2. Enter an (inpatient, outpatient, recovery facility or halfway house) program within ___ days.
   [or]
   Complete the treatment program in which I am currently enrolled and comply with discharge recommendations, if any.

3. Attend _____Diversion Group meetings per week. If unable to attend, I will contact my group facilitator and case manager prior to the scheduled meeting. I agree to stay current with group fees or make payment arrangements with my group facilitator.

4. Attend 90 Alcoholics Anonymous/Narcotics Anonymous/Cocaine Anonymous/other _____ 12-step meetings in 90 days from the date this Agreement is signed. Then attend _____ Alcoholics Anonymous meetings per week. I will obtain and maintain a sponsor. I will provide my case manager with meeting attendance verification monthly.

5. Undergo a psychiatric medication/medication evaluation within thirty days of receipt of this document with _____ to examine _____. I will ensure the results of the evaluation are sent to my case manager within 30 days afer the examination.

6. Obtain a battery of psychological tests and/or neurological evaluation to examine _____. I will ensure that the results are sent to my case manager within 30 days after the examination.

7. Engage in psychiatric/medication management for _____ with Dr. _____. I will ensure that my psychiatrist/physician submits quarterly progress reports to my case manager.

8. Obtain a primary care physician who is knowledgeable about my addiction history. I will provide the name and contact information of my primary care physician to my case manager.

9. Begin/Continue individual therapy. I will ensure that my therapist submits quarterly progress reports to my case manager.

10. Surrender my current pocket license/DEA permit to the Diversion Program.
    A. Not have any samples or _____ in my office.
    B. Not write any prescriptions.
    C. Restrict prescribing privileges to _____ drugs.

11. Obtain a worksite monitor, within ten days from the date this Agreement is signed or upon return to work, for each of my works sites to observe my condition, appearance and performance in and about the work place. I will ensure that each monitor submits quarterly reports to my case manager.

12. Obtain a hospital monitor, within ten days from the date this Agreement is signed or upon return to work, for each hospital where I have privileges. I will submit the name of my monitor to my case manager. I will ensure that each monitor submits quarterly reports to my case manager.

13. Abstain from the use of alcohol, all psychoactive drugs and over-the-counter medication which contains alcohol except those prescribed for me by another physician and approved by Diversion. **I understand that if I use any pre-approved prescribed controlled substances from Schedules II-V, I will not practice medicine.**

14. Begin/Continue to take Naltrexone/Antibuse unless contraindicated by my primary care physician. I will have my primary care physician write the prescription and my group facilitator/worksite monitor will monitor the use of this medication.

15. If leaving the area where I live and/or practice medicine (e.g., vacation, etc.) interferes with my treatment plan, I will submit a written request to my group facilitator fourteen (14) days in advance of leaving the area. In the event of an emergency (i.e. family death, illness) I will immediately, upon notification of the emergency, contact my case manager to request leave. I understand that only in emergency situations will a request be approved without a fourteen day notice.

16. Agree to remain in the Program for a period of five years. If my recovery program requires additional time, I will extend my agreement and remain in the Program.

17. Recommend Al-anon and/or _____ to my wife/husband/partner/family.

18. Other provisions_____

PART II

I understand that the Physician's Diversion Program is responsible for protecting the public health and welfare as well as guiding me in my recovery process. I hereby acknowledge and agree to the following conditions:

1) I will obey all federal, state and local laws and rules governing the practice of medicine in the State of California. I will immediately report by telephone to my Case Manager any arrest or conviction of any offense.

2) I will immediately report by telephone to my case manager all "slips" from total abstinence before confrontation or scientific evidence of use.

3) I will not self-prescribe any medications for which I must use my prescription pad privileges.

4) I will notify the Well-Being Committee at each hospital where I practice medicine of my participation in the Diversion Program and give the Diversion Program permission to communicate with the Committee about my participation. If the hospital does not have such a Committee, I will notify the Chief of Staff or the Hospital Administrator of my program participation. I understand and agree that if I am unsuccessfully terminated from the Program, the Well Being Committee, the Chief of Staff or the Hospital Administrator will be notified.

5) I will provide observed biological fluid samples upon request. The laboratory analysis of these tests will be submitted to the Program. I understand that if I am on Probation with the Medical Board of California (MBC) lab testing results will be forwarded to the Probation Monitoring Unit of MBC.

6) I will report by telephone to my case manager all personal use of prescription drugs and the name of the prescribing physician. I will obtain a copy of all prescriptions written for me prior to having them filled and will provide these copies to my case manager within 3 days of having the prescription filled.

7) I will make up all missed Diversion group meetings within the following week. If unavailable, I will substitute attendance at an Alcoholics Anonymous/Narcotics Anonymous meeting with my case manager's approval.

8) I will not change my present place or manner of employment without prior approval of the Program.

9) At various intervals and with reasonable notice, I will report by telephone or appear in person for interviews with the DEC, case consultant, case manager, or members of the Program staff.

10) At the direction of the DEC, I will submit to additional examinations and/or evaluations at my own expense if they become necessary for competency. The results of the examinations and/or evaluations will be submitted to the Program Manager.

11) I will obtain 10 hours of continuing education annually for the first three years of this agreement in substance abuse/mental health education approved by the Program until I have accumulated a total of 30 hours. I will provide copies of Certificates of Completion to my case manager within 5 days of receipt of certificate.

12) I will submit semi-annual reports of my recovery progress to the Program.

13) I understand that any expenses related to the requirements of the Program (e.g., hospitalization, psychiatric evaluations, biological fluid analysis, doctor fees, meeting fees, etc.) are my responsibility.

I understand that payment of fees are to be kept current. Fees must be paid in full for successful completion of the Diversion Program.

14) a) I understand that the DEC may amend this agreement to add additional restrictions on practice, additional biological fluid testing, and other provisions necessary to ensure public safety upon showing that I have demonstrated non-compliance with the terms, conditions, and provisions of this agreement.

b) I understand that I may make a written request to the DEC to amend or revise this agreement. I further understand that no request for an amendment will be approved if I am not in full compliance with this Agreement, and in no event shall my biological sample testing requirements be reduced below four (4) per month.

15) If I am in the Program as a result of a Probation Order from the Medical Board, I agree to sign the Authorization for Release and Exchange of Information provided to me by the Medical Board.

16) I understand and agree that my participation in the Diversion Program does not affect, alter, or curtail in any manner the MBC's authority to investigate and take disciplinary action against my license for any unprofessional conduct committed by me (except for the basis for which I am entering Diversion) whether before, during, or after my participation in the Diversion Program.

17) All confidential communications between the DEC and myself are privileged.

18) I may be suspended from the practice of medicine and terminated from the Program under the following circumstances:

a) Practicing medicine while under the influence of alcohol and/or other drugs, or upon receipt of a biological test result which contains the presence of a prescribed controlled substance from Schedules II-V.

b) Refusing to comply with the terms, conditions, and provisions of this agreement.

c) Refusing to submit to biological fluid testing to detect the presence of alcohol and/or drugs in my system.

I understand and agree that the Diversion Evaluation Committee (DEC) has authorized the Program Manager to suspend me from the practice of medicine if any of the above circumstances occur. If I am suspended from practice, I agree to comply with the suspension.

20) I understand that termination from the Program can only be imposed by the Diversion Program Administrator after recommendation by the DEC.

21) If I am terminated from the Program by the Program Administrator after recommendation by the DEC for any reasons other than successful completion of the Program, and am known to the Medical Board through Enforcement or other related activity, the fact of my termination will be reported to the Enforcement Program.

22) If I am a self- referral who is unknown to the Medical Board through Enforcement or other related activity and I am terminated from the Program by the DEC for any reasons other than successful completion of the program, and the DEC determines that I am unable to practice medicine safely, the fact of my termination will be reported to the Enforcement Program.

23) As an express condition for participation, I hereby release and forever discharge MBC, the Division, and my assigned DEC, its agents, representatives, employees, staff members, the Diversion Group Facilitators, the personnel designated by the DEC to assist me, and each of them and all of them, past present and future from any claims, demands, obligations, costs incurred, expenditures, damages, or causes of actions of any nature whatsoever arising out of omission in connection with my application or participation in the Physician Diversion Program.

24) I further understand and agree that my Diversion records may be used in disciplinary or criminal proceedings if I am terminated from the Diversion Program and (1) my participation in the Diversion Program is a condition of probation; or (2) I have disciplinary action pending or I was under investigation at the time I entered the Diversion Program; or (3) a Diversion Evaluation Committee determines that I present a threat to public health and safety. However, I do not authorize the release of my alcohol or drug treatment records in violation of federal or state law.

25) I also understand and agree that the Diversion Program may exchange information about my recovery with a hospital Well-Being Committee or monitor and with the Medical Board's Licensing Program, where appropriate.

My signature on this Agreement acknowledges that I have received and read a copy of the agreement and that I agree to be bound by and comply with the terms, conditions, and provisions of this agreement. I understand that it is my responsibility to ensure that all reports from my worksite, hospital or therapist are provided to my case manager in the specified timeframe.

_____ Date: _____
Participant, MD

_____ Date: _____
Case Manager/Witness

_____ Date: _____
Frank L. Valine
Diversion Program Administrator

_____ Participant's Initial

DIVERSION PROGRAM

Mailing Address:	1420 Howe Avenue, Suite 14 Sacramento, CA 95825
Telephone:	(916) 263-2600 Office (916) 263-2607 FAX

****

Case Consultant:

Medical Board of California
1420 Howe Avenue, Suite 14
Sacramento, CA 95825
(916) 263-2600

Case Manager:

_____ Participant's Initial

STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
1420 Howe Avenue, Suite 14
Sacramento, CA 95825-3236
(916) 263-2600 FAX (916) 263-2607
www.mbc.ca.gov

Medical Board of California
Diversion Program
Well Being Committee Acknowledgment

I have been notified that Dr. _____, M.D. is in the Diversion Program. I also am aware that this doctor will have a monitor and agree that the Well Being Committee will work cooperatively with the Diversion Program.

_____ _____
Signature Date

_____ _____
Print Name Telephone Number

_____
Title

_____
Hospital/Facility

_____
Facility Address

_____
Email address

STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY
ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

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Chairperson of the Well Being Committee:

A physician on the medical staff of your hospital has been accepted into the Medical Board of California's Diversion Program by a Diversion Evaluation Committee. The Committee is composed of three physicians and two public members with expertise in the diagnosis and treatment of chemical dependency or mental disorders. The Diversion Program monitors physicians while they are recovering from chemical dependency or mental illness. Since its inception in 1980, the Diversion Program has been effective in helping physicians make changes that support a constructive lifestyle. We have enclosed information explaining the Diversion Program.

We want to work with your Well Being Committee to support this physician during his or her recovery. Support from your committee will enhance his or her efforts and by working together we can also provide better protection for the public.

Physicians are required to have monitors at all facilities where they practice. The monitor is someone who has regular contact with the physician and provides quarterly reports to the Diversion Program.

Your primary contact with the Diversion Program will be with a Case Manager. Case Managers are responsible for assisting physicians in recovery and monitoring compliance with the provisions of his or her Diversion Agreement. We urge you to obtain information about this physician's requirements. With signed consent from the physician, we will provide you with a copy of his or her Diversion Agreement.

If drug or alcohol use is suspected, immediately contact the Case Manager or the Diversion Program office at (916) 263-2600. If it is necessary to stop the physician from practicing, refer to the medical staff bylaws for appropriate action.

Please sign the Well Being Committee Acknowledgment and return it in the enclosed envelope. By signing, you acknowledge being notified that Dr. , M.D. is in the Diversion Program, and you agree to work with us.

If you have any questions, please contact the Case Manager.

If you are starting a Well Being Committee or appointing new members, we recommend obtaining the CMA Guidelines for a Well Being Committee. They can be obtained from the CMA at (415) 541-0900.

Sincerely,

Frank L. Valine
Diversion Program Administrator

Enclosures

MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
1420 Howe Avenue, Suite 14
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AGREEMENT TO MONITOR AT THE WORKSITE AND/OR HOSPITAL
PAGE 1 OF 2

Introduction
The role of the worksite and/or hospital monitor (monitor) is to ensure, to the extent possible, that the participant will conduct his/her practice with safety to the public and in a competent manner. The monitor is responsible for reporting to the Board any of the participant's behavior in the following areas: absenteeism, changes in personal habits, changes in practice performance, changes in interpersonal relationships, changes in social behavior, and compliance with his/her work hour restrictions. The monitor is also responsible for informing the Diversion Program whether, in his or her opinion, patient safety may be at risk. The monitoring function is important in assisting the participant to restore his/her personal life. In order to provide this type of objective oversight, the monitor must not have any prior or current business, personal, or other relationship with the participant that could reasonably be expected to compromise the ability of the Monitor to render fair and unbiased reports to the Diversion Program.

The Board's Expectations
Prior to agreeing to monitor the participant's practice, you must carefully review the Diversion Agreement, and if applicable the Accusation (which explains the reasons for the disciplinary action against the probationer) and the Decision (which explains the terms and conditions of the probationer's probation). You should also meet the participant so that both of you will have a clear a understanding of the nature of the monitoring responsibilities. If you accept the monitor role, you will be expected to be at the participant's practice location whenever the participant is engaging in the practice of medicine. You must report your observations to the Case Manager using the Monitor' Quarterly Report, once each quarter. **If you believe the participant is using drugs or alcohol in violation of his/her agreement, or that patient safety might be at risk, immediately contact the Case Manager.** If you are no longer able or willing to monitor the participant, you must immediately notify the assigned Case Manager.

Reports- Due Dates
The monitor will submit a Monitor's Quarterly Report, once each quarter to the assigned Case Manager regarding his/her observations of the participant. The monitor's Quarterly Report shall bear the monitor's original signature. The reports must be mailed or faxed to the Case Manager's office within the (10) calendar days of after the end of the preceding quarter as follows:

Reporting Time Period	Due No Later Than
January 1 to March 31	April 10
April 1 to June 30	July 10
July 1 to September 30	October 10
October 1 to December 31	January 10

AGREEMENT TO MONITOR AT THE WORKSITE AND/HOSPITAL
PAGE 2 OF 2

I, _____, "Monitor", hereby agree to monitor

_____, **M.D.** at the worksite and/or hospital.

I understand that:

- I have received and have read a copy of the Participant's Diversion Agreement, and if appropriate, the Accusation and Decision.
- I clearly understand the role of a Monitor and what is expected of me.
- I have no prior or current business, personal or other relationship with the participant that could reasonably be expected to compromise my ability to render fair and unbiased reports to the Diversion Program.
- I have reviewed and agree with the conditions of the Monitoring Plan. I agree to regularly submit written reports to the assigned Case Manager regarding my review of the participant's behavior and/or practice. The due dates and required content of these reports is detailed in the Monitoring Plan.
- If I am no longer able or willing to continue to monitor the participant, I agree to immediately notify the assigned Case Manager.

My signature below affirms the following:

_____ _____
(Monitor's Signature) **(Date)**

_____ _____
(Monitor's Printed Name) **(Monitor's License Number, if applicable)**

_____
(Monitor's Address)

_____
(Monitor's Office Telephone Number) **(Monitor's Cell Number)**

_____
(Monitor's Email)

DIVERSION PROGRAM
POLICY GUIDELINES FOR
WORKSITE/HOSPITAL MONITORS

Worksite Monitor Requirement

The Physicians Diversion Program Participant (participant) is required to comply with his/her Diversion Agreement. Prior to returning to practice, the participant shall submit to the Diversion Program Compliance Specialist I (case manager) for prior approval as a worksite monitor: 1) the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing; 2) the name and qualification of one or more licensed allied health practitioners (e.g., podiatrist, physician assistant, physical therapist, pharmacist, licensed clinical social worker, psychiatric social worker, registered nurse, licensed vocational nurse, or dentist) whose licenses are valid and in good standing; or 3) the name of a contracted healthcare facility office manager who is not an employee of the participant nor in the supervisory chain of the participant.

A worksite monitor shall have no prior or current business, including but not limited to any form of bartering, personal, or familial relationship with the participant, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Physicians Diversion Program (the Program), and must agree to serve as participant's worksite monitor.

The case manager will contact the proposed worksite monitor and meet with him/her in person. The case manager shall provide the proposed worksite monitor with copies of the Diversion Agreement, **Agreement to Monitor**. Within 10 calendar days, after receipt of the Agreement to monitor the proposed monitor shall submit the original signed Agreement, indicating that he/she understands the role of a worksite monitor, and agrees or disagrees with the proposed monitoring plan. If the proposed monitor disagrees with the proposed monitoring plan, the proposed monitor shall not be approved as a worksite monitor.

Prior to return to practice, the participant shall have an approved worksite monitor who will be available to monitor the participant at the worksite. Continuing throughout the Diversion Program, and as long as the participant engages in the practice of medicine, he/she shall be monitored at the worksite by an approved worksite monitor.

The worksite monitor(s) shall submit a **Monitor's Quarterly Report** to the case manager, which includes a summary of the participant's behavior in the following areas: absenteeism, changes in personal habits, changes in practice performance, changes in interpersonal relationships, and changes in social behavior.

It shall be the sole responsibility of the participant to ensure that the worksite monitor submits the quarterly written reports to the case manager within 10 calendar days after the end of the preceding quarter.

If the worksite monitor resigns or is no longer available, the participant shall immediately notify the case manager of such resignation or unavailability, and submit to the case manager for prior approval the name and qualifications of a replacement monitor who is available to assume that responsibility. If the participant fails to obtain approval of a replacement monitor within 5 calendar days of the resignation or unavailability of the monitor, the participant shall cease the practice of medicine until a replacement worksite monitor is approved and prepared to assume immediate monitoring responsibility. The participant shall cease the practice of medicine immediately after being so notified by telephone by the case manager.

Procedures
Prior to Diversion Program approval to return to the practice of medicine, the case manager shall advise the participant to nominate a worksite and/or a hospital monitor, as specified in his/her Diversion Agreement.

Initial Approval of Worksite and/or Hospital Monitor
The case manager shall explain the expectations and guidelines of a worksite monitor, the monitoring process, and quarterly reports. The case manager shall direct the participant to submit the name of the proposed monitor for prior approval. The case manager shall document all interactions (verbal and written) with the participant in the Diversion Report and updated into the Diversion Tracking System (DTS). The DPCS II must approve any deviations from this procedure.

Required License Status, Professional Training and Experience for Monitors, if applicable
The proposed worksite and/or hospital monitor shall meet the following criteria related to license status, professional training, and experience:

1. A current California license, if applicable.
2. No record of disciplinary action by MBC or cases pending at the Office of the Attorney General (AG).
3. No active investigations by MBC or prior investigations closed within the past three (3) years due to insufficient evidence.
4. Must have active or courtesy hospital privileges in good standing, if the participant practices at a hospital.
5. Peer review experience (hospital, medical society, or equivalent) is recommended, but not required.
6. No prior or current business relationship that could reasonably be expected to compromise the ability of the monitor to evaluate the participant's practice fairly and objectively, e.g., shared real estate ventures.
7. No prior or current personal or familial relationship, e.g., meeting socially or taking vacations together.
8. No other relationship that could reasonably be expected to compromise the ability of the monitor to evaluate the participant's practice fairly and objectively, e.g., bartering in exchange for the monitor's services.

Relationship with Participant
Worksite monitors are expected not to be biased toward the participant to ensure that the monitor can make appropriate observation of the participant's behavior. The purpose of inquiring about any prior or current business, personal, familial or other relationships between the participant and proposed worksite monitor is to ensure that the monitoring process is fair, objective and reliable. The case manager should consult with the DPCS II if there is any question regarding the interpretation of this policy.

Agreement to Monitor
Side One of the **Agreement to Monitor** includes an Introduction and the Diversion Program's expectations which explain the role of a monitor and, in general terms, what the monitor will be expected to monitor at the participant's worksite or hospital, and when the monitor is expected to report to the Diversion Program.

Side Two is the Agreement in which the monitor declares, under penalty of perjury, that he/she has reviewed the participant's Diversion Agreement and has no prior or current business, personal, or other relationship with the participant, and will oversee the participant's practice in accordance with a written

monitoring plan. The agreement also requires the monitor to immediately notify the case manager if he/she is no longer able or willing to monitor the participant's practice.

Monitor's Quarterly Report
The **Monitor's Quarterly Report** is a written protocol for monitoring the participant's practice. The case manager shall review the Agreement to Monitor with the monitor prior to resuming the practice of medicine and will explain the general requirements, the monitor must:

1. Review the Diversion Agreement (and, if applicable, the Accusation and Decision) and should meet with the participant and be immediately available to assume the monitor role prior to accepting the position.

2. Be at the participant's practice location. If the participant has multiple practice locations, the monitor shall be at each location where the participant is working.

3. Submit the Monitor Quarterly Report to the case manager within ten (10) calendar days after the end of the preceding quarter.

4. Sign and date the Agreement. The case manager shall give the monitor a copy of the form and retain the original in the master file.

Format and Content of Monitoring Reports
The monitor shall complete, sign and date the standard Monitor's Quarterly Report. The Monitor's Quarterly Report requires, *at minimum*, the monitor's observations of the participant in the following areas:

Absenteeism
a. Any sick leave and reason for the leave (e.g., cold, flu, headache)
b. Any unscheduled absences
c. Arriving late to work, especially on Mondays or after holidays
d. Leaving work early
e. Improbable excuses for absences

Monitoring Work Hour Restrictions
a. The participant is in compliance with the work hours allowed by the Diversion Program

Changes in Personal Habits
a. Arriving to work "disheveled"
b. Exhibiting different behavior after any break including lunch, dinner
c. Inattention to personal hygiene
d. Deteriorating personal appearance
e. Deteriorating professional appearance (e.g., dirty or wrinkled clothes)

Changes in Practice Performance
a. Complaints from patients;
b. Excuses for poor performance;
c. Erratic practice habits;
d. Diminished performance;
e. Lapses of memory.

Changes in Interpersonal Relationships

a. Over-reaction to feedback;
b. Over-reaction to real or implied criticism;
c. Mood swings;
d. Hostility;
e. Complaints from colleagues;
f. Avoidance of associates and friends;
g. Argumentative with colleagues and associates;
h. Excessive talking with colleagues and associates.

Changes in Social Behavior

a. Problems with law enforcement;
b. Problems with credit or financial difficulties;
c. Loud arguments;
d. Fights;
e. Inappropriate behavior;
f. Problems with marital/co-habitant relationship.

Tracking Receipt of Monitor Report

The **Agreement to Monitor** requires the monitor to submit quarterly written reports no later than 10 calendar days after the end of the preceding quarter. The case manager shall track the Monitor's Quarterly Report received including the reporting quarter, date received, and comments.

Interviewing Monitor

Although the participant is responsible for ensuring the monitor's quarterly reports are submitted in a timely manner, the case manager should contact the monitor at least once quarterly. Such communication should include the following questions:

1. Have there been any changes in the participant's practice since the date of the last contact?
2. Has the participant's behavior in the specified areas improved, stayed the same, or deteriorated over time?
3. Has the monitor abided by the Monitoring Plan and submitted quarterly reports on time?

Removal of Monitor

During the Diversion period, it may be necessary to replace a monitor. The following are examples of situations that may prompt this change. The monitor:

1. resigns or is no longer able to continue monitoring the participant's practice;
2. no longer meets the qualification standards specified above;
3. is convicted of a crime;
4. fails to provide reports or timely, accurate or objective quarterly reports;
5. has demonstrated bias toward the participant or the monitor process;
6. has been uncooperative with the case manager or has acted in a manner which would constitute unprofessional conduct;
7. has a new complaint filed at the MBC;

The case manager should refer to the Diversion Agreement for the purpose of proposing a new Monitor. Additionally, the case manager should advise the participant that failure to obtain an approved replacement Monitor immediately will result in the participant ceasing the practice of medicine.

Failure to Comply with Monitoring Requirements
When a participant fails to submit for approval the name of a replacement monitor immediately upon the resignation or unavailability of the monitor, the participant shall cease the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility.

If the case manager has a case in which the participant has violated this condition, the case manager should advise the participant that he/she is in violation and that he/she must immediately cease the practice of medicine. The case manager should document the notice to the participant and send an e-mail to the DPCS II with the facts to justify the request to cease the practice of medicine.

Diversion Program Failure to Comply
If the participant fails to comply with any conditions, the case manager should follow the procedures for Diversion Program failures.

Changes in Personal Habits

arriving to work "disheveled"	No	Yes	Not Applicable
exhibiting different behavior after breaks	No	Yes	Not Applicable
inattention to personal hygiene	No	Yes	Not Applicable
personal appearance deteriorating	No	Yes	Not Applicable
professional appearance deteriorating	No	Yes	Not Applicable
*other	No	Yes	

*If other is marked "Yes" please explain, use additional paper as necessary.

Changes in Practice Performance

complaints from patients	No	Yes	Not Applicable
excuses for poor performance	No	Yes	Not Applicable
erratic practice habit	No	Yes	Not Applicable
diminished performance	No	Yes	Not Applicable
lapse of memory	No	Yes	Not Applicable
*other	No	Yes	

*If other is marked "Yes" please explain, use additional paper as necessary.

Changes in Interpersonal Relationships

over-reaction to feedback	No	Yes	Not Applicable
over-reaction to real/implied criticism	No	Yes	Not Applicable
mood swings	No	Yes	Not Applicable
hostility	No	Yes	Not Applicable
complaints from colleagues	No	Yes	Not Applicable
avoidance of associates/friends	No	Yes	Not Applicable
argumentative at colleagues/associates	No	Yes	Not Applicable
excessive talking at colleagues/associates	No	Yes	Not Applicable
*other	No	Yes	

*If other is marked "Yes" please explain, use additional paper as necessary.

Changes in Social Behavior

problems with law enforcement	No	Yes	Not Applicable
problems with credit/finances	No	Yes	Not Applicable
any loud arguments	No	Yes	Not Applicable
any inappropriate behavior	No	Yes	Not Applicable
problems with spouse/co-habitant	No	Yes	Not Applicable
*other	No	Yes	

*If other is marked "Yes" please explain, use additional paper as necessary.

MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
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MONITOR QUARTERLY REPORT

Check one

☐January 1 to March 31 ☐April 1 to June 30 ☐July 1 to September 30 ☐October 1 to December 31

Participant Name: _____ License Number, if applicable: _____

Worksite Location: _____

I agreed to serve as the worksite/hospital monitor in this case. I acknowledge that I have read the Diversion Agreement, and if appropriate, the Accusation and Decision. I am aware of the facts and circumstances leading to the imposition of the worksite/hospital monitor condition, requiring my presence at the worksite and /or hospital whenever the participant engages in the practice of medicine. I agree to cooperate with, and provide information to, the Case Manager. This includes submitting a Monitor Quarterly Report each quarter. If I resign my responsibility as a monitor, I agree to immediately notify the Case Manager.

_____	_____	_____
Monitor Signature	Monitor Print Name	Date
_____	_____	_____
Title	Monitor's License Number, if applicable	Phone

I certify that throughout the quarter indicated above, I observed the participant each time the participant has engaged in the practice of medicine at the designated worksite and/or hospital, and report my observations in the following areas. (If you circle "Yes" to any of the item below, please provide a detailed response.)

Absenteeism

any sick leave	No	Yes	Not Applicable
any unscheduled absences	No	Yes	Not Applicable
arriving late to work	No	Yes	Not Applicable
leaving early from work	No	Yes	Not Applicable
improbable excuses for absences	No	Yes	Not Applicable
*other	No	Yes	

*If other is marked "Yes" please explain, use additional paper as necessary.

Work Hour Restrictions

participant has work restrictions	No	Yes	Not Applicable

Meeting Attendance Verification

I hereby certify as a secretary of a 12-Step meeting that _____ has attended a regular meeting of AA, NA, or other support meeting sober and stayed the full meeting.

Month _____ **Year** _____

DATE	GROUP	SECRETARY
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
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24		
25		
26		
27		
28		
29		
30		
31		

I herby certify that I attended all support meetings clean, sober and stayed the full meeting.

_____

Participant Signature

MUST BE SUBMITTED MONTHLY TO THE CASE MANAGER

MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
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PHYSICIAN'S DIVERSION PROGRAM
THERAPIST PROGRESS REPORT

Period of Report
_____ to _____

Participant's Name: _____

Therapy Goals:

1. _____
2. _____
3. _____
4. _____
5. _____

Treatment Strategy (Please include recommended frequency of therapy sessions):

1. _____
2. _____
3. _____
4. _____
5. _____

Progress in Attaining Treatment Goals:

1. _____
2. _____
3. _____
4. _____
5. _____

Comments:

_____

_____

_____ _____
Therapist's Signature Date

_____
Therapist's Name (please print)

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Diversion Program Application

Name: *First*	*Middle*	*Last*	
Street Address	City	State	Zip
Email address			

Telephone Number Include Area Code	Home	Work	Pager	Cell

Date of Birth	Age	Gender: ☐ Male ☐ Female	Ethnicity

Marital Status and Living History: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Domestic Partner			Spouses Name
Children: ☐ Yes ☐ No	Number	Ages	
With whom do you live?			
Number of prior marriages?			
Children from prior marriages?			

Specialty			CA Medical License Number
Work Status: ☐ Resident	☐ Fellow	☐ Group	☐ Private ☐ Unemployed
Work Street Address			
City		State	Zip

Hospital Staff Privileges:

Name	
Street Address	City, State, Zip
Name	
Street Address	City, State, Zip
Name	
Street Address	City, State, Zip

Problem:

Primary Substance	Length of Use	Mode of Use
Secondary Substance	Length of Use	Mode of Use
Mental Illness		Date Diagnosed
Physical Illness		Date Diagnosed

Prior Hospitalization or Treatment of Problem:

Date	Facility	Problem & Setting (I) (O) (H)
Date	Facility	Problem & Setting (I) (O) (H)
Date	Facility	Problem & Setting (I) (O) (H)

Who referred you to Diversion? ☐ Self ☐ Investigator ☐ Hospital ☐ Partner ☐ Family ☐ Unemployed ☐ Other	
Attending Group Meetings? ☐ Yes ☐ No	Group Facilitator Name

History of Alcohol/Drug Use or Mental Illness

1. Do you think your alcohol/drug use or mental condition is a problem? ☐ Yes ☐ No ☐ Maybe

Explain:

2. What reason(s) do you have for seeking treatment at this time?

Indicate lifetime usage and/or experience you have had with each of the following chemicals:				
	Frequency of Usage	Amount Used per Episode	Age First Used	Date of Last Use
Alcohol (beer, wine, liquor) other:				
Narcotics (morphine, codeine, tylenol, fentanyl, darvon, talwin, demerol, Percodan,) other:				
Stimulants (amphetamines, methamphetamines, cocaine, volatile inhalants) other:				
Sedatives (seconal, quaalude) other:				
Tranquilizers (valium, ativan, xanax) other:				
Anti-Psychotics or Anti-Depressants (haldol, elavil, lithium, sinequan, impramine) other:				
Psychedelics & Hallucinogens (LSD, PCP, mushrooms, marijuana, hashish) other:				
Anabolic Steroids				

Comments

4. Describe any distinctive patterns of multiple drug use:

5. Symptoms you have experienced due to alcohol/drug use (If yes, indicate how recently):						
	Yes	No	3 months	6 months	1 year or less	More than 1 year
Shakes						
Blackouts						
Hallucinations						
Convulsions						
Delerium Tremens						

Comments

6. Methods you have used in an attempt to control or stop alcohol/drug usage:				
Method Used	Facilitator/Therapist	Attend Month/Year	Length of Time Seen	Length of time Sober
AA/NA/CA				
Other Self Help				
Individual Psychotherapy				
Group Psychotherapy				
CD Treatment Inpatient				
CD Treatment Outpatient				
Chemical Interventions	☐ Buprenorphine ☐ Antabuse ☐ Naltrexone ☐ Methadone ☐ Other			

7. Methods you have used to deal with mental health problems:			
Treatment or Psychotherapy	Therapist Name or Program, address/telephone	Dates	Frequency of Therapy
Individual			
Group			
Inpatient			
Outpatient			

8. Family history of chemical dependency:			
Family Member	Alcohol	Drug (describe)	Prescription Drug
Father			
Mother			
Aunt			
Uncle			
Brother			
Sister			
Grandmother			
Grandfather			
Other			

9. Prescription and over-the-counter drugs you are currently taking:				
Drug	Dosage	Medical Condition	RX Physician	Phone

10. Legal history:
Have you ever filed for bankruptcy or had a pending malpractice case against you?
Have you ever had any citations for driving while under the influence of alcohol or drugs? If yes, please list dates?
Have you ever been arrested? If so, when and for what reason?

Personal Physician	Telephone
Address	
City, State, Zip	Date of Most Recent Physical Exam:

Notice on Collection of Personal Information

Collection and Use of Personal Information. The Medical Board of California of the Department of Consumer Affairs collects the personal information requested on this form as authorized by Business and Professions Code Sections 2350 and following. The Medical Board of California uses this information principally to identify and evaluate applicants for Diversion Program participation. **Mandatory Submission.** Submission of the requested information is mandatory. The Medical Board of California cannot consider your application unless you provide all of the requested information

Signature _____ Date _____

MONTHLY CASE MANAGER ACTIVITY REPORT FOR (MONTH/YEAR)
CASE MANAGER:
CURRENT CASE LOAD:

INTAKE INTERVIEWS
Name:

THERAPISTS CONTACTED
Name:

AGREEMENTS SIGNED
Name:

HIGH RISK OR MAINTENANCE PARTICIPANTS
Name:

WORK / HOSPITAL SITE MONITOR SITE VISITS
Name:

WELL BEING COMMITTEE CONTACTS
Name:

GROUP MEETINGS ATTENDED
Group Date

DEC MEETINGS ATTENDED
DEC Date

[month] Activity Report, Page 2

OTHER ACTIVITIES		OTHER ACTIVITIES	
Participants Observed in Group	___	Training	_____
Participant Meetings Outside Group	___	Staff Meetings	_____
Participant Telephone Contacts	___	Vacation (hours)	_____
Worksite/Hospital Monitor Contacts	___	Sick Leave (hours)	_____

PRACTICE RESTRICTIONS
(1. Inpatient Tx; 2. Outpatient Tx; 3. Recovery Facility; 4. Limited Hrs; 5. Stop Practice)

Name:	Type of Restriction:	Period of Time:

M.D. LICENSES OR DEA PERMITS SUBMITTED TO DIVERSION
Name:_____

_____

POTENTIAL PARTICIPANT CONTACTS/INTERVENTIONS (Please indicate C or I)
Action: 1. Provided Program Information; 2. Recommended Diversion Group Meetings; 3. Recommended Tx Programs

Name	Referral Source	C/I	Action	Outcome

[month] Activity Report, Page 3

PRESENTATIONS

Audience: 1. Well Being Committee; 2. Medical Staff/Hospital; 3. Other (please define)

Date	Facility	Audience	Number	Comments

Follow-up Actions Indicated:

_____

_____

_____

CHAPTER 2

DIVERSION PROGRAM COMPLIANCE SPECIALIST II

CHAPTER 2
DIVERSION PROGRAM COMPLIANCE SPECIALIST II

Role of the Diversion Program Compliance Specialist II

The Diversion Program Compliance Specialist II (DPCS II) role is the direct supervision of the Diversion Program Compliance Specialist I (case manager). The case manager is responsible for managing each of their participant's compliance with their Diversion Agreement. The DPCS II may also manage a small caseload of Diversion Program participants.

Direction and Management of Staff

The DPCS II supervises and provides direction to case managers located within their assigned geographical regions. The DPCS II also is responsible for coordinating and directing the monitoring of participants and their compliance with their Diversion Agreements. That direction includes the following:

- Assure the public is being protected.
- Maintain and update case manager procedures to provide the most current information for standardization of case management, documentation, work productivity, and participant files.
- Evaluate the work performance of the case managers for accuracy, completeness and timeliness.
- Directs the regularly scheduled preparation of management reports.
- Consults with case managers regarding signs of relapse, and recommendations for approved treatment options for participants.
- Reviews the most complex and difficult cases to determine the appropriate course of action.
- Provide technical assistance and make presentations regarding the Diversion Program to private and governmental agencies, health care facilities, and alcohol/drug treatment programs.

DPCS II Priorities

The DPCS II shall organize their activities according to the following priorities:

- Discuss and review with the case managers all crisis and relapse situations involving a public safely issue. Review written documentation incidents with the case manager and as necessary, discuss recommendations with the Diversion Program Administrator.
- Review new participants who are immediate threats to public safety with the case manager.
- Quarterly attendance at all Diversion group meetings within their assigned regional areas.
- Assure case managers are attending each Diversion group meeting monthly.
- Assure case managers are updating the Diversion Tracking System (DTS) on a daily basis.
- Attend DEC meetings.
- Assure case managers are submitting necessary documentation for DEC meetings within deadlines.
- Assure DEC meeting requests are submitted within deadline.
- Assure administrative deadlines and documentation including: travel claims, activity reports, attendance reporting, filing of participant documentation, vehicle logs, and copying.

Case Manager Overtime and Flex Schedules
The DPCS II is responsible for reviewing and approving or disapproving requests for overtime from the case manager. The case manager's work hours are from 8:00 a.m. until 5:00 p.m., unless approved otherwise. Flex schedules are approved for attendance to either a scheduled DEC meeting or attendance at Diversion group meetings.

Monthly Case Manager Calendars
The DPCSII is responsible for reviewing the monthly case manager calendar. The case managers submit this monthly calendar by the 3rd day of each month. The purpose of the monthly calendar is to document the case manager's required monthly attendance at the group meetings within their case load.

Diversion Group Meetings
The DPCS II randomly attends Diversion group meeting within his/her supervising geographic area to directly observe the case manager, the group facilitator (GF) and participant interaction. If the case manager finds there are concerns with the manner of the GF meeting conduction or with the meeting facilities, it will be addressed by the DPCS II. If a change is necessary, the case manager will document a revised plan and submit a copy to the DPCS II for approval.

Positive Urine Lab Results
A participant must be removed from the practice of medicine immediately with any positive drug test. After removal, investigations will begin on the reason for the positive drug test. The DPCS II must discuss any positive lab results with the case manager immediately to address whether the positive lab result is from a **pre-approved** prescription, over the counter medication or the result of a relapse.

Critical or High Risk Situations
The DCPS II must discuss critical or high risk situations with the case manager immediately. The case managers must first make personal contact with the participant, therapist, CC and GF. After gathering necessary information, the case manager will contact the DPCS II to discuss a recommendation and the DPCS II will approved the recommendation or provide further guidance. Some examples of critical situations are as follows: participants who have relapsed; psychotic episodes; suicidal or homicidal ideations.

Diversion Evaluation Committee
The DPCS II attends all DEC meetings within the geographic areas of the case manager.
The responsibility of the DPCS II is not only to critique the case manager and GF presentations, but to assure participant's compliance or non compliance with their Diversion Agreement is addressed and documented. Additionally, the DPCS II must also assure that approved templates and protocol with DEC members are adhered to.

Termination from Diversion and Availability of Diversion Records
The DPCSII must ensure that appropriate action is taken upon termination from the program. In the event a participant does not complete the Diversion Program successfully, the Medical Board of California may wish to pursue the complaint for which the physician had been referred to Diversion originally, or open a new case if the physician is self-referred. In some cases, the participant's Diversion records may be provided to the Enforcement Program to aid in the investigation. Whether or not the record can be provided depends on the date the agreement was signed.

1. On January 1, 1991, the Division of Medical Quality adopted the following policy which applied to agreements signed after that date:

   a. All Board referrals, if unsuccessfully terminated, will have their Diversion file routed to the Enforcement Program (no matter what the termination reason) for evaluation, re-opening of a prior case, or for initiating a new action.
   b. Self-referrals, if unsuccessfully terminated, will be reported to the Enforcement Program with the file if the DEC regards the participant as a danger to themselves or their patients.

Case Manager Monthly Activity Report

The DPCS II is responsible to review the case manager monthly report which must be submitted no later than the 3rd working day of the following month. Any concerns about the case manager activities will be discussed with the case manager and a plan to correct the problems will be submitted.

CHAPTER 3

GROUP FACILITATOR POLICIES AND PROCEDURES

CHAPTER 3
GROUP FACILITATOR POLICIES AND PROCEDURES

Group Facilitator Role

Diversion Program Group Facilitators (GF) facilitate the Diversion Program group meetings using skills within the scope of their license or certificate. Diversion Program group meetings (group meetings) provide support for recovery and monitoring of Diversion Program participants (participants). The GF must understand and apply the principles of interpersonal interaction group process while giving priority to recovery. In addition, the GF must be thoroughly familiar with Alcoholics Anonymous and Narcotics Anonymous language, step work, traditions and other community based self-help groups.

The GF works in partnership with the case manager. Any difference of opinion between the GF and the case manager regarding the direction of a participant's recovery will be decided by the CC, DPCS II, and Diversion Program Administrator.

The GF will maintain the confidentiality of participants as required by Section 2355 of the Business and Professions Code.

The GF shall complete and sign a Memorandum of Understanding "Group Facilitator Agreement" (Chapter 3, Attachment A). The Group Facilitator Agreement specifies that the GF is not an employee, agent, joint venture or partner of the Medical Board of California (MBC) for all purposes, including but not limited to workers' compensation. Additionally, the GF is not a MBC representative.

Diversion Group Meeting Attendees

Physicians holding a valid license and approved for participation in the MBC Physician's Diversion Program must attend group meetings. With approval of the Diversion Program Administrator, group meetings may also be attended by professional licensees participating in the Maximus Program.

When a prospective participant contacts the GF about the Diversion Program without first contacting the Diversion Program administrative staff and completing a telephone intake, the prospective physician is allowed to attend group meetings for up to one month, anonymously. Within that month, he/she must contact the Diversion Program administrative staff to initiate a telephone intake. Failure to do so will result in termination of group meeting participation. It is the GF's responsibility to advise the case manager in the geographical area about the prospective participant's attendance at group meetings.

Meeting Frequency and Length

Meetings are held twice a week for a minimum of 1.5 hours each. In rural areas, group size or travel distance may limit the group meeting to once a week. Deviations regarding frequency and length of meetings must be approved in advance by the Diversion Program Administrator.

Meeting Locations

The GF provides a location for the group meeting. The location should be central to the majority of participants, comfortably accommodate the group size, and must have lavatory facilities. The group meeting location cannot be a participant's office or any building owned or used by a participant or by a DEC member.

Group Size
Group meetings should not routinely exceed 10 participants, but may be as large as 12 participants in anticipation of splitting into two groups of seven or eight participants. Any exceptions to the size must be approved by the Diversion Program Administrator.

Telephone Reporting
The GF must telephonically contact the case manager at least once weekly (or on as needed basis) with the following information:

1. A participant is experiencing any life crisis that threatens recovery (e.g., marital, family, financial, professional, and physical problems).
2. Participant attendance.
3. A participant is using or appears to be using. **Call must be made immediately after group meeting**.
4. A participant is exhibiting a change in attitude or behavior that suggests relapse.
5. Participants who provided urine specimens at the case manager's request.
6. Other relevant information concerning participants.

Group Facilitator Protocol
The GF shall perform the following tasks:

1. Facilitate group meetings.
2. Record attendance.
3. Observe each participant for any sign of substance abuse or problems.
4. In the event of an acute problem (such as a participant under the influence), notify the case manager immediately for appropriate action.
5. Collect random urine specimens from participants if noncompliance is suspected or if requested by the case manager or the Diversion Program Administrator. Deliver the urine specimens to the nearest assigned overnight courier service for transportation to the lab.

Administering Antagonists
Participants required to take a narcotic or alcohol antagonist must provide the case manager and GF with a copy of their prescription. If applicable, the dose is taken at the group meeting in the presence of the GF. The GF oversees the administration of the antagonists naltrexone and antabuse/disulfiram at group meetings. The GF must observe the participant closely to ensure the participant has swallowed the dose. The GF must note an "n" for naltrexone or "a" for antabuse/disulfiram on the meeting attendance sheet to indicate the participant has taken the antagonist medication. The meeting attendance sheets will be included in the weekly reports the GF submits to the case manager, CSM, and DPCS II.

Designated Alternate Group Facilitator
When the GF is unavailable, he/she must designate an approved alternate group facilitator for coverage. The alternate group facilitator must be a licensed therapist approved in advance by the Diversion Program Administrator. Under no circumstances may a participant lead any group meeting in the absence of the GF.

The GF shall provide the case manager, participants, and the Diversion Program Administrator with at least two weeks notice of vacation.

The GF shall submit to the Diversion Program Administrator the resume or CV of an alternate group facilitator in case the GF becomes unavailable. The GF shall provide the alternate group facilitator with sufficient information regarding the participants to ensure a smooth transition between the GF and the alternate group facilitator.

Fees & Billing

The GF cannot refuse services to a participant unable to pay and must make arrangements with the participant for partial payments based on ability to pay. The GF uses his/her best judgment regarding billing a non-working participant but shall not create a financial hardship impairing the participant's recovery or the welfare of his/her family.

The GF is responsible for billing and collecting fees from each participant in a timely manner and for keeping participant accounts current. Participants are responsible for meeting their financial obligations with the GF **before** they graduate from the Diversion Program.

Diversion Evaluation Committee

When a participant is scheduled to appear at a Diversion Evaluation Committee (DEC) meeting, the GF must attend and provide information regarding the participant's recovery progress, unless prior approval has been provided by the Diversion Program Administrator.

The GF shall complete and submit the Annual Written Assessment of each participant scheduled for each DEC meeting by the deadline provided by the DEC coordinator. The GF can contact the DPCS II for the Annual Written Assessment format.

The DEC meetings travel expenses are reimbursed after the GF submits a completed Travel Expense Claim form. Travel expenses are submitted monthly but a claim must total at least $10 before it can be filed. Travel Expense Claim forms are available through the Diversion Program administrative staff.

Holidays

Group meetings are not held on New Years Eve, New Years Day, Martin Luther King's Birthday, Caesar Chavez Day, Washington's Birthday, Columbus Day, Veteran's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Eve, Thanksgiving Day, Christmas Eve and Christmas Day.

Training

The GF shall participate in two six hour continuing education seminars every two years in substance abuse, mental health, or group process (therapy). The GF shall provide verification of success/completion to the Diversion Program Administrator.

Initial Participant Assessment

Prior to the initial DEC meeting, the GF shall complete an individual assessment session with each new participant entering the Diversion Program.

The GF shall maintain a record for each Diversion Program participant in accordance with the Diversion Program Policy and Procedures. The record must include the following:

1. The background evaluation report prepared for the DEC meeting.
2. Initial medical, addiction, psychiatric evaluation or treatment records.
3. Initial interview summary and/or initial intake interview.
4. Problem list.
5. Treatment plan and goals.

6. Notification of any positive urine test results.
7. Record of attendance.
8. Clinical progress notes prepared by the GF.
9. Notation of any acute or new problem.
10. Notes regarding observation of warning signs indicating a need for different or more intensive treatment.

The GF shall require each participant to sign a release of information permitting the GF to share with the Diversion Program any information regarding the participant.

Group Facilitator Assessment

The Headquarters office will maintain a file for each GF. Each file will contain:

- Original GF agreement
- Copies of any licenses the GF holds (and subsequent documentation showing that the license is still current)
- Copies of CME certificates
- Any evaluations or performance assessments
- Any other documentation or correspondence pertaining to the GF

Annually the Diversion Program headquarters staff will determine whether the GF's licenses are current and still in good standing and whether the GF has complied with the CME requirement. This assessment will be done in August of each year.

In addition, the GF is annually evaluated by the case manager, DPCS II, the Diversion Program Administrator, and the DEC members using "Group Facilitator Job Performance Rating" (Chapter 3, Attachment B). The assessment will be based, in part, upon compliance with the GF policies and procedures. The case manager attends the GF meetings once a month for observation. The DPCS II shall attend each GF meeting quarterly. The Diversion Program Administrator may elect to attend the GF meetings for observation and meet periodically to discuss the GF performance. These evaluations will be completed in August of each year.

Failure of a GF to comply with the policies and procedures or inadequate performance of his/her duties and responsibilities **will result in the termination of the Group Facilitator Agreement.**

Written Reports

The GF shall submit attendance reports to the case manager, CSM, and the DPCS II weekly. If the attendance reports are not received, the case manager shall contact the GF to obtain the attendance reports. The GF prepares an annual written assessment of each participant prior to the annual DEC review and prior to the participant being released from the Diversion Program.

Specimen Collections

Urine specimens are collected by local collectors on each participant according to a random list of dates. In addition to the collectors, the GF and case manager are provided with the collection dates. The production of a urine specimen is observed and a chain of custody protocol is followed. The GF responsibilities are as follows:

1. Assist in the recruitment of local providers serving as specimen collectors.
2. Serves as a backup for specimen collections if a local collector is unavailable.
3. Collect random specimens for drug testing when suspicious of a relapse. Alert the case manager and DPCS II of any relapse suspicions.

Referring Participants to Treatment Programs
During the evaluation process to determine if treatment is warranted, the GF and case manager involve the case consultant and the Diversion Program Administrator in the decision regarding a participant's treatment needs (e.g., hospitalization, outpatient or inpatient treatment, etc.) However, the GF and case manager can ask a participant to attend a treatment facility for admission evaluation without the case consultant involvement under the following circumstances:

1. There is no case consultant assigned, and the Diversion Program Administrator has been consulted.
2. A participant is considered a danger to self or patient care due to use of drugs and alcohol and/or mental, physical disorders.
3. It is after hours or on the weekend and immediate intervention is necessary.
4. An attempt has been made to contact the case consultant and he/she is unavailable or does not respond within a reasonable time frame. What is reasonable is determined by the criticalness of the situation.

When a recommendation is made for a participant to attend treatment or therapy, the participant is given a choice from among several names, except in the following circumstances:

1. The treatment is being provided free because the participant cannot afford the cost.
2. An immediate intervention must be made and an approved facility has an available bed.
3. Providing the participant a choice in facility may cause a delay.

Disclosure of Information
The GF shall not issue any public announcements, or press releases, concerning the performance of services, the Diversion Program, the MBC or confidential information without obtaining the prior written consent of MBC.

The GF shall use only Diversion Program approved audio visual aids and/or outside physician speakers at meetings.

Conflict of Interest
The GF shall not provide individual or couples counseling to participants. However, the GF may bring participants and their significant others together in a group meeting as an adjunctive service. Also, the GF may see a family member individually to assess family progress and appropriateness to couples/family group. However, a fee cannot be charged for these adjunctive services.

The GF should not refer participants to a treatment facility where the GF has a current or past financial interest, employment or relationship. **Friendship and socialization beyond the existing professional relationship is unacceptable and may result in the termination of Group Facilitator Agreement.**

MEDICAL BOARD OF CALIFORNIA
Physicians Diversion Program
1430 Howe Avenue, Suite 14
Sacramento, CA 95825-3236
(916) 263-2600 FAX (916) 263-2607
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MEMORANDUM OF UNDERSTANDING

Group Facilitator Agreement

The Medical Board of California's Diversion Program ("Program") is designed to identify, monitor, and rehabilitate physicians who are impaired due to abuse of drugs or alcohol, or due to mental illness affecting competency, so that physicians so afflicted may be treated and practice medicine in a manner that will not endanger the public health and safety. The Medical Board of California ("Board") recognizes that a successful Diversion Program requires professional services provided by appropriately qualified, licensed mental health professionals and certified chemical dependency counselors to lead and facilitate group meetings.

_____ agrees to serve as a Physician Diversion Program Group Facilitator
Group Facilitator Name
(Group Facilitator) in _____, effective _____.
City *Start Date*

As a Group Facilitator I agree to:

1. Maintain and send copies to the Medical Board of a current valid California license that authorizes treatment of chemical dependency and/or mental illness, as appropriate, or possess a certification as an alcohol and drug counselor issued by the California Association of Alcoholism and Drug Abuse Counselors.

2. Maintain in full force and affect the following insurance policies, and upon demand, provide evidence of the required coverage to MBC:

   a. Professional liability insurance with a general aggregate limit of at least one million dollars ($1,000,000); with a limit of at least five hundred thousand dollars ($500,000) per claim;

   b. Commercial general liability insurance with a general aggregate limit (other than products/completed operations) of at least two million dollars ($2,000,000); at least one million dollars ($1,000,000) personal and advertising injury limit; at least one million dollars ($1,000,000) premises and operations limit.

   c. Immediately notify the Diversion Program Headquarters when it becomes aware of any cancellation or material change in the amounts of or type of coverage of the insurance policies prescribed above.

3. Immediately notify the Diversion Program Headquarters of the filing of any criminal or administrative disciplinary charges against me, my license, or my certification.

4. Comply with the Group Facilitator Policy and Procedures set forth in the most recent version of Chapter 2 of the Medical Board of California Diversion Program Manual, which is incorporated herein by reference as though set forth.

MEMORANDUM OF UNDERSTANDING
Group Facilitator Agreement

5. That any records, data, electronic information, files, and any other materials or information, maintained in the course of performing services or obtained either directly from any source or through deduction, that could be used to identify a particular individual who has sought assistance from the Program, including any copies, notes or memoranda thereof created by the facilitator are confidential information which is, at all times, the sole and exclusive property of the MBC through its Program.

6. Deliver all confidential information to the Program director within forty-eight (48) hours of demand.

7. Safeguard confidential information by taking all necessary steps to protect it from loss or accidental disclosure. Upon completion/termination of participant forward all document to the headquarters office.

8. Comply with all applicable laws, ordinances and regulations adopted or established by federal, state or local governmental bodies or regulatory agencies as they may apply to the Group Facilitator or the provision of services.

I acknowledge:

1. That I am not an employee, agent, joint venturer or partner of the MBC for any purpose, including but not limited to workers' compensation,

2. That neither I nor my employees or agents will perform any act or acts which might lead those with whom they deal to believe that it or they are representatives of the MBC.

3. That this agreement can be canceled by me or the diversion Program with 60 days written notice to the other party.

4. That this agreement can be terminated immediately by MBC without notice if the Group Facilitator is out of compliance with the provisions of this MOU or the Group Facilitator Policy and Procedures set forth in the most recent version of Chapter 2 of the Medical Board of California Diversion Program Manual.

I have read the forgoing and agree to carry out the functions and responsibilities and honor the obligations as listed above. For the provision these services I will bill a participant not more than $322 per month for those who attend two meetings per week and $225 per month for those who attend one meeting per week.

_____
Group Facilitator **Print Name**

_____ _____
Group Facilitator **Signature** Date

_____
Diversion Program Manager **Print Name**

_____ _____
Diversion Program Manager **Signature** Date

Diversion Program
Group Facilitator Job Performance Assessment

The Group Facilitator is expected to meet program standards in all content categories. However, if "needs improvement" or "needs significant improvement" is endorsed, a written explanation will be provided, as well as a plan for improvement and a time frame for resolution. Please reference the item when making a written comment. The rater may also wish to comment on any extraordinarily good job performance beyond the "meets standards" rating.

Evaluation Required By: _____

ADMINISTRATION	MEETS PROGRAM STANDARDS	NEEDS IMPROVEMENT	NEEDS SIGNIFICANT IMPROVEMENT
Record Keeping			
Preparation of Annual Reviews			
Reporting Attendance: Weekly and Monthly			
Discussion of Participant's Progress With Case Manager			
Management of Group Guidelines (Diversion's M.O.U.)			
Coordination of Urine Monitors and Following Urine Collection Guidelines			
Adequate Provisions to Cover Facilitator Absences			
Group Facilitator CEUs Up-To-Date			

CLINICAL	MEETS PROGRAM STANDARDS	NEEDS IMPROVEMENT	NEEDS SIGNIFICANT IMPROVEMENT
Recovery program problem identification			
Developing treatment plans for problem areas			
Recovery program problem identification - physician specific			
Developing treatment plans for problem areas - physician specific			
Facilitator's understanding of relapse indicators & application of intervention processes			
Effectiveness in establishing and maintaining a therapeutic relationship with the physician			
Attempts to make provisions for family treatment or to engage the family in recovery			
Assessment of physician substance use status & identification of physician impairment			
Effectiveness at assisting in coordination of referrals to treatment programs & outside therapy			
Effectiveness at establishing & maintaining cohesive group recovery process			
Maintenance of a good working relationship with Case Manager			
Communications with Diversion Program staff			
Maintaining policy & ethical standards of the Diversion Program			
Relationship with the D.E.C.			
Development of a good community liaison with physician "well being committees"			

Comments:

_____ _____

Group Facilitator Date

_____ _____

Diversion Program Administrator Date

CHAPTER 4

DIVERSION EVALUATION COMMITTEES

CHAPTER 4
DIVERSION EVALUATION COMMITTEES

Role of the Diversion Evaluation Committees

The Diversion Evaluation Committee (DEC) evaluates:

- participants seeking entrance into the Diversion Program
- participant's Diversion Agreement terms (including treatment and monitoring requirements)
- if participant has had a relapse
- participant's ability to practice medicine safely
- participant's progress in recovery
- participant's readiness for release/successful completion
- participant's termination

All DEC recommendations must receive final approval from the Diversion Program Administrator.

Policies Regarding DEC Recommendations for Approval/Denial of Participation

Physicians are eligible for the Diversion Program if they meet the following criteria, as set forth in Section 1357.1 of Title 16 of California Code of Regulations:

1. The physician shall be licensed, or be otherwise legally authorized to practice medicine in this state.
2. The physician is found to abuse dangerous drugs or alcoholic beverages, or suffer from mental or physical disability in a manner which may affect their ability to practice medicine safely or competently.
3. The physician shall have voluntarily requested admission to the Diversion Program.
4. The physician has signed a Statement of Understanding (SOU) while under investigation, or is required to participate due to a disciplinary or probationary license order from the Medical Board Enforcement Program.
5. The physician agrees to undertake any medical or psychiatric examinations ordered to evaluate the application for participation.
6. The physician cooperates with the program by providing medical information, disclosure authorizations and releases of liability as may be necessary for participation in the program.
7. The physician agrees, in writing, to cooperate with all elements of the Diversion Agreement.

Physicians may be denied admission to the Diversion Program for any of the reasons set out in Section 1357.4 of Title 16 California Code of Regulations:

1. The physician does not meet the requirements set forth in section 1357.1.
2. The physician has been disciplined by another state medical licensing authority.
3. Complaints or information have been received by Medical Board of California which indicate the applicant may have violated a provision of the Medical Practice Act, or committed any other act that would be grounds for discipline, excluding Section 2239 and 822 of the Business and Professions Code, (excessive use of drugs or alcohol; physical or mental illness affecting competency).
4. The DEC recommends the physician will not substantially benefit from participation or participation creates a great risk to the public's health, safety, or welfare.

DEC Evaluation for Single Diagnosis of Mental Illness Only

All participants with either a confirmed diagnosis of mental illness or those referred for evaluation of a mental health-related disorder, will begin the evaluation phase under an obligation to comply with all conditions of monitoring as set forth by the Diversion Program. The participant will continue under these set provisions with the knowledge and understanding that:

1. The participant will be scheduled to meet with a DEC for evaluation to determine if participation is appropriate or would be of benefit to the physician.
2. At the initial meeting with the DEC, if the participant is deemed appropriate for participation, the DEC will individualize the provisions of the participants monitoring. In making recommendations, the DEC considers clinical assessments and other evaluative measures, as well as recommendations provided by the participant's case manager, DPCS II, and the GF.
3. The participant will abide by the provisions, as outlined below, while participating in the Diversion Program's evaluative phase.

At the initial DEC meeting, the participant's current condition and/or situation will be evaluated by the DEC. If the participant is formally accepted, a Diversion Agreement will be formalized. Depending upon the diagnosed mental health-related disorder, treatment history, and psychiatric evaluation, a DEC recommendation to individualize the Diversion Agreement involves consideration of what best benefits the participant, as well as conditions or requirements ensuring public protection. Typical modifications may include, but are not limited to, the following:

- Treatment: After the initial DEC meeting, the DEC may recommend the participant either enter inpatient or outpatient treatment or continue with the current treatment regimen.
- Attendance of group meetings: The DEC shall recommend the level of group attendance to best support and monitor the participant.
- The DEC recommends the length of participation required for the Diversion Agreement.

Diversion Agreement Changes

All changes in a participant's Diversi on Agreement must be discussed at the participant's DEC meeting or annual review meeting. The following criteria must be met to be considered for a reduction change in a participant's Diversi on Agreement:

1. Semi-Annual reports are current.
2. Worksite/hospital monitor reports are up-to-date.
3. 30 continuing education units are completed.
4. Recovery substantiates a change.
5. Participant is in full compliance with his/her Diversion Agreement

No participant will be allowed to reduce a requirement if he/she is not in compliance with his/her Diversion Agreement.

Completion or Termination:

The DEC considers and recommends a participant for successful completion from the Diversion Program and termination from the Diversion Program.

For a participant with substance related and/or mental health disorders to complete the Diversion Program successfully, he/she must:

- Be in full compliance with their Diversion Agreement.
- Complete at least five years Diversion Program participation
- Have the statutorily required 1) three years of continuous sobriety and a documented lifestyle supporting and maintaining ongoing recovery from the participant's condition or 2) three years of mental health stability and a documented lifestyle supporting and maintaining a state of mental health stability.

Participants may be terminated from the Diversion Program for the following reasons, as specified in Section 1357.5 of Title 16 California Code of Regulations:

- 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.
- Any cause for denial of an applicant in Section 1357.4.
- The physician has failed to comply with any of the requirements set forth in Section 1357.1.
- 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 Enforcement Program is notified of all unsuccessfully terminated board action participants. Self-referred participants, who are unsuccessfully terminated, are referred to the Enforcement Program if they are determined to be a risk to public safety. If there is not sufficient information to determine the participant is unsafe to practice at the time of termination, he/she is not referred to the Enforcement Program. The determination to refer or not refer to the Enforcement Program is made by the Program Administrator after recommendation by the DEC. Details of this procedure can be found in the DEC Member Handbook. All recommendations of the DEC must be approved by the Diversion Program Administrator and documented in the participant's file and in DTS.

Records:

Under current law, California Physician Diversion Program records may be provided to the Enforcement Program for those participants who are terminated and who signed their Diversion Agreements after January 1, 1999, as follows:

1. Those whose participation is a condition of Medical Board Probation.
2. Those who have a disciplinary action pending or were under investigation at the time of entering Diversion Program.
3. Those whom the DEC determines to be a threat to public health or safety.

Diversion Program participant file information is protected by both state and federal law and will be provided in accordance with California law and in the federal confidentiality regulations governing alcohol and drug abuse records. Absent participant authorization, information protected by federal law cannot be released in response to subpoena unless there is also a court order for release which complies with requirements specified in federal regulations. (42 USC 290dd-3; 290ee-3; 42 CFR 2.1 et seq.)

Policies regarding DEC Members

Although the entire committee participates in the evaluation of applicants, each participant is assigned to a DEC member who serves as the case consultant. If necessary, the case consultant advises the

participant's case manager about treatment and recovery concerns pertaining to an assigned participant between DEC meetings. Participants do not contact their case consultant directly.

A DEC member may be contacted for a consultation regarding any of the following:

1. A participant has relapsed and/or is jeopardizing public welfare. If this should come to light in the evening or weekend hours, the case manager may take immediate action and then contact the case consultant within **24-48 hours**.
2. Positive drug screening results - involve case consultant in discussion of intervention strategy.
3. The case manager determines treatment is necessary.
4. A participant refuses to comply with DEC direction. The case manager may make attempts to work through the participant's resistance prior to contacting the case consultant (The DPCS II is also contacted.)
5. The case manager concludes the participant should be brought to a DEC for further evaluation, motivation or change in the participant's Diversion Agreement.

Note: If the Case Consultant is not available, the Case Manager will contact the DEC Chairperson.

Expectations:
DEC members must attend all of their respective committee meetings and the annual DEC member meeting. Attendance records are compiled and reviewed annually by the Diversion Program Administrator. The Diversion Program Administrator is obliged to report any DEC member not meeting his/her obligations as a DEC member to the Division of Medical Quality.

As a case consultant, the DEC members must return all calls from the Diversion Program within 24 hours. The case consultant notifies the Diversion Program immediately of any changes in contact information. The Diversion Program Administrator is obliged to include in an annual report to the Division of Medical Quality situations when the case consultant did not return calls timely.

As a case consultant, DEC members will receive and maintain files on participants assigned to them. Upon a participant's completion of or termination from the Diversion Program, the case consultant shall return all case file information to Headquarters.

Diversion Evaluation Committee Members Evaluations
Due to the complex nature of the DEC, a high level of knowledge and expertise is required for appointment as a DEC member. The DEC members will be evaluated annually for quality improvement and to assist the Division of Medical Quality in determining reappointments using the form "DEC Peer Evaluation" (Chapter 4, Attachment A). The evaluation is completed for each DEC member by the other members of his/her committee, the Diversion Program Administrator, the case manager, and the GF. A summary of the evaluation will be provided to the Division of Medical Quality annually.

The Headquarters office will maintain a file for each DEC member. Each file will contain:

- DEC member CV
- Copies of any licenses the DEC member holds (and subsequent documentation showing that the license is still current)
- Any evaluations or performance assessments
- Any other documentation or correspondence pertaining to the DEC Member

Failure of a DEC member to comply with the policies and procedures or inadequate performance of his/her duties and responsibilities **will result in the request to the Medical Board to terminate the DEC member.**

DEC Chairperson

In order to share committee duties equally and to develop each committee member for the chairperson role, the chairperson role is rotated every two years. The case consultant takes the lead in interviewing the participants in the cases he/she has been assigned.

The DEC chairperson duties are as follows:

1. Keep the meetings on schedule.
2. Assign new cases to committee members.
3. Assist staff in the orientation of new committee members.
4. Act as backup consultant in the absence of a case consultant

DEC Meeting Procedures

The following is a uniform process and set of procedures for DEC members to conduct business during their DEC meetings.

Meeting Called to Order by the DEC Chairperson:

- The DEC chairperson conducts the meeting.
- A quorum of three (3), one of whom shall be a public member, is required for the transaction of business of any meeting (B&P 2344).

Program Information Sharing:

- Diversion Program administrative staff and DEC members have the opportunity to share any pertinent information.
- Diversion Program Administrator provides the DEC with updates on any changes in Diversion Program Policies and/or Procedures. Updates may include any information from the Diversion Committee and/or the Medical Board.
- DEC members may also share information that may be of interest.

DEC Chairperson Assigns a Case Consultant to the Participant:

- The case consultant acts as the lead person in the interview discussion.
- If the participant is meeting the DEC to request formal participation, the DEC chairperson assigns the participant a case consultant.
- The DEC chairperson may assign the participant to a case consultant based on specialty, caseload, and/or preference.
- In the event the case consultant assigned is not present, the DEC chairperson acts as lead and guides case discussion.

Participant Case Presentation Discussion Begins:

- The participant's case summary is reviewed and discussion takes place in closed session.
- The case manager provides the DEC with a summary of the participant's history. The information includes pertinent factors, including the following:
  - Basic characteristics.
  - Ongoing concerns, if any (pressing issues, compliance, etc.).

    - Status updates on pressing issues (treatment, psychological, return to work, etc.).
- The GF provides information about the participant's recovery and progress in group meetings. This information should include the following:
    - Participant's current recovery efforts
    - Emphasis on step work.
    - Significant problems in recovery.

Participant is invited into the DEC meeting:

- The case manager introduces each DEC member, the Diversion Program Administrator, and all attendees.
- The case manager brings the participant before the DEC to discuss his/her case.

Case Discussion Begins:

- The case consultant explains to the participant the process of the meeting and leads the interview.
- The participant is given the opportunity to ask questions and make comment.
- Each DEC member has the opportunity to ask follow-up questions.

Participant Exits the Meeting:

- The case consultant explains where the participant can wait while the DEC has further discussion, if applicable.

DEC Develops Consensus:

Any recommendation requires a majority of the DEC. However, DEC consensus on a recommendation is preferred.

- If the participant is requesting formal participation, the DEC makes a recommendation whether or not participation is appropriate.
    - The DEC makes a recommendation on the appropriate recovery process and formulates the Diversion Agreement.
    - The assigned case consultant completes the Diversion Agreement Worksheet.
- If the participant is meeting the DEC for re-evaluation, the DEC makes a recommendation regarding the recovery program.
    - The DEC may recommend an amendment to the participant's existing Diversion Agreement.
    - **No reduction in requirements may be approved if participant is not in full compliance with the Diversion Agreement. All worksite/hospital monitor and therapist reports must be up-to-date and in the participant's file prior to considering a reduction in requirements.**

Participant Returns to the Meeting:

- Participant is invited back into the meeting to discuss the DEC recommendation.
- The case manager brings the participant back into the meeting.

The DEC Presents Recommendation:

- The case consultant explains to the participant the DEC recommendation.
- The case consultant explains that the case manager will meet with the participant to review the formal Diversion Agreement or Agreement Amendment for signature.

- The case consultant informs the participant of the procedures, responsibilities, and consequences of noncompliance.
- The participant is given the opportunity to ask questions or make further comment.

Conclusion:

- The Diversion Program Administrator notes the DEC recommendations for final decision.
- A letter to participant is prepared by Headquarters administrative staff confirming the meeting results and the action by the Program Administrator.
- A face-to-face meeting will occur between the case manager (or group facilitator) to sign the new and revised Diversion Agreement and copies of the agreement will be sent to the worksite/hospital monitor, group facilitator, therapist, and participant's file.

Liability

The DEC members shall not be personally liable for acts in performance of their duties as members of the DEC. If a DEC member is sued for acts related to their duties as a DEC member, the State Attorney General's Office will provide legal defense. (Business and Professions Code Sections 2317 & 2318)

Conflict of Interest

DEC members are asked to identify any participant with whom they have a significant personal or professional relationship. DEC members shall not participate in discussion or action related to these participants. If a situation arises where a DEC member knows a participant and there is doubt regarding how that might affect the evaluation process, the participant will be asked whether he/she has an objection to the DEC member participating in the discussion.

In addition, all DEC members are required to complete an annual Conflict of Interest Statement (Form 700) to indicate if they have any personal financial income which may influence their decisions related to a participant.

Confidentiality

All information DEC members obtain from Diversion Program participants is confidential. Participant files are strictly confidential and DEC members shall return all files to the Diversion Program at the time of the participant's completion of the Program or the completion of the DEC member's term.

Time & Reimbursement for Meetings

DEC meetings begin at 8:00 a.m. and usually last until 4:00 p.m. It is important the meeting starts on time to maintain the schedule for reviewing participants. The first few minutes of each meeting are devoted to announcements, policy changes and other administrative information. If a DEC member is unable to attend or has to leave early from the meeting, he/she needs to inform the DEC Coordinator as soon as possible so the DEC Coordinator may arrange a substitute. If a DEC member must make a telephone call, it is preferred to do so during breaks.

Diversion Evaluation Committee
Peer Evaluation

Evaluation of: _____ Date: _____

Circle all that apply.

Preparedness: Does the committee member thoroughly review materials prior to scheduled meetings, particularly in cases assigned to the committee member and in new cases?	**Excellent**	**Acceptable**	**Poor**	**Unacceptable**
Cooperation: Does the committee member collaborated and cooperated with others to help the DEC function effectively?	**Excellent**	**Acceptable**	**Poor**	**Unacceptable**
Communication: Does the committee member communicate his/her ideas effectively?	**Excellent**	**Acceptable**	**Poor**	**Unacceptable**
Knowledge: Does the committee member demonstrate current knowledge in the field of substance abuse related disorders and/or mental health related disorders?	**Excellent**	**Acceptable**	**Poor**	**Unacceptable**
Appropriateness/Clinical Judgment: Does the committee member made recommendations regarding physician participation that are appropriate and within an acceptable standard of care?	**Excellent**	**Acceptable**	**Poor**	**Unacceptable**
Interview Skills: Does the committee member shown empathetic and effective interview skills?	**Excellent**	**Acceptable**	**Poor**	**Unacceptable**
Public Protection: Does the committee member make decisions that will protect the public?	**Excellent**	**Acceptable**	**Poor**	**Unacceptable**
Comments:				

Prepared by: _____
Name

_____
Signature

CHAPTER 5

PREPARATION FOR DIVERSION EVALUATION COMMITTEE MEETINGS

CHAPTER 5
PREPARATION FOR DIVERSION EVALUATION COMMITTEE MEETINGS

New Participants

Diversion Program Headquarters (Headquarters) receives telephone calls from physicians requesting entry into the Physician's Diversion Program. Staff will complete the telephone intake form which includes a review of the Consumer Affairs System (CAS). If the CAS documents open cases on the participant, copies of each case must be printed and submitted with the telephone intake form. Staff will provide a copy of the completed telephone intake form to the Collection System Manager (CSM), and a faxed copy will be sent to the case manager, GF, and DPCS II. The original intake form will go to the administrative support staff (support staff) for entry into the Diversion Tracking System (DTS). After entry into the DTS, the support staff gives the completed telephone intake to the DEC Coordinator. Should the participant have any open cases on CAS, the DEC Coordinator will complete the "request to participate" memo and forward to the Deputy Chief of Enforcement. If no pending action is found, the process will begin immediately.

The DEC Coordinator will maintain a file for all pending new participants who are to be seen by the DEC. The DEC Coordinator will schedule the participant for a DEC meeting.

Scheduling Participants: Re-evaluations, Extensions, Completion/Terminations

Scheduling of participants to be re-evaluated, terminated, released from the Diversion Program, or whose contract expired must be initiated by the case manager. Case managers are to make a written request to the DEC Coordinator for scheduling the participant at the next available DEC meeting.

Annual Reviews

The DEC Coordinator will review the computer listing of the participant's first DEC meeting date to schedule the annual review. The DEC Coordinator will send the case managers and the GF an agenda listing the participants scheduled for an annual review. It will be the case manager's and the GF's responsibility to submit completed evaluations by the date designated by the DEC Coordinator.

Preparation & Distribution of DEC Agenda & DEC Packet

The DEC Coordinator compiles and reviews all DEC requests and annual reviews. The DEC Coordinator prepares and mails out an agenda to the case manager and GF, with a memo indicating the date all documentation is due into the Headquarters office.

The assigned analyst compiles all information and documentation and prepares a packet of information for each participant on the agenda. The packet is then given to the support staff for copying and distribution. The packet is sent to DEC members, case managers, and the GF one week prior to the DEC meeting via overnight mail.

Staff at DEC Meetings

The Diversion Program Administrator or the DPCS II will attend each DEC meeting to answer policy questions, evaluate the meeting and those in attendance, and to assist in keeping the meeting progressing. The DEC Coordinator and the Diversion Program Analyst will also be in attendance.

Roles of the Diversion Staff at DEC Meetings

Diversion Program Administrator:

- Attends DEC meetings
- Advises the DEC regarding Diversion Program policies and procedures
- Reviews DEC recommendations and makes a final decision
- Oversees preparation for letters and other DEC documentation
- Keeps the DEC meeting progressing

Diversion Program Compliance Specialist II (DPCS II – Supervising Case Manager):

- Attends DEC meetings
- Ensures Diversion protocol is followed by case manager
- Advises the DEC regarding Diversion Program policies and procedures
- Reviews compliance and non-compliance issues of participants being seen or reviewed at the DEC meeting
- Oversees preparation for letters and other DEC documentation
- Reviews DEC recommendations
- Keeps the DEC meeting progressing

Diversion Program Analyst:

- Attends DEC meetings (takes the place of DPA / DPCS II when unable to attend)
- Prepares DEC overview
- Prepares DEC documentation packets
- Oversees preparation of letters and other DEC documentation
- Prepares letters regarding DEC decisions

Diversion Program Compliance Specialist I (DPCS I - Case Manager):

- Provides information regarding participant's progress
- Monitors participant compliance with the Diversion Agreement
- Recommends resources and treatment options
- Introduces the participant to the DEC and Diversion Program staff

Group Facilitators:

- Provides information regarding participants progress in Group
- Recommends resources and treatment options

DEC Coordinator:

- Serves as meeting coordinator
- Schedules meetings for the year
- Schedules participants for the meetings
- Coordinates preparation of the agenda and packets
- Takes notes at the meetings
- Takes attendance at the meetings and places attendance verification in each DEC member file
- Coordinates appointments and recruitment of DEC members
- Prepares DEC member paper work

Office Assistant:

- Processes DEC member travel claims

CHAPTER 6

COLLECTION SYSTEM

CHAPTER 6
COLLECTION SYSTEM

Random Collection System

All participants will have a minimum of four random drug screenings monthly (unless the participant has an agreement/amendment signed prior to July 1, 2007 indicating otherwise). The collection of random drug screenings is the collaborative work of local collection service providers (collectors), the Collection System Manager (CSM), case managers and Group Facilitators (GF). The CSM distributes a list of dates provided by the Random Date Generatation (RDG) program to the collectors, case managers, and the GF by the 25th day of the month for the following month. All collections are observed and the Chain of Custody (COC) protocol is followed. Collection costs and laboratory fees are paid by the participants to the collectors at the time of collection. Collections may be done at groups meetings, a participant's home or office, and any agreed upon site.

Collector Responsibilities

1. Be the same gender as the participant.
2. Follow randomized list of participants and dates for collection provided by the CSM. **The collector may not change a collection date. If a problem arises, the collector must contact the CSM. The first time a collector changes a collection date without prior approval will receive a written warning. A second offense will result in dismissal of the collector.**
3. Contact participants to arrange for time and place of collection. Collectors must collect within four hours of the initial verbal communication with the participant.
4. Resolve logistical collection problems with participants.
5. When unable to collect a specimen due to failure of participant to call or appear, contact the CSM **immediately** who will contact the case manager. The collector completes a "Drug Test Collection Incident Report" (Chapter 6, Attachment A) and submits it to the case manager and CSM.
6. Collect the number of times specified on the Random Date Generator (RDG) calendar provided by the CSM.
7. Ensure the specimen bottles are filled to the appropriate levels (do not overfill bottle).
8. Ensure specimens are sent to the drug screening laboratory (via overnight delivery within 12 hours of the collection of for weekend collections by the next business day) and must be accompanied by a participant's check or money order to cover laboratory processing fees. Ensure correct case number is written on the check and the COC paperwork.
9. Collect $25 fee per collection directly from participants.
10. Provide a collection report to the CSM **semi-monthly**. The first report will include data from the 1st through the 15th and second report will include data for the entire month. The first report is due on the 17th of the month and the second report is due on 2nd of the following month.
11. Give CSM at least two weeks notice of a planned vacation and provide a substitute collector, if necessary, who is approved by the Diversion Program Administrator.
12. Notify the CSM immediately if not able to perform collection that day due to illness or emergency. Failure to do so will be documented and may result in termination.

Group Facilitator Responsibilities

1. Assist the CSM by recommending a local collector who can provide the services described under Collector Responsibilities and with whom the CSM and GF can

develop a good working relationship. The Diversion Program Administrator will make the final selection in conjunction with the CSM recommendations.

2. Serve as backup for collections. Make spontaneous collections when circumstances warrant and alert both the case manager and CSM upon collection completion.

Case Manager Responsibilities

1. Check drug screening results daily.
2. Verify the appropriate amount of collections are completed for each participant and are made according to the random list provided by the CSM.
3. Monitor the quality of collections by talking with participants, the GF, and observing the collector at the collection worksite, if applicable. If any problems arise the matter will be discussed with the collector. If problems continue the collector will be dismissed.
4. Ensure the CSM is notified of new participants for scheduling of collection. Thereafter, ensure the CSM is notified of any changes to collection participant's pattern of screening and also the release of participants who no longer require drug screenings. A pattern of screening is the number of random screens per month, the type of panel, and any consistent special circumstances noted on the randomized list of dates for collection of specimens.
5. In conjunction with the CSM, assist the collector to resolve logistical problems interfering with participant drug screening collections.
6. Immediately suspend a physician who fails to call the collector or appear for a drug screening and contact the worksite monitor.
7. Order special tests for other drugs of abuse and required medications or antagonists (such as Naltrexone). Notify the CSM when participants are tested for any of these drugs and when the antagonist is discontinued.
8. Ensure absence request protocol is followed.

Collection System Manager Responsibilities

1. Notify the Program Administrator, DPCS II, and case manager daily of all positive drug screening results via e-mail. Also, notifies the DPCS II and the case manager daily of negative dilutes, invalids, and rejected test results.
2. Provide oversight and coordination for the collection system process. Act as liaison between the laboratory, case managers, the GF, and collectors.
3. Ensure all participants are included in the RDG database and verify all participants are scheduled for the required number of tests.
4. Verify collections are completed on the random date assigned by the RDG or another date to accommodate a participant's approved absence request.
5. Verify all specimens are received at and processed by the Diversion Program's drug screening laboratory, and results are correctly downloaded and appended to each participant's record in the Diversion Tracking System (DTS).
6. Verify that each collector submits the collection reports timely.
7. Ensure a calendar of randomized dates for UDS collection is sent to the collectors, case managers and the GF by the 25th of each month for the following month.
8. Work with the collector, case manager, and the GF to resolve problems interfering with a participant's collection.
9. Obtain a report twice a month from DTS listing all participants, the assigned test dates, the dates the test was actually collected, and the test results. Determine any dates where the collection was not performed on the date requested. Reconcile this information with the semi-monthly report sent by the collectors to determine

individuals who were not tested on the required dates and why, ensure accuracy of information, and document any discrepancies in the reports. Ensure any problems with the collector (e.g. changing test dates without prior approval, failing to file a report, making an error in submission, etc.) are adequately addressed with the collector and a note is placed in the collector's file. Take any further necessary action.

10. Provide a summary of the report reconciliation to the Diversion Program Administrator who will review to ensure the reconciliation is accurate.
11. Provides a written report to the Diversion Committee that includes how and in what time frame positive urine tests were processed. The report should identify current issues or problems in the urine collection system.

Participant Responsibilities

It is the participant's responsibility to be available for collection. The participant must provide the collector with a telephone or pager number where he/she can be reached at all times.. The participant must return the collector's call within 2 hours, and must appear for collection within the time period specified by the collector (a maximum of 6 hours from the initial call from the collector).

Participants may request to be excused from drug screenings for vacation. **(All requests must be submitted in writing at least 14 days in advance.)** The GF and case manager approve/disapprove all vacation requests. The case manager faxes the approved/disapproved form to the Collection System Manager. **Only if there is an emergency (e.g. family death or illness) will a request be approved without a 14-day prior notice.**

Collection System Managers are not authorized to approve a participant's vacation request. The authorization must be approved by the GF and the case manager.

Consequences for Missed Collections

Missed collections are categorized as follows: 1) No call back to collector; 2) No shows for collection appointments. **If the participant does not appear for the test or fails to contact the collector within the specified time, then the physician will be suspended from the practice of medicine. The participant cannot practice medicine until a thorough investigation of the incident has occurred and another drug testing with negative results has been taken.**

In addition, to ceasing the practice of medicine, the Diversion Program may require any or all of the following:

1. An increase in group meeting attendance.
2. Meeting with the DEC for reevaluation.
3. Termination from the Diversion Program.

In cases of work-related emergencies that preclude a collection, the participant must contact the case manager immediately. The case manager will contact the CSM immediately to communicate the work-related emergency. A work related emergency will need to be confirmed by the worksite or hospital monitor. The CMS will immediately request another collection from the collector and discuss the incident with the Diversion Program Administrator.

New Collectors

New collectors will be subject to a 30-day evaluation period. The CSM will conduct this written evaluation to ensure the collector is providing adequate services. If the 30-day evaluation is favorable,

the new collector will sign an agreement to provide services for one year. If the evaluation is not favorable, the collector will be notified that his/her services will no longer be needed.

Collector Training and Evaluations

The Headquarters office will maintain a file for each collector. Each file will contain:

- Agreement signed by the collector
- Certification of completion of training
- Any evaluations or performance assessments
- Any notes from the CSM indicating problems with work performance, including written warnings for non-compliance
- Any other documentation or correspondence pertaining to the collector

Failure of a collector to comply with the policies and procedures or inadequate performance of his/her duties and responsibilities **will result in termination.**

The Diversion Program shall conduct yearly refresher/training courses to ensure the collectors are adequately trained and to review any changes in protocols or processes. The collectors must attend this training. The Diversion Program will also conduct yearly individual evaluations for all current collectors. The evaluation will consist of a written evaluation and discussion of the services provided the past year. After the training and evaluation, a new agreement will be completed and signed.

Testing Protocol and Test Results

Drug detection is performed at the lowest recommended reagent or methodology detection level. Results are available to appropriate personnel on the current drug screening lab website immediately after certification and are transmitted to the Diversion Program via electronic download daily (Monday through Friday).

Confidentiality

The identity of the Diversion Program participants and the drug screening results are confidential. Each result is reported by an assigned participant number and specimen identification number.

Payment

Participants are responsible for all collection and lab testing fees. The participant pre-pays the lab costs at time of collection with either money order or check. Payments are stapled to the chain of custody form and placed in the outside pocket of the collection package. The participant's case number is written on the check or money order. The current drug screening lab requires full payment for each panel and any individual drug screens at the same time.

Cost

Fees for panels, add-on screens, and confirmation tests are $35 for MEDPRO C panel and $25 for Etg.

The current drug screening lab also provides hair analysis to test for a 3-month history of marijuana, cocaine, amphetamines (amphetamine, methamphetamine, and Ecstasy), opiates (codeine, morphine, hydrocodone, hydromorphone, oxycodone, oxymorphone, 6-Acetylmorphine) and PCP use. These tests must be specially arranged by the case manager, at a cost of $42 for laboratory fees, and require a special collection process.

The current drug screening lab provides all supplies and equipment, timely reporting, statistical services, primary screening and confirmation of the presence or absence of the following drugs:

DRUG	SCREEN	DRUG	SCREEN
Ethanol (alcohol)	20 mg/dl	**BENZODIAZEPINES (continued)**	
AMPHETAMINES		Lorazepam (ativan)	100 ng/ml
D-Amphetamine	300 ng/ml	Midazolam (versed)	100 ng/ml
Methamphetamine	300 ng/ml	Oxazepam (serax)	100 ng/ml
MDEA (eve)	300 ng/ml	Prazepam (centrax)	100 ng/ml
MDMA (ecstasy)	250 ng/ml	Temazepam (restoril)	100 ng/ml
MDA (adam)	300 ng/ml	Triazolam (halcyon)	100 ng/ml
BARBITURATES		**CANNABINOIDS**	50 ng/ml
Amobarbital (amytal)	300 ng/ml	**COCAINE (metabolites)**	300 ng/ml
Butalbital (fiorinal)	300 ng/ml	**METHADONE**	300 ng/ml
Pentobarbital (nembutal)	300 ng/ml	**NARCOTICS/OPIATES**	300 ng/ml
Phenobarbital (luminal)	300 ng/ml	Codeine	50 ng/ml
Secobarbital (seconal)	300 ng/ml	Hydrocodone (lortab)	50 ng/ml
BENZODIAZEPINES		Hydromorphone (dilaudid)	50 ng/ml
Alprazolam (xanax)	100 ng/ml	Meperidine (demerol)	100 ng/ml
Chlordiazepoxide (librium)	100 ng/ml	Morphine	50 ng/ml
Clonazepam (klonopin)	100 ng/ml	Oxycodone (percodan)	100 ng/ml
Clorazepate (tranxene)	100 ng/ml	Oxymorphone (numorphan)	100 ng/ml
Diazepam (valium)	100 ng/ml	Tramadol (ultram)	100 ng/ml
Flurazepam (dalmane)	100 ng/ml	PHENCYCLIDINE (PCP)	25 ng/ml
Flunitrazepam (rohypnol)	100 ng/ml	PROPOXYPHENE (darvon)	300 ng/ml
Halazepam (paxipam)	100 ng/ml	KETAMINE	100 ng/ml
FENTANYL	750 ng/ml	BUPRENORPHINE	750 ng/ml
NALBUPH/NALTREX/ BUTORPH	100 ng/ml	PENTAZOCINE	1.5 ng/ml
CARISOPRODOL	200 ng/ml	OXIDANTS	200 ng/ml

State of California
Department of Consumer Affairs

Medical Board of California
Diversion Program

Drug Test Collection Incident Report

Date: _____

Participant Name: _____

Collector: _____

Collector's Telephone Number: _____

Group Facilitator: _____

Case Manager: _____

Date Collection Scheduled: _____

Date Specimen Collected: _____

I had the following problems with the collection: (Notify Case Manager immediately)

_____ (1) Participant could not be contacted.

_____ (2) Participant was contacted but did not show up.

_____ (3) Participant appeared to be using some type of psychoactive drug.

_____ (4) Participant's attitude was not cooperative.

_____ (5) Other serious incident.

Comment on all checked items: _____

_____

_____

_____

_____

_____

Collector's Signature: _____

Section 1357.7 is added to Title 16 of the California Code of Regulations to read:

(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 the purposes of this section, reasonable cause shall be demonstrated by one or more clinical evaluations or by written documentation 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 the program manager ordering a clinical competency examination pursuant to subsection (a)(2), the diversion evaluation committee or the 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.

Medical Board of California
Division of Medical Quality
Diversion Program
Specific Language of Proposed Changes—Draft 7/11/07

1. Amend section 1357.4 to read as follows:

1357.4 Causes for Denial of Admission

(a) The program manager shall deny an applicant admission to the program if the applicant has been disciplined in California, previously participated in the program as a condition of probation, and was terminated from the program as unsuccessful.

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

(~~a~~1) The applicant does not meet the requirements set forth in Section 1357.1.
(~~b~~2) The applicant has been disciplined by another state medical licensing authority.
(~~c~~3) 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~~4) 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.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2350 and 2354, Business and Professions Code.

2. Amend section 1357.5 to read as follows:

1357.5 Causes for Termination from the Program

(a) The program manager shall terminate a physician's participation in the program if the participant:

(1) Fails or refuses to stop practice when directed to do so by the committee.
(2) Fails or refuses to comply with an order for a clinical competency exam.

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

~~(a)~~ (b) 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)~~ (c) Any cause for denial of an applicant in Section 1357.4.
~~(c)~~ (d) The physician has failed to comply with any of the requirements set forth in Section 1357.1.
~~(d)~~ (e) 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.

Note: Authority cited: Sections 2018 and 2355, Business and Professions Code. Reference: Sections 2350, 2351 and 2354, Business and Professions Code.

Medical Board of California
Division of Medical Quality
Diversion Program
Alternate Version—Draft 7/16/07

1. Amend section 1357.4 to read as follows:

1357.4 Causes for Denial of Admission

(a) The program manager shall deny an applicant admission to the program if the applicant either participated in the program within three years immediately preceding the date of application or has been disciplined in California, previously participated in the program as a condition of probation, and was terminated from the program as unsuccessful.

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

(~~a~~1) The applicant does not meet the requirements set forth in Section 1357.1.
(~~b~~2) The applicant has been disciplined by another state medical licensing authority.
(~~c~~3) 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~~4) 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.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2350 and 2354, Business and Professions Code.

2. Amend section 1357.5 to read as follows:

1357.5 Causes for Termination from the Program

(a) The program manager shall terminate a physician's participation in the program if the participant:

(~~a~~1) Fails or refuses to stop practice when directed to do so by the committee.
(~~b~~2) Fails or refuses to comply with an order for a clinical competency exam.
(3) Has had three relapses (as defined in section 1357.75) on or after the effective date of this subsection.

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

~~(a)~~ (1) 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)~~ (2) Any cause for denial of an applicant in Section 1357.4.

~~(c)~~ (3) The physician has failed to comply with any of the requirements set forth in Section 1357.1.

~~(d)~~ (4) 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.

Note: Authority cited: Sections 2018 and 2355, Business and Professions Code. Reference: Sections 2350, 2351 and 2354, Business and Professions Code.

2. Adopt section 1357.75 in Article 2 of Chapter 2 of Division 13 to read as follows:

1357.75. Response to Relapses

(a) A relapse is defined as the unauthorized use of alcohol and/or drugs that has been confirmed either by a biological test or by admission of use by the participant or both.

(b) Upon notification by the program of a relapse, the participant shall immediately cease the practice of medicine until the participant has been deemed by the program manager to be safe to return to the practice of medicine.

(c) Every relapse shall be evaluated by the program manager, in consultation with the committee, to determine whether the participant meets the criteria set forth in section 1357.5 for termination from the program.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2350, 2351 and 2354, Business and Professions Code.

PROPOSED CONCEPTUAL DRAFT
REGARDING 'UNDER INVESTIGATION' DIVERSION PARTICIPANTS

1. Section 2350 of the Business and Professions Code is amended to read:

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.

(1) Any statement of understanding executed pursuant to this subdivision may contain a provision that upon a physician and surgeon refusing to provide biological fluid samples for testing or providing a sample, after testing, which indicates that the physician and surgeon has taken, consumed or otherwise used an unauthorized or unapproved drug or alcohol, the division may immediately suspend his or her certificate pending a hearing held pursuant to section 2350.5. Prior to issuing an order of suspension, the division and the diversion manager shall consult with the physician and surgeon's diversion evaluation committee.

(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.

2. Section 2350.5 is added to the Business and Professions Code is added to read:

(a) <u>Any physician and surgeon, who has received a written order of suspension of his or her certificate pursuant to subdivision (b) of section 2350, may request a hearing on the matter. The request for a hearing shall be made within ten (10) days of the suspension order or the right to hearing shall be deemed waived. The rights afforded to the physician and surgeon at the hearing shall include:</u>

<u>(1) To be represented by counsel.</u>

<u>(2) To present written evidence.</u>

<u>(3) To present oral argument.</u>

<u>(4) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.</u>

<u>(b) The only issues at the hearing on the suspension of the certificate shall be the following:</u>

(1) In the case of a refusing to provide a biological fluid sample, whether good cause existed for the refusal.

(2) In the case of a test result which indicates the use, consumption or taking of an unauthorized drug or alcohol, whether:

(A) The use, consumption, or taking of the drug or alcohol was authorized or approved by the program or the physician and surgeon's diversion agreement or statement of understanding.

(B) The collection and testing of the fluid sample were performed in accordance with established procedures and the results of the test were reported accurately to the program.

(c) A request for an administrative hearing does not stay the suspension of the physician and surgeon's certificate. If a hearing is not held within twenty (20) days of the request, the physician and surgeon's certificate shall be restored.

(d) Where the order of suspension is upheld, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. If the order of suspension is not upheld, the physician and surgeon's certificate shall be restored.

(e) Any order of suspension issued pursuant to subdivision (b) of section 2350 shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure.

State of California

Department of Consumer Affairs
Medical Board of California

MEMORANDUM

To: Medical Board of California
Diversion Committee

Date: July 16, 2007

From: Frank L. Valine
Diversion Program Administrator

Subject: Quality Review Report – 4th Quarter of FY 2006/2007

Attached are the quarterly reports of Quality Review issues requested by the Diversion Committee. They include a review of Intakes, Relapses and Releases during the period of April1, 2007 through June 30, 2007.

INTAKES

A total of **17** physicians contacted the Program during the 4th Quarter. The following charts reflect the outcomes of contact with these physicians as of June 30, 2007, as well as, other categories of information.

Status at Intake	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Totals
Active: Approved by DEC & Signed Agreement	0	1	0	0	1
Accepted; Waiting for Signature:	2	1	1	2	6
Intake Complete; Awaiting DEC:	11	4	14	3	32
Contacted Program/Telephone Intake:	8	5	3	9	25
Ineligible:	1	3	0	0	4
Not interested in Program:	5	4	1	2	12
Terminated	0	0	1	1	2
Out-of-State:	1	0	0	0	1
Total Contacts	28	18	20	17	83

Other Information		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Totals
In Treatment;	At intake:	11	5	3	2	21
	Currently:	5	4	8	2	19
Referral Type;	Board Action:	12	6	7	8	33
	Self-Referral:	16	12	13	9	50
Impairment[1];	Chemical:	17	12	14	14	57
	Dual Disorder:	5	6	6	3	20
	Mental Only:	6	0	0	0	6
Practicing;	Yes:	8	12	9	7	36
	No:	20	6	11	10	47

[1] The determination of a participant's status as Chemically Dependent, Dual Disorder, or Mentally Ill frequently changes as additional information is gathered. Initially, the Program receives self-reported information during the intake process. Additional information, resulting in a change of status, may be received during either the evaluative or formal participation periods from evaluation reports and treatment records.

Table 1: Program Response Times

Table #1 shows the average response times for intakes (excluding physicians in treatment and those delayed in entry into the Program) during this period, as well as the Program's target timeframes, from the date the physician initially contacted the Program to the completion of the major steps of the evaluation process. These steps include the first face-to-face contact with Program staff; the intake interview; the initial urine test; and attendance at the first DEC meeting.

	Process	Physicians	Average # of Days	Program Target	Time Periods	Physicians	Percentage
A	From initial contact to Intake Interview (6 of the 17 intakes did not have an intake interview during this reporting period; 1 was being terminated; 2 were not interested; 1was entered into treatment; 1 have not been performed.	**11**	**16**	**ASAP**	0-7 DAYS 8-14 DAYS 15-21 DAYS 22+ DAYS	4 3 2 2	37% 27% 18% 18%
B	From initial contact to 1st urine test [2 of the 17 intakes did not have an initial UA during this reporting period; 1 entered into treatment; 1 not interested in program.	**15**	**11**	**ASAP**	0-7 DAYS 8-14 DAYS 15-21 DAYS 22+ DAYS	10 2 2 1	67% 13% 13% 7%
C	From initial contact to attendance at 1st DEC Meeting *(**No** Enforcement Activity)* *1 intakes completed and awaiting DEC*	**1**	**39**	**90**	0-60 DAYS 61-90 DAYS 91+ DAYS	0 1 0	100%
D	From initial contact to attendance at 1st DEC Meeting *(**With** Enforcement Activity)* *3 intakes completed and awaiting DEC*	**2**	**52**	**N/A**	0-60 DAYS 61-90 DAYS 91+ DAYS	0 2 0	100%

The data in A & B total intakes often misses program target because the process is delayed when the physician is in treatment and unavailable for an intake interview or UDS's.

The number of total intakes shown in C & D does not match the actual number of intakes during the reporting quarter because it takes 60-90 days to schedule the DEC meetings and this report does not include updates from the previous quarter.

CASE	Status as of June 30, 2007	Enforcement Action	Contacted Program/ Telephone Intake	Intake Interview	1st UDS	DEC Meeting (Scheduled)	COMMENTS
2446	Intake Complete; Initial DEC was 6/15/07	SOU dated 4/3/07	4/3/07	5/7/07	4/10/07	6/15/07	In treatment.
2447	Intake Complete; Initial DEC was 5/30/07	SOU dated 3/27/07	4/5/07	4/12/07	4/10/07	5/30/07	Cannot practice medicine until a work-site monitor has been approved.
2448	Intake Complete; Awaiting DEC	None; Self Referral	4/13/07	5/22/07	4/19/07	None	Full-time work week.
2449	Intake Complete; In treatment	None; Self Referral	4/19/07	5/3/07	4/23/07	None	In treatment on 7/2/07.
2450	In the process of being terminated	Probation Date Of Action 11/29/06	4/18/07	None	4/24/07	None	Restricted from practice.
2451	Intake Complete; Awaiting DEC	Probation Date Of Action 5/7/07	5/7/07	5/14/07	5/14/07	None	Out of practice; Was terminated from Diversion Program on 2/05 and 6/06.
2452	Intake Complete; Awaiting DEC	Probation Date Of Action 5/9/07	5/9/07	5/22/07	5/30/07	None	Full-time work week. On vacation from 5/9/07 – 5/30/07, went on vacation for 3 weeks after contacting program. Had a negative-dilute urine sample on 7/9/07 (No file note. Scheduled for 7/18/07 DEC.
2453	Intake Complete; In treatment	None; Self Referral	5/15/07	6/1/07	6/7/07	None	In treatment at In-take.
2454	Intake Complete; In treatment	Self; Investigating Pending re: assault with firearm	5/16/07	6/7/07	6/7/07	None	In treatment at In-take.
2455	Currently working part-time.	Investigation Pending re: multiple DUIs	5/17/07	5/29/07	5/30/07	None	Restricted work hours up to 20 hours per week. Missed collection on 5/23/07. Per evaluation from BFC. no further in-patient treatment further input treatment recommended. OK to work - Will benefit from Diversion.
2456	Not interested in Program	None; Self Referral	5/23/07	Scheduled for 6/6/06 but was cancelled	5/31/07	None	Out of practice.

CASE	Status as of June 30, 2007	Enforcement Action	Contacted Program/ Telephone Intake	Intake Interview	1st UDS	DEC Meeting (Scheduled)	COMMENTS
2457	In Treatment on 6/21/07 at Betty Ford Center	None	6/18/07	6/20/07	None	None	Self Referral.
2458	Intake Completed	SOU dated 6/13/07	6/18/07	6/25/07	6/24/07	None	Arrested for DUI.
2459	In Out-patient treatment as of 7/5/07	None	6/21/07	None	6/26/07	None	Out-patient treatment.
2460	As of 7/11/07, not sure if wants to be in the program	Arrested for Falsifying prescriptions	6/26/07	None	6/29/07	None	Court date for his arrest is 7/25/07 after being arrested on 6/22/07.
2461	Not interested in Program	None	6/28/07	None	None	None	Not interested in the program after all. Awaiting CM file note to see if he is a threat to the public. Left Betty Ford Center on his own on 7/5/07.
2462	Out of Practice, possibly looking into entering treatment center.	None	6/29/07	None	7/2/07	None	Participant tested positive via an EtG for alcohol on 7/2/07. On 7/5/07, participant relocated to the Bay Area. Participant will be tested in SF and assigned to Jim O'Donnell's SF Group. He will be assessed for the development and consideration of a treatment plan. Formal intake interview to be scheduled. Participant has not at this writing signed an interim agreement.

EVALUATION PERIOD: The period between the Participant signing the Interim Agreement and his or her appearance before the DEC is an evaluation period. During this initial assessment period, information from a variety of sources is gathered and reviewed as follows:

- Case Manager's Intake Interview
- Participation at Diversion Group meeting
- Evaluation by an addictionologist and/or a psychiatrist
- Treatment program records
- Lab testing results
- Worksite Monitor reports

KEY TO CASE REVIEW TERMS	
DEC	Diversion Evaluation Committee
GF	Group Facilitator
CM	Diversion Program Case Manager
CC	DEC Case Consultant
PM	Diversion Program Manager
UDS	Urine Drug Screen
PCP	Primary Care Physician
Etg*	Ethyl Glucuronide Lab Screen

* (Special lab screen for Alcohol; detects Alcohol in the urine for up to 80 hours prior to the date a specimen is collected.)

RELAPSES (7)

The table below shows the case details for total participant relapses during the time period reported. There were **7 relapses** during the time frame from **April 2007 – June 2007, the 4th Quarter.**

Quarters		1st	2nd	3rd	4th	Totals
Type of Referral:	Board Action:	6	3	2	2	13
	Self- Referral:	2	1	2	5	10
Participant Impairment:	Chemical Dependency:	5	3	2	5	15
	Dual Disorder:	3	1	2	2	8
Length of Time in Program at Relapse:	0-1 year	3			3	6
	1-2 years	2			1	3
	2-3 years		2	2		4
	3-4 years		2	1		3
	4-5 years	2		1	3	6
	7-8 years	1				1
Total with Prior Relapses:		4	3	3	1	11
Method of Detection:	Random UDS:	7	4	3	7	21
	Collector Detection:					
	DUI:					
	Self Report:	1		1		2
	Fellow employee reported:					
Practice Restrictions in Response to Relapse:	Stop Practice Initiated:	5	4	1	5	17
	Stop Practice Continued:	1		3	2	6
Clinical Response to Relapse:	Inpatient treatment:			2	3	5
	Increase group/urine tests:	2				2
	Retesting:				2	2
	Outpatient Treatment:	3			1	4
	DEC further review:	4				4
	Termination:	1		2		3
	Death:				1	1
Withdrew from Program:		1				1

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2287	Died of Overdose	No	Self	No	Alcohol.Opiates	No	2/22/07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Fentanyl		2 years, 1 Month		Died of overdose the following morning that the CM notified him of his positive and to immediately stop working.				

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2102	In treatment	No	Self	No	Meth.	No	4/9/07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Amphetamines		1 year, 1 week		Sent to treatment.				

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2138	Seeking work	No	Board	SOU	Alcohol, Cocaine	No	4/12/07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Alcohol		3 years, 8 months		Sent to treatment.				

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2415	Heading to treatment	No	Board	Pending invest.	Oxycontin	Yes	4/27/07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Alcohol		6 months (not officially in program)		Heading to treatment on 8/2/07.				

200

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2444	In treatment	Yes	Self	No	Alcohol	No	5/28/07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Alcohol		2 months (not officially in program)		Sent to treatment.				

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2448	Working	Yes	Self	No	Alcohol and Darvocet.	No	5/15/07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Propoxyphene		1 month (not officially in program)		Working full-time.				

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2159	Working	Yes	Self	No	Cocaine, Meth, and Ritalin	Yes	6/25/07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Oxazepam, Temazepam		3 years, 10 months		Off work pending DEC discussion.				

Physician Diversion Program –

Releases (14 participants for the time period of April 2007 – June 2007, the 4th Quarter)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Treatment prior to Diversion	Relapses(s)	Treatment during Diversion	Practice Status at Release
2047	Completed	Self	No	Cocaine	No	5 years	Yes	No	No	Practicing
2063	Completed	Board	Probation	Ambien	Yes	5 years	Yes	No	No	Practicing
2058	Completed	Self	No	Fioricet	No	5 years	Yes	No	No	Practicing
2044	Completed	Self	No	Meth., Cocaine	Yes	5 years	Yes	No	No	Practicing
1993	Completed	Self	No	Alcohol, Valium, Meth.	Yes	5 years, 1 month	Yes	No	No	Practicing
2037	Completed	Board	SOU	Codeine, Ativan	Yes	5 years	Yes	No	No	Practicing
2043	Completed	Self	No	Xanax	Yes	5 years	Yes	No	No	Practicing
1915	Completed	Self	No	Benzos, Opiates	Yes	7 years	Yes	No	No	Practicing
2065	Completed	Self	No	Marijuana, Ecstacy	No	5 years	Yes	No	No	Practicing
2056	Completed	Self	No	Alcohol	No	5 years	Yes	No	No	Practicing
2068	Completed	Self	No	Alcohol	No	5 years	Yes	No	No	Practicing

Physician Diversion Program –

Releases (14 participants for the time period of April 2007 – June 2007, the 4th Quarter)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Treatment prior to Diversion	Relapses(s)	Treatment during Diversion	Practice Status at Release
2050	Completed	Self	No	Sufenta	No	5 years	Yes	No	No	Practicing
1268	Terminated -Unsuccess	Self	No	Alcohol, Meth, Benzos, Soma, Phentermine	Yes	13 Years	Yes	No	No	Referred to Enforcement
2046	Completed	Self	No	Alcohol	Yes	5 years	No	No	No	Practicing

SHANNON V. CHAVEZ, M.D.

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DIVERSION EVALUATION COMMITTEE MEMBERS FOR RE-APPOINTMENT
July 2007

Shannon V. Chavez

Dr. Chavez is a physician member whose first term expires in July 2007. Dr. Chavez has an excellent attendance record and program staff believes that she is a solid Diversion Evaluation Committee Member. I support her re-appointment.

July 9, 2007

Medical Board of California
Diversion Program

Attention: Frank Valine, Program Manager.

Dear Mr. Valine:

I am the Medical Director of UCSD Outpatient Psychiatric Services and the Chairman of the UCSD Physician Well-being Committee. I have been a DEC member for four years and am requesting to continue in that position.

I am a recovering addict/alcoholic and have been sober and working a program of recovery for fourteen years. My passion is helping the impaired medical professional find recovery and continue working as a safe and effective care provider.

It is an honor to also sit on the State Bar Lawyer Assistance Program Evaluation Committee, as well as the Board of Registered Nursing Diversion Program DEC.

I hope you will consider me for another term as an MBC DEC member. It is a privilege to serve in this capacity. Thank you for your consideration.

Sincerely,

Shannon V Chavez, MD
Medical Director
UCSD Outpatient Psychiatric Services

SHANNON V. CHAVEZ, MD

EDUCATION

Psychopharmocology Research Fellowship **7/98 – 6/99**

UCSD Department of Psychiatry
9500 Gilman Drive
San Diego, CA 92121

Forensic Psychiatry Fellowship **7/89 – 8/92**

Atascadero State Hospital
Atascadero, CA 93007

Residency in Psychiatry **7/86 – 6/89**

UC San Francisco/San Joaquin Valley
Valley Medical Center
430 Ash Avenue
Fresno, CA 94820

Rotating Internship **7/85 – 6/89**

UCSF/San Joaquin Valley
VA Medical Center
Fresno, CA 94835

UC San Diego School of Medicine **9/79 – 6/85**

9500 Gilman Drive
San Diego, CA 92121

UC Irvine **2/77 –8/79**

Campus Drive
Irvine, CA 92520

Saddleback Community College **9/73 – 7/75**

School of Registered Nursing – RN Degree

SHANNON V. CHAVEZ, MD

CALIFORNIA MEDICAL LICENSE # G59169

DEA CERTIFICATE # XBC6189270 – with special license to prescribe Buprenophine

EMPLOYMENT

Medical Director
UCSD Outpatient Psychiatric Services
140 Arbor Drive Ste 331
San Diego, CA 92103 **2005 - Current**

Assistant Clinical Service Chief **Current**

Department of Psychiatry, UCSD
9500 Gilman Drive – MC 0985
La Jolla, CA 92093

Associate Professor of Psychiatry **Current**

VA San Diego Healthcare System
3350 La Jolla Village Drive – 116A
San Diego, CA 92161

Clinical Assistant Professor **Current**
UC San Diego

Department of Psychiatry
8950 Villa La Jolla Drive, Ste C207
La Jolla, CA 92037

Assistant Medical Director **1/00 – 2/05**

Community Research Foundation
9500 Gilman Drive -- MC 0985
La Jolla, CA 92093

SHANNON V. CHAVEZ, MD

Medical Director 9/99 – 7/02

VA Outpatient Mental Health Services
9330 Rio San Diego Drive
San Diego, CA 92106

Staff Psychiatrist 7/98 – 8/99

UCSD Department of Psychiatry
VA Medical Center
8950 Villa La Jolla Drive, Ste C207
La Jolla, CA 92037

Clinical Research Coordinator 7/96 – 6/98

UCSD Department of Psychiatry
8950 Villa La Jolla Drive, Ste C207
La Jolla, CA 92037

Registered Nurse/Cardiac Bypass Technician 7/75 – 8/79

UC Irvine Medical Center
100 Irvine Way
Orange, CA 92862

SHANNON V. CHAVEZ, MD

ACADEMIC AFFILIATIONS

Chair, UCSD Physician Well-Being Committee

Chair, UCSD Physician's Well-Being Committee

Chairman, Lawyer's Assistance Program Southern Division, California State Bar Association

Former Chairman, California Society of Addiction Medicine Physician Committee for Physician Well-Being

Committee Member, Medical Board of California, Physician Diversion Program

Member, American Society of Addiction Medicine

Member, Executive Council, California Society of Addiction Medicine

Member, International Doctors in AA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
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AGENDA ITEM 9B

AGENDA ITEM 9D

MEMO

Date: July 16, 2007

To: Diversion Committee

From: Frank L. Valine
Diversion Program Administrator

Subject: Worksite Monitor/Conflict of Interest
Case Managers' Caseloads

The recent report by the Bureau of State Audits, concerning the Medical Board of California's Physicians Diversion Program found that the Board has made many improvements to the program since the release of the November 2005, report of the Enforcement Monitor. The report concludes, however, that there are still some areas which the program must improve in order to adequately protect the public from physicians who abuse alcohol/drugs.

In response to the auditor's findings, the Board ordered the immediate implementation and immediate review of all Worksite Monitors and the removal of any Worksite Monitor who has a conflict of interest with the physician he or she is monitoring. If a Worksite Monitor is removed, the physician must cease the practice of medicine immediately until another appropriate Worksite Monitor is in place.

During a Case Manager training on June 21, 2007, the above changes were discussed and the new policy was implemented. As of July 2, 2007, Case Managers had met with all Worksite Monitors that had conflicts and established a new Worksite Monitor that met the new policy. Each Case Manager met with the new Worksite Monitor and had them sign the new Worksite Monitor Agreements. The Case Managers are in the process of contacting the remaining Worksite/Hospital Monitors and will be having them sign the new Worksite Monitor Agreements. This will be completed by July 25, 2007.

Northern California Case Load Size:

Fayne Boyd	2
Sally Smith	28
Jim Thiel	33
John Melendez	25

Southern California Case Load Size:

Paul Booth	9
Ann Glassmoyer	37
Ramona Drake	47
Bernard Karmatz	42

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AGENDA ITEM 9E

Date: July 16, 2007

To: Members, Diversion Committee
Division of Medical Quality
Medical Board of California

From: Frank Valine
Diversion Program Manager

Subject: Diversion Program Budget Report

Senate Bill 231 (Figueroa 2005) added Section 2343(b) to the Business and Professions Code. This section requires the Diversion Program Manager to… "account for all expenses and revenues of the Diversion Program and separately report this information to the board on a quarterly basis."

Attachment #1 details the Diversion Program (Program) final budget status for fiscal year (FY) 2005/2006.

Attachment #2 details the Program's budget for FY 2006/2007. The Program's budget for FY 2006/2007 is $1,747,180. Expenditures from July 1, 2006 through May 31, 2007 are $1,247,355. As requested by the Diversion Committee, this is 71% of the 2006/2007 FY Budget.

The Program's budget includes travel for Program staff to over 35 Diversion Evaluation Committee (DEC) meetings and four board meetings each year. The budget also includes travel and per diem expenses for DEC members.

Travel for staff and DEC members through June 2007 totaled: $ 59,148.61

Per diem for DEC members from April 2007 through June 2007 totaled: $ 6,200

Please let me know if you have any questions.

Attachment

MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
BUDGET REPORT
JULY 1, 2006 - MAY 31, 2007

	FY 06/07 BUDGET	EXPEND/ ENCUMB YR-TO-DATE	PERCENT OF BUDGET EXP/ENCUMB	LAG TIME (MONTHS)
PERSONAL SERVICES				
Salaries & Wages	701,095	658,414	93.9	current
Staff Benefits	292,521	237,457	81.2	current
TOTAL PERSONAL SERVICES	993,616	895,871	90.2	
OPERATING EXPENSES & EQUIPMENT				
General Expense	40,921	22,074	53.9	1-2
Printing	10,000	5,282	52.8	1-2
Communications	21,276	12,186	57.3	1-2
Postage	5,255	1,673	31.8	1-2
Insurance	1,582	1,130	71.4	current
Travel In-State	72,055	59,220	82.2	1-2
Travel Out-of-State	0	0		current
Training	4,418	3,544	80.2	1-2
Facilities Operation	32,000	28,342	88.6	current
Consultant/Professional Services	300,000	0	0.0	current
Departmental Services	135,782	123,171	90.7	current
DP Maint/Supplies	2,500	85	3.4	1-2
Central Administrative Services	48,025	48,025	100.0	current
Major Equipment	56,750	32,014	56.4	current
Vehicle Operations	11,000	12,931	117.6	1-2
Minor Equipment	12,000	1,807	15.1	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	753,564	351,484	46.6	
TOTAL BUDGET/EXPENDITURES	**1,747,180**	**1,247,355**	71.4	

g/admin/diverprg.xls
6/20/2007

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.	Completed
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.	New Worksite/Hospital Monitor contracts have been implemented. All new and old contracts will be signed by July 25, 2007.	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 was discussed at the DAC on July 10, 2007.Proposals will be taken to the Diversion Committee meeting on July 26, 2007	Jul-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 was discussed at the DAC on July 10, 2007.Proposals will be taken to the Diversion Committee meeting on July 26, 2007	Jul-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 Committee/DMQ in Feb-06. A Diversion Advisory Council was approved at the Nov-06. A work group will meet Jan 22, 2007 to establish language and make-up of the membership.	The Diversion Advisory Council meeting was held on June 12, 2007. There was a Election of Officers, and the Role, Responsibility, Mission and Vision was established.	Completed
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.	Procedures identified in the Policy & Procedures manual.	Completed

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. This issue will be discussed at the next Diversion meeting.	Jul-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.	Completed
Issue #12			
Develop criteria/regulations for a competency exam requirement for Diversion Program participants.	There are currently no Regulations established, but B & P 2350 (3) gives the DEC the authority to order a participant to be examined to determine competency.	This issue was discussed at the Diversion Advisory Council meeting. New proposed language will be forwarded to the Diversion Committee on July 26, 2007.	Jul-07
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.	Completed
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	Completed
Issue # 15			
Develop and Update Policy and Procedure Manual	The manual has been up-dated with several additions. The manual had been edited and awaits approval from the Legal Department.	The Policy and Procedures are being forwarded to the Diversion Committee for approval on July 26, 2007.	Jul-07

State of California

Department of Consumer Affairs
Medical Board of California

Memorandum

To: Frank Valine
Diversion Program Administrator

Date: June 16, 2007

From: Letitia Robinson
Collection System Manager

Subject: Collection System Status Report for April - June 2007

Attached are the charts reporting the collective test results for Urine Drug Screen (UDS) samples taken during the 4th Quarter, April - June of FY 2006/2007.

The majority of positive results continue to be a result of approved prescriptions for Naltrexone taken by some participants, or medications prescribed for surgery. One participant still shows positive results on occasion as a result of sugar imbalances from his diabetes.

Seven participants with positive UDS samples were determined to have relapsed. One participant is deceased and four participants were ordered into inpatient treatment, as indicated on the quarterly report.

During this reporting period the "Turn Around Time" as reported by Quest lab:

	Collection to lab receipt	*Lab receipt to results reported*	*Total Time*
Averages:	3.9 days	2 days	5.9 days

Attachments

UDS Test Results – 4th Quarter April – June 2007

POSITIVE TEST RESULTS

Month 2007	*Total # of Tests*	*Total Positive Results*	*Number of Positives*	*Comments*
April	848	69	1	Participant relapsed; sent to treatment. (Amphetamine)
			2	Two participants relapsed; sent to treatment. (Alcohol)
			1	Participant relapsed; deceased. (Fentanyl)
			5	Approved prescriptions other than Naltrexone by case manager.
			57	Approved prescriptions by case manager for Naltreoxne.
			1	Positives resulting from alcohol-producing microorganisms associated with participant's diabetes.
			1	Positive for alcohol; EtG negative.
			1	Not considered a relapse. (Alcohol)
May	801	69	1	Participant relapsed; sent to treatment. (Alcohol)
			1	Participant relapsed; new, self-referral participant. (Propoxyphene)
			3	Participant positive for alcohol. Ineligible to participant in Program per DEC 6/6/07.
			5	Approved prescriptions other than Naltrexone by case manager.
			55	Approved prescriptions by case manager for Naltreoxne.
			3	Positives resulting from alcohol-producing microorganisms associated with participant's diabetes.
			1	Positive for alcohol; EtG negative.
June	808	62	1	Participant relapsed. (Oxazepam/Temazepam)
			9	Approved prescriptions other than Naltrexone by case manager.
			50	Approved prescriptions by case manager for Naltreoxne.
			1	Positive for alcohol; EtG negative.
			1	Pending DEC consideration. (Morphine)
TOTAL	**2457**	**200**	**200**	

NEGATIVE-DILUTE TEST RESULTS

Month 2007	*Total # of Tests*	*Total Negative- Dilute Results*	*Number of Negative-Dilute Results*	*Comments*
April	848	2	2	Case Managers notified and retesting ordered.
May	801	4	4	Case Managers notified; 3 retested and 1 in treatment.
June	808	6	6	Case Managers notified; 5 retested and 1 in treatment.
TOTAL	**2457**	**12**	**12**	

Action taken on Positive (UDS Test) Results – 4th Quarter April – June 2007

JUNE POSITIVE TEST RESULTS (other than Naltrexone)					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Substance***	***Action Taken/Comments***
1	6/1/07	6/4/07	6/7/07	Clonazepam Metabolite	@ RX; prior DEC approval to work.
2	6/4/07	6/6/07	6/8/07	Clonazepam Metabolite	@ RX; prior DEC approval to work.
3	6/9/07	6/13/07	6/19/07	Meperidine/Metablotie	@ RX; Dr. notified CM on 6/9 of ER visit and medication administered.
4	6/9/07	6/12/07	6/15/07	Buprenorphine	@ RX; not working.
5	6/10/07	6/14/07	6/19/07	Meperidine Metabolite	@ RX; Dr. notified CM on 6/9 of ER visit and medication administered.
6	6/11/07	6/12/07	6/15/07	Clonazepam Metabolite	@ RX; prior DEC approval to work; removed from work 6/22.
7	6/11/07	6/18/07	6/20/07	Morphine	Removed from work 6/21. Participant says positive due to poppy seed.
8	6/16/07	6/20/07	6/24/07	Buprenorphine	@ RX; participant on vacation; notified 6/25 may not return to work.
9	6/19/07	6/22/07	6/29/07	Buprenorphine	@ RX; continued no work (removed 6/25).
10	6/25/07	6/29/07	7/3/07	Oxazepam/Temazepam	Relapse. Participant on vacation; notified 7/5 may not return to work.
11	6/26/07	6/29/07	7/7/07	Buprenorphine	@ RX; not working.
12	06/28/07	7/2/07	7/5/07	Alcohol, Ethyl	Removed from work 7/6. EtG test negative.

JUNE NEGATIVE-DILUE TEST RESULTS					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Result***	***Action Taken/Comments***
1	6/3/207	6/6/07	6/7/07	Negative-Dilute	Negative tests: 6/6; 6/7; 6/11; 6/16, 6/21, and 6/26/07.
2	6/7/07	6/11/07	6/13/07	Negative-Dilute	6/15: Discussed with participant; negative tests: 6/12 and 6/30/07.
3	6/18/07	6/25/07	6/26/07	Negative-Dilute	6/27: Written explanation provided; negative tests: 6/25 and 6/28/07.
4	6/23/07	6/27/07	6/28/07	Negative-Dilute	6/27: Participant entered treatment.
5	6/26/07	6/29/07	7/3/07	Negative-Dilute	Negative tests: 6/29 and 7/2/07.
6	6/28/07	7/2/07	7/5/07	Negative-Dilute	Negative tests: 7/5 and 7/8/07.

Action taken on Positive (UDS Test) Results – 4th Quarter April – June 2007

JULY POSITIVE TEST RESULTS (other than Naltrexone)					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Substance***	***Action Taken/Comments***
1	7/1/07	7/6/07	7/10/07	Alcohol	Relapse: Removed from work on 7/11; participant admitted drinking.
2	7/2/07	7/9/07	7/11/07	Alcohol	New, self-referral participant quit Program on 7/6.
3	7/3/07.	7/9/07	7/12/07	Alcohol	Relapse: not working; ordered into treatment 7/12.
4	7/8/07	7/11/07	7/13/07	Alcohol	No action: EtG negative; glucose 4+; due to participant's diabetes.
5	7/9/07	7/11/07	7/13/07	Alcohol	EtG negative.

JULY NEGATIVE-DILUE TEST RESULTS					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Result***	***Action Taken/Comments***
1	7/4/07	7/9/07	7/10/07	Negative-Dilute	Participant on vacation through 7/17/07; retest scheduled.
2	7/9/07	7/12/07	7/14/07	Negative-Dilute	DEC 7/18; retest pending DEC outcome.