



Medical Board of California's Physician Diversion Program

While Making Recent Improvements, Inconsistent Monitoring of
Participants and Inadequate Oversight of Its Service Providers
Continue to Hamper Its Ability to Protect the Public

June 2007 Report 2006-116R



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June 7, 2007

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The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Medical Board of California's Physician Diversion Program (diversion program).

This report concludes that although the diversion program has made many improvements since the release of the November 2005 report of an independent reviewer, known as the enforcement monitor, there are still some areas in which the program must improve in order to adequately protect the public. For instance, although case managers appear to be contacting participants on a regular basis and participants appear to be attending group meetings and completing the required amount of drug tests, the diversion program does not adequately ensure that it receives required monitoring reports from its participants' treatment providers and work-site monitors. In addition, although the diversion program has reduced the amount of time it takes to admit new participants into the program and begin drug testing, it does not always respond to potential relapses in a timely and adequate manner. Specifically, the diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug.

Further, of the drug tests scheduled in June and October 2006, 26 percent were not performed as randomly scheduled. Additionally, the diversion program currently does not have an effective process for reconciling its scheduled drug tests with the actual drug tests performed and does not formally evaluate its collectors, group facilitators, and diversion evaluation committee members to determine whether they are meeting program standards. Finally, the medical board, which is charged with overseeing the diversion program, has not provided consistently effective oversight.

Respectfully submitted,



ELAINE M. HOWLE
State Auditor

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Summary

Results in Brief

The Medical Board of California (medical board), a consumer protection agency with the goal of protecting the public by ensuring the initial and continued competence of the health care professionals under its jurisdiction, administers a program designed to rehabilitate physicians impaired by substance abuse or by mental health disorders. This program—the Physician Diversion Program (diversion program)—monitors participants’ attendance at group meetings, facilitates random drug testing, and requires reports from work-site monitors and treatment providers. State law authorizes the diversion program and charges the medical board with its oversight and administration.

In addition to state employees who are principally responsible for the administration of the diversion program, other outside service providers, such as urine collection monitors (collectors) and group facilitators, participate in the monitoring and treatment of program participants. The program also uses seven regional diversion evaluation committees (DECs), made up of individuals with experience in the evaluation and management of persons impaired due to alcohol or drug abuse or a physical or mental illness, to determine prospective participants’ appropriateness for and terms of participation in the program, as well as to make decisions on participants’ successful completion of or termination from the program.

In our review of the diversion program, we focused on activities occurring after the November 2005 report was issued by an independent entity known as the enforcement monitor. Legislation passed in 2002 required that such an entity conduct a review of the medical board’s enforcement and diversion programs. A November 2004 interim report issued by the enforcement monitor raised a number of concerns and made recommendations related to the diversion program. The November 2005 final report provided an update on these issues. We found that although the diversion program has made a number of improvements since the enforcement monitor’s final report, it must continue to improve its performance and procedures in some specific areas to adequately protect the public.

The diversion program has established requirements designed to monitor participating physicians as they seek to overcome addictions and ailments that have the potential to impede their

Audit Highlights . . .

Our review of the Medical Board of California’s (medical board) Physician Diversion Program (diversion program) revealed the following:

- » *Case managers are contacting participants on a regular basis and participants appear to be attending group meetings and completing drug tests, as required.*
- » *The diversion program does not adequately ensure that it receives required monitoring reports from its participants’ treatment providers and work-site monitors.*
- » *The diversion program has reduced the amount of time it takes to bring new participants into the program and begin drug testing, but the timeliness of testing falls short of its goal.*
- » *The diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug, thus putting the public’s safety at risk.*
- » *Twenty-six percent of drug tests in June and October 2006 were not performed as randomly scheduled.*

continued on the next page . . .

- » *The diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed needs to be improved.*
- » *The diversion program has not been formally evaluating its collectors, group facilitators, and diversion evaluation committee members to determine how well they are meeting program standards.*
- » *The medical board has not provided consistently effective oversight of the diversion program.*

ability to practice medicine. Our review found that although the diversion program is generally complying with some of these requirements, its compliance with other requirements falls short. Specifically, case managers appear to be contacting participants on a regular basis, as required, and participants generally appear to be attending group meetings and completing drug tests. However, the diversion program is not adequately ensuring that it receives required monitoring reports from participants' treatment providers and work-site monitors and receives all required meeting verification cards from participants. For example, for the sample of participants we reviewed, the diversion program should have obtained 51 reports from participants' therapists, but it obtained only 17 (33 percent). This low level of compliance may actually be an improvement over that achieved in the past, as indicated by the statistics obtained during the enforcement monitor's review. However, by not adequately ensuring that it receives required monitoring and treatment reports and meeting verification cards, the diversion program has less assurance that its participants are complying with their treatment plans and program requirements.

In addition to the monitoring requirements it has established, the diversion program has set goals related to the timeliness with which participants will be brought into the program. Of the three goals it has established for this purpose, the diversion program appears to be meeting two, and it has made substantial improvement in all three areas in recent years. Specifically, case managers, on average, are completing intake interviews with prospective participants within the goal of seven days from initial contact with the program, and participants are appearing before a DEC for final approval to join the program within the goal of 90 days from initial contact. Although the length of time from initial contact to first drug test decreased from an average of 35 days in 2003 and 2004 to an average of 18 days in 2005 and 2006 for the sample of participants we reviewed, the diversion program has not yet reached its goal of seven days for this activity.

In reviewing the diversion program's response to positive drug tests and other indications that a physician has relapsed into drug or alcohol abuse, we found that in some instances the program did not always respond in a timely manner and did not demonstrate that its actions were adequate, thus putting the public's safety at risk. Specifically, the diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug, as required by program policy; has determined that positive drug tests were not a relapse without providing any justification for such a determination; and has not followed the advice of its advisory committee to have a trained medical review officer review contested results.

In addition, we found that the diversion program has generally not overseen its drug test system and its service providers in an adequate manner. Specifically, although it has shown improvement in this area in recent years, a large number of drug tests are still not being performed according to the randomly generated schedule. The most frequent reason given for drug tests not being completed as scheduled was that participants had requested vacations on those days. However, a significant portion of these vacation requests never received approval from appropriate program personnel. Other reasons drug tests were not completed as scheduled were that collectors moved the tests to other dates and participants did not show up to take the tests. In these instances, the program did not document the inadequate performance of collectors and did not ensure that collectors submitted an incident report for each missed test, as required by program policy.

Further, the diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed does not adequately or quickly identify missed drug tests or data inconsistencies between collectors' reports and lab results. We also found that although the diversion program relies heavily on its collectors, group facilitators, and DEC members in the monitoring and treatment of its participants, it has not been formally evaluating these individuals to determine how well they are meeting program standards.

For its part, the medical board has not provided consistently effective oversight of the diversion program. The medical board uses a committee made up of some of its members to oversee the program (diversion committee). However, the diversion committee's ability to oversee the program is hindered by a reporting process that does not give it a complete view of the program's performance and by a policy-making process that does not ensure that adopted policies are incorporated into the program's policy manual. Consequently, rather than discovering deficiencies through the reporting process and correcting them through a policy-making process that maintains some level of continuity, the diversion committee has been notified of program deficiencies in recent years by an outside entity—the enforcement monitor. Although improvements have been made, most of the enforcement monitor's recommendations have not yet been fully implemented, even though almost two years have elapsed since the publishing of the enforcement monitor's final report. Therefore, it does not appear that the diversion committee has made a diligent effort to ensure that the program promptly implements those recommendations with which it agreed.

Recommendations

To better monitor diversion program participants, program management should create mechanisms to ensure that group facilitators, therapists, and work-site monitors submit required reports, and that the participants submit required meeting verifications.

To ensure a timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:

- Immediately remove practicing physicians from work when notified of a positive drug test.
- Require DEC members to provide justification when they determine that a positive drug test does not constitute a relapse.
- Have a qualified medical review officer evaluate all disputed drug test results if its new advisory committee determines that this action is needed.

To provide adequate oversight of participants' random drug tests, the diversion program should ensure that both the case manager and group facilitator approve all vacation requests and should 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.

To ensure that it adequately oversees its collectors, group facilitators, and DEC members, the diversion program should formally evaluate the performance of these individuals annually.

To effectively oversee the diversion program, the medical board should require it to create a reporting process that allows the medical board to view each critical component of the program.

To ensure that it adequately oversees the diversion program, the medical board should have its diversion committee review and approve the program's policy manual. Thereafter, the diversion committee should ensure that any policy change it approves is added to the manual.

The medical board should ensure that areas of program improvement recommended by the enforcement monitor are completed within the next six months.

Agency Comments

The State and Consumer Services Agency agrees with our audit recommendations and has directed the Department of Consumer Affairs (department) to follow through with the medical board to ensure their implementation. The department also concurs with the recommendations and describes specific actions it would take to assist and encourage the medical board to ensure timely completion. The medical board agrees with each recommendation and describes a number of programmatic changes it has already implemented in response to the audit.

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Introduction

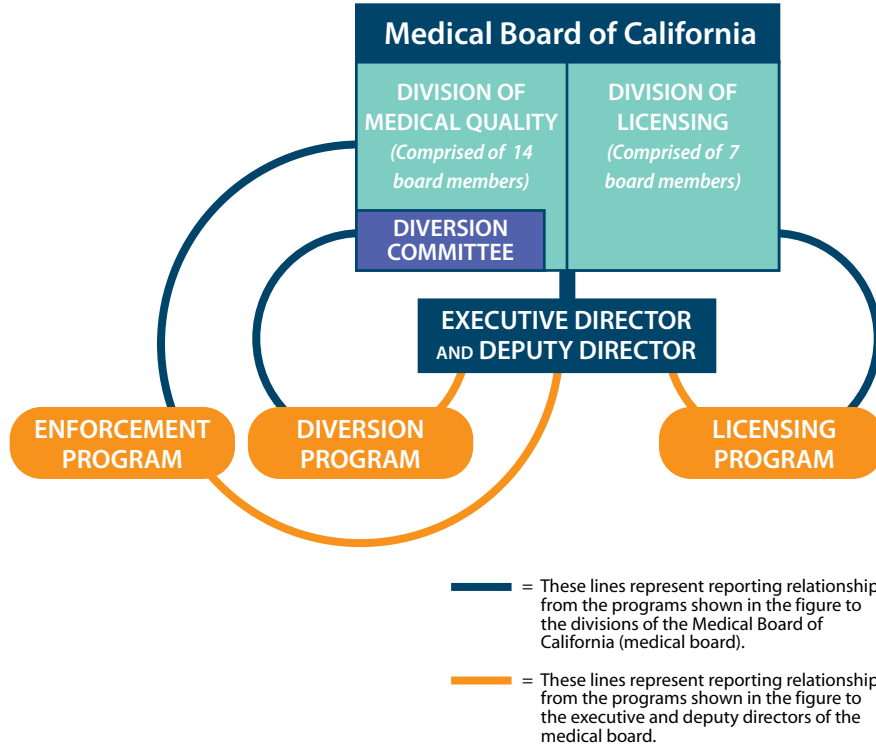
Background

The Medical Board of California (medical board) is a consumer protection agency with the goal of protecting the public by ensuring the initial and continued competence of the health care professionals under its jurisdiction. The medical board licenses physicians, surgeons, and other health professionals; investigates complaints against its licensees; and disciplines those found guilty of violating the law or regulations. In addition, the medical board administers a program designed to rehabilitate physicians impaired by substance abuse or by mental health disorders. This program—the Physician Diversion Program (diversion program)—monitors participants’ attendance at group meetings, facilitates random drug testing, and requires reports from work-site monitors and treatment providers.

Medical Board

The medical board, which has 21 appointed members and is within the Department of Consumer Affairs, comprises two divisions—the Division of Licensing and the Division of Medical Quality—and employs an executive director and a deputy director to oversee the day-to-day operations of its programs, as indicated in Figure 1 on the following page. The Division of Licensing is responsible for approving medical education programs, administering physician and surgeon examinations, issuing licenses and certificates, and administering the medical board’s continuing education and student loan programs. The Division of Medical Quality, through its enforcement program (enforcement), is responsible for investigating complaints against licensees of the medical board and disciplining those found guilty of violating the Medical Practice Act. The type of discipline the medical board administers depends on the nature of the violation and includes restrictions of medical duties, license suspension, license revocation, probation, and participation in the diversion program. As Figure 1 illustrates, the Division of Medical Quality has established a committee made up of some of its members (diversion committee) to directly oversee the diversion program.

Figure 1
The Structure of the Medical Board of California as It Relates to the Diversion Program



Source: The medical board's organizational chart for fiscal year 2006–07.

Diversion Program

Current state law authorizes the diversion program and charges the Division of Medical Quality with its oversight and administration. The intent of the legislation was that the medical board seek ways to identify and rehabilitate physicians and surgeons whose competency is impaired due to abuse of dangerous drugs or alcohol, or due to mental or physical illness, so that they may be treated and returned to the practice of medicine in a manner that will not endanger public health and safety. The medical board explained that the diversion program was started as a cost-effective alternative to the discipline process, which often takes years to complete, and that it better protects the public because it encourages physicians to seek assistance on their own, prior to the violation of any laws or professional codes and prior to the filing of any complaints. The medical board stated that this means a self-referring physician is being monitored and is seeking treatment one to two years earlier than if he or she had waited until disciplinary action was initiated. According to statistics provided in the medical board's annual

reports from the last seven fiscal years, the average number of participants in the program at the end of each fiscal year was just over 250, with a high of 273 in fiscal year 2000–01 and a low of 215 in fiscal year 2005–06.

When an individual enters the diversion program, he or she signs an agreement containing the specific provisions that must be followed while in the program.¹ The agreements vary by individual but generally include entrance into an inpatient treatment program for some length of time and, thereafter, attendance at two diversion group meetings and a minimum of three support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous, each week; submission to at least four random drug tests each month; submission to work-site monitoring by a colleague; and an agreement to not practice medicine if requested and to remain in the program for five years. These requirements can be reduced after a period of time.

The requirements for physicians who enter the diversion program because of mental illness can vary somewhat, but generally follow the same pattern as those for participants who are dealing with substance abuse. For instance, participants with a mental illness receive drug tests and attend diversion group meetings alongside participants who have addictions to drugs and alcohol. The program administrator explained that, more often than not, participants with a mental illness have also had some form of drug or alcohol abuse in their past. For those who have not, the program does not want drug or alcohol use to interfere with their treatment and therefore prohibits the use of drugs or alcohol and conducts monitoring accordingly. Since fiscal year 2002–03 four participants per year, on average, have entered the diversion program primarily as the result of a mental illness.²

According to state law, successful completion of the program is to be determined by the program administrator and shall include, at a minimum, three years of sobriety and adoption of a lifestyle designed to maintain a state of mental health stability. According to statistics provided in the medical board's annual reports from the last seven fiscal years, the average number of participants leaving the program each year was 56. Of those, an average of 43 (77 percent) did so successfully.

¹ While an individual is being evaluated for entrance into the program, monitoring begins based on a standard interim agreement signed by the candidate, which is subsequently replaced by a formal diversion agreement after acceptance into the program.

² In 2002 state law was amended to permit enforcement to refer physicians diagnosed with mental illness into the diversion program. Although the state law included references to physicians with physical illnesses, the program administrator explained that the diversion program is not currently set up to assist physicians whose primary impairment is a physical illness.

Entry Into the Diversion Program

Physicians enter the diversion program in one of three ways. First, they may choose on their own to enter the program (self-referred).

According to the medical board, these physicians often request entry at the urging of a hospital, colleague, or family member. Second, state law allows a physician to participate in the diversion program in lieu of potential discipline stemming from an investigation by enforcement, if the investigation is based primarily on mental illness or on the self-administration of alcohol or other drugs, and if there is no evidence of patient harm (board-referred). Participants diverted from the discipline process must sign a statement of understanding in which they agree that a violation would be a basis for discipline and could be prosecuted should the physician be terminated from the diversion program for failure to comply with program requirements. However, if a physician successfully completes the program, state law says that he or she shall not be subject to any disciplinary actions by the medical board for any alleged violation that resulted in the referral to the diversion program. The third way an individual may enter the diversion program is if the medical board directs the physician to participate in the program as part of a disciplinary order (board-ordered).

Pathways Into the Diversion Program

Self-referred—Participants can enter the program of their own volition.

Board-referred—Enforcement may refer physicians to the program instead of pursuing disciplinary action.

Board-ordered—The medical board may direct physicians to participate in the program as part of a disciplinary order.

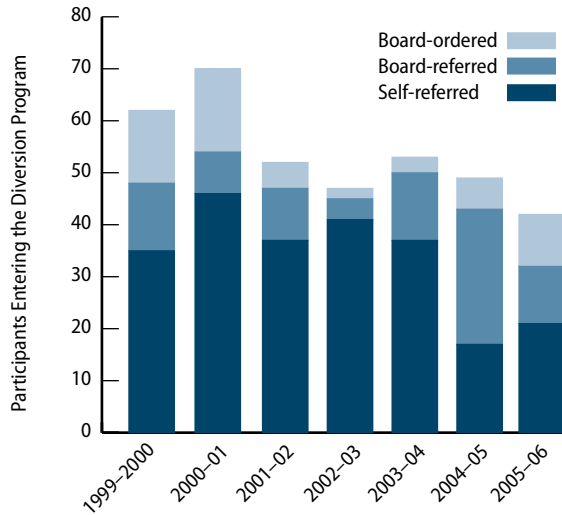
Source: March 2006 Physician Diversion Program informational pamphlet.

One of the key differences between board-ordered participants and those who are either self-referred or board-referred is that information related to self- or board-referred participants must be kept confidential from the public. Conversely, information on participants who have been ordered into the diversion program as part of a disciplinary action is a matter of public record.

According to statistics provided in the medical board's annual reports, the number of participants entering the program³ in the last seven fiscal years averaged 54 each year, ranging from a high of 70 in fiscal year 2000–01 to a low of 42 in fiscal year 2005–06. As shown in Figure 2, the majority of participants entering the diversion program were self-referred in all the years except fiscal year 2004–05, in which board-referred participants outnumbered the other categories.

³ The annual reports defined this term as being approved to enter the program and signing a formal diversion agreement.

Figure 2
Number and Type of Referral for Participants Entering the Physician Diversion Program During Fiscal Years 1999–2000 Through 2005–06



Source: Statistics provided in the medical board's annual reports.

In reference to the steep drop in self-referred participants in fiscal year 2004–05, the diversion program’s administrator explained that, because of excessive caseloads in some regions, the program instituted a policy in fiscal year 2003–04 that delayed prospective participants’ entry into the program. He stated that this practice grew in scope and impact until the policy was ended in the beginning of 2005. He indicated that this policy, as well as the fact that legislation had put a sunset date on the program and required a review by an outside entity, gave prospective participants and individuals within the treatment community the impression that the program was either not accepting new participants or would not be around to see participants through the recovery process. The program administrator explained that the program still has not fully recovered from this perception and said that he looks forward to the time when he can perform more extensive program outreach.

As to the sharp increase in board-referred participants in fiscal year 2004–05, the chief of enforcement explained that it was around this time that a statutory and policy change allowed enforcement to refer physicians affected by mental illness to the diversion program while continuing to complete an investigation into any quality-of-care issues. According to the chief, because this was new policy, enforcement may have referred some physicians affected by mental illness who it learned over time were not ideally suited for the diversion program. Thus, it reduced the number of these referrals in subsequent years. The chief also explained that a number of

participants enter the diversion program as self-referred but then become board-referred after enforcement receives a complaint regarding them. She said that the diversion program's delayed entry policy quite possibly caused a number of participants to be classified as board-referred who might, without the delay in entry, have been classified as self-referred. The diversion program administrator agreed that this could be a plausible explanation for the increase in board referrals during fiscal year 2004–05.

Administrative Structure of the Diversion Program

In addition to state employees who are principally responsible for the administration of the diversion program (program staff), other outside service providers, such as urine collection monitors (collectors) and group facilitators, participate in the monitoring and treatment of program participants. However, although these service providers are paid directly by participants, program staff are responsible for screening the providers for competence. The program also uses seven regional diversion evaluation committees (DECs) to determine prospective participants' appropriateness for and terms of participation in the program, as well as to make decisions on participants' successful completion of or termination from the program. According to state law, each DEC is composed of five members who are appointed by the Division of Medical Quality and who have experience in the evaluation and management of persons impaired due to alcohol or drug abuse or a physical or mental illness.

As shown in Figure 3, the diversion program, which reported expenditures of approximately \$1.1 million for fiscal year 2005–06, is staffed by 15 employees: a program administrator, two case manager supervisors, six case managers, a DEC coordinator, a collection system manager, and four administrative staff. Although the program administrator is ultimately responsible for carrying out program priorities, the day-to-day monitoring of participants' progress falls to the case managers. The diversion program has six case managers located in different regions of the State. A case manager is assigned to each participant based on his or her geographic location, and is responsible for monitoring the participant's compliance with his or her diversion agreement and coordinating information from all monitoring and treatment sources. The case manager is required to have one-on-one contact with each participant on a regular basis.

Figure 3
The Organizational Chart of the Diversion Program



Source: The medical board's organizational chart.

For each participant, the case manager leads a local case management team that includes the following key members:

- **An assigned DEC case consultant**—The DEC as a whole functions as an expert consultant for cases within its region. However, each participant is assigned one member of the DEC to act as a case consultant.
- **Group facilitator**—Each participant attends meetings conducted twice a week by a group facilitator who provides support for recovery and monitors program participants by observing them for any unusual behavior, tracking their attendance, and notifying the case manager of any issues or concerns. These individuals are selected and assigned by the program but are paid directly by the participants for their services.
- **Collectors**—Each participant is assigned a collector who is responsible for conducting observed urine collections and following the chain of custody protocol in submitting collections to the laboratory. The diversion program selects and assigns collectors. Participants pay collection costs and laboratory fees to their collector at the time of collection.
- **Work-site and hospital monitors**—Participants who are practicing must find, and obtain program approval for, a work-site monitor whose license with the medical board is valid and in good standing. Participants with hospital privileges must also have a hospital monitor. These individuals are responsible for observing the participant's condition while he or she practices medicine and submitting quarterly reports to the case manager.

Past Reports Involving the Diversion Program

In 1982 the Office of the Auditor General released the first in a series of audit reports on the diversion program titled *Review of the Board of Medical Quality Assurance*, followed by *The State's Diversion Programs Do Not Adequately Protect the Public From Health Professionals Who Suffer From Alcoholism or Drug Abuse* (1985), and *The Board of Medical Quality Assurance Has Made Progress in Improving Its Diversion Program: Some Problems Remain* (1986). In 2002 a bill was passed requiring the director of the Department of Consumer Affairs to appoint an independent "enforcement monitor" to evaluate the medical board's enforcement and diversion programs for a period not to exceed two years. The enforcement monitor was responsible for evaluating the effectiveness and efficiency of the medical board's diversion program and making recommendations regarding the continuation of the program and any changes or reforms required to ensure that physicians and surgeons participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired.

In both the auditor's and the enforcement monitor's reports, the findings and criticisms were similar, and included the following:

- The diversion program does not adequately monitor its assigned participants.
- Program monitors are not adequately trained and supervised.
- The diversion program does not terminate or notify enforcement regarding participants who have not complied with significant terms and conditions of their treatment plans.
- The medical board does not adequately supervise and review the program.

The enforcement monitor's initial and final reports, published in November 2004 and November 2005, respectively, raised additional issues and made specific recommendations that the medical board has recently made efforts to implement. We describe these issues and recommendations, and the medical board's responses, in greater detail in Chapter 3 and the Appendix.

Scope and Methodology

In response to the findings and recommendations from the study conducted by the enforcement monitor, the Joint Legislative Audit Committee requested the Bureau of State Audits to conduct

a review of the diversion program. Specifically, we were asked to review the program's effectiveness and efficiency in achieving its goals by evaluating the following:

- The timeliness of diversion services provided by the program.
- The thoroughness of the program's documentation of treatment services received by participants.
- The notification procedures when participants are terminated from the diversion program.
- The approval process and oversight of individuals providing services for the diversion program and the corrective action taken when these individuals fail to provide effective or timely services.
- The current administrative structure of the program.

To obtain an understanding of the diversion program, we reviewed associated laws and regulations. We also examined the program's policies and procedures and interviewed key personnel from the program and the medical board. To evaluate the timeliness of services provided by the diversion program and evaluate the monitoring of program participants, we reviewed the files of 40 randomly selected physicians who participated in the program between November 2005 and October 2006. We also obtained information on physicians participating in the diversion program during this time period from the program's Diversion Tracking System (DTS) and, in accordance with standards from the U.S. Government Accountability Office, obtained reasonable assurance that the data provided to us were complete. We conducted a preliminary assessment of using the DTS to perform analyses on all diversion program participants but determined that, for the purposes of this audit, reviewing the files of a sample of participants would be sufficient.

As shown in Table 1 on the following page, we randomly selected 10 physicians from the 83 who began their participation during our sample year—20 from the 206 physicians who participated in the program throughout the entire year and 10 from the 77 who ended their participation during the year we reviewed. Selecting our sample in this manner allowed us to review 11 percent of the overall population and at least 10 percent of each of the three categories shown in Table 1.

Our review of participant files included a number of elements, as indicated in the text box. In reviewing these elements, we took note of the thoroughness of the program's documentation—at times requesting additional documents from case managers and group

Table 1
Selection of a Sample of Physicians Who Participated in the Physician Diversion Program Between November 2005 and October 2006

	BEGAN PARTICIPATION DURING TIME PERIOD	PARTICIPATED DURING ENTIRE TIME PERIOD	ENDED PARTICIPATION DURING TIME PERIOD	TOTALS
Number of participants	83	206	77	366*
Random sample taken from group	10	20	10	40
Percentage of total	12%	10%	13%	11%

Source: Statistics provided from the Physician Diversion Program's Diversion Tracking System.

* The total includes all the participants who were in the program for any length of time between November 2005 and October 2006. This number differs from the statistics provided in the Introduction, which reported the total number of participants in the program at a given point in time.

facilitators so that we could complete our analysis. When evidence in the file, such as a positive drug test, indicated that a physician may have relapsed, we determined what steps the diversion program took in response. In some cases, the appropriate program response would have been to notify enforcement. In such instances, we determined whether the program did so.

In addition to our review of the monitoring of participants, we evaluated how the diversion program approves and oversees the collectors, group facilitators, and DEC members who assist with the program. As part of our review of the practices of collectors, we determined whether the randomly scheduled drug tests in June and October 2006 were completed as scheduled. If they were not, we attempted to ascertain the reasons why. We selected these

two months because they were recent enough that information would still be readily available and because the July 2006 hiring of the current collection system manager fell between these two months.

Information Obtained in Our Review of a Sample of Diversion Program Participant Files

- From the initial phone contact, the length of time the diversion program took to complete the intake process, perform the first drug test, and have the participant meet with a DEC.
- The number of case manager contacts.
- The number of therapist and work-site monitor reports.
- The average number of diversion and other support group meetings attended.
- The average number of drug tests taken.
- The completion of an annual review by the DEC.
- The existence of any work restrictions.

Finally, we evaluated the current administrative structure of the diversion program by analyzing the cause of any shortcomings discovered during the audit procedures just described and determining whether the problems were caused or exacerbated by structural deficiencies within the program. Further, we evaluated the effectiveness of the reporting mechanisms used by the medical board to oversee the program, the level of oversight it has exercised over program policies, and the efforts the medical board has undertaken to respond to the enforcement monitor's reports.

Chapter 1

ALTHOUGH THE PHYSICIAN DIVERSION PROGRAM HAS SHOWN IMPROVEMENT IN SOME AREAS, ITS MONITORING OF PARTICIPANTS REMAINS INCONSISTENT

Chapter Summary

The Physician Diversion Program (diversion program) of the Medical Board of California (medical board) has established a number of requirements designed to monitor participating physicians as they seek to overcome addictions and ailments that have the potential to impede their ability to practice medicine. While the diversion program's compliance with these requirements is good in some areas, it is lacking in others. Specifically, case managers appear to be contacting participants on a regular basis, as required, and participants generally appear to be attending group meetings and completing drug tests. However, the diversion program is not adequately ensuring that it receives required monitoring reports from participants' treatment providers and work-site monitors. Despite this lack of assurance that participants are meeting treatment requirements and not demonstrating signs of relapse at work, the diversion program has in some instances granted physicians reductions in the required number of group meetings or in the work restrictions originally placed on them.

In addition to the monitoring requirements it has established, the diversion program has set goals related to the timeliness with which participants are to be brought into the program. Of the three goals it has established for this purpose, the diversion program appears to be meeting two, and it has made substantial improvement in all three areas in recent years. Specifically, case managers, on average, are completing intake interviews with prospective participants within the goal of seven days from initial contact with the program, and participants are appearing before a diversion evaluation committee (DEC) for final approval to join the program within the goal of 90 days from initial contact. With respect to its goal of conducting the first drug test within seven days of the initial contact, we found that the diversion program has decreased its average time from 35 days in 2003 and 2004 to 18 days in 2005 and 2006 for the sample of participants we reviewed; however, it still is not meeting its goal of seven days.

In reviewing the diversion program's response to positive drug tests and other indications of a relapse, we found that in some instances the program did not respond in a timely manner and did not demonstrate that its actions were adequate, thus putting the public's safety at risk. Specifically, the diversion program has not always required a physician to immediately stop practicing medicine after testing positive for

alcohol or a nonprescribed or prohibited drug, as required by program policy; has determined that positive drug tests were not a relapse without providing any justification for such a determination; and has not followed the advice of its advisory committee to have a trained medical review officer examine contested results.

The Quality of the Diversion Program's Monitoring of its Participants Varies

Overall, diversion program case managers appear to be contacting participants on a regular basis, and participants generally appear to be attending group meetings and completing drug tests as required. In contrast, case managers and program management are not adequately ensuring that the program receives reports for participants that would, among other things, provide evidence that participants are going to group meetings and individual therapy when required, and are not exhibiting signs of substance abuse in the workplace. However, despite not receiving all of their required reports, the diversion program granted some physicians reductions in the required number of diversion group meetings or in the work restrictions originally placed on them.

To determine how well the diversion program monitors its participants and how compliant participants are with program requirements, we reviewed a random sample of 40 physicians who participated in the diversion program for some amount of time between November 2005 and October 2006.⁴ In summarizing the data from the various functional areas of compliance, we found that the overall levels of program compliance fell within three distinct groups—good, fair, and poor. As indicated in Table 2, it was in the receipt of required reports that the program and its participants underperformed.

Case Managers Are Generally Contacting Participants on a Regular Basis

Diversion program policies require case managers to have regular in-person or telephone contact with their assigned program participants. The program administrator explained that the general expectation is that case managers have monthly contact with participants. For the 40 participants we reviewed, we determined that to meet this expectation overall, case managers would have needed to have 334 contacts with these participants during the time period November 2005 to October 2006. In total, they made 342 contacts, slightly more than the expected number.⁵

⁴ Three of the 40 randomly selected participants reside outside of California and were thus considered out-of-state participants. We chose to focus most of our review on physicians located in-state.

⁵ The length of time each participant was in the program varied. The expected number of case manager contacts is based on the number of full months the participants in our sample were in the program.

Table 2
The Overall Level of Compliance for a Sample of Diversion Program Participants

CATEGORY OF COMPLIANCE	LEVEL OF COMPLIANCE*
Case manager contacts	Good
The following reports were received as required:	
Diversion group attendance reports	Fair
Therapist reports	Poor
Work-site monitor reports	Fair
Verification of support group attendance	Poor
The levels of attendance at the following meetings or events:	
Diversion group	Good
Support group	Good
Drug tests	Good

Source: Auditor analysis of information obtained from a sample of participant files at the Physician Diversion Program.

* Good (above 80 percent), Fair (60 percent to 80 percent), Poor (below 60 percent).

While this overall level of performance is good, some participants received more contacts from their case managers than required, while a relative few received significantly less. In particular, four in-state and the three out-of-state participants received three to nine fewer contacts than the expected number. Focusing our review on the physicians located in-state, we found that there were eight months in which all four were assigned to the only case manager supervisor at the time and a program employee who was not yet trained as a case manager. The employee who was assisting the case manager supervisor explained that they were primarily performing the “paperwork duties” on these participants during that time and that participant contact consisted of handling participants’ problems over the telephone.

The case manager supervisor explained that this practice was used during a time when they did not have enough case managers to oversee the diversion program’s caseload and said that, with the recent hiring of three case managers and a new case manager supervisor, she does not expect this to occur again.

The Diversion Program Is Not Ensuring That Required Monitoring Reports Are Submitted

In addition to regular contact from case managers, the diversion program monitors participants by requiring regular reports from group facilitators, therapists, and work-site monitors, and by requiring verification of support group attendance in some instances.

However, based on our review, it appears that the diversion program does not adequately ensure that these reports are received. The reasons provided for missing reports indicate that the program has not created mechanisms to ensure that program staff, and case managers in particular, have performed the duties required of them. In addition, it also appears that the diversion program does not carefully document changes to participants' program requirements by amending diversion agreements to reflect such changes. Consequently, the program has less assurance that its participants are in compliance with their diversion agreements and has less ability to hold participants and program personnel accountable for fulfilling program requirements.

The Level of Compliance for Diversion Group Attendance Reports Is Fair

Diversion program participants are required to attend one or two diversion group meetings a week. As we indicated earlier, they appear to substantially comply with this requirement. Without accounting for vacations and other approved absences, the participants we reviewed attended 92 percent of their required diversion group meetings. However, to calculate this percentage we had to contact a number of group facilitators to obtain attendance reports that had not been submitted to the program. In fact, of the 35 physicians for whom this requirement was applicable, the diversion program had a complete set of attendance sheets for only 24 (69 percent) of them.⁶

The diversion program policies require group facilitators to submit monthly attendance reports. However, when we reviewed the files, it became clear that no one was making sure that these reports were submitted. The collection system manager said that although she files the attendance reports, it has never been her responsibility to ensure that all attendance reports are received. The program administrator explained that the case managers are responsible for ensuring the receipt of attendance reports. However, this view neglects the fact that not all case managers are located at program headquarters, where the files are to be stored. In addition, program management has a responsibility to ensure that case managers are performing the duties required of them.

The Level of Compliance for Therapist Reports Is Poor

The diversion program also requires some participants to attend individual therapy. In these instances, the participant is to ensure that the case manager receives written quarterly reports from the

Although group facilitators are required to submit monthly attendance reports, no one at the diversion program is making sure that these reports are received.

⁶ Of the five participants to whom this requirement did not apply, three were living out of state and two dropped out of the program prior to attending a diversion meeting.

therapist. If these reports are not received in a timely manner, policy states that case managers should follow up with participants or their therapists to make sure that reports are forwarded to the program. However, based on our review, it appears that case managers are not adequately performing these duties. For the sample of participants we reviewed, 51 therapist reports should have been received but only 17 (33 percent) actually were.

For the sample of participants we reviewed, 51 therapist reports should have been received but only 17 (33 percent) actually were.

Some written reports were not received because a new case manager was not following policy at the time and took verbal reports from therapists over the phone. However, a more frequent problem was that participants discontinued therapy without a formal amendment to their diversion agreement being processed and sometimes without even notifying the diversion program. For example, a board-ordered participant submitted a therapist report in August 2005 and discontinued therapy in October 2005 without notifying the program. In December 2005 the program should have noticed that no subsequent quarterly therapist report had been received for this individual. However, the program did not notify the participant until March 2006 that he was out of compliance, and it did not learn until a month later that this participant had stopped attending therapy. This participant and others were allowed to end the therapy required in their diversion agreements without having a formal amendment approved by a DEC. Although the discontinuance of therapy may not have led directly to a relapse, the physician in this example tested positive for alcohol in July 2006 and was terminated from the diversion program by December 2006 after testing positive for cocaine.

The Level of Compliance for Work-Site Monitor Reports Is Fair

Of the participants we reviewed, 18 were required to have work-site monitors. For these participants, the program had received 59 of the 78 required work-site monitor reports. Although these results are fair, there is room for substantial improvement.

It appears that new case managers do not always understand diversion program policies regarding work-site monitor reports. Specifically, the missing reports were for eight participants, three of whom had the same case manager, who was new to the program at the time. Instead of requiring written reports, the case manager was having conversations with work-site monitors over the phone. Although she documented in the Diversion Tracking System that these conversations had occurred, this documentation is deficient because it neither recorded what was said nor what time period the conversation covered. The case manager indicated that she now requires written reports from work-site monitors. Nevertheless, it should be noted that this new case manager was

not requiring written reports for at least a year, during which time program management was not aware of this issue and therefore never corrected it. This failure to require written reports indicates that program management has not created an adequate process to detect when case managers are not following policy.

In addition, it appears that work-site monitors are not always approved in advance by the diversion program. Prior to acting as a participant's work-site monitor, an individual agreeing to serve in this capacity must be approved by the case manager and must sign an acknowledgment form indicating that he or she will carry out the responsibilities of a monitor. In our review, we found that there was no acknowledgment form in the files of two participants and that files for three other participants had acknowledgment forms that were signed after the work-site monitors had already begun monitoring a physician. When these forms are not present or are filled out after the fact, the program cannot ensure that case managers have approved work-site monitors in advance and informed them of their responsibilities.

Further, the current work-site monitor agreement contains no conflict-of-interest language. According to a policy that took effect in July 2006, a work-site monitor shall have no business or personal 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. This policy was incorporated into a conflict-of-interest statement included in the program's new acknowledgment forms for work-site monitors. However, according to the Northern California case manager supervisor, these new forms have not yet been approved by the executive director's office of the medical board and remain to be implemented. These new forms, and enforcement of the relatively new policy, need to be implemented because we found that some participants' relationships to their work-site monitors would constitute a conflict of interest. Specifically, we found two work-site monitors who work directly for the physician they are to monitor. Thus, because their livelihood is at stake, fair reporting could be compromised.

We found two work-site monitors who work directly for the physicians they are to monitor.

Finally, the work-site monitoring could be improved if the diversion program had work-site monitors report on whether participants are complying with any work restrictions imposed by the program. Currently, the work-site monitoring reports do not convey whether work restrictions, such as a limit on the number of work hours, are being followed, and there is no indication that work-site monitors are even aware of these restrictions. In fact, we found only one instance in which the file of a participant contained any sort of positive assurance that work restrictions were being followed. If the diversion program leveraged the existing work-site monitoring

reporting procedures to gain information on compliance with work restrictions, the program could eliminate what is currently a potential weakness.

The Verification of Support Group Attendance Is Poor

In addition to weekly diversion group meetings, the diversion program requires participants to attend other support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous. In some instances, the program requires the participant to provide verification of meeting attendance in the form of signed attendance cards. Of the 37 in-state participants whose files we reviewed, 26 were required to provide verification of meeting attendance. Of these 26, three have since successfully completed the program and their files have been purged of treatment records, including attendance cards, as required by state law. Of the remaining 23, we could obtain attendance cards for only 10 participants (43 percent). Rather than finding this information in the participant's files, we had to contact a number of case managers to obtain the attendance cards, and in some instances it was clear that the case managers received these cards only after our request. Despite the poor level of documentation, the overall attendance at support group meetings for the 10 participants we could review was quite good—approximately 90 percent.

Quite often the reason case managers gave for not obtaining attendance cards was that they were not sure that the requirement was still in effect. The program administrator explained that verification of attendance at support group meetings is often an initial stipulation in diversion agreements, but that after a period of time the verification requirement is no longer applicable; however, an amendment is not always made to document this change. This practice explains why case managers were not sure whether the requirement was still in effect. Therefore, it appears that the lack of formality in documenting participants' current program requirements leads to uncertainty among diversion program officials and reduces the accountability to which participants and program personnel can be held.

Moreover, even when it was known that a participant was to provide verification of attendance at group meetings, some case managers simply did not hold participants accountable for this requirement. For example, one participant provided her case manager with attendance cards in which she initialed next to the dates on the cards that she had attended support groups for more than a six-month span. She did not, however, specify which groups she attended and did not obtain the initials of a group secretary as she had done in the past and as required in the instructions on

The lack of formality in documenting participants' current program requirements leads to uncertainty among diversion program officials and reduces the accountability to which participants and program personnel can be held.

the card. The case manager acknowledged that the participant should have noted which meetings she attended but said he was confident, based on his contacts with and clinical observations of this participant and his conversations with her group facilitator and diversion group peers, that she was attending her support group meetings.⁷ Finally, he added that “to verify any participant’s attendance at [support group meetings] is not always possible. It is . . . essentially an ‘honor system.’”

We disagree with this case manager’s assessment, however. Attendance cards provide verification of support group attendance, and case managers should make sure that they are submitted correctly. Further, it is troubling that a diversion program official whose primary responsibility is to monitor physicians’ compliance with their diversion agreements would not do so in this instance. The approach displayed by this case manager illustrates the reason that program management should ensure that case managers are adequately performing their assigned role.

The Diversion Program Eases Program Requirements for Some Participants Despite Their Noncompliance With Reporting Elements

Despite statements and policies to the contrary, the diversion program grants some participants reductions in the number of diversion meetings they are required to attend and increases in the number of hours they are allowed to work, even when the participants are not in full compliance with the reporting components of their diversion agreements. In the November 2004 interim report, the enforcement monitor found that the diversion program lifted participants’ work restrictions despite deficiencies in the submission of work-site monitor reports and, in reference to lapses in therapist reports, said that it does not appear that participants are ever sanctioned or penalized in any way for failure to comply with diversion agreements. In the November 2005 final report, the enforcement monitor reported that program management had responded to these deficiencies by instituting a policy that work restrictions would not be lifted and drug testing would not be decreased if a participant is not in compliance with reporting requirements.

During our review, we searched for this policy and found no written record of it. However, we did find the principle behind it embedded within a policy, which stipulates that only participants with continuous compliance with their diversion agreements will

The enforcement monitor reported that the program instituted a policy that program requirements would not be lifted if a participant is not in compliance with reporting requirements. We searched for this policy and found no written record of it.

⁷ As we have used the term, support group meetings are Alcoholics Anonymous or Narcotics Anonymous meetings that participants are often required to attend in addition to the diversion group meetings that are facilitated by a group facilitator.

be considered for a reduction in diversion meetings after the first few years. Despite this policy and the diversion program's earlier statements to the enforcement monitor, we found five instances in which participants received reductions in program requirements despite being out of compliance with the reporting components of their diversion agreements. In two of these instances, the program increased the number of hours physicians were allowed to work despite the fact that they were out of compliance with work-site monitoring requirements. For example, in October 2006 a diversion program DEC increased the number of hours a physician could work from 20 to 32 hours a week, even though the physician had not had an approved work-site monitor for three months and had not submitted a required work-site monitor report.

For the three other participants, the program granted their requests to attend one group meeting per week instead of two, despite the fact that they had not submitted quarterly reports from their work-site monitor, therapist, or both. In one of these cases, the diversion program allowed the participant to reduce the number of group meetings in July 2006 despite not receiving all work-site monitor reports for the previous nine months. The participant later relapsed in October 2006. Although this reduction in diversion meetings, despite a record of noncompliance, did not necessarily set up the conditions for the relapse, it certainly did not send the appropriate message to this individual. Rather, the message sent to these participants is that program requirements are not always tracked and enforced.

Overall, Participants Appear to Receive the Required Number of Drug Tests

The diversion program required the participants in our sample to take between two and six random drug tests each month. Between November 2005 and October 2006, we found that our sample of participants generally received the number of drug tests required by their diversion agreements. Specifically, 1,100 drug tests were required in our sample and 1,084 (99 percent) were actually taken. However, it should be noted that some participants took more than the required number for various reasons, and these additional tests balanced out the number of tests that a few participants did not receive. Further, as we describe in Chapter 2, a number of drug tests were performed on dates other than the ones that were randomly selected. Consequently, although the overall results from our sample indicate that the diversion program is doing well in having required drug tests completed, there is need for a number of improvements that we describe in detail in the next chapter.

The diversion program increased the number of hours a physician could work even though the physician had not had an approved work-site monitor for three months and had not submitted a required work-site monitor report.

The Diversion Program Has Reduced the Time It Takes to Bring New Participants Into the Program

Although it is still meeting only two of its three goals in this area, the diversion program has made substantial improvement in the timeliness of its initial evaluation of prospective participants. The diversion program's established goal, when a physician initially contacts the diversion program and a telephone intake interview is completed, is to have the prospective participant meet with a case manager and complete his or her first drug test within seven days. After participants sign a standard interim agreement with the case manager and begin drug tests and group meetings, the diversion program has them finish the evaluation phase of the program by meeting with a DEC so that an individualized diversion agreement can be developed and later signed. The diversion program's goal is to have participants meet with a DEC within 90 days of the telephone intake interview. As will be discussed further in Chapter 3, the diversion program provides ongoing reports to the medical board on the results of its efforts to achieve these goals.

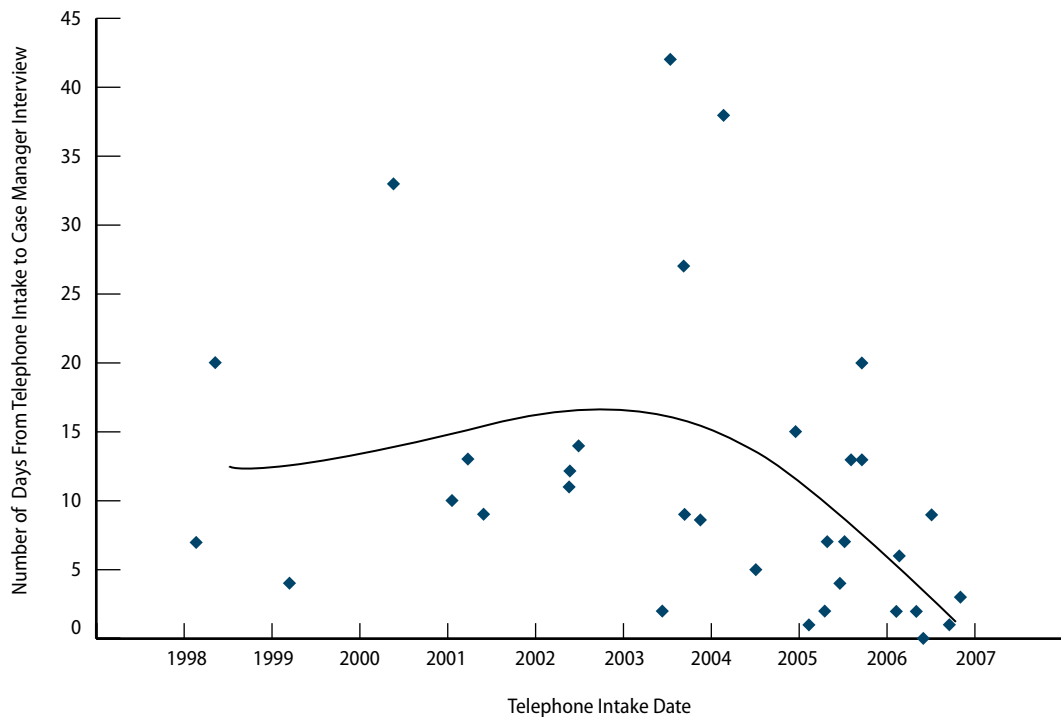
Using our random sample of participants, we determined how well the diversion program was meeting its goals and found that for all three areas—timeliness of case manager intake interviews, first drug tests, and first DEC meeting—the program has reduced the number of days it takes to accomplish these tasks in recent years. In fact, for case manager interviews and first DEC meetings, the diversion program appears to have met its goals, on average, in 2005 and 2006. However, although dramatically improved, the timeliness of first drug tests continues to lag behind the program's stated goal. Nevertheless, the overall improvement the program has made in moving participants through the evaluation phase in a timely manner should be commended. This improvement demonstrates the value of establishing, striving for, and reporting on performance goals—a subject that is further discussed in Chapter 3.

Case Managers Have Been Contacting Prospective Participants in a Timely Manner in Recent Years

When a physician contacts the diversion program, an analyst at program headquarters conducts a telephone intake interview and then notifies the appropriate regional case manager. The case manager is to then contact the prospective participant and complete a face-to-face intake interview within seven days. As indicated in Figure 4, the case managers have not always performed this task in a timely manner. For example, for the seven participants in our sample who contacted the program in 2003 or 2004, the average number of days case managers took to complete their interviews was 19. However, as indicated by the trend line in

Figure 4, the diversion program has dramatically decreased the time it takes to conduct a case manager intake interview. In fact, the average number of days for the 16 participants in our sample who contacted the program in 2005 and 2006 was seven. Based on these results, the program appears, on average, to be meeting its stated goal for timeliness of case manager intake interviews.

Figure 4
Timeliness of Case Manager Intake Interviews for Sample of Physician Diversion Program Participants



Source: Auditor analysis of information obtained from a sample of participant files of the Physician Diversion Program.

Note: This figure contains 33 data points instead of 40 because our sample included three out-of-state participants who were monitored by parties in other states. In addition, two participants dropped out of the program prior to a case manager intake interview being conducted and two participants had case manager intake interviews prior to the initial telephone intake.

There are various reasons for the length of time it took for case managers to conduct intake interviews in 2003 and 2004. As we discuss in the Introduction, the diversion program delayed some participants' entry into the program during 2003 and 2004 to ease the caseload of case managers in some areas. This delayed entry accounts for the highest data point in Figure 4. Other reasons that case managers did not contact participants in a timely manner included having an insufficient number of case managers in the past and waiting for participants to receive approval from enforcement to participate in the program. To decrease the time it took for case managers to complete their intake interviews, the

The average length of time before a participant's first drug test was 18 days—well exceeding the program's target time frame of seven days but showing improvement.

diversion program ended the delayed entry policy, hired additional case managers, and started contacting prospective participants immediately for an intake interview rather than waiting for final approval from enforcement.

Although the Length of Time Before a Participant's First Drug Test Does Not Appear to Meet Program Goals, Substantial Improvement Has Been Made

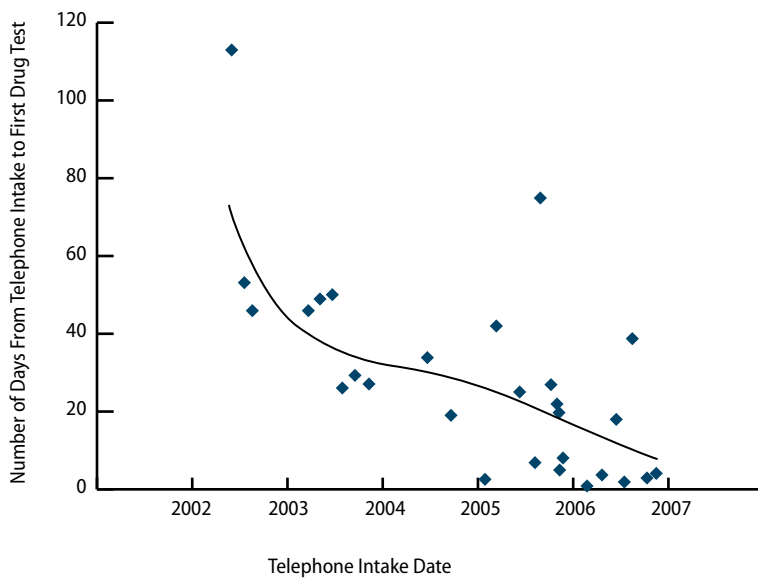
Once a telephone intake interview with a prospective participant is completed, a diversion program analyst notifies the collection system manager to schedule the physician for random drug tests. In 2005 the program established a target time frame of seven days after the telephone intake for completing the first drug test. As indicated by the trend line in Figure 5, the program had difficulty even approaching this goal in the past, but it has dramatically improved in recent years. For our sample of participants who contacted the program in 2005 or 2006, the average length of time before their first drug tests was 18 days—well exceeding the goal but representing a marked improvement over the 2003 and 2004 average of 35 days.

In reviewing the reasons why some initial drug tests were not completed in a timely manner, we found that in the past diversion program personnel would not immediately schedule a participant for drug tests if they knew that the individual would be entering a residential treatment center in the near future. In fact, they would delay drug tests even when the participant was not scheduled to enter treatment for several weeks. The diversion program has since changed this policy and now has the collection system manager schedule drug tests immediately after the initial phone call from the participant. In the past, program personnel would also sometimes not schedule drug tests while the participant was being treated by an outpatient treatment center in California—a circumstance that nevertheless would still allow for drug testing. Finally, another reason first drug tests were not always completed in a timely manner was that program personnel failed to schedule the tests immediately after a participant was released from treatment.

The program administrator explained that it is the policy of the diversion program to perform drug tests when possible, which would include when the participant is in outpatient treatment. He indicated that when testing is not possible because the participant is in residential treatment, the policy calls for resuming drug testing quickly after the participant gets out. He further explained that, although such errors could still exist to a limited extent, the program has made strides in eliminating delays in drug tests due to scheduling errors. He attributed part of this improvement

to changes in policy but stated that he believes setting the goal to complete the first drug test within seven days and reporting on these efforts, starting in April 2005, has been the driving force behind the policy changes and the improvements the program has experienced.

Figure 5
Timeliness of First Drug Tests for Sample of Physician Diversion Program Participants



Source: Auditor analysis of information obtained from a sample of participant files of the Physician Diversion Program.

Note: This figure contains 28 data points instead of 40 because our sample included three out-of-state participants who were monitored by parties in other states. In addition, of the 37 in-state participants in our sample, there were seven participants who entered the program over six years ago and the date of their first drug test could not be determined. There were two others who dropped out of the program prior to a drug test being conducted.

The Diversion Program Appears to Be Achieving Its Goal of Having Participants Meet With a DEC Within 90 Days

Until participants can meet with a DEC, they operate under a standardized interim agreement. The diversion program’s goal is to have participants meet with a DEC within 90 days so that an individualized program plan can be developed and agreed upon. Adjusting for time during which the diversion program must wait for approval from enforcement for some participants, the program did quite well in achieving this goal for our sample of participants. For the participants who contacted the program in 2003 or 2004,

the average length of time before their first meeting with the DEC was 86 days. The average for the 2005 and 2006 participants in our sample improved to 64 days.

According to state law and medical board policy, physicians who have an open enforcement investigation cannot go before a DEC for formal program acceptance until enforcement has approved their participation in the diversion program. Fourteen of the participants in our sample had to wait for enforcement approval prior to appearing before a DEC. For example, one participant's formal acceptance into the program was delayed for 14 months while waiting for enforcement approval.⁸ Because the diversion program has little to no control over the length of time it takes enforcement to approve such physicians' entry into the program, we subtracted wait times of this type from our calculations.

The Diversion Program Fails to Ensure a Timely and Adequate Response to Potential Relapses

State law requires the diversion program to ensure that participants have at least three years of continuous sobriety in order to successfully complete the diversion program. To enable it to monitor their sobriety, the program requires participants to submit randomly scheduled urine samples each month and analyzes these samples to determine whether they contain unauthorized drugs. In some cases, participants try to hide their drug use by increasing their fluid intake, thereby diluting their urine. This is known as a negative dilute. We analyzed drug test results obtained between November 2005 and October 2006 for our sample of participants and found that, of the 1,084 drug tests administered, 31 were reported as positive for drugs and 11 were considered negative dilutes.⁹

Because these test results provide the diversion program with a strong indication that a participant may have relapsed into drug abuse, it is critical for the program to respond quickly and adequately in these instances. However, we found that in some instances the program did not respond in a timely manner and did not demonstrate that its actions were adequate, thus putting the public's safety at risk. Specifically, the diversion program did not always require a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited

⁸ We did not evaluate why enforcement was not able to provide approval sooner because we considered this to be outside the scope of the audit we were asked to conduct.

⁹ When a negative dilute occurs, program policy requires participants to receive another drug test but does not specify how quickly this test should occur. For the 11 negative dilutes in our sample, we determined that this policy was reasonably followed.

drug, as required by program policy, determined that positive drug tests were not a relapse without providing any justification for such a determination, and failed to have a trained medical review officer review contested results.

The Diversion Program's Actions Following a Participant's Relapse Have Not Always Been Timely or Adequate

The diversion program failed to follow program policy when it allowed physicians to continue practicing medicine after being notified of positive drug test results. Further, the diversion program has not established written protocols for its communication with enforcement and has consequently not always followed the practice the program administrator says should be employed. According to state law, the diversion program's top priority is to protect the public. In order to fulfill this priority, the diversion program's policies prohibit any participant who tests positive for prohibited drugs or alcohol from practicing medicine until the program can further analyze the positive drug test result and determine whether the physician can return to work. The program administrator stated that if a physician tests positive for a drug, even if the drug is prescribed, the program pulls the physician from work immediately, unless the prescribed medication is authorized. In addition, the program administrator indicated that the physician is not allowed to return to work until he or she receives two consecutive clean drug tests after the work suspension. Although in some cases the diversion program allows participants taking prescribed drugs to practice medicine, the program has determined that they cannot do so when the drug is on a list that it provides to physicians when they enter the program. Of the 31 instances in which participants tested positive for a prohibited drug, 12 involved physicians who were practicing medicine at the time. Although the diversion program should have removed the physicians from work immediately in all 12 instances, it did so in only three. In five instances, physicians were removed within periods ranging from two to 14 days, and in four the program did not remove them from work at all.

Of the four instances in which the diversion program did not remove a practicing physician from work, three related to drugs that were prescribed to the physician that are on the program's list of drugs that participants cannot use while practicing medicine, and one related to a drug that was not prescribed that the participant claimed was taken by accident. In each instance, policy required the program to remove the physician from work until he or she was no longer under the influence of the prohibited drug or until the reasons for the positive drug test result could be determined, but the program did not do so.

Of the 12 instances in which a practicing physician tested positive for a prohibited drug, the program immediately removed the physician from work in only three instances.

Despite the case manager's assertion that the doctor did not return to work until he was off this pain medication, the doctor indicated that he returned to work shortly after testing positive for the drug.

For example, the diversion program failed to remove a physician from work who tested positive for a particular prohibited drug on two separate occasions, once in December 2005 and again in August 2006. The program did not determine either instance to be a relapse. In the first instance, the physician had more than 10 times the cutoff level needed for a positive result. He notified the program after being tested that he may have unknowingly taken the drug because his wife accidentally placed the drug in a common pain reliever container. The case manager at the time indicated that she used her judgment and did not pull the participant from work or consider the positive result as a relapse based, in part, on the participant's past history of not testing positive. The program administrator agreed that the case manager did not follow program policy and should have consulted with others concerning the positive result. In the second instance, the physician tested positive for the same drug but this time had a prescription. However, despite the case manager's assertion that the physician did not return to work until he was off this pain medication, the physician indicated that he returned to work shortly after testing positive for the drug. This may indicate that he was under the influence of this drug while practicing medicine. The diversion program should have ensured that he was not under the influence by having him complete two drug tests with negative results prior to returning to work, as policy prescribes.

In the instances in which the diversion program removed practicing physicians with positive drug tests from work, it did so immediately, as required, in only three instances. In one example, the program allowed a physician to work for 14 days after the lab reported that the participant had tested positive for alcohol in February 2006. According to information contained in the participant's file, a case manager confronted the physician with the results and the physician denied the use of alcohol, stating that he had consumed barbecue sauce that may have contained alcohol. Although the program administrator stated that it is the program's policy to immediately remove the physician from work until the reasons for the positive result could be determined, the program did not do so until after the physician tested positive for alcohol again and also tested positive for a painkiller for which the physician had a prescription. In part because of concerns over the physician practicing medicine while under the influence of this painkiller, the case manager asked the participant to stop working 14 days after the original test result was received.

Although in this example, removal from practice occurred 14 days after the date the diversion program received the first positive drug test result from the lab, it should be noted that, because of the time lag between urine collection monitors (collectors) submitting test samples and the lab posting the test results to the program, the first

positive drug test had actually occurred 21 days before the physician was removed from work. Because of the time it takes to ship urine samples and to analyze them, a lag in receiving drug test results is unavoidable to some extent. However, in 10 of the 42 positive or negative-dilute test results we reviewed, the lag exceeded seven days. The diversion program indicated that for the period of January through March 2007, receiving results could still take as long as a week. This lag time makes it even more critical that the diversion program immediately remove physicians from work when they have tested positive for alcohol or a nonprescribed or prohibited drug. When it does not do so, the diversion program endangers those patients a physician sees while potentially under the influence of drugs or alcohol.

In another example, although the enforcement monitor recommended that it do so, the diversion program has not yet developed protocols for its communications with enforcement. According to a prior policy manual, the program must notify enforcement when a board-ordered participant relapses into chemical use. Further, the participants' standard agreements with the diversion program stipulate that the lab results of board-ordered participants will be forwarded to enforcement. The program administrator clarified that only positive results are communicated to enforcement. However, we found that one board-ordered participant had positive drug test results in May and July 2006, and in fact was determined to have relapsed in both instances, yet enforcement was not notified until December 2006 when he relapsed again and was terminated from the program. This example highlights the need for the program to develop written protocols. The program administrator agreed that such protocols need to be developed so that all program staff know what information needs to be shared with enforcement.

The Diversion Program Does Not Adequately Justify Its Determination That a Positive Drug Test Is Not a Relapse

When the program determines that a physician has relapsed, diversion program policy requires case managers to document the positive drug result. The documentation provides information concerning the positive test and insight into why it was considered a relapse. However, no such documentation or justification is required when the program determines that positive drug test results or other indications of drug abuse do not constitute a relapse. As a result, the diversion program has less assurance that its decisions regarding whether a physician has relapsed are correct and consistent. These decisions are important because a participant cannot successfully complete the program unless he or she has had no relapses in three years. Additionally, program policy requires the

One board-ordered participant had positive drug test results in May and July 2006, and in fact was determined to have relapsed in both instances, yet enforcement was not notified until December 2006.

By not documenting why it determined that a particular positive drug test result was not a relapse, the program risks allowing participants to graduate without three years of sobriety.

DECs to consider program termination for any physician who has had three or more relapses. Consequently, by not documenting why it determined that a particular positive drug test result was not a relapse, the program risks allowing participants to graduate without three years of sobriety and also risks not terminating a physician with numerous relapses soon enough.

For example, one participant in our sample, who graduated from the diversion program in December 2005, tested positive for alcohol in March 2004. According to the case file, an anonymous caller notified the program that the participant was drinking alcohol while away on out-of-town trips. As a result, the program immediately ordered a drug test. The test results indicated that the participant had more than three times the cutoff level needed for a positive result for alcohol. Despite this evidence, the program did not determine that this instance constituted a relapse. Further, it did not, and was not required to, justify this decision. The participant graduated from the program 21 months later. We reviewed this instance with a case manager supervisor who, at the time the physician graduated from the program, was acting as the case manager, and she agreed that the program should document the reasons that a positive test result is not considered a relapse. She indicated that she will, in conjunction with the program administrator, consider adding this requirement to diversion program policies.

The Diversion Program Does Not Have Contested Drug Test Results Evaluated by a Trained Professional as Recommended by a Panel of Experts and Its Own Diversion Committee

Despite the continued recommendations of a panel of experts the diversion program used to provide it with advice (liaison committee) and the recommendation of its diversion committee, the diversion program does not have a qualified medical review officer (MRO) review drug test results that are contested by participants. Consequently, the diversion program may have less assurance that its decisions regarding whether a positive drug test result constitutes a relapse are valid. According to its February 2005 meeting minutes, the liaison committee asked the diversion program administrator for an update on the hiring of an MRO to review participants' drug test results. In November 2005 the liaison committee reiterated its desire that an MRO be hired, especially in those instances in which a participant contests a positive drug test result. Although we did not obtain the exact date on which the liaison committee first recommended the hiring of an MRO, the current diversion program administrator explained that, prior to his arrival in January 2005, the liaison committee had already recommended that the diversion program have an MRO

review drug test results, and that the diversion committee had recommended the hiring of an MRO. However, as of June 2007, the diversion program has yet to use or hire such a consultant.

Obtaining the opinion of a qualified MRO would help the diversion program determine whether a positive drug test result is a relapse. When physicians in our sample were confronted with a positive drug test result, some admitted to relapsing, but a more common response was to deny taking the prohibited substance that the test identified. Of the eight disputed results in our sample, the diversion program, or the DECAs that assist the program with these decisions, considered half of them not to be relapses. In these instances, the reasons offered by the participants, and apparently accepted by the program, included the following:

- A pharmacy must have incorrectly filled a prescription, dispensing a prohibited drug for which the participant later tested positive.
- The wife of a program participant accidentally placed a powerful prescription drug in a common pain reliever container. The physician later consumed this drug, apparently thinking it was the common pain reliever, and subsequently tested positive for it.
- A participant denied drinking alcohol, stating that she is not inclined to do so in general.

Certainly, an MRO would not have been able to directly ascertain the truthfulness of these explanations, but having a person specifically trained to independently analyze drug test results, and additional information in the participant's file, would allow the diversion program to better ascertain whether the reasons offered were at all consistent with the results. Further, in those cases in which the diversion program determines that a positive drug test represents a relapse, despite the explanation offered by the participant, the program's position would be bolstered by having the documented opinion of a qualified MRO.

Although he generally agreed that an MRO should be hired to review contested results, the program administrator stated that no MRO has yet been hired because the individuals on the list of candidates the liaison committee provided either did not possess desired certificates or did not want to work part time. The liaison committee has since been disbanded, and the program administrator stated that he does not plan to hire an MRO until the replacement for the liaison committee is reconstituted. The program administrator said that, in the meantime, the diversion program would continue to use lab personnel when it has questions concerning a positive drug result. Although the program indicates

Because many participants deny taking prohibited substances, obtaining the opinion of a qualified medical review officer would help the diversion program determine whether a positive drug test result is a relapse.

that it utilizes lab personnel for advice on drug test results, the program administrator agrees that an MRO would be advantageous to provide an independent review. In addition, an advisory committee to the program in November 2005 reiterated how important it feels an MRO is to the process of evaluating lab results.

Recommendations

To better monitor diversion program participants, program management should create mechanisms to ensure that group facilitators, therapists, and work-site monitors submit required reports, and that participants submit required meeting verifications. When such documentation is not received, program management should have case managers make an effort to obtain this information.

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 work-site monitoring requirements.

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.

To ensure that work-site monitors provide unbiased and complete reports, the diversion program should do the following:

- Ensure that each participant's work-site 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.
- Ensure that the newly developed work-site monitor agreements containing conflict-of-interest language are approved by the medical board's executive office and signed by all work-site monitors.
- Notify work-site monitors of any work restrictions imposed on the participant they are monitoring, and direct them to report on compliance with these requirements.

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.

To ensure a timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:

- Immediately remove practicing physicians from work upon receiving notice of a positive drug test.
- Provide sufficient justification when it determines that a positive drug test does not constitute a relapse.
- Have the reconstituted liaison committee assess the need to have an MRO evaluate disputed drug test results and hire such an individual if it determines that this action is needed.

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Chapter 2

THE PHYSICIAN DIVERSION PROGRAM'S OVERSIGHT OF RANDOM DRUG TESTS AND ITS SERVICE PROVIDERS IS INADEQUATE

Chapter Summary

The Physician Diversion Program (diversion program) of the Medical Board of California (medical board) has not adequately overseen its drug-testing system and the service providers it uses to monitor and treat program participants. Specifically, although the diversion program appears to have improved in the drug-testing area in recent years, a large number of tests are still not being performed as randomly scheduled. The most frequent reason drug tests were not completed as scheduled was because of vacations requested by participants. However, a significant portion of these requests never received approval from appropriate program personnel. Other reasons drug tests were not completed as scheduled were that urine collection monitors (collectors) moved the tests to other dates, and that participants did not show up to take the tests. However, the program did not document the instances of inadequate performance by collectors and did not ensure that collectors submitted incident reports for each missed test, as required by program policy.

Further, the diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed does not adequately or quickly identify missed drug tests or data inconsistencies between collectors' reports and lab results. Finally, although the diversion program relies heavily on its collectors, group facilitators, and diversion evaluation committee (DEC) members in the monitoring and treatment of its participants, it has not been formally evaluating these individuals to determine how well they are meeting program standards.

Many of the Participants' Random Drug Tests Were not Completed as Scheduled

Prior to the beginning of each month, the collection system manager uses a random date generator within the Diversion Tracking System (DTS) to create a calendar of all the participants' drug tests for the upcoming month. A copy of the calendar is then sent to each collector, case manager, and diversion group meeting facilitator. The purpose of randomly selecting drug test dates is so that participants cannot anticipate when a test will be given and have an opportunity to affect the outcome of the test.

***For the two months tested,
74 percent of the drug tests
scheduled were completed on their
randomly chosen dates.***

Although there are indications that the diversion program is improving in this area, many drug tests are still not being performed on the dates selected by the program's random date generator. In November 2004, which was prior to the implementation of the current version of the DTS and also prior to the hiring of the current full-time collection system manager, the enforcement monitor reported that only 40 percent of the 378 scheduled drug tests she reviewed were completed as scheduled. We found that for the months of June and October 2006, 74 percent of the 1,692 drug tests scheduled were completed on their randomly chosen dates. This indicates that the diversion program has made some progress in having drug tests completed as randomly scheduled. However, as we describe later, the current system still has a number of deficiencies that need to be corrected. As a result of these deficiencies, some participants may be able to determine patterns in their drug testing and engage in substance abuse such that the opportunity to detect their abuse expires prior to their drug tests. Further, because the diversion program grants vacation requests that have not been planned and approved in advance, some participants could relapse and then request an unplanned vacation to avoid detection. In fact, these deficiencies caused one participant to comment in a program-conducted survey regarding drug tests, "Mine wasn't very random—I was able to 'game' it for several years and almost 'graduated' while still using."

Of the 1,692 total drug tests scheduled in June and October 2006, 439 were not completed on their scheduled date. As shown in Table 3, vacation requests were the most common reason for a participant not having a drug test on the randomly selected date, representing about 46 percent of all drug tests not completed as scheduled. As we will discuss later, a significant number of these requests were granted without appropriate approvals from program officials. Other reasons drug tests were not completed as scheduled were that collectors performed the drug test on a different date (27 percent), participants were in residential treatment (14 percent), the participant missed or refused to take the test on that date (5 percent), and the collector failed to complete the ethyl glucuronide portion of the scheduled test, which specifically tests for alcohol consumption (3 percent).

The Diversion Program Rescheduled Drug Tests Based on Unapproved Vacation Requests From Participants

The diversion program's current policy states that participants must submit a vacation request to their case manager, or to their group facilitator if they will miss any group meetings, at least two weeks in advance in order to have their random drug tests

Table 3
Number of Drug Tests Not Completed as Scheduled in June and October 2006

MONTH	NUMBER OF DRUG TESTS NOT COMPLETED AS SCHEDULED DUE TO:					
	NUMBER OF DRUG TESTS NOT COMPLETED AS SCHEDULED	PARTICIPANT IN TREATMENT	PARTICIPANTS		COLLECTOR [†]	OTHER [‡]
			VACATION (WITH PROPER APPROVAL)*	VACATION (WITHOUT PROPER APPROVAL)		
June 2006	244	29	82	20	79	34
October 2006	195	34	74	22	39	26
Totals	439	63	156	42	118	60
Percentage of drug tests not completed as scheduled		14%	36%	10%	27%	14%

Sources: Auditor analysis of the June and October 2006 drug test calendars, lab results, and collectors' reports.

* This column includes 48 drug tests that did not have corresponding approved vacation request forms but rather had entries by the case managers in the program's diversion tracking system.

† This column includes seven tests that were rescheduled by the collection systems manager to make sure that a test was performed each week and to ease the weekend work of collectors.

‡ This column includes 24 drug tests that were not completed as scheduled because the participant missed or refused to take a drug test (5.5 percent), 12 drug tests not completed as scheduled because the collector failed to administer the ethyl glucuronide portion of the test to detect alcohol consumption (3 percent), and 24 drug tests not completed as scheduled for reasons that could not be determined (5.5 percent).

rescheduled. Despite this policy, we found that of the 198 drug tests that were rescheduled because of vacation requests in June and October 2006, 42 (21 percent) were related to requests that never received approval. In some instances, participants sent vacation requests directly to the collection system manager, who then rescheduled the test dates. Thus, these requests did not receive the scrutiny of appropriate program officials.

In addition, although we counted them as approved in Table 3, another 48 vacation requests did not have signed and approved vacation request forms but rather had corresponding entries in the DTS in which the case manager acknowledged receipt of the vacation request. The program administrator said it is understood by the case managers that entering vacation dates into the DTS is equivalent to approval. Although this may be true, the current collection system manager stated that it is not part of her regular process to check the DTS to see if a case manager has approved a vacation request and that she does not have the time to verify with case managers that all vacation requests have been approved. Consequently, although it appears that the case managers were aware of these 48 vacation requests, the randomly selected drug tests were being rescheduled without assurance that case managers had in fact approved the rescheduling. Therefore, although 42 vacation requests in our sample had no approval, there was an

We also found that 14 of the 42 vacation requests without approvals were faxed directly from the participants to the collection system manager.

even higher number of vacation requests for which the collection system manager had no indication that the request had been approved—yet the scheduled drug tests were moved anyway.

For example, in June 2006, the collection system manager rescheduled a participant's test due to a vacation request. However, the group facilitator and case manager never approved the vacation request, as the form is blank where their signatures should have been. Despite the fact that the approval portion of the form was blank and there was no entry in the DTS indicating that the case manager was aware of the request, the collection system manager considered the request approved and moved the participant's test date.

Although we could not determine the transmittal of every vacation request, we also found that 14 of the 42 vacation requests without approvals were faxed directly from the participants to the collection system manager. For example, in June 2006, one participant faxed a vacation request directly to the collection system manager, who then moved the scheduled test to another date. Although there was no signature of either the group facilitator or case manager on the form, the participant had checked the box stating that the request was approved. On the form, it appears that the participant hand-wrote the names of the group facilitator and case manager (instead of obtaining their signatures). There was no sign of any correspondence between the case manager and participant about this vacation request in the DTS. Because participants can, if they are so inclined, make the request appear to have been signed and approved, the collection system manager should not be receiving vacation requests directly from participants.

We also found that 13 of the 156 approved vacation requests had signatures only from the group facilitators. Although this is deemed to be sufficient approval under current policy, we believe that participants should also receive approval from their case managers, because case managers are the program officials charged with monitoring the participants assigned to them. In addition, group facilitators are not employed by the State and therefore cannot be held to the same standard of accountability as case managers.

Collectors Did Not Always Complete Tests on the Scheduled Dates

According to diversion program policy, collectors are to complete drug tests on the dates randomly scheduled and are to give the program 14 days advance notice if they will not be available to perform testing. If this notice is provided soon enough, the dates that collectors are not available are taken into account prior to the drug test calendar being prepared. Of the 439 drug tests not completed as scheduled in June and October 2006, 118 (27 percent)

were completed on a different date chosen by the collector. In 86 of these instances, the collectors notified the program prior to testing on a different date.¹⁰ Even so, when collectors are allowed to move drug tests to dates that are more convenient for them, the diversion program runs the risk that a participant will gain an understanding of his or her collector's pattern and potentially allow the participant to time substance abuse so as not to be detected. For example, a collector was scheduled to test two participants on a Saturday in October 2006 but instead completed the tests on the Tuesday prior to the weekend date. In that same month, another collector also had two drug tests scheduled for a Saturday. This collector moved both tests to a Monday, nine days later. A third collector moved the two randomly selected Saturday test dates for one participant to the following Tuesdays. Although not all test dates moved by a collector were from a weekend to a weekday, these three examples illustrate a pattern that could develop if collectors are allowed to move randomly selected dates.

Of further concern is that collectors did not notify the diversion program in advance for 32 of the 118 drug tests rescheduled by the collector. In addition to potentially creating a pattern that participants can detect, these instances indicate a loss of control by the program that is further exacerbated by the fact that the program does not make note of these failures to follow program policy and does not formally evaluate its collectors (as we discuss later). To address this deficiency, in February 2007, the collection system manager sent a memo to all collectors stating that the diversion program will not tolerate changes in scheduled test dates without prior approval. The memo also stated that the new policy, effective February 2007, requires all collectors to submit a written request for any changes to scheduled collection dates at least two weeks in advance and that telephone calls alone will not be accepted.

The collectors did not always notify the diversion program in advance as required when rescheduling test dates.

Participants in the Diversion Program Missed Scheduled Test Dates for Other Reasons

As noted in Table 3 on page 41, we found that 60 drug tests scheduled during June and October 2006 were not completed as scheduled for a combination of other reasons. Specifically, 24 drug tests were not completed as scheduled due to a participant not returning a collector's phone call or refusing to take a drug test when contacted, 12 were not completed as scheduled because the

¹⁰Although available information did not allow us to determine whether collectors gave a 14-day advance notice in most of these instances, we were able to determine that advance notice was not given in 11 instances.

collector failed to administer the ethyl glucuronide portion of the test to detect the presence of alcohol, and 24 were not completed as scheduled for unknown reasons.

When a participant does not return a collector's phone call or refuses to take a drug test when contacted, the program's policy manual states that the collector is to notify the collection system manager immediately and submit an incident report explaining what happened to the case manager, collection system manager, and group facilitator within 24 hours. This alerts the collection system manager that a participant missed a test, which may need to be rescheduled. However, we found that there were incident reports for only 11 of the 24 drug tests (46 percent) that were missed, and not all of these reports were submitted in a timely manner. Of the 11 incident reports, five were submitted between two and three days after the participant missed the test, with remaining reports being submitted either the day of or the day after the missed test. For the remaining 13 missed drug tests, no incident reports were submitted.

If the collectors do not send in incident reports, the collection system manager has no way of knowing that a participant has missed a drug test until she reconciles the scheduled drug tests with the drug tests actually performed, which she does after the end of each month.

The collection system manager stated that if the collectors do not send in incident reports, she has no way of knowing that a participant has missed a drug test until she reconciles the scheduled drug tests with the drug tests actually performed after the end of each month. The collection system manager said that if she notices a missed test, she may contact the collector or case manager to find out why or check the DTS for any case manager entries regarding this issue. She indicated that after determining the reason for the missed test, she does not then require the collector to submit an incident report describing the event. We question this decision, because requiring collectors to submit these reports, even well after the event, would reinforce the program's policy by sending a message to collectors that it is important for them to send in their incident reports as required. Of further concern is that in the 11 instances in which the program received an incident report, the program's only response was to reschedule another drug test, even though the program's policy manual lists other steps that could be taken, such as removing a physician from work or increasing the number of drug tests the participant must complete each month.

In addition to the tests that participants missed, we could not determine why another 24 drug tests were not completed as scheduled. In these cases, the collector did not submit a monthly report or the monthly report did not explain why a test was missed. For these drug tests, we confirmed that the collection system manager did not have any vacation requests or incident reports on file for the participant.

In June 2006 one participant had four out of five of his tests rescheduled for unknown reasons. Because the participant did not submit a vacation request and the collector did not submit the June monthly report or any incident reports, we could not determine the reason for these changed dates. Also, because the collection system manager reconciles lab results only with collectors' reports, and not to the monthly calendar, she was not aware that the drug tests were not completed as scheduled and consequently did not have an explanation for these missed tests.

Some Tests Not Completed as Scheduled Were Never Made Up

Of the drug tests that were not completed as scheduled during the months of June and October 2006, the vast majority were made up on a different date; however, we found eight missed drug tests that were never made up. In these instances, the participants were not required to complete the requisite number of drug tests specified in their agreements.

For example, one participant took a drug test in June 2006; however, it was not reflected in the lab results because the collector sent the sample to the lab without the chain of custody form or payment for the test. Because the diversion program's reconciliations of scheduled drug tests with actual drug tests are not completed promptly, this error was not discovered until August 2006. To make up for this invalid test, the collection system manager intended to add an additional drug test for this participant in August 2006. We checked the August 2006 calendar and saw that the collection system manager had included a note on the bottom of the page stating that a makeup collection should be taken for this participant; however, the test was not added to the calendar itself. We also checked the August 2006 lab results and found that no additional test was taken. Further, there was no indication that this test would be rescheduled to another date. As a result, this missed collection was never made up.

Because the diversion program's reconciliations of scheduled drug tests with actual drug tests are not completed promptly, a June 2006 error by a collector was not discovered until August 2006.

The Diversion Program's Process for Reconciling Scheduled Drug Tests With Actual Results Needs to Be Improved

The diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed does not promptly identify missed drug tests or data inconsistencies between collectors' reports and lab results. In particular, the current process can be slowed by late collector reports and does not allow the program to confirm that drug tests added to the master schedule after its original distribution to the collectors have been completed. Further, program management has not been reviewing

the reconciliations to ensure that they are performed accurately and that there is adequate follow-up on discrepancies identified during the reconciliation process.

According to the program's policy manual, collectors are required to submit monthly reports to the collection system manager that include the participant's name and case number and a unique identifying number for each completed drug test. The reports should also cite the reason why a participant was not tested on an assigned date, if applicable. To check for consistency, this report is to be reconciled to the monthly lab results report and the calendar of randomly generated test dates. If discrepancies exist, the collector may be contacted for an explanation. Although the program's policy manual states that the monthly collector reports should be reconciled to both the lab results and the calendar, the current collection system manager reconciles the collector reports only to the lab results. As demonstrated below, not using the calendar as part of the reconciliation process causes a number of problems.

In June 2006 a collector's monthly report indicated that a particular drug test was completed as scheduled; however, the lab report had no record of this drug test.

For example, in June 2006, a collector's monthly report indicated that a particular drug test was completed as scheduled; however, the lab report had no record of this drug test. After we questioned program staff regarding this issue, they provided documentation indicating a drug test had been completed on the scheduled date but the collector had failed to write the identifying number on the sample submitted to the lab. Although a reconciliation of these reports should have discovered this error, program staff explained that they could not do the reconciliation at the time because the collector's report was not sent to them promptly. However, this view fails to recognize that the lab results could have been reconciled immediately to the calendar prepared by the collection system manager.

In addition to delaying the reconciliation, the practice of using the collectors' reports rather than the calendar introduces unnecessary risk to the process because the collectors' reports may not include all scheduled drug tests. In particular, some drug tests are scheduled after the randomly generated calendar is completed. These drug tests are manually added to the master schedule and the collectors are notified. If collectors fail to perform these tests, the manually added dates will not be shown on their reports. Also, these manually added drug tests are not reflected in the lab report, as it displays dates only from the randomly generated schedule. As a result, the current reconciliation process does not identify these missed collections.

For instance, in June 2006, after the schedule was created, the collection system manager manually added an additional test for one participant. However, the lab results show that this test was

never completed. The collector's report, which is filled out after the month is over, did not include this additional test date in the list of scheduled dates. Because the collection system manager's reconciliation process does not include checking the original calendar, which would include any tests added manually, she did not realize that this drug test was not performed.

The collection system manager stated that program management does not check her reconciliation each month. This could contribute to the inefficiency and ineffectiveness of the diversion program's reconciliation process, as management does not ensure that the collection system manager's reconciliation is complete and accurate or that she follows up on any issues discovered. Having someone check the collection system manager's work would provide stronger accountability in the reconciliation process.

The Diversion Program Does Not Formally Evaluate Its Collectors, Group Facilitators, and DEC Members

Although the diversion program relies heavily on its collectors, group facilitators, and DEC members in the monitoring and treatment of its participants, it has not been formally evaluating these individuals to determine how well they are meeting program standards. Collectors have not faced any consequences for rescheduling drug test dates and failing to submit required reports, group facilitators have continued to provide treatment services without demonstrating that they have a current license and meet continuing educational requirements, and some DEC members have had poor attendance at required meetings without being removed from their positions. In those cases in which the program did take action in response to noncompliance by its collectors, group facilitators, or DEC members, it often waited months or even a year before doing so.

The Diversion Program Does Not Evaluate Its Collectors

A critical component to ensuring that diversion program participants are sober, and to document instances when they are not, is the use of random drug tests. However, as we discussed earlier, collectors do not always follow through on the schedules of drug tests provided to them and sometimes make errors in submitting drug test documentation to labs. Even so, the diversion program does not document instances when collectors do not adequately perform their critical function and has not developed an evaluation mechanism for the 27 collectors it currently uses. In

The diversion program does not document instances when collectors do not adequately perform their critical function and has not developed an evaluation mechanism for the collectors it currently uses.

addition, diversion program collectors do not sign any contracts or agreements with the program but are simply sent copies of the collection procedures.

According to the collection system manager, the diversion program does not conduct any formal evaluations of the collectors' performance but is in the process of developing an agreement for the collectors. She explained that unless she hears complaints from the participants, she assumes that everything is okay. If she does receive a complaint, she first contacts the collector. The collection system manager then talks to the case manager, group facilitator, and program administrator, and together they decide whether the collector should be let go. Although this form of monitoring may identify collectors who mistreat participants, it does not evaluate, for instance, whether the collectors are completing drug tests on the randomly generated dates and submitting necessary paperwork to the labs. As a result, collectors have been able to reschedule drug-test dates and make critical errors without facing any consequences.

We also checked to see whether the collectors had complied with the requirement to submit the monthly collector's report. For the month of October 2006, the collection system manager received 23 of the 25 required reports. One of the collectors who did not submit a report for that month had not submitted a monthly collector report since March 2006. According to the collection system manager, the collector was continually late in submitting reports. Although she followed up with him, he still did not submit the reports. The program, however, did not replace this collector until March 2007, a year after he was noted as being noncompliant with the program's policies.

The Diversion Program's Group Facilitators Have Not Been Formally Evaluated in More Than 10 Years

Although the diversion program's policy manual states that each group facilitator should be evaluated annually, no group facilitators have been formally evaluated since 1997. The program administrator indicated that he instead evaluates and monitors the group facilitators through informal conversations throughout the year. For example, the program administrator mentioned that he visited at least two meetings conducted by each of the 13 group facilitators during 2005 (the year he joined the diversion program) but indicated that he did not perform an evaluation or take written notes of these visits. According to the program administrator, evaluating the group facilitators has not been one of the diversion program's top priorities in recent years, since most of them have been facilitating groups for many years.

According to the program administrator, evaluating the group facilitators has not been one of the diversion program's top priorities in recent years.

Even though the group facilitators have been in their positions for many years, it would still be valuable to evaluate their performance, especially since it is required in the diversion program's policy manual. Without formal evaluations, the group facilitators would not be made aware of whether they are fully meeting the expectations of the program. In addition, the program administrator mentioned that he has received some complaints about the group facilitators from participants and case managers. However, he attributes many of these complaints to differences in personal opinion. Although this could be the case, performing formal evaluations would create stronger accountability for the group facilitators and better ensure that they are meeting program standards.

The Diversion Program Does Not Appear to Ensure That Its Group Facilitators Stay Current With Required Licenses, Certifications, and Continuing Education

The diversion program does not do enough to ensure that its group facilitators hold a current license or certification, or meet their continuing education requirements. According to the current memorandum of understanding (MOU), which most group facilitators have signed, group facilitators must be California-licensed therapists "experienced in, and knowledgeable about substance-related disorders and mental health issues." According to the program administrator, group facilitators who were with the program prior to the enactment of this new MOU, can be certified by the California Association of Alcoholism and Drug Abuse Counselors rather than being a licensed therapist as the new MOU requires.

A review of diversion program files indicated that of the 13 program group facilitators, nine are licensed marriage and family therapists or marriage, family, and child counselors; two are licensed clinical social workers; and two are certified alcohol and drug counselors. However, we observed that many of the copies of licenses and certifications in diversion program files were outdated, and some dated back to the 1970s and 1980s. This indicates that the program does not regularly confirm that group facilitators maintain active licenses or certifications. Consequently, the diversion program has less assurance that its group facilitators continue to be qualified to provide services to program participants.

The diversion program's policy manual states that the group facilitators must participate in at least two continuing education seminars in substance abuse, mental health, or group therapy every two years, and should provide verification of their participation to the diversion program. However, 11 of the 13 group facilitators' files did not contain any verification of continuing education. After we brought this to

The program does not regularly confirm that group facilitators maintain active licenses or certifications.

their attention, program management obtained documentation from the group facilitators indicating that each had fulfilled the continuing education requirements. Nevertheless, the deficiency in documentation at the time of our review indicates that the program is not ensuring that facilitators are meeting these requirements.

The Diversion Program Did Not Evaluate Its DEC Members Between 2003 and 2007

Although diversion program policies require annual written evaluations of DEC members, the program did not perform these evaluations between 2003 and March 2007 (it completed its recent evaluations near the end of our review). Consequently, some members may not have been adequately performing their duties and were not replaced in a timely manner. During a 1999 medical board meeting, concern was expressed about the insufficiency of the evaluation process used at the time, which included tracking the DEC members' attendance and the time it takes them to respond to inquiries. As a result, a new procedure was developed requiring written evaluations of each DEC member that included ratings from other members of the committee on the member's preparedness, cooperation, communication, knowledge, clinical judgment, and interview skills. The evaluations were also to include data from diversion case managers about the timeliness and helpfulness of consultations, attendance records from the DEC coordinator, and comments and a summary from the program administrator.

Although the evaluation procedures were approved by the medical board's Division of Medical Quality in 2001, they were never added to the diversion program's policy manual, and the program stopped using the evaluation procedures after 2003. After that date, no formal evaluations of DEC members occurred until March 2007, during our review. This deficiency weakened the diversion program's ability to assess the performance of DEC members in the key areas previously outlined and potentially allowed individuals to continue to occupy a position on a DEC, even though they were not always performing all of their duties.

Although the diversion evaluation committee member evaluations were approved in 2001, they were never added to the diversion program's policy manual, and the program stopped using the evaluation procedures after 2003.

For example, in reviewing all of the DEC members' attendance records from November 2005 to October 2006, we found that eight out of 33 members (24 percent) missed two or more of their quarterly meetings. Although the DEC coordinator provided explanations for many of these absences, we found one instance in which the program responded slowly when a member had poor attendance. This member, who became the mayor of his town in November 2006, stopped attending DEC meetings after February 2006. Although the diversion program eventually replaced

the DEC member, it did not do so until March 2007. Collecting information for the formal evaluation process would have identified the need to replace this DEC member much sooner.

The current program administrator, who came to the diversion program in February 2005, explained that he does not know why evaluations of DEC members did not occur in 2004 but agreed that not having the evaluation requirements in the policy manual contributed to them not being performed in 2005 and 2006. He explained that in addition to immediately implementing the evaluations, he plans to get the requirements into the current policy manual as soon as possible.

Recommendations

To ensure that it adequately oversees participants' random drug tests, the diversion program should do the following:

- Change existing policy to require both the case manager and the group facilitator to approve all participant vacation requests prior to the rescheduling of any drug tests.
- 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.
- Clarify the vacation request policy for participants, and incorporate the 14-day notice requirement for vacation requests into the participants' diversion agreements.
- 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.
- Require a program manager to review the drug test reconciliation to ensure that it is complete and accurate.

To ensure that it adequately oversees its collectors, group facilitators, and DEC members, the diversion program should do the following:

- Document instances in which a 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.

- Maintain updated files on group facilitators to ensure that they stay current with required licenses, certifications, and continuing education requirements.
- Formally evaluate collectors, group facilitators, and DEC members annually and take timely corrective action when these individuals do not fulfill their responsibilities.

Chapter 3

THE PHYSICIAN DIVERSION PROGRAM COULD BE IMPROVED THROUGH BETTER OVERSIGHT BY THE MEDICAL BOARD

Chapter Summary

The Physician Diversion Program (diversion program) of the Medical Board of California (medical board) lacks consistently effective oversight by the medical board, and its program structure overburdens its top manager. As indicated in the Introduction, the medical board uses a committee made up of some of its members to oversee the diversion program (diversion committee). However, the diversion committee's ability to oversee the program is hindered by a reporting process that does not give it a complete view of the program's performance and by a policy-making process that does not ensure that adopted policies are always added to the program's policy manual.

Consequently, rather than discovering deficiencies through the reporting process and correcting them through a policy-making process that maintains some level of continuity, the diversion committee has been notified of program deficiencies in recent years by an outside entity—the enforcement monitor (as described in the Introduction). As shown in the Appendix, the diversion program has made improvements as a result of the findings and recommendations issued by the enforcement monitor in her November 2004 interim and November 2005 final reports. However, almost two years after the final report, the diversion program has not fully implemented most of the enforcement monitor's recommendations. In one instance, the medical board implemented the enforcement monitor's recommendation of supporting the program administrator with two other managers but chose to create two case manager supervisor positions, rather than one case manager supervisor position and one manager position to oversee other program staff, as the enforcement monitor had recommended. In this instance, we believe the medical board should reconsider whether this choice best alleviated the problem of an overloaded program administrator.

The Current Reporting Process Does Not Provide the Medical Board With a Complete View of the Diversion Program's Performance

One of the primary ways the medical board evaluates the diversion program's performance is through reviewing quarterly reports. However, the current reporting process does not provide the medical board with a complete view of the program's operations,

The diversion program's quality review report was created to help the Division of Medical Quality answer the following questions:

- Does the diversion program protect the public?
- Are participants compliant with the diversion program's monitoring methods?
- Is the diversion program following its own procedures and doing so in a timely fashion?
- Is the diversion program effective in rehabilitating participants?

Source: Diversion task force meeting minutes from May 2000.

thus hindering its ability to provide program oversight. As required by state law, the diversion program must provide information to the Division of Medical Quality as it may prescribe to assist it in evaluating the program, directing the program's operation, or proposing changes to the program. In 1998 the Division of Medical Quality created the diversion task force to comprehensively study the diversion program; in 2000 it converted this task force to a standing diversion committee. In addition to a financial status report required by state law, the diversion committee requests that the diversion program submit quality review reports on a quarterly basis to answer the questions shown in the text box.

To answer these questions, the former diversion program administrator developed, in June 2000, a list of components that the program would include in its quality review reports. As shown in Table 4, this list included data on intakes, drug tests, diversion group attendance, case manager contacts, relapses, and successes/outcomes. Although it was not able to report on all of the components at the time, the diversion program expected to provide full reporting by fiscal year 2000-01.

Reporting on all of the components shown in Table 4 would have provided the diversion committee with a more complete view of the diversion program. However, in reviewing all of the quality review reports between June 2000 and January 2007, we found that the diversion program has never reported on four of the six originally envisioned reporting components. Specifically, the diversion program has not reported on drug tests, diversion group attendance, case manager contacts, or outcomes.

As the table indicates, the reports provide some additional information beyond what was originally envisioned. For example, starting in January 2001, the program began reporting information related to participants released from the program, whether through successful completion or termination. However, these data do not fully answer one of the four central questions of whether the program is effective in rehabilitating participants. To answer this question, the program would have needed to develop a way to determine how many graduates remain relapse-free after a certain number of years, as outlined by the former diversion program administrator in June 2000. Furthermore, none of the information added to the quality review reports, except for the length of time before the first urine test, directly measures whether the program promptly follows its own procedures.

Table 4
The Physician Diversion Program's Quality Review Reporting

REPORTING COMPONENTS ORIGINALLY ENVISIONED BY THE DIVERSION PROGRAM IN JUNE 2000	WAS THIS COMPONENT IMPLEMENTED?	ADDITIONAL INFORMATION INCLUDED IN REPORTS
<p>Intakes</p> <p>Number of days between initial telephone contact and intake interview, signed interim agreement, and initial diversion evaluation committee meeting.</p>	Yes	In June 2000 the program began reporting on the participant's current status and type of board action. It also added the number of participants not interested or ineligible for the program in December 2001 and the length of time before the participant's first urine test in April 2005.
<p>Drug Testing</p> <p>Presentation and explanation of collection incident reports, action taken by program in response, timeliness of response.</p>	No	In June 2005 the program began to include the total number of positive, negative-dilute, and invalid tests.
<p>Diversion Group Attendance</p> <p>Number of unexcused absences, action taken by program in response, timeliness of response.</p>	No	
<p>Case Manager Contact</p> <p>Frequency and type of contact with participants, number of cases where minimum number of contacts are not achieved.</p>	No	
<p>Relapses</p> <p>Number of participants who relapse, how relapses are detected, action taken by program in response, timeliness of response.</p>	Yes	In June 2000 the program provided information on the participant's current status, drug of abuse, and length of time in program. It also reported on the type of referral/enforcement activity starting in January 2001.
<p>Outcomes</p> <p>Number of participants who have new disciplinary action taken by board, graduated after previously being terminated, and remained relapse free after graduating.</p>	No	In January 2001 the program added the participant's release status, time in program at release, drug of abuse, and type of referral; whether participant relapsed, had a mental disorder, or had treatment prior to/during the program.

Sources: Quality review reports from June 2000 to January 2007 and a memorandum from the former diversion program administrator from June 2000.

The current program administrator stated that he had never seen the memorandum issued by the former program administrator in June 2000 listing the components to be included in the quality review reports. He believes that over the years, this list of reporting components was forgotten and there was no follow-up to ensure that the diversion program reported on all of them. As a result, this memorandum and the ideas within it were never passed down to him. The program administrator is currently reviewing the memorandum to determine the necessity and feasibility of implementing each reporting component.

Upon reviewing the former program administrator's list of what should be reported, the diversion committee chair (chair) stated that a number of these components could be helpful. Because she also had never seen this memorandum before, the chair explained

Due to personnel turnover and the lack of follow-up, some policies are never fully implemented or are forgotten over time.

that she, along with the other committee members, would need to determine what measures would currently be most helpful. In addition, the committee may explore other program measures not described in this document, such as case managers' workloads.

The Diversion Program Has Not Formally Adopted and Included All of Its Policies in Its Policy Manual

The diversion committee does not always ensure that policies it adopts are included in the diversion program's policy manual. As a result, due to personnel turnover and the lack of follow-up, some policies are never fully implemented or are forgotten over time. In addition, the program adheres to some policies in its daily practices that were never formalized in the policy manual. Although some program staff may be aware of these policies, adding them to the policy manual would create consistency in practice among all staff and would decrease the chance of their being forgotten in the future. Finally, although policy changes have been approved by the diversion committee in pieces, the policy manual as a whole has never been reviewed and approved by the diversion committee.

As we mentioned in Chapter 2, the Division of Medical Quality approved criteria for annual evaluations of diversion evaluation committee (DEC) members, but this policy was never added to the diversion program's policy manual. Although the former program administrator was aware of this policy and therefore conducted the evaluations, this information was never passed down to the current program administrator, who came to the program in February 2005. As a result, DEC member evaluations have not been conducted since 2003.

Likewise, as we mentioned in the previous section, the medical board and the diversion program did not implement a number of components in the quality review reports that the former program administrator envisioned. This lack of follow-up is due to the fact that policies addressing the planned components of the quality review reports were never added to the program's policy manual.

The program also has other policies that it follows in its daily activities that were never included in its policy manual. For example, as we mentioned in Chapter 2, participants must submit a vacation request to their case managers, or to their group facilitator if they will miss any group meetings, at least two weeks in advance in order to have their random drug tests rescheduled. Although this requirement is stated on the vacation request form, it is not included anywhere in the diversion program's policy manual or in

the participants' diversion agreements. Having this requirement formalized into policy would help create consistency among program staff in handling and approving vacation requests.

In addition, the program's policy manual currently states that case managers are to have regular contact with their participants. Although the policy is not specific in defining how many times per month a case manager should contact each participant, the program administrator explained that case managers should do so at least once each month. Because this is not clearly defined in the program's policies, case managers may be unaware of this standard and fail to follow it.

The chair stated that she recognizes the need for the program to formalize its policies. She indicated that the committee members have not seen all of the policies compiled as one manual and that policy changes are approved in discrete pieces. In the future, the chair stated, she would like to see the committee review and approve the policy manual as a whole and then, on an ongoing basis, ensure that approved policy changes are incorporated into the manual. She indicated that she is aware that without a process to ensure that approved policy changes are documented for the future, they can get lost, as there is turnover among the committee members and staff.

In reference to the diversion committee reviewing and approving the policy manual as a whole, the executive director of the medical board (director) explained that the policy manual includes both policy statements and detailed procedures that program staff use to implement program policy. While he believes that it is imperative that the diversion committee approve program policy, the director said that it is not efficient for the diversion committee, which is made up of physicians who essentially volunteer their time in assisting the medical board, to review and approve all the specific procedures used to carry out its policy directives. Consequently, he suggested that the program administrator and the chair identify policy statements in the manual and then have the committee review and approve these statements rather than the entire manual.

The Diversion Program Still Has Not Implemented a Number of the Enforcement Monitor's Recommendations

As of April 2007 the diversion program had yet to fully implement a number of recommendations from the enforcement monitor's November 2005 final report. In spite of the diversion program's lack of progress in implementing these recommendations, the medical board has not stepped in to ensure that the recommendations are implemented in a timely manner. As a result, the diversion program

In spite of the diversion program's lack of progress in implementing the enforcement monitor's recommendations, the medical board has not stepped in to ensure that the recommendations are implemented in a timely manner.

continues to lack development in some areas. As indicated in Table 5, the enforcement monitor provided 14 recommendations to the diversion program—eight regarding actions the program should take and six regarding actions the program should consider. Of the eight recommendations regarding actions the program should take, the diversion program has fully implemented only two. The diversion program’s efforts to implement the remaining six recommendations are still in progress.

Table 5
The Physician Diversion Program’s Response to the Enforcement Monitor’s November 2005 Recommendations

RECOMMENDATIONS FROM THE ENFORCEMENT MONITOR			
THE DIVERSION PROGRAM SHOULD DO THE FOLLOWING:	IMPLEMENTED	IN PROGRESS	NOT GOING TO IMPLEMENT AT THIS TIME
1 Develop standards for work-site and hospital monitors		•	
2 Develop a set of consequences for relapses		•	
3 Evaluate the role, purpose, and structure of the liaison committee	•		
4 Develop protocols for communication with enforcement		•	
5 Update the quarterly quality review reports so they contain the most important information		•	
6 Review the role and duty statements of the group facilitators		•	
7 Develop regulations establishing qualifications and criteria for “evaluating physicians”	•		
8 Develop regulations governing competency examinations for program participants		•	
THE DIVERSION PROGRAM SHOULD CONSIDER THE FOLLOWING:	IMPLEMENTED	IN PROGRESS	NOT GOING TO MAKE A POLICY CHANGE AT THIS TIME
1 Whether there should be a maximum participant cap			•
2 Whether the program should charge practicing participants a fee to cover overhead costs			•
3 The establishment of consistent criteria for termination from diversion program		•	
4 The establishment of a mechanism for termination and revocation of license for board-ordered and board-referred participants who continuously repeat the program		•	
5 Whether there should be a mandatory “practice-cessation” period for participants upon entry into program			•
6 Whether the diversion program is equipped to handle mentally ill participants			•

Sources: Enforcement monitor’s final report, diversion committee meeting minutes, and statements from Physician Diversion Program management.

One of the two recommendations that the diversion program implemented is the review and evaluation of the role, purpose, and structure of the liaison committee. The liaison committee was originally created in 1982 to solicit suggestions, submit recommendations, and provide expertise on issues to enhance the diversion program. In February 2006 the Division of Medical Quality and the diversion committee disbanded the liaison committee with the intent of reconstituting an advisory body that would better serve the diversion program. The diversion program is now in the process of developing a diversion advisory council, which will consult on issues facing the diversion program.

One of the six recommendations the diversion program is still in the process of implementing is the development of consequences for relapses. This will include a review of the relapse referral matrix, which guides the diversion program staff in their assessment of the appropriate programmatic response for participants who have relapsed. The enforcement monitor recommended that this matrix be restated and adopted as policy. Although the diversion program has had conversations with the DEC members, group facilitators, and case managers about this issue, the program delayed the completion of the matrix so that it could be discussed at the next annual DEC meeting. As of May 2007 the program had not yet scheduled an annual DEC meeting for 2007. For its part, the medical board has not pressured the program to complete this work, even though it has been nearly two years since the recommendation was made.

In addition, although the diversion program considered all six recommendations that the enforcement monitor proposed it consider, the program has decided not to implement four of them, choosing instead to continue its current policies and practices. The diversion program has delayed its decision as to whether to implement the remaining two recommendations, as it is waiting for the establishment of the diversion advisory council, which will then meet 30 days after each board meeting to discuss these issues. As of April 2007 the diversion advisory council had not yet been formed.

According to the program administrator, it has been the diversion program that has prioritized the enforcement monitor's recommendations and established due dates for their implementation. The diversion program provides the diversion committee with written reports that describe its progress in implementing the recommendations and the due dates for the next actions to be taken. The program administrator indicated that the diversion committee has not requested or attempted to enforce the due dates described in reports to the committee.

The diversion committee has not requested or attempted to enforce the due dates described in reports to the committee.

We found that because the due dates are not being enforced, the diversion program often pushed back the dates set for implementing the recommendations. For example, for the recommendation that the program consider establishing consistent termination criteria, the initial update report to the diversion committee listed January 2006 as the date these criteria would be adopted. However, according to the program administrator, the majority of the time at the January 2006 meeting was spent providing the diversion committee with background information regarding the diversion program rather than discussing each recommendation in detail. In subsequent reports, the program listed November 2006 as the due date for establishing termination criteria because the matter was pending discussion by a subcommittee of the diversion committee. In January 2007 the due date was again delayed, this time to February 2007. The next report to the diversion committee listed the due date as April 2007. As of April 2007 this recommendation still had not been implemented.

The program administrator also stated that, in addition to the lack of pressure from the diversion committee to get recommendations implemented, the length of time the committee meets also slows the implementation of the enforcement monitor's recommendations. The diversion committee meets for only one hour each quarter to discuss the entire agenda, including quality review reports, DEC member appointments, and other outstanding issues. According to the program administrator, discussion of the enforcement monitor's recommendations has traditionally taken place at the end of these meetings, and there has not always been enough time to get the diversion committee's full input on each issue.

The recently appointed chair indicated that she shares the concern that changes to the diversion program in response to some of the enforcement monitor's recommendations have not yet been completed. For instance, she stated that she is concerned that standards have not been implemented for work-site and hospital monitors, even though the committee approved them quite some time ago. In reference to the one-hour committee meetings, the chair agreed that the length of time the committee meets does, at times, affect its ability to fully discuss the enforcement monitor's recommendations. However, she pointed out that the committee members have demonstrated a willingness to attend extra meetings if warranted—as evidenced by the special sessions held shortly after the enforcement monitor published her report.

The chair also stated that she believes the slow implementation of the enforcement monitor's recommendations could be partially attributable to the fact that the same issues are discussed repeatedly. She believes that they should close down discussion of recommendations that both the diversion program and the

The recently appointed diversion committee chair indicated that she shares the concern that changes to the diversion program in response to some of the enforcement monitor's recommendations have not yet been completed.

committee do not think should be implemented at this time and focus on the outstanding recommendations that need to be discussed and implemented. In addition, the chair believes that the committee should revisit the enforcement monitor's recommendations each year as the diversion program evolves.

The Medical Board Added Another Manager to the Diversion Program but Did So in an Area That Did Not Address the Primary Concern of the Enforcement Monitor

Rather than follow the November 2004 recommendation of the enforcement monitor to reduce the workload of the diversion program administrator by adding two managers—one to supervise the case managers and another to supervise the program support staff—the medical board provided the program administrator with two case manager supervisors. Consequently, although the program administrator received some relief from the hiring of a case manager supervisor in 2005, the addition of a second case manager supervisor at the end of 2006 did little to alleviate the scope and breadth of the duties for which he is responsible. As a result, the program administrator is not able to perform some of the policy development and program outreach he would otherwise like to perform.

In the November 2004 interim report, the enforcement monitor said that the diversion program administrator position was “handling supervision, program oversight, and program development—a burdensome combination of duties which one person cannot completely handle alone.” She then recommended that the medical board add two managers to the program, as previously described. In the final report, published in November 2005, the enforcement monitor noted that the medical board added a case manager supervisor in February 2005 to ensure that case managers fulfill their duties. Subsequently, in July 2006, the medical board created another case manager supervisor position to oversee the three case managers in Southern California, reducing the number of case managers the existing supervisor oversees to three in Northern California.

Although this change likely eased the existing case manager supervisor's burden, we question whether it alleviated in a substantial manner the burden on the program administrator, as described by the enforcement monitor. The program administrator said that, now that the creation of a second case manager supervisor position has already taken place, he questions whether going through the process to switch the role of this manager would really be worth the effort. Although he agrees that he needs more time to focus on policy development and program outreach, the

Because the addition of a second case manager supervisor did little to alleviate the burden on the program administrator, he is not able to perform some of the policy development and program outreach he would otherwise like to perform.

program administrator stated that he might be able to reduce his workload by delegating more duties to staff and by creating efficient mechanisms to oversee staff, as we have suggested. He further explained that, in fact, he will be delegating a number of duties to the two case manager supervisors. For example, he plans on having them evaluate group facilitators and also represent program management at many of the DEC meetings. He believes that this last task in particular will allow him the time for many of the other activities, such as program outreach, that he has wanted to perform.

Although we still believe that the organizational structure outlined by the enforcement monitor would have provided greater relief to the program administrator's workload, we can appreciate the argument that a second case manager supervisor position has already been approved and an individual has already been selected and hired. To the extent that the program administrator can delegate tasks to these supervisors, such as attendance at DEC meetings, he should be able to focus on improving the program's policy development and oversight mechanisms, reporting to the diversion committee, and performing program outreach. We encourage the medical board to ensure that its diversion program administrator does so.

Recommendations

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.

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 currently 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.

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.

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.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of the report.

Respectfully submitted,



ELAINE M. HOWLE
State Auditor

Date: June 7, 2007

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Appendix

THE PHYSICIAN DIVERSION PROGRAM HAS MADE IMPROVEMENTS SINCE THE FINAL ENFORCEMENT MONITOR REPORT

As we discussed in the Introduction, the enforcement monitor was appointed to review the Physician Diversion Program (diversion program) of the Medical Board of California (medical board). The enforcement monitor issued two reports—an interim report in November 2004 and a final report in November 2005. As indicated in Table A on the following pages, the diversion program began addressing some of the enforcement monitor’s concerns prior to the issuance of the final report and has made additional progress since then. However, we also noted that the diversion program has not yet responded to some enforcement monitor concerns, and these areas continue to be deficient.

Table A
Progress Made by the Physician Diversion Program Since the Issuance of the Enforcement Monitor's Reports

FUNCTIONAL AREA OF DIVERSION PROGRAM (ATTRIBUTE)	KEY STATISTICS AND FINDINGS FROM THE ENFORCEMENT MONITOR		KEY FINDINGS FROM OUR REVIEW	PROGRESS SINCE ENFORCEMENT MONITOR'S REPORTS
	NOVEMBER 2004 INITIAL REPORT	NOVEMBER 2005 FINAL REPORT		
Staffing	The program administrator position in the diversion program is overloaded; the position should be supported by a case manager supervisor and a supervisor of other staff and functions.	In February 2005 the medical board hired a case manager supervisor.	As indicated in Figure 3 of the Introduction, the medical board has hired a second case manager supervisor. However, as discussed in Chapter 3, this administrative structure has not sufficiently relieved the burden on the program administrator.	The diversion program has improved in this area, but deficiencies still exist.
Staffing	The program's five case managers are so overloaded that all they are able to do is react to relapses; case managers should have no more than 50 cases each.	The medical board submitted a budget change proposal for additional case managers and the conversion of a seasonal clerk position to full time.	As indicated in the Introduction, the diversion program now has six case managers. According to case manager reports, average caseloads have decreased from 53 in November 2005 to 37 in March 2007.	This issue has been addressed.
Staffing	The collection system manager position is significantly understaffed.	In March 2005 the program expanded its existing collection system manager position to a full-time position devoted almost entirely to overseeing drug tests.	Nothing additional to report.	This issue has been addressed.
Case managers (reporting)	Program management allowed two of the program's five case managers to file very few monthly reports between January 2003 and August 2004.	The new case manager supervisor now requires and reviews case managers' monthly reports.	Between November 2005 and October 2006, all case manager reports were submitted as required.	This issue has been addressed.
Drug testing (timeliness)	Twenty-five percent of new participants are not scheduled for any drug tests within one month of their intake interview.	No additional findings or information provided in the final report.	18 percent of the new participants in 2005 and 2006 from our sample did not receive a drug test within one month of their intake interview. As indicated in Chapter 1, the program has dramatically decreased the length of time to perform the first drug test but does not appear to have met its goal of seven days quite yet.	The diversion program has improved in this area, but deficiencies still exist.
Drug testing (timeliness)	Out of 20 relapses reviewed, four participants' drug tests were not resumed within one month following completion of treatment.	No additional findings or information provided in the final report.	The program no longer follows the same process as was reported in the enforcement monitor's report. Participants remain on the drug testing calendar while in treatment. Drug tests resume following completion of treatment according to the dates assigned on the randomly generated calendar.	This issue has been addressed.
Drug testing (randomness)	Only 40 percent of a sample of drug tests were completed as scheduled.	No additional findings or information provided in the final report.	74 percent of scheduled drug tests in June and October 2006 were completed on their randomly scheduled dates.	The diversion program has improved in this area, but deficiencies still exist.
Drug testing (randomness)	The program does not make an effort to track actual collections to ensure that participants receive the required number of drug tests and that the tests occur on their randomly scheduled date.	The program requires monthly reports from the collectors that document that tests have been administered on the scheduled dates. The collection system manager manually verifies that participants are given the required number of tests each month.	The program now reconciles collector reports with actual drug tests. However, as we point out in Chapter 2, this reconciliation process has significant weaknesses that must be improved.	The diversion program has improved in this area, but deficiencies still exist.

KEY STATISTICS AND FINDINGS FROM THE ENFORCEMENT MONITOR

FUNCTIONAL AREA OF DIVERSION PROGRAM (ATTRIBUTE)

	NOVEMBER 2004 INITIAL REPORT	NOVEMBER 2005 FINAL REPORT	KEY FINDINGS FROM OUR REVIEW	PROGRESS SINCE ENFORCEMENT MONITOR'S REPORTS
Drug testing (reporting)	Out of 20 relapses reviewed, the results from 40 positive drug tests were not reported in time frames ranging from 10 to 14 days and another was not reported for at least three weeks.	No additional findings or information provided in the final report.	As indicated in Chapter 1, out of the 43 positive or negative-dilute tests we reviewed, the results from 10 were not reported within seven days.	The diversion program has improved in this area, but deficiencies still exist.
Drug testing (recording)	The program does not ensure that test results are actually received from the laboratory and downloaded into the Diversion Tracking System (DTS), leading to gaps in the participants' collection records. In addition, more than 300 lab reports received during the testing period did not contain a donor ID and therefore had not been appended to the appropriate participant's record in the DTS.	The medical board's information systems branch created a new DTS whereby urine test results forwarded by the lab are automatically downloaded into the DTS and appended to the participant's DTS file. The collection system manager conducts spot checks for accuracy.	All of our sampled participants' urine test results were automatically downloaded into DTS and no gaps in their collection records were found. However, we found some instances where errors in the recording of participants' donor IDs or collection dates led to inaccuracies in the drug test results.	The diversion program has improved in this area, but deficiencies still exist.
Collectors (evaluation of performance by program)	Deviations from the drug test schedule appear to be tolerated with no discussion or sanction.	The program terminated several collectors who would not adhere to the random schedule and other program requirements.	As indicated in Chapter 2, the program does not document instances when collectors do not adequately perform their duties and has not developed an evaluation mechanism for its collectors.	The diversion program has not adequately addressed this area.
Collectors (reporting)	Only five of the 30 required collector reports were received for December 2003.	No additional findings or information provided in the final report.	23 of the 25 required collector reports were received in October 2006. Missing reports received adequate follow-up.	This issue has been addressed.
Work-site monitors (policy)	The program has not set forth a workable definition of the duties or qualifications of a work-site monitor.	The diversion committee has not yet established meaningful standards for work-site monitors but the program has instituted a new policy that it will no longer approve increases in participant's work hours, or reductions in drug tests, if a participant is not in compliance with work-site monitoring requirements.	As indicated in Chapters 1 and 3, the board's expectations for work-site monitors have been developed but have not been approved or fully implemented. In addition, the current manual does not contain the new policy on increases in participants' work hours or reductions in drug tests, and we did not see evidence of this practice in our review.	The diversion program has not adequately addressed this area.
Work-site monitors (reporting)	Only seven of a sample of 20 participants had a complete, or nearly complete, set of quarterly work-site monitor reports in their file.	Program staff are working with the medical board's information technology unit to develop a mechanism to identify participants not in compliance with the work-site monitoring requirements.	Fifteen of the 18 physicians in our sample who required work-site monitoring reports during the period of our review had a complete, or nearly complete, set of reports in their file. However, as we point out in Chapter 1, there are a number of improvements the diversion program still needs to make in this area.	The diversion program has improved in this area, but deficiencies still exist.

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June 2007

FUNCTIONAL AREA OF DIVERSION PROGRAM (ATTRIBUTE)	KEY STATISTICS AND FINDINGS FROM THE ENFORCEMENT MONITOR			KEY FINDINGS FROM OUR REVIEW	PROGRESS SINCE ENFORCEMENT MONITOR'S REPORTS
	NOVEMBER 2004 INITIAL REPORT	NOVEMBER 2005 FINAL REPORT			
Therapists (reporting)	None of the 11 participants reviewed had a complete, or nearly complete, set of therapist reports in their file.	The new case manager supervisor is beginning to address this issue with case managers and the program has instituted a new policy that it will no longer approve increases in participant's work hours, or reductions in drug tests, if a participant is not in compliance with therapist reporting requirements.	Six of the 18 physicians in our sample who required therapist reports during the period of our review had a complete, or nearly complete, set of reports in their file. As noted in Chapter 1, the current manual does not contain the new policy on increases in participants' work hours or reductions in drug tests and we saw no evidence in our review that this practice is followed.	The diversion program has improved in this area, but deficiencies still exist.	
Diversion Evaluation Committee (policy)	Diversion evaluation committees (DECs) operate without any written standards that would help ensure that recommendations are fair, consistent, and protective of the public. For instance, there is no consistently applied and enforceable rule regarding consequences for relapse.	The diversion program undertook an overhaul of its manual. The new manual needs to be reviewed by legal counsel, the diversion committee, and the Division of Medical Quality.	The diversion program added a chapter on diversion evaluation committees to its policy manual outlining the role of the DEC and standards for its recommendations. Discussions were held with DEC members, group facilitators, and case managers regarding the consequences for relapse.	The diversion program has improved in this area, but deficiencies still exist.	

Sources: Auditor analysis of information obtained from enforcement monitor's initial and final reports and our review of the Physician Diversion Program.

(Agency response provided as text only.)

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May 30, 2007

Ms. Elaine Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle,

Thank you for giving me the opportunity to respond to your audit addressing the Medical Board of California. I understand that your audit sample included physicians from between November 2005 and October 2006.

In preparing for my confirmation as Agency Secretary in February 2007, I committed to implement recommendations from the Bureau of State Audits. I have directed the Department of Consumer Affairs' new director Carrie Lopez to follow through on your audit recommendations to the Medical Board. Her specific comments are attached.

I have directed the Medical Board to send a six month and one year update on their efforts through the Department of Consumer Affairs. I recognize your recommendations as an opportunity to improve the Medical Board and truly appreciate your support of the Department of Consumer Affairs' goals of protecting California's consumers.

Most Sincerely,

(Signed by: Rosario Marín)

Rosario Marín, Secretary
State and Consumer Services Agency

*California State Auditor's comments appear on page 81.

(Agency response provided as text only.)

Department of Consumer Affairs
1625 North Market Blvd., S308
Sacramento, CA 95834

May 25, 2007

In reply to: Medical Board of California's Physician Diversion Program Audit

Elaine M. Howle
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

At the direction of Secretary of State and Consumer Services Agency Secretary Rosario Marin, I am responding to the Bureau of State Audit's findings on the Department of Consumer Affairs' (Department) Medical Board of California (Board), Physician Diversion Program.

It is my understanding that the Board is currently drafting its response and developing an implementation plan for addressing the concerns identified in the audit. It is also my understanding that SB 761 (Ridley-Thomas) is a placeholder bill to address any shortcomings in the diversion program.

The Department's responses to the audit recommendations are listed below.

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. *The Department concurs with this recommendation. Action: We will work with the Board to review their current technology infrastructure and recommend program improvements where necessary.*
2. To ensure a timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:
 - Immediately remove practicing physicians from work when notified of a positive drug test.
 - Require diversion evaluation committees (DECs) to provide justification when they determine that a positive drug test does not constitute a relapse.
 - Have a qualified medical review officer evaluate all disputed drug test results if its new advisory committee determines that this action is needed.

The Department concurs with this recommendation. Action: We will encourage the Board to seek Interim Suspension Orders when appropriate, through the Office of the Attorney General and support their efforts in seeking such orders.

3. The diversion program should ensure that both the case manager and group facilitator approve all vacation requests and should 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. *The Department concurs with this recommendation. Action: None.*
4. To ensure that it adequately oversees its collectors, group facilitators, and the DEC members, the diversion program should formally evaluate the performance of these individuals annually. *The Department concurs with this recommendation. Action: We will assist and facilitate the Board's efforts in obtaining a Budget Change Proposal (BCP) should it be determined that a BCP is necessary to implement this recommendation.*
5. To effectively oversee the diversion program, the Board should require it to create a reporting process that allows the Board to view each critical component of the program. *The Department concurs with this recommendation. Action: None.*
6. To ensure that it adequately oversees the diversion program, the Board should have its diversion committee review and approve the program's policy manual. Thereafter, the diversion committee should ensure that any policy change it approves is added to the manual. *The Department concurs with this recommendation. Action: None.*
7. The Board should ensure that areas of program improvement recommended by the enforcement monitor are completed within six months. *The Department concurs with this recommendation. Action: If a BCP is necessary to fulfill this recommendation, we will work with the Board to ensure its timely completion.*

The Department will actively encourage the Board to send you a six-month and one-year status reports on its progress with respect to the implementation of the audit recommendations.

Thank you for giving me the opportunity to respond to your audit report. Please feel free to contact me at (916) 574-8200 should you have any questions. Thank you.

Sincerely,

(Signed by: Carrie Lopez)

CARRIE LOPEZ, Director
Department of Consumer Affairs

(Agency response provided as text only.)

Medical Board of California
1434 Howe Avenue, Suite 92
Sacramento, CA 95825-3236

May 29, 2007

Elaine M. Howle
California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: Draft Audit Report – Medical Board of California’s Physician Diversion Program

Dear Ms. Howle:

The Medical Board of California (Board) is in receipt of your draft audit report for the board’s Physician Diversion Program. Thank you for allowing the board to respond to the issues and concerns raised in the report. Enclosed please find our responses to each recommendation.

The board would like to thank the Bureau of State Audits for conducting this audit. Several of the Diversion Program’s processes have been improved, based upon the findings during the auditor’s review. Several of the recommended changes already have been implemented, even before the audit was completed. Other changes are in process and should be finalized in the very near future.

We are gratified that the auditor recognizes the many programmatic improvements made over the past two years, including: a new, real time, Diversion Tracking System; a far superior method of managing and controlling the collection of urine samples from participants, including a full-time collection system manager; the addition of two new case manager supervisors; the lowering of case manager caseloads to an acceptable level by adding additional case managers to the program; the elimination of the Diversion Liaison Committee (which was largely ineffective) and replacing it with a new Diversion Advisory Council which answers to the Board’s Diversion Committee; and the implementation of policies and procedures to ensure the program will operate in a manner that provides maximum public protection.

The Board is committed to implementing the State Auditor’s recommendations and believes these will enhance the public protection improvements already made to the Program. We invite the State Auditor to conduct follow-up reviews at six-months and one-year to ensure the Board has followed through and implemented the recommendations contained in the report.

If you have any questions regarding this response, please contact me at (916) 263-2389.

Sincerely,

(Signed by: Dave Thornton)

Dave Thornton
Executive Director

Medical Board of California
Response to Recommendations of Bureau of State Audits

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Chapter 1 Recommendations

Recommendation: 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.

Response: The Medical Board (Board) concurs with this recommendation. The Board has been working to finalize written policies and procedures for the entire Diversion Program. These policies and procedures are awaiting final review and approval by the Board's legal counsel. The policies and procedures will include direction to all parties to ensure required documentation is provided to the Program. The policies and procedures will not only inform the reporting party of their requirement to provide written verification/documentation, but also will provide direction to the case manager as to his/her responsibility to update the Diversion Tracking System (DTS) and the participant's file. The policies and procedures also will require the case manager supervisor to conduct follow-up on compliance by case managers for each participant's required documentation by all pertinent parties.

Moreover, the Board will be looking into the feasibility of having all documentation for a participant's file scanned into the DTS so it is documented and readily available for all staff to review. Reports could be generated from the scanned documents indicating whether they have been received. This will greatly assist both the case managers in follow-up of their cases as well as provide the case manager supervisor II the necessary tools to oversee the work of the case managers.

Recommendation: 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.

Response: The Board concurs with this recommendation. The new policies and procedures mentioned above have established a minimum period of compliance with agreement requirements before any changes in a participant's contract will be allowed. No reductions in any participant's agreement (including work restrictions) will be considered if the individual is not in full compliance with his/her agreement (including documentation requirements).

These new policies and procedures will state that a reduction in group meetings will not be considered unless the participant has completed at least three years in the Diversion Program and is in full compliance with his/her agreement. All such requests must be approved by the Diversion Evaluation Committee (DEC) or a DEC consultant.

Reductions in drug screens will require the participant to: 1) be in full compliance with his/her agreement and 2) have no relapses for three years. This request by a participant must also be approved by the DEC or a DEC consultant.

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It will be the responsibility of the Program Administrator, in conjunction with the DPCS II, to ensure that these policies are adhered to by case managers and the DEC. All case managers were recently reminded of these requirements.

Recommendation: 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.

Response: The Board concurs with this recommendation. The new policies and procedures will include the requirement that any change in requirements will be in the form of a written formal amendment to the participant's agreement. This procedure has been provided to case managers.

Recommendation: To ensure that worksite monitors provide unbiased and complete reports, the diversion program should do the following:

- 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.
- 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.
- Notify worksite monitors of any work restrictions imposed on the participant they are monitoring, and direct them to report on compliance with these requirements.

Response: The Board concurs with this recommendation. The Diversion Program staff began drafting worksite monitor policies after the release of the enforcement monitor's report. The Diversion Committee approved the draft worksite monitor policy changes in July 2006, however they have not been finalized and implemented. Since these policies were in the drafting process while this audit was being conducted, the auditor's early recommendations also were discussed and included in the draft policies and procedures. The new Diversion Program policies and procedures include the requirements for the worksite monitors as well as instruction to the case managers in outlining what is required for a worksite monitor. The case managers have been given the new requirements and agreements and have been reminded of the importance of compliance with the new worksite monitor policies.

All new potential worksite monitors will be met, in person, by the case manager. The case manager will go over the Agreement to Monitor, which includes the conflict-of-interest information. The monitor's roles and responsibilities will be discussed with the monitor to ensure he/she knows his/her role. Program staff intends that by July 1, 2007 all existing worksite monitors will be provided with the new agreement form and will have signed this new form. Case managers will meet with the existing monitors as well, to discuss the changes. All new worksite monitors will receive the new agreement. The Program will determine if any current worksite monitors have a conflict-of-interest with their participants and take appropriate action, if necessary, to resolve the situation.

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Additionally, case managers have begun to, and will continue to, contact worksite monitors when changes occur with a participant's work restrictions. The monitor also will be provided a copy of the participant's new agreement with the amendment which may affect the participant's work.

Recommendation: 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.

Response: As pointed out by the auditor the Program has dramatically improved the time it takes to do the first drug test from 35 days in 2004/2005 to 18 days in 2005/2006 and will continue to work to improve its processes to meet the seven-day goal. At the April 26, 2007 Diversion Committee Meeting, it was reported that the average during the second quarter of fiscal year 2006/2007 was five and one half days from the initial interview to the first drug test. Additionally, the Program is considering requiring the first drug test at the time of the intake interview.

Recommendation: To ensure timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:

- Immediately remove practicing physicians from work upon receiving notice of a positive drug test.
- Provide sufficient justification when it determines that a positive drug test does not constitute a relapse.
- Have the reconstituted liaison committee 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.

Response: The Board concurs with this recommendation. The Board feels strongly that there should be zero tolerance when a positive drug test is received. It is the Program's policy to remove a physician from practicing immediately upon notification of a positive drug test; however, as in any program, mistakes or errors in judgment can be made. Due to the seriousness of this recommendation, the Program Administrator will endeavor to ensure that every positive outcome results in the removal of the physician from practicing until further analysis and research can be completed. The Program will develop a method whereby the Program Administrator is notified of every positive drug test, so that he/she can follow-up on the action taken or assist in determining any change in the action to be taken.

Additionally, it will be required that every positive drug test, where it is determined that a relapse did not occur, be justified in writing and this justification will be placed in the participant's file.

The Board will ask the DAC to assess the need for an MRO. If this position to perform an assessment is still needed, then the Board will move forward to hire an MRO to evaluate disputed drug tests.

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Chapter 2 Recommendations

Recommendation: To ensure that it adequately oversees participants' random drug tests, the diversion program should do the following:

- 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.
- 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.
- Clarify the vacation request policy for participants, and incorporate the 14-day notice requirement for vacation requests into the participants' diversion agreements.
- 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.
- Require a program manager to review the drug test reconciliation to ensure that it is complete and accurate.

Response: The Board concurs with these recommendations. In regards to vacation requests, the new policies and procedures have been amended to reflect these recommendations. Specifically, the procedure has been changed so that both the group facilitator and the case manager will approve and sign all vacation requests. If a request is sent to the Collection System Manager without the case manager's approval, DTS is checked to see if the request has been noted as approved. If there is no notation in DTS, an email is sent to the case manager to verify that the request has been approved. Only after the case manager notifies the Collection System Manager that the request has been approved, are the collection dates changed to accommodate the request. Lastly, the Program will amend the Diversion Participant Agreement to include the 14-day notice requirement for vacation requests. This has been the policy, but it has not been specified in the agreement so the participant is not fully aware of this requirement in writing at the beginning of his/her enrollment.

Regarding the timely reconciliation of scheduled drug tests, the Program now will reconcile the lab results to the scheduled test twice a month using the calendar and the collectors' collection report and ensure any missed scheduled test will be rescheduled. Further, the Collection System Manager will follow-up with the collector and verify that the proper documentation has been received and provided to the case manager (and other staff as necessary) for further follow-up. Additionally, the Collection System Manager will provide the Program Manager with a bi-monthly summary of the reconciliation of the lab results and scheduled test to ensure the reconciliation is done timely and issues are discovered and addressed quickly.

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Recommendation: To ensure that it adequately oversees its collectors, group facilitators, and DEC members, the diversion program should do the following:

- 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.
- Maintain updated files on group facilitators to ensure that they stay current with required licenses, certifications, and continuing education requirements.
- Formally evaluate collectors, group facilitators, and DEC members annually and take timely corrective action when these individuals do not fulfill their responsibilities.

Response: The Board concurs with these recommendations. As previously stated, the Program has developed new policies and procedures for all persons involved in the Diversion Program, including collectors, group facilitators, case managers, worksite monitors, and DEC members. These policies and procedures will indicate each person's responsibility in the diversion monitoring process. When any new person starts with the Program, he/she will be provided with these policies and procedures and discussions will take place with this person to ensure he/she understands his/her role.

On February 11, 2006 and May 11, 2007, the Program held refresher/training courses to ensure collectors are adequately trained on the policies and procedures related to urine collections. The Program will continue to provide yearly refresher/training courses and conduct individual annual evaluations for current collectors. The evaluation will consist of a written evaluation and discussion of the service provided during the past year. The collectors will sign a contract containing terms and conditions to continue providing services for the upcoming year. The evaluations and contracts will be done yearly.

New collectors will sign a contract containing terms and conditions regarding providing services during the first year and will be closely monitored for the first 30 days to ensure that policies and procedures are being followed. A 30-day evaluation will be conducted that consists of a written evaluation and discussion of the service provided over the past 30 days. If the evaluation is favorable and the Program allows the collector to continue providing services, evaluations and contracts will be done annually as indicated above.

As evidence that these new procedures are providing adequate tools to ensure the Program hires quality collectors, two newly hired collectors were recently terminated within the first 30 days because their performance did not warrant their continued service.

Program staff will conduct an annual review of all group facilitators. This review will include checking the status of their licenses/certifications and ensuring they are in compliance with continuing education requirements. Meetings were held with the group facilitators to discuss the new policies and procedures. New agreements have been drafted and signed by existing group facilitators. In addition to other requirements, the new agreement states the facilitator must notify the Program of any criminal or

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administrative action pending against them or their license/certificate. On an annual basis, the group facilitator will be evaluated by the case manager, the DPCS II, the Program Administrator, and the DEC members.

The Board is aware that the DEC members have not been evaluated for some time. However, based upon discussion with the auditors, the Program Administrator began an evaluation process for the DEC members. This evaluation will be completed by other DEC members, group facilitators, and case managers. Evaluation forms were sent to all parties and have been received back by the Program. These evaluations will be reviewed and any necessary action will be taken. This evaluation process will be placed into the policies and procedures and will be conducted on an annual basis.

Failure to comply with the policies and procedures by any person involved in the monitoring process will be discussed with that individual and continued noncompliance will lead to termination of duties.

Chapter 3 Recommendations

Recommendation: 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.

Response: The Board concurs with these recommendations. The Program has added several elements to its Quarterly Review Reports. However, the Diversion Committee will meet to review the recommendations from June 2000 (as mentioned in the audit report) and determine what elements it believes should be in a report from the Program to the Committee. Once these determinations are made, reports will be set up within the DTS to assist in obtaining the necessary information.

Recommendation: 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.

Response: The Board concurs with this recommendation. As stated in the first response above, Program staff is in the final stages of putting together a policies and procedures manual. All policies within the manual will be reviewed by the full Diversion Committee. Changes requested by the members will be incorporated into the policies and procedures. Once this final version has been completed, any future amendments will be tracked by revision date and revision number. Additionally, any future policies approved by the Diversion Committee will be added to the Program's policies and procedures prior to the next Diversion Committee meeting. Follow-up of this requirement will be performed by the Program Administrator, the Deputy Director, and the Executive Director.

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Recommendations: 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.

Response: The Board concurs with this recommendation. The Diversion Committee has had several meetings to discuss the Enforcement Monitor's report at length. Based upon these meetings, determinations were made that some of the issues/recommendations of the monitor will not be implemented or discussed further. At the April 26, 2007 Diversion Committee meeting other issues were referred to the DAC for review and consideration. The Board intends that the Program and the Committee meet this recommendation and finalize its review and discussion of all the recommendations within six months.

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Recommendation: 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.

Response: The Board concurs with the delegation of some of the day-to-day tasks from the program administrator. Based upon this recommendation, the Board will be putting forward a budget change proposal requesting a supervisor for the administrative staff of the Program. This will allow the Board to continue to maintain two case manager supervisors and have a supervisor over the support staff.

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The addition of another case manager supervisor was a decision that the program administrator and the executive staff believe is necessary for several reasons. The case managers are located statewide. The case managers are the individuals responsible for monitoring participants, which is a time-consuming task. In addition to ensuring that the participant is doing everything required in his/her agreement and following up on positive drug tests, they also need to ensure that the group facilitators and worksite monitors are completing their role in the diversion monitoring process (including ensuring documentation is received for all processes). The case manager attends group meetings and DEC meetings. The supervisor is responsible for ensuring that the case managers are performing all of these duties. To do this, the supervisor must also attend group facilitator meetings and DEC meetings as well as meetings with case managers to go over their caseloads.

For one individual to perform this duty statewide is not logical. The travel time did not allow this individual to meet with all case managers and attend group facilitator meetings and DEC meetings as needed. Therefore, the Program Administrator also was attending group facilitator meetings and DEC meetings regularly, which required considerable travel time. In an attempt to provide better oversight, another case manager supervisor was hired. This second supervisor has been able to hold the case managers accountable for their duties and attend necessary meetings. In addition, supervisors have a small caseload of their own, which assists in being aware of the issues of the case managers. This has and will continue to assist the program in ensuring compliance by all involved in the diversion process.

By having two case manager supervisors and requesting a supervisor for the support staff, the Program Administrator will have more time to focus on his responsibilities in accessing the overall compliance of the program with its statutory mandate of public protection.

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE MEDICAL BOARD OF CALIFORNIA

To provide clarity and perspective, we are commenting on the response to our audit from the Medical Board of California (medical board). The numbers correspond with the numbers we have placed in the department's response.

We appreciate that the medical board can choose not to implement all of the enforcement monitor's recommendations. However, for those it intends to implement, we are recommending that the medical board ensure that the recommendations be completed in the next six months, not just reviewed and discussed.

①

To clarify, our recommendation was not that the medical board add a third supervisory position to the Physician Diversion Program (diversion program). Rather, we recommended that the medical board direct the diversion 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 does not accomplish this goal, we recommended that the medical board reconsider its decision to have two case manager supervisors, rather than one case manager supervisor and one supervisor of other program staff.

②

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State
Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press