



Effectiveness and Efficiency Evaluation of the Oregon Medical Board Health Professionals Program

July 2009



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The logo consists of the letters 'TKW' in a bold, serif font, enclosed within a dark red rectangular border.

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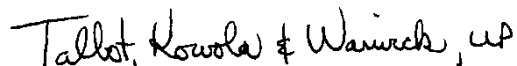
July 2009

Ms. Kathleen Haley
Executive Director
Oregon Medical Board
1500 SW First Avenue, Suite 620
Portland, OR 97201-5847

Dear Ms. Haley:

We have completed the effectiveness and efficiency evaluation of the Oregon Medical Board Health Professionals Program. This report contains our analysis and conclusions based on our review.

We wish to express our appreciation to HPP council members and employees, and those persons from other organizations we spoke with for their cooperation and assistance during this analysis.

A handwritten signature in dark ink that reads 'Talbot, Korvola & Warwick, LLP'.

Talbot, Korvola & Warwick, LLP



Effectiveness and Efficiency Evaluation of the Oregon Medical Board Health Professionals Program

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Report Summary

Report Summary

Talbot, Korvola & Warwick, LLP, was contracted by the Oregon Medical Board (OMB), to evaluate the efficiency and effectiveness of the Health Professionals Program (HPP or Program).

The assessment focused on evaluating the Program to:

1. Determine the progress which has been made by HPP towards addressing the findings and implementing recommendations from the 2006 Audit report,
2. Evaluate whether the HPP has completed a policies and procedure manual and implemented procedures and standards that:
 - a. Are consistently adhered to by Program staff and independent contractors, and
 - b. Adequately protect the public from harm by licensees who are assessed to have a substance use disorder,
3. Evaluate the effectiveness and efficiency of the HPP and make recommendations regarding any changes or reforms required to assure that licensees participating in the Program are appropriately monitored and the public is protected from practitioners who are impaired due to alcohol or drug abuse, and
4. Reassess the degree and quality of toxicology testing enrollees arranged and supervised by HPP, and make recommendations with regard to the adequateness of this supervision.

Results

2006 Audit

Objective: Evaluate the Board's Health Professionals Program (HPP) and its procedures to determine the progress which has been made by HPP towards addressing the findings and implementing recommendations from the 2006 Audit report.

The OMB contracted with an independent consultant to evaluate the effectiveness and efficiency of the HPP and provide recommendations necessary to ensure licensees were being appropriately monitored and the public was adequately protected from impaired licensees. The report outlined 50 recommendations in the areas of:

- 1) oversight and governance,
- 2) HPP office operations, policies, and procedures,
- 3) body fluid (urine) monitoring,
- 4) management of relapse prodromal behavior and relapses,
- 5) referrals and HPP census, and
- 6) other issues.

HPP has made a concerted effort to address many of the recommendations presented within the 2006 Audit report. From progress identified, it appears that HPP has dedicated a tremendous amount of time and resources implementing specific recommendations. However, HPP did not effectively address significant issues identified in its body fluid monitoring program. The Program was unsuccessful in addressing concerns with frequency, timing/scheduling, and service provider compliance.

To date, the Program has implemented 26 of the 50 audit recommendations. Five were rejected, six rejected in part, and 13 not implemented.

Policies and Procedures

Objective: Evaluate whether the HPP has completed a policies and procedure manual and implemented procedures and standards.

HPP personnel developed a policies and procedures manual that covers an array of subjects. All policies developed to date have been approved by the Supervisory Council, with the exception of the Supervisory Council Policy that is in the initial stages of being drafted.

The HPP is working with its consultants to develop a procedure for the use of consulting psychiatrists in relation to monitoring licensees with mental health conditions. These procedures will address the role of the consulting psychiatrists and the overall monitoring of mental health participants.

The developed policies and procedures currently provide a solid base and should continue to be reviewed and modified for clarity, succinctness, and applicability.

Efficiency and Effectiveness of Program

Objective: Evaluate the effectiveness and efficiency of the HPP.

The mission of the Health Professionals Program is to “*protect the public health through maintenance of the health of licensees of the Oregon Medical Board.*” To effectively achieve this mission, the HPP must identify licensees who have substance use disorders and/or mental health conditions, persuade them to take part in the Program, manage monitoring of participants to assure compliance with the terms of their agreement, and assure that these practitioners are not impaired in their ability to practice medicine with reasonable skill and safety. In addition, the Supervisory Council and Program staff must manage the operations of the Program in an effective manner that adequately weighs public safety with maintaining the health of OMB licensees. These activities require the successful integration of planning, practices, resources, and leadership.

Our review of the HPP focused on three areas: the ability of the Program to identify and enroll participants, the success of the Program in assuring that licensees participating in the Program are appropriately monitored and the public is protected from practitioners who are impaired due to alcohol or drug abuse, and the efficiency and effectiveness of the administration of the Program.

Promoting/Marketing the Program

The HPP has had a difficult time recruiting participants. At the end of 2008 there were approximately 11,085 active licensees in the state of Oregon. Of those, a total of 102 cases (1.1%) were being monitored by the HPP, with an additional 20 that had been discharged throughout the year. Discussions with Program staff suggest that the maximum expected number of licensees with an active substance use disorder should be closer to 2%, or approximately 278 licensees.

Various factors appear to be contributing to these challenges. Recent interpretations of the diversion provision of ORS 677.655(3) stated that the statute does not serve to shield a licensee enrolled in HPP from Board investigation and sanction until the licensee has successfully completed the Program. This interpretation has raised the concern that any voluntary participant will be subject to investigation and disciplinary action by the Board,

regardless of the status of their involvement in HPP. HPP staff indicated that as a result of these actions, some participants who have successfully completed the Program and signed extended voluntary agreements have decided to discontinue their involvement in the Program.

Program personnel have focused time and energy on a variety of operational activities but have not strategically approached marketing. The Medical Director is the primary person allocated to promoting and marketing the Program. However, the position also is responsible for a variety of other activities that limited the time available to market the Program. Additional marketing materials, more outreach to hospitals, universities, medical associations, and treatment facilities throughout the State, educational programs for recognizing signs of substance use disorders and mental health conditions, and a coordinated strategy with the Oregon Medical Association and the Oregon Medical Board could also be developed.

Managing the Monitoring of Participants

Random Toxicology Testing

Toxicology testing is one of the most effective ways of ensuring participants are complying with their agreements with HPP. However, even this method has shortcomings. Licensees are medically trained, and as such, understand how testing works and would likely know better than most of the general population how to effectively manipulate tests to assure a desired result. Therefore, the randomness and frequency of the tests is highly important.

As indicated in the 2006 Audit, HPP has had problems with its toxicology service provider. Not only has the provider not collected enough tests for some of the participants to satisfy the agreement between HPP and the licensee, the randomization of these tests has been flawed. The audit found that most tests fell on Tuesdays through Thursdays, with minimal testing occurring on Mondays and Fridays and very little testing on Saturdays.

Although HPP staff have made efforts in addressing these shortcomings, they have not proven effective. Two and one-half years after the prior audit, the results of toxicology testing have not shown significant improvement - average collections on or over target for 2007 was 56.5% while 2008 saw an improvement to 89.5%.

Group Facilitation Meetings

Group meetings are lead by an experienced group facilitator and are attended by a number of HPP participants. Based on case files reviewed, group facilitators, with only a few minor exceptions, completed and sent monthly reports for each participant within their care.

Monitoring Consultant Reports (Monthly or Quarterly)

Monitoring consultants provide independent verification of a participant's recovery progress. Based on case files reviewed, it appeared that participants generally met with the consultants as scheduled, the information was consistent with group facilitation reports, and the consultants provided the reports to HPP as instructed.

Annual HPP Evaluations

Participants are expected to have an official annual meeting with HPP's Medical Director (or designee) to assess progress and modify the terms of the treatment plan as necessary. During our review of case files, we noted that some annual evaluations had "Annual" written on the top of the form. Otherwise, the only ways we could determine whether it was a quarterly report or an annual evaluation was by identifying who completed the form, which was often difficult because the signature was hard to read, whether there were two reports completed within the same quarter, or if the space for the next meeting was completed, indicating either the next quarter or the next year.

Continuing Medical Education Credits

Continuing Medical Education Credits (CME) for HPP participants has been required since 2004. Substance use disorder participants are required to complete at least 20 hours of CME in addictive medicine or HPP-approved courses. Mental health disorder participants are required to complete at least 20 hours of CME approved by HPP in studies related to their illness. Dual-diagnosed participants are to complete 10 hours in each category. Based on cases reviewed, no concerns were noted regarding CME requirements.

Workplace Monitors

All participants identify workplace associates that HPP periodically contacts to determine the status of their progress. On agreements to participate, workplace monitors are identified, depending upon the reason the participant is in the Program. Workplace monitors are used to prevent and detect typical signs of relapse such as increasingly being late to work or a practitioner being unusually moody.

Until recently, workplace monitors have not been utilized very often in the treatment plan. HPP or their consultants have not typically visited the workplace to observe the participant's surroundings and to ensure that safeguards are in place to help alleviate risks associated with relapse. Monitors have not received documentation or formal training to help them identify signs of relapse. Workplace reintegration meetings may be held with the employer, staff, or supervisor in cases of particular concern or when otherwise indicated.

Workplace monitors could play a significant role in the Program by having another individual looking out for participants functioning within the workplace. HPP should ensure that monitors are properly trained to identify relapse behavior, understand their responsibilities as a workplace monitor, and provide regular updates about the behavior of the participant.

Other Observations

Many of the progress notes, especially those in some of the older case files, are handwritten and difficult to decipher. It appears that HPP is moving to typed progress notes, although not in all cases. Institutional knowledge of the staff administering the Program should not have to be relied upon to determine what had occurred. In order to assure someone not directly involved with the case can follow and understand the progress of a participant, progress notes should be typed.

Managing the Operations of the Program

Administratively, the HPP has two primary management components – the Supervisory Council and the Medical Director. The Council is charged with directing policies and procedures, supervising clinical decisions, and developing and implementing a program for chemically dependent licensees of the OMB. The Medical Director is responsible for oversight of all Program services including case identification, intervention, initial assessment, referral, post treatment monitoring, and relapse management. The Director also manages HPP personnel and operations by developing and implementing policies and procedures in compliance with State requirements and all legal regulations.

The Oregon Medical Board also plays a part in the management of the Program's operations. In addition to appointing members of the Supervisory Council, the Board develops specific rules and practices to achieve its mission. The implementation of those rules and practices has, at times, dictated how the HPP manages its operations.

Efficiency and Effectiveness of the Program

Our review of the HPP identified two primary areas that extensively impact Program operations and effectiveness: the relationship of HPP with the OMB and Program management.

The HPP and OMB have recently had a difficult relationship. Views have been so divergent that HPP has elected to use separate DOJ attorneys. Although both entities have similar missions, a cooperative approach to achieving their ultimate goals is not always present.

An ongoing disagreement exists about what information can be shared when OMB Investigations is investigating a Program participant. When the Supervisory Council determines that a participant is non-compliant or a safety risk and reports to the Board, all information relating to that case is available for review. However, when Investigations is informed of a possible violation of the Medical Practices Act and opens an investigation that is unrelated to substance use disorders or mental health conditions, 42 CFR, Section 2, restricts how confidential treatment records can be used by the licensing board. Opinions differ regarding how this law should be interpreted.

Conflicting perspectives also appear to impact how the Supervisory Council approaches some decisions. During our observations of two recent Supervisory Council meetings, it was apparent that, in several instances, the Council had tried to anticipate what the Board would decide instead of considering what was right for the Program or case that was being considered.

The strained relationship is also evident with the Medical Director and extends both to the OMB and the Supervisory Council. The Medical Director is a strong advocate for diversion programs in general, and the HPP in particular. To that end, the passion and commitment shown by the Medical Director appears to have sometimes alienated others. In an attempt to make a point or persuade others to see things a different way, the Medical Director has essentially caused others to believe that she is inflexible and uncompromising. This drive and focus has caused some to question whether public safety is weighed adequately when considering the maintenance of the health of licensees. In addition, some Supervisory Council members have lost confidence in the Medical Director's performance.

Program management has also been impacted by this relationship. The OMB and HPP Medical Director differ on policies, rules, and decisions that are shaping the Program. The OMB is tasked with a very specific mission that includes helping to evaluate disciplinary actions imposed on licensees and considering whether the licensee should be referred to HPP for evaluation and potential entry into the Program. The Board is not kept informed of who has entered the Program voluntarily, only learning about a participant when independently investigated and incidentally discovers that the licensee is in the Program or when HPP reports a participant for non-compliance or safety risk. In an effort to ensure licensees self-report impairment or competency issues, the Board has modified certain Administrative Rules. HPP personnel see this as detrimental to voluntary participation.

HPP Supervision of Toxicology

Objective: Reassess the degree and quality of toxicology testing enrollees arranged and supervised by HPP, and make recommendations with regard to the adequateness of this supervision.

Our analysis and conclusions relating to the supervision of toxicology testing can be found in the *Managing the Monitoring of Participants* section, above.

Introduction

Introduction

Objectives

Talbot, Korvola & Warwick, LLP, under contract to the Oregon Medical Board (OMB), conducted an evaluation of the efficiency and effectiveness of the Health Professionals Program (HPP or Program). The assessment focused on evaluating the Board's HPP and its procedures to:

5. Determine the progress which has been made by HPP towards addressing the findings and implementing recommendations from the 2006 Audit report,
6. Evaluate whether the HPP has completed a policies and procedure manual and implemented procedures and standards that:
 - a. Are consistently adhered to by Program staff and independent contractors, and
 - b. Adequately protect the public from harm by licensees who are assessed to have a substance use disorder,
7. Evaluate the effectiveness and efficiency of the HPP and make recommendations regarding any changes or reforms required to assure that licensees participating in the Program are appropriately monitored and the public is protected from practitioners who are impaired due to alcohol or drug abuse, and
8. Reassess the degree and quality of toxicology testing enrollees arranged and supervised by HPP, and make recommendations with regard to the adequateness of this supervision.

Project Approach and Methodology

To gain a comprehensive understanding of the Health Professionals Program, we spoke with staff responsible for administering the Program, the Executive Director of the OMB, members of the Supervisory Council, counselors, and the Oregon Department of Justice attorney assigned to the HPP.

The information gained from these individuals and from other corroborative sources provided insight into the issues, needs, and expectations surrounding the evaluation and was invaluable in reaching the conclusions presented within this report.

As part of our review, we evaluated numerous HPP documents and files. Included were ORS Chapter 677 (Medical Practice Act) and 42 CFR (confidentiality), job descriptions, budget



documents, HPP policies and procedures, the 2006 Audit, the BME-HPP Administrative Consultant Report, the draft survey conducted of HPP participants, information associated with the Federation of State Physician Health Programs, various national medical articles, and other states' websites. In addition, we selected 23 files for case review to determine what information was maintained in the files, how the files were organized, and what processes have been used. Eight were successful completion files, ten were open files, three were "other," such as transfers to another state, and three were unsuccessful. Once the files were segregated into these four categories, we randomly selected the files using Excel's random selection function. We also attended two Supervisory Council meetings and one Group Facilitator meeting.

The Health Professionals Program

Overview of the Program

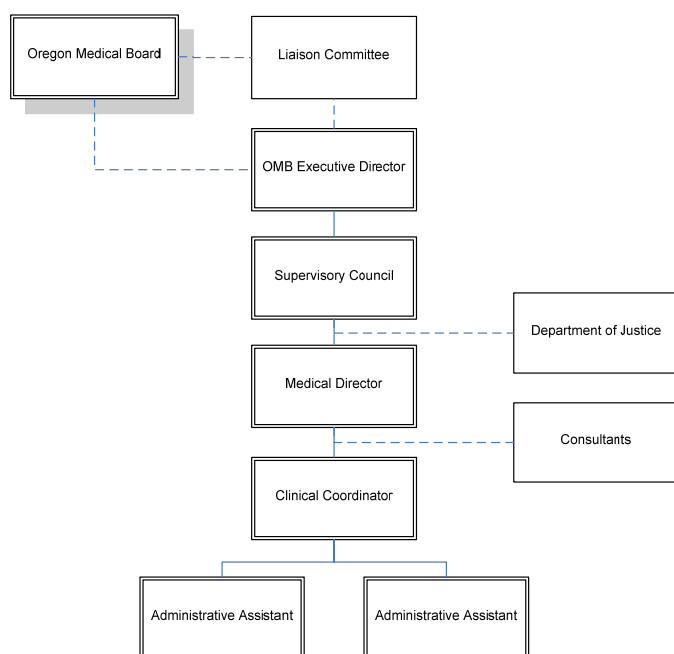
HPP Mission:

To protect the public health through maintenance of the health of licensees of the Oregon Medical Board.

In the late 1970's, the Oregon Medical Association (OMA) formed an informal diversion program for medical professionals that later became the OMA Monitored Treatment Program. However, due to financial constraints, the program was discontinued. In 1989, the Oregon Legislature, through the passage of Senate Bill 1032, established the Health Professionals Program, designed to “provide a therapeutic alternative for licensees of the Oregon Medical Board suffering from alcohol or drug abuse or dependency.” Twenty-five participants of the Monitored Treatment Program were referred to the HPP at that time.

HPP is a component program of the Board, receiving administrative and financial oversight. HPP reports general statistical information and progress of the Program and identifies potentially impaired physicians to the Board.

The HPP facilitates confidential assessments for potential substance use disorders and mental health conditions. They are responsible for providing interventions, arranging treatment and referrals, and monitoring licensees with these disorders. The HPP office is located separately from the OMB office to help maintain the confidentiality of its participants.



The Oregon Medical Board

The Oregon Medical Board, who is tasked with the mission and authority to protect the public and to exercise general supervision over the practice of medicine in the State, provides administrative and financial support for the Program. It is responsible for appointing the seven Supervisory Council members. In addition, the Board has appointed the OMB Executive



Director to provide oversight and guidance to the Program. When the Supervisory Council determines that a licensee has failed to comply with the Program contract, the Board is responsible for determining whether the licensee should be able to continue practicing medicine.

Supervisory Council

The Supervisory Council is responsible for developing and implementing the HPP for chemically dependent and mentally impaired licensees regulated by the OMB. Members of the Council are familiar with the recognition, intervention, assessment, and treatment of chemically dependent and mentally impaired licensees and cannot be a current Board member or staff of the OMB. Council members serve at the pleasure of the Board for two-year terms and are eligible for reappointment.

Liaison Committee

This committee was created in 2007 to increase and improve communication between the OMB and HPP. It is responsible for providing a forum for Council and Board members to review policies and procedures and propose appropriate administrative rules for referral to the OMB. The Liaison Committee consists of two Board members and two members of the HPP Supervisory Council. Others attending the meetings include the OMB Executive Director and the HPP Clinical Coordinator. This committee does not review HPP case files or make any determinations relating to participant compliance.

OMB Executive Director

The OMB Executive Director acts as the Public Information Officer and provides oversight and direction to all OMB staff. This position ensures Board and advisory committee members have the information needed to make sound decisions in addition to overseeing the development of laws and rules. The Executive Director provides information to the Supervisory Council relating to the Board's views and decisions, and legislative updates. In addition, the Executive Director, in conjunction with the Chief Investigator and the OMB Medical Director, determines whether a licensee under investigation or an applicant for licensure should be offered an opportunity to



participate in HPP. This position attends the public session portion of the Supervisory Council meetings, as well as the Liaison Committee meetings.

Medical Director

The Medical Director (MD) is responsible for oversight of all Program services including case identification, intervention, initial assessment, referral, post treatment monitoring, and relapse management for program participants. These services are performed in compliance with confidentiality laws and evidence-based addiction medicine principals specific to health professionals. The MD provides addiction medicine consultation to program participants and their medical providers, approves and monitors use of potentially addictive medication when medically required, determines the need for medical and psychiatric assessments and makes appropriate referrals and orders and reviews all toxicology tests. The Medical Director also manages HPP personnel and operations by developing and implementing policies and procedures in compliance with State requirements and all legal regulations. This position is responsible for educational outreach to licensees, health organizations, other regulatory agencies, and the public, and promoting the Program. The MD reports directly to the Chair of the Supervisory Council. The current MD is certified Preventive Medicine, Addiction Medicine and has additional credentials as a Medical Review Officer facilitating in-house review and interpretation of toxicology results.

Clinical Coordinator

The Clinical Coordinator is responsible for providing quarterly reporting requirements to a variety of medical-related stakeholders including hospital administrators, medical staff coordinators, physician well-being committees, HMO's, malpractice insurance carriers, medical societies, and other health licensing boards in and outside Oregon. This position has primary responsibility for case management of HPP participants, and resource development for the Program. This position was created to help develop and implement the new mental health component of the Program. The Clinical Coordinator reports directly to the Medical Director.

Administrative Assistant

The Administrative Assistant provides clerical support to the Medical Director and the Clinical Coordinator. This position is responsible for tracking a variety of information for the Program, including, but not limited to:

- participant personal data and treatment plan, including updates,
- consultant lists,
- toxicology data including when tested, results, and changes in individual requirements,
- approved prescriptions being taken by participants,
- when consultant reports are due and received, and
- receipt and routing of monitoring reports.

The Administrative Assistant has also spearheaded the development of HPP's area within techMed, the system that will be utilized to help manage cases. In addition, this position performs administrative technical tasks to increase the efficiency and effectiveness of the Program.

Administrative Assistant¹

A temporary administrative assistant was assigned to the HPP to assist with receptionist and clerical duties during the development and implementation of the techMed system, as well as prepare closed case files to be scanned by a contractor.

Office Manager

The position of Office Manager has been approved and, if funding is granted, would provide administrative oversight of the Program. This position would be similar to the Program Coordinator position that was replaced by the Clinical Coordinator. This would include monitoring Program operations for compliance with regulations and adherence standards. This position would also conduct research on a variety of issues covering governing Program regulations, legislative and executive intent, operating policies and end results, evaluating

¹ Currently a temporary position. This position will not be funded for the 2009-2011 biennium.

findings, and prepare and present comprehensive reports and recommendations to the Supervisory Council and the OMB, as necessary.

The Office Manager would also identify short- and long-range operational goals and objectives, and develop plans to meet those goals and objectives, manage office affairs, develop policies and procedures, and direct training to help staff understand changes as they occur. In addition, the Office Manager would provide staff guidance and help promote the Program, as time allows.

Department of Justice

The Oregon Department of Justice currently provides all legal assistance to the HPP. This attorney is not the same as the one that represents the OMB. The position spends one full day every two months attending the Supervisory Council meeting. In addition, the attorney is asked to provide legal opinions.

Use of Consultants

The HPP uses consultants extensively to assist participants with treatment, ongoing care, and monitoring. HPP has contracted with consultants throughout the State that facilitate group meetings, and serve as monitoring consultants. These consultants are experienced in treating health professionals with substance use disorders. All have professional credentials, most frequently at the masters or PhD level and several are graduates of the Program. Consultants used to assist participants with mental health disorders have clinical credentials and extensive knowledge in psychiatric disorders, diagnosis, and treatment. Consultants are expected to provide regular reports on the participants assigned to them and notify HPP when they believe a participant shows signs of relapse or an inability to practice medicine with reasonable skill and safety.

The Federation of State Physician Health Programs

Oregon's Health Professionals Program is a member of the Federation of State Physician Health Programs (FSPHP), and generally follows the guidelines established by this organization. The FSPHP is a non-profit corporation focusing on education and exchanging information among

state programs, developing common objectives, goals, and standards, enhancing awareness of issues related to physician health and impairment, advocating for physicians, and assisting state programs protect the public. Forty-six out of 51 states (including Washington, D.C.) have physician health programs and are members of the FSPHP.

techMed

The Oregon Medical Board is in the final stages of testing and implementing techMed, a data management program designed to capture and organize licensing and case file information electronically in an effort to improve the efficiency and effectiveness of the organization. The HPP Medical Director and Administrative Assistant have provided the conceptual design and functionality for the HPP case management portion of the project.

Case Management

The HPP is responsible for promoting public safety by facilitating assessments for potential substance use disorders and mental health conditions of OMB licensees, providing intervention, facilitating treatment and referrals, and monitoring the progress of licensees with these disorders. Many services provided, such as addressing an initial inquiry about a potential impaired licensee or answering questions from the general public, a hospital/treatment center administration or staff, or licensee who is considering participation in the Program, do not necessarily result in a new case.

The following conditions must be met before a licensee is eligible for participation:

1. The individual must be a current OMB licensee or referred to by the OMB in conjunction with licensure,
2. The licensee must have a treatable mental health condition or substance use disorder requiring treatment/monitoring to prevent workplace impairment,
3. The licensee must accept or request HPP services, and
4. The HPP must be able to design and implement a functional evaluation, treatment, and/or monitoring program for the licensee.

In addition to self referrals, HPP may be contacted about the professional or behavior conduct of a licensee through a variety of sources including the OMB, colleagues, treatment professionals, hospital/clinic personnel, patients or their families, etc.

HPP considers licensees who seek Program assistance on their own or through an intervention of others without prior OMB knowledge to be voluntary. Referrals from the OMB include an investigative or a licensure referral. These may be in the form of a Board order or may be confidential.

When a licensee is introduced to the Program, information is obtained through an Intake/Screening form and a case number is assigned. HPP collects as much relevant information as possible and, when feasible, a screening interview is conducted. In cases where others have notified the Program of a potential issue, the HPP learns about the licensee and devises a plan of action and an intervention may take place. Once enough information has been obtained, a determination of eligibility is conducted based on established admission criteria. When initial contact has been made with the potentially impaired licensee, the clinical staff attempts to get the licensee to sign an Evaluation and/or Treatment Agreement that establishes a formal relationship between the two parties. By signing the Agreement, the licensee agrees to abstain from all potentially addicting substances until the evaluation/treatment is completed. The Agreement also permits HPP to notify the OMB if the licensee does not comply with the agreement.

In most cases, the Agreement requires the licensee to seek the HPP recommended evaluation and/or treatment within 72 hours at a HPP approved provider/facility. At a minimum, a comprehensive interdisciplinary evaluation including medical, psychiatric, psychological, chemical dependency, and practice assessment examination is conducted and treatment recommendations are made.

Once an evaluation has been completed, a determination of whether the licensee should participate in the Program is made. If it is determined that the licensee does not have a substance

use disorder or mental health condition, the information is filed and the case is closed. If it is determined that the licensee has a treatable mental health condition or substance use disorder, the licensee is asked to sign a Continuing Care Contract - the agreement that establishes the treatment plan and identifies steps the licensee must take to successfully complete the Program. Failure to enroll in situations where there is a concern of impairment in the workplace may lead to HPP informing the referring organization to report the licensee to the Board. . In the case of imminent patient harm, the HPP Medical Director must contact the OMB Medical Director to report the incident even if the licensee has revoked their consent to report non-compliance (as required under 42 CFR).

There are several types of Continuing Care Contracts:

2. Continuing Care Program Voluntary Agreement – the standard agreement used for licensees that have substance use disorders, mental health problems, or both. This is typically a five year contract.
3. Extended Care Voluntary Agreement – used for those participants who have successfully completed the Program, but believe they could benefit from continued support and monitoring. Participants who sign this agreement do so voluntarily and may withdraw from the Program without penalty.
4. Diagnostic Monitoring Agreement – used for licensees who have demonstrated symptoms suggestive of substance abuse or who need to document their sobriety for the workplace.
5. Reciprocal States Voluntary Continuing Care Agreement – This agreement is used when licensees hold licenses in multiple states and have a primary practice in another state.

In most cases, during the evaluation and treatment stage of the process, the licensee agrees not to practice medicine until representatives of the HPP or the treatment facility believes that the licensee can practice safely and competently. When the licensee has been diagnosed with a substance use disorder or mental health condition and agrees to participate in the Program, there are certain requirements that are generally integrated into the treatment plan, including:

1. Attending support (mutual help) group meetings, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Caduceus (support group for healthcare provider recovery), or other programs approved by HPP. Generally, participants are required to attend no fewer than three mutual help recovery meetings per week during the first two years, and no fewer than two meetings per week for the remaining three years of the contract.

2. Attending facilitated peer group meetings weekly for the first two years of recovery. The participant is expected to have 100% attendance the first 90 days in the Program, and at least 90 meetings in the two-year period, with no more than six absences allowed per year. If these requirements are not met, the participant may be required to attend group sessions for a longer period of time.
3. All dual-diagnosed and mental health participants will be under the care of a treating psychiatrist or approved mental health provider. Consent for release of information between the psychiatrist/therapist and HPP is required. The treatment provider is required to notify HPP immediately if the participant's ability to practice with reasonable skill and safety is in question. Quarterly progress reports are provided to HPP.
4. HPP monitoring consultant meetings occur monthly for three months for a substance use disorder, six months for dual diagnosis, and one year for mental health conditions, and quarterly thereafter. Reports from the consultant are provided to HPP after each meeting.
5. Abstinence from alcohol and other potentially addicting substances is required during the entire monitoring period for those with substance use disorders. Those with mental health conditions are asked to abstain for six months. After consultation with treatment providers and consultants and no evidence of substance use disorder is found a participant may be approved to return to light social alcohol use. Once permission is given, participants are asked not to exceed three drinks on any occasion and no more than twice weekly. When abstinence is a treatment requirement, toxicology testing is utilized. Recreational use of drugs is prohibited during the contract period for every participant.
6. Toxicology testing is mandatory during any period when an HPP participant is required to be abstinent. Random urine collections are ordered for all participants with substance use disorder and for the first six months for those with a mental health condition. An appropriate testing panel is ordered based upon clinical history and may require additional urine collections or alternative chemical monitoring (blood, saliva, breath, or hair) as appropriate. The general requirements for toxicology testing are as follows:
 - a. 1st and 2nd years: 25-30 tests per year
 - b. 3rd year: 19-24 tests
 - c. 4th year: 15-18 tests
 - d. 5th year: 11-14 tests
 - e. Extended voluntary: 6-8 tests per year minimum
7. Continuing Medical Education (CME) is required for HPP participants. Substance use disorder participants are required to complete at least 20 hours of CME in addiction medicine or HPP-approved courses. Mental health disorder participants are required to complete at least 20 hours of CME approved by HPP in studies related to their illness. Dual-diagnosed participants must complete 10 hours in each category.
8. Annual reviews with the HPP treatment team are required for each Program participant. Dual diagnosis and mental health participants may be assigned more frequent clinical review meetings. Additional treatment team meetings are scheduled with participants for cause or crisis management.



HPP personnel monitor participant's health condition for detection of relapse, recurrence, and/or deterioration, and evaluates (to a reasonable degree of medical certainty) whether a participant's health condition is likely to impair his or her ability to practice medicine with reasonable skill and safety. The Supervisory Council reviews all cases of relapse and approves or revises case management plans, and determines when participants must be reported to the OMB. When patients are at risk, the licensee is taken out of practice, placed on medical leave, and referred to appropriate medical service for treatment. In situations involving potential impairment, the Medical Director calls an emergency Supervisory Council meeting to determine reporting obligations. When no workplace impairment has occurred, the treatment plan will be evaluated and modified as needed and Council will provide input at the next Council meeting.

Results

2006 Audit

Objective: Evaluate the Board's Health Professionals Program (HPP) and its procedures to determine the progress which has been made by HPP towards addressing the findings and implementing recommendations from the 2006 Audit report.

The OMB contracted with an independent consultant to evaluate the effectiveness and efficiency of the HPP. The consultant was tasked with making recommendations necessary to ensure licensees were being appropriately monitored and to ensure that the public was adequately protected from impaired licensees. The report outlined 50 recommendations in the areas of:

- 1) oversight and governance,
- 2) HPP office operations, policies, and procedures,
- 3) body fluid (urine) monitoring,
- 4) management of relapse prodromal behavior and relapses,
- 5) referrals and HPP census, and
- 6) other issues.

To determine the progress of each recommendation, we spoke with HPP personnel, attended Supervisory Council and Group Facilitator meetings, reviewed available documentation, and reviewed a sample of case files. Recommendations and outcomes to date have been summarized and listed below.

Oversight and Governance - Sixteen recommendations were made regarding oversight and governance of the Program in the following areas:

- Supervisory Council should:
 - 1) Develop a long-term plan for developing the Supervisory Council governance and oversight processes:
 - *Supervisory Council policies and procedures are in the initial stages of being drafted.*
 - 2) Develop a set of oversight criteria that is regularly reported to it by the Medical Director:
 - *A new status report has been drafted and additional reports are being developed within techMed, the system being developed for collecting and tracking licensee and case file information, expected to go live in July 2009.*
 - 3) Meet more frequently, preferably a minimum of eight times per year:

- *The Supervisory Council rejected this recommendation, stating that eight meetings are too much of a time commitment for Council members as well as HPP staff.*
- *The Council has increased its meetings to six per year in addition to emergency meetings held as necessary.*
- 4) Restructure its meetings to allow for more time to deliberate Council issues by itself:
 - *As of January 1, 2009, public meetings are no longer applicable to HPP.*
- 5) Appoint specific Supervisory Council committees, starting with a Board Liaison Committee. A clinical committee is strongly recommended:
 - *The Liaison Committee, made up of Supervisory Council and Board members, was created in 2007 and has met intermittently since.*
 - *The clinical committee was initially rejected by the Supervisory Council because the Council wished to continue as a whole in this function; however this topic is likely to be revisited in the future.*
- 6) Expand the number of Supervisory Council members from five to seven or nine, and increase the diversity of the Council, both in terms of skills and recommendations. Other skills, particularly administrative skills and outreach/marketing/networking, are needed.
 - *The Supervisory Committee Council now has seven members.*
 - *One new member has strong administrative skills.*
 - *Although the Medical Director, Clinical Coordinator, and the OMB Executive Director conduct presentations to the medical community, Supervisory Council members have not performed outreach/marketing/networking activities.*
- Joint Liaison Committees should:
 - 7) Be created, one including two Board members, and one including two Council members that would then form a Joint Committee to work collaboratively on matters of mutual concern. Joint meetings should occur on a regular basis, preferably quarterly, and when critical matters arise.
 - *Members have been appointed and meetings have occurred intermittently since 2007.*
 - 8) Review and develop formal criteria initially for quarterly Supervisory Council reports to the OMB, defining relapse and relapse prodromal behavior, developing criteria for reporting relapses and non-compliance to the Board for both Board-mandated HPP participants and voluntary participants, defining sexual violations, and developing criteria and expectations for reporting sexual violations to the BME.

- *Supervisory Council quarterly reports including statistical information has been developed for the OMB.*
 - *The definition of relapse and relapse prodromal behavior has been documented within the Case Management Policy.*
 - *Criteria for reporting relapses and non-compliance to the Board for both Board-mandated HPP participants and voluntary participants have been created within the Mandatory Reporting of Participants to the OMB Policy.*
 - *The definition of sexual violation is defined under the Oregon Administrative Rules² and can be found in the Mandatory Reporting of Participants to the OMB Policy.*
- 9) Discuss the 2006 Audit Report for collaborative planning to prioritize and address its conclusions and recommendations.
- *No direction has been provided by the Liaison Committee regarding the 2006 Audit Report.*
- HPP should not:
- 10) Take on any new non-essential projects such as expanding the outreach program or implementing a mental health program until the office organization has been improved, a new Program Coordinator has been hired and oriented, and staffing levels are adequate for new ventures. There needs to be a parallel improvement in the oversight process before any major new programs are undertaken.
- *HPP has converted 1 FTE to a Clinical Coordinator. This position was filled in 2007.*
 - *HPP has increased the Administrative Assistant position from 0.8 FTE to 1.0 FTE and a temporary office assistant was available to assist with administrative duties for six months ending in July 2009.*
 - *An Office Manager has been requested and approved for the 2009-10 biennial budget, but the budget has not yet been finalized.*
 - *The Program has implemented a mental health program starting January 1, 2009. To date, five licensees with mental health conditions have entered the program.*
 - *The Program has designed and implemented the techMed computer system.*
 - *The Program, with the help of a consultant, has conducted a participant survey.*
 - *The Program has participated in a second Program audit.*

² OAR 847-010-0073 (3.b.G.i)

- HPP should:
 - 11) Ensure the workplace monitoring system is improved and expanded to be more consistently used.
 - *Workplace monitors have been added as part of the treatment plan, except in cases where it would be inappropriate i.e., where there has never been a workplace impairment issue.*
 - 12) Ensure a specific workplace monitor is identified for each participant, voluntary or mandated, when enrolled in HPP, unless there are extenuating circumstances that preclude such an arrangement. Communication between HPP and the monitor needs to be established promptly. Regular reports should be received from the monitor and placed in the participant's chart.
 - *Workplace monitors have been identified for participants who have had workplace impairment issues. Currently, not all submit a formal report; however, HPP contacted all workplace contacts in late 2008 to discuss the participant's workplace performance for all open cases.*
 - 13) Develop policies and procedures for workplace monitors.
 - *Policies and procedures have been developed and can be found in Oregon HPP Policy and Procedure Manual, Chapter 11.*
 - 14) Develop educational programs for workplace monitors.
 - *HPP plans on providing written training materials to workplace monitors in addition to having discussions with them. It is anticipated that this will be implemented once techMed is functional in order to better track who has received the material.*
- The Supervisory Council should:
 - 15) Survey participants about their experience with HPP, with particular emphasis on the role of the groups, confidentiality, the degree of trust of the participants, the willingness to report personal difficulties, how the monitoring functions of the group impact trust and self reporting, the role of medical consultants, conduct of HPP staff, etc.
 - *A survey was conducted by an outside consultant of current and former participants of the Program. Approximately 170 surveys were mailed to participants. Some agreed to be interviewed, while others completed a questionnaire. 71 responses were received in total. The survey was in draft form expected to be finalized by June 30, 2009.*
 - 16) Reassess the role of groups and the desired balance between monitoring and recovery functions once the survey is complete. Written guidelines for sharing information between HPP and group leaders should be developed. These guidelines should be shared with participants to create greater

transparency and develop trust. Any anticipated changes in current policies and procedures should be discussed with the Board.

- *An assessment has not taken place, partly because the survey has not been finalized. However, written guidelines can be found in the Oregon HPP Policy and Procedure Manual, Chapter 7.*

HPP Office Operation, Policies, and Procedures – Eighteen recommendations were made regarding HPP office operations, policies, and procedures:

- HPP personnel should:
 - 17) Ensure a policies and procedures manual is developed and presented to the Supervisory Council, in consultation of the Board, for review and approval.
 - *An Operations Manual containing clinical policies and procedures has been created. All procedures developed to date have been approved by the Supervisory Council, with only three sections within the Manual yet to be completed.*
 - 18) Ensure the development of specific policies and procedures, including but not limited to the list shown in the Appendix of the 2006 Audit Report.
 - *The policies and procedures listed in the 2006 Audit Appendix have been developed and approved by the Supervisory Council. Some of the policies and procedures listed in the 2006 audit appendix are combined with other procedures within the Operations Manual.*
 - 19) Keep a log book for all incoming referrals and inquiry calls, identified by type of call, and should be tabulated and reviewed periodically and reported to the Supervisory Council. Consideration should be given to computerizing this function.
 - *A log book of incoming calls is not being maintained. All HPP staff are responsible for answering incoming calls and per staff interviews, staff are too busy to track each call. The Medical Director has conducted periodic studies tracking calls for a specific period of time, but information has not been analyzed in detail.*
 - 20) Develop and implement a referral information sheet to summarize all pertinent information needed for referral calls. This could be included in a computerized system.
 - *An Intake Form has been developed and is currently in use.*
 - 21) Ensure the HPP voice message for when no one is available to answer the phone should be recorded by the Medical Director. All messages should clearly state that the calls are confidential.

- *The HPP rejected the idea of the Medical Director personally recording phone messages. The current after-hour message does not state that all calls are confidential.*
- 22) Block the identification of all outgoing calls to protect the confidentiality of HPP participants.
- *There is a technical glitch relating to this recommendation. The phone bill is through the OMB and is set up to identify OMB as the caller. Caller Identification can be restricted on two lines; however, some phone numbers will not accept unknown incoming calls.*
- 23) Initiate caller identification for all incoming calls.
- *This recommendation was rejected. The HPP does not want to discourage people from calling. Without having caller identification, the HPP can state clearly that all incoming calls are confidential.*
- 24) Develop a formal, written intake policy and procedure. An intake interview and HPP enrollment should take place before referral treatment whenever possible.
- *An Intake form and related policies and procedures have been developed, reviewed, and approved by the Supervisory Council. The policy states that the intake interview and enrollment take place before referral whenever possible.*
- 25) Collect data at intake in a standard format that begins the database for the individual participant and that allows for data collection for the Program.
- *A survey is provided to participants at the time of admission into the Program; however, sometimes the surveys are not completed until after intervention and treatment have occurred. These surveys are viewed as not very reliable, since some of the participants are in denial at the beginning of treatment.*
- 26) Review the HPP chart organization to devise a method to easily track the progress of participants. All major events, from admission to discharge, should be noted in a central place such as progress notes. Whenever there is an important event, a notation should be placed in the chart, including a brief summary of the event. More detailed information should be retained in the specific sections of the chart as is currently done.
- *Based on input from a Supervisory Council member and the Clinical Coordinator, charts have been reorganized. No summary of significant events shown in chronological order has been developed; however, once records are incorporated into techMed, HPP will be able to list events by date.*

- 27) Consider using a contact management program such as ACT! Or Goldmine to record contacts with participants, to create a “tickle” file, record database information, etc.
- *Recommendation rejected. techMed will be used, which will have a reminder function to alert staff of significant upcoming events.*
- 28) Consider converting the chart system to a paperless one to make tracking and organizing easier.
- *External reports (i.e., workplace monitor reports, monthly group facilitator reports, quarterly counselor reports) will be scanned into the techMed system. Currently there is no email encryption to safeguard confidential participant information.*
- 29) Have a certified medical records professional evaluate the current charting system and make recommendations necessary to ensure HPP records meet current standards for medical records.
- *Charts have been reorganized, based on input from a Supervisory Council member and the Clinical Coordinator.*
- 30) Revise the Monthly Monitoring Report to be renamed Monthly Progress Report, and include a section for the participants to complete and sign that relate to recovery activities, taking more ownership in the reporting process.
- *Monthly Monitoring Reports for group facilitation meetings were revised in 2006 and meet these recommended changes.*
- 31) Develop a standardized Practitioner Database to collect participant information to assist with treatment as well as statistical information related to the Program. This information should be updated periodically.
- *A participant survey was developed and is being used as of January 2009.*
- 32) Develop a computerized tracking system for the participants’ status, to increase accuracy as well as assist Program staff with ensuring compliance in an efficient and effective manner.
- *techMed was selected as the computerized system for housing participant information and should go live in July 2009.*
- 33) While the computerized tracking system is being developed, the HPP should collect personal and statistical information through the use of a hardcopy questionnaire in a form that makes it readily transferrable to a computerized, relational database.
- *Currently, the survey/questionnaire is not electronic, but a paper copy that is completed by the participant manually.*

- 34) Develop the Practitioner Database that could be self-administered by participants on a HPP computer, with the data being downloaded electronically into the HPP Client Database.
- *HPP does not have the technology to support this. In addition, other reports, such as the group facilitators' reports and the quarterly consultant reports, are used for reporting to the Supervisory Council and the OMB, as well as for Program evaluations, Program management, and research purposes.*

Body Fluid Monitoring – Eight recommendations were made regarding toxicology testing:

- HPP personnel should:
 - 35) Ensure that the frequency of urine specimens actually collected is brought to the level targeted within participant contracts. It is recommended that actual vs. targeted collections be audited on a monthly basis.
 - *RSS performance has been monitored since 2003. Performance has periodically improved; however, improvements have not been sustained. RSS will be replaced by First Lab starting in June 2009. Participants will have to contact First Lab on a daily basis (Sundays and holidays excluded) to see if they have been selected for testing for the day.*
 - 36) Collections are strongly weighted toward the middle of the week, with too few collections on Mondays and Fridays.
 - *techMed, the system that will be used for case management, has the capability of generating a random testing schedule for participants. First Lab also will generate a random schedule for each participant.*
 - 37) Provide more scheduling oversight to ensure that Monday and Friday collections are promptly brought to a frequency at least as great as the frequency of Tuesday to Thursday collections, and perhaps even more frequently, for a time.
 - *HPP staff have monitored RSS collections and has made efforts at increasing Monday and Friday collections. In its last two reporting periods, RSS did improve its Monday and Friday collections.*
 - 38) Obtain some weekend collections on selected participants, especially those that have demonstrated evidence that they might not be in compliance or might be slipping out of recovery.
 - *There are minimal sites throughout Oregon that provide Saturday collections. Most are in the Portland area. RSS improved its Saturday collections intermittently over the last two years, but for its last*

quarter of reporting, no Saturday collections were reported. The Supervisory Council determined that when First Lab takes over toxicology testing services, Saturday testing (at least two annually for each participant in the first couple of years within the Program) will take place if Saturday collections are available within the participant's area.

- 39) Ensure that direct observation of specimen collections take place more frequently.
- *This is out of the control of the HPP. The many labs that are used offer different services. First tier labs – preferred labs that offer all services required by HPP, such as the type of test or observing collections, are not in every area of the State. In addition, there must be a same sex attendant on duty in order for the collection to be observed.*
- 40) Ensure that time span between the initial call and when the participant arrives to provide a specimen is within four hours.
- *HPP's current procedure is to require specimens to be collected within four hours of notification and always within eight hours of notification. This information is received on compliance reports provided by RSS; however, although collections taken within four hours are ideal, HPP considers collections taken on the same day as compliant.*
- The system has recently changed. Participants can now either call or check online between 5am and 2pm (Mondays through Saturdays) to determine if they need to submit a specimen that day.*
- 41) Review the payment schedule for toxicology testing to ensure that the flat monthly fee system does not create potential negative incentives for the service provider to collect sufficient specimens to reach the target number.
- *Participants pay for testing directly to the service provider and, as a result, HPP cannot dictate the payment schedule. In 2009, RSS did alter its billing practices to base cost on actual collections rather than subscription fees. The new service provider will charge per test, increasing the incentive to conduct tests at the higher end of the range instead of the lower, i.e. first year participants require 25-30 tests per year, so the provider will have a greater incentive to test 30 instead of 25.*
- 42) Consider other recommendations relating to toxicology testing such as:
- a. Review the collection schedule for the next month with RSS in advance to ensure that the number of scheduled tests meets the target number.

- *The service provider did not create an advanced schedule nor did the HPP follow-up to request it.*
- b. Review the collection schedule by days of the week, and make adjustments to ensure collections are made at least as frequently on Mondays and Fridays.
 - *HPP has been tracking collections by day since the fall of 2006 periodically. For the time periods tracked, it appears Monday and Friday collections improved.*
- c. Change the randomization schedule so that target levels of collections are met over a shorter period (i.e., one or two months initially, rather than annually).
 - *HPP made many attempts to encourage the service provider to comply with this, without success.*
- d. Ask RSS to report actual collections vs. targeted collections on a weekly basis.
 - *RSS provided weekly reports during the last half of 2006 and the first quarter of 2007. Retirements of two HPP staff with delayed replacement in 2007 interrupted this process. Attempts to reinstate the process in 2007 were unsuccessful.*
- e. Insist that any collections missed in the previous week be made up the following week.
 - *The service provider complied with this requirement.*
- f. Consider instituting penalties if RSS does not perform satisfactorily.
 - *HPP refers participants to RSS and does not have a contractual relationship with the company. The Program has attempted to improve service voluntarily but has no ability to levy penalties. The Program has chosen to limit or discontinue using the RSS system.*

Management of Relapse Prodromal Behavior Relapses – One recommendation was made relating to managing relapses:

- HPP personnel should:
 - 43) Consider developing a tracking form for those participants who are felt to be at increased risk for relapse.

The following is taken from the 2006 Audit Report:

“It might be useful to have a specific relapse prodrome/relapse management tracking form that is initiated when a participant is suspected

of being at risk (repeated low-level EtG determinations; relapse prodromal behavior; positive urine; etc.) This would facilitate easier follow up and would also facilitate ongoing review of these cases by HPP staff.”

- *Recommendation rejected as not implementable. Standard tracking is used for all participants; however, no form has been developed for tracking participants who may be at risk of relapse. Relapse behavior is most easily identified in retrospect. Problematic behavior does not always represent a relapse prodrome. It is believed that this would be a form of speculative interpretation of behavior and that the Program should respond to behavior, not subjective assessment of risk.*

Referrals and HPP Census – Six recommendations were made regarding toxicology testing:

- HPP personnel should:
 - 44) Work to increase the number of referrals to HPP of eligible practitioners who need HPP services.
 - *Some steps to increase the number of referrals have occurred such as an article in the OMB newsletter, new brochures, a new backdrop for conferences/ presentations, presentations given, etc. However, a plan for increasing Program participants has not been developed.*
 - 45) Increase the number of referrals to HPP to most effectively and efficiently utilize HPP services to protect the public, as well as to rehabilitate practitioners.
 - *Some steps have been taken to increase the number of referrals to HPP, such as an article in the OMB newsletter, new brochures, new backdrop for conferences/presentations, presentations given, etc. However, a plan for increasing referrals to HPP has not been developed.*
 - 46) Solicit assistance from the medical community, with strong support from OMB and, perhaps OMA, to provide a cohesive outreach effort to get more licensees into the Program, as needed.
 - *The Medical Director, OMB Executive Director, and the Clinical Coordinator have presented information to the medical community advocating the Program.*
 - 47) Place particular emphasis on outreach and education to hospitals to increase the referrals made by hospitals. Hospitals should be encouraged to stay actively involved when they refer a practitioner to HPP.

- *HPP has not placed a particular emphasis on outreach and educational presentations to hospitals to increase hospital referrals. HPP does respond to requests for presentations.*
- 48) Direct more HPP resources, particularly those of the Medical Director, towards outreach and education.
 - *HPP agrees with this recommendation; however, more resources are needed before more outreach and education can take place.*
- HPP personnel should:
 - 49) Develop/implement a proactive plan for “marketing” HPP services and increase referrals to HPP, particularly among hospitals.
 - *No formal marketing plan has been developed.*

Referrals and HPP Census – one recommendation was made regarding the mission statement:

- Supervisory Council and HPP personnel, in consultation of the OMB, should:
 - 50) Review and revise the mission statement of the HPP, to broaden the scope and better reflect the full range of HPP functions. In addition, a set of goals and objectives that outline how the mission of HPP is to be accomplished should also be developed.
 - *The mission statement has been revised to include mental health. OMB has a strategic plan that includes HPP; however, HPP believes that they should have their own strategic plan.*

Summary:

HPP has made a concerted effort to address many of the recommendations presented within the 2006 Audit report. The objective of the Audit was to evaluate the effectiveness and efficiency of the HPP, making recommendations to ensure that “(a) licensees are being appropriately monitored and (b) the public is adequately protected from impaired licensees.” From progress identified, it appears that HPP has dedicated a tremendous amount of time and resources implementing specific recommendations. However, HPP did not effectively address significant issues identified in its body fluid monitoring program. The Program was unsuccessful in addressing concerns with frequency, timing/scheduling, and service provider compliance.

To date, the Program has implemented 26 of the 50 audit recommendations. Five were rejected, six rejected in part, and 13 not implemented.

Policies and Procedures

Objective: Evaluate whether the HPP has completed a policies and procedure manual and implemented procedures and standards that (a) are consistently adhered to by program staff and independent contractors (b) adequately protect the public from harm by licensees who are assessed to have a substance use disorder.

HPP personnel developed a policies and procedures manual that covers an array of subjects. All policies developed to date have been approved by the Supervisory Council, with the exception of the Supervisory Council Policy that is in the initial stages of being drafted. The Program is also in the process of developing additional policies and procedures for the Supervisory Council, Program History, Authority, and Structure, and Referral Sources. The Board and the Liaison Committee provide input into the policies and procedures that should be developed.

Many of the Program elements utilized to monitor the treatment of impaired licensees are those identified by the Federation of State Physician Health Programs guidelines, a leading authority on Health Physician Programs. The policies and procedures developed to date incorporate many of these elements and are consistent with best practices.

The HPP is working with its consultants to develop a procedure for the use of consulting psychiatrists in relation to monitoring licensees with mental health conditions. These procedures will address the role of the consulting psychiatrists and the overall monitoring of mental health participants.

Summary:

The policies and procedures appear to be consistent with those recommended by the Federation. They currently provide a solid base and should continue to be reviewed and modified for clarity, succinctness, and applicability. If Oregon Medical Board resources are available, consideration should be given to using the technical capabilities of the Agency to assist in future modifications.

The Liaison Committee should also review and edit the manual and provide input to the Supervisory Council.

Efficiency and Effectiveness of Program

Objective: Evaluate the effectiveness and efficiency of the HPP and make recommendations regarding any changes or reforms required to assure that licensees participating in the Program are appropriately monitored and the public is protected from practitioners who are impaired due to alcohol or drug abuse.

The mission of the Health Professionals Program is to “*protect the public health through maintenance of the health of licensees of the Oregon Medical Board.*” To effectively achieve this mission, the HPP must identify licensees who have substance use disorders and/or mental health conditions, persuade them to take part in the Program, manage monitoring of participants to assure compliance with the terms of their agreement, and assure that these practitioners are not impaired in their ability to practice medicine with reasonable skill and safety. In addition, the Supervisory Council and Program staff must manage the operations of the Program in an effective manner that adequately weighs public safety with maintaining the health of OMB licensees. These activities require the successful integration of planning, practices, resources, and leadership.

Our review of the HPP focused on three areas: the ability of the Program to identify and enroll participants, the success of the Program in assuring that licensees participating in the Program are appropriately monitored and the public is protected from practitioners who are impaired due to alcohol or drug abuse, and the efficiency and effectiveness of the administration of the Program. Specific observations regarding the ability of the Program to achieve various components of these activities are discussed below.

Promoting/Marketing the Program

At the end of 2008 there were approximately 11,085 active licensees in the state of Oregon. Of those, a total of 102 cases were being monitored by the HPP, with an additional 20 that had been discharged (13 successfully completing the Program, six

unsuccessful, and one that was disqualified) throughout the year. This equates to 1.1% of active licensees who participated in the Program in 2008.

Statistical information relating to the number of current licensees that would likely have a substance abuse or mental health problem at a given time is difficult to obtain. A recent study of U.S. Physician Health Programs (PHPs)³ indicated that 42 PHP's reported admitting an average of 34 new physicians with substance use disorders annually, ranging between zero and 150 cases, with a median of 21. HPP had 29 new contracts, including 26 continuing care contracts and three treatment contracts. The PHP's reported an average active caseload of 138 physicians under monitoring contracts, with a range between nine and 541, with a median of 86. HPP had 122 annual contracts throughout 2008, with 102 physicians being monitored at the end of the year. HPP is below the average on each measure, but above the median for both as well. Discussions with Program staff suggest that the maximum expected number of licensees with an active substance use disorder would be closer to 2%, or approximately 278 licensees.

As these numbers indicate the HPP has had a difficult time recruiting participants. Various factors appear to be contributing to these challenges:

Interpretation of ORS 677.655(3)

In anticipation of a case going before the Oregon Administrative Hearings (OAH), the Department of Justice (DOJ) recently provided an interpretation of the diversion provision of ORS 677.655(3). The case involving substance abuse by a licensee in the workplace resulted in the DOJ concluding that the statute does not serve to shield a licensee enrolled in HPP from Board investigation and sanction until the licensee has successfully completed the Program. The interpretation has sparked a debate about what this means for participants who voluntarily enter and remain in HPP. The concern is that any voluntary participant will be subject to investigation and disciplinary action by the

³ How are Addicted Physicians treated? A National Survey of Physician Health Programs, Journal of Substance Abuse Treatment 37 (2009) 1-7

Board, regardless of the status of their involvement in HPP. HPP staff indicated that as a result of these actions, some participants who have successfully completed the Program and signed extended voluntary agreements have decided to discontinue their involvement in the Program.

Program Resources

Resources such as a website that explains services and identifies how licensees or those concerned about a practitioner can contact the Program, flyers and publications explaining the Program, and articles published in the Oregon Medical Board newsletter on a periodic basis are currently used to inform perspective participants. However, Program personnel have focused time and energy on a variety of operational activities but have not strategically approached marketing. Organizational changes have also contributed to this difficulty. In 2007, the Program chose to eliminate the position of Program Coordinator and replace it with a Clinical Coordinator to implement the mental health program. The Clinical Coordinator is responsible for most case management duties, works with consultants to develop policies and procedures for the mental health program, and sends out quarterly reports to requiring entities, such as insurance carriers, hospitals, etc. In addition, the Clinical Coordinator prepares packets and attends Supervisory Council meetings, attends Liaison Committee meetings, and markets the Program and educates stakeholders as needed. This position also attends FSPHP functions when time allows. However, little Program marketing occurs.

The Medical Director is the primary person allocated to promoting and marketing the Program. However, the position also is responsible for a variety of other activities including: initial case and referral assessment, medication reviews, pain management guidance, coordinating treatment and evaluation referrals, managing return to work and workplace issues, tracking legislative and administrative rule changes, interventions, some case management duties, preparing for and attending Supervisory Council Meetings, monitoring and interpreting the toxicology monitoring system, and educating the community. This position is also an active member of FSPHP, attending meetings

and receiving and providing training as necessary. In addition, the Medical Director is providing oversight to a number of different projects, including implementation of the mental health program, developing and maintaining clinical policies and procedures, oversight of the participant survey and the second Program audit, scanning case files, and developing and implementing the techMed system.

More could be done to market the Program. A periodic newsletter could be created and sent to participants, universities, hospitals, treatment facilities, interested stakeholders, etc. Topics could cover basic Program information, upcoming trainings, contact information, legislative changes, statistical information, excerpts from national articles in the field of substance abuse and mental health disorders, etc. More outreach to hospitals, universities, medical associations, and treatment facilities throughout the State could also occur. Educational programs for recognizing signs of substance use disorders and mental health conditions could be given. A coordinated strategy with the Oregon Medical Association and the Oregon Medical Board could also be developed.

Managing the Monitoring of Participants

HPP, with guidance from the Supervisory Council, is charged with monitoring participants in the Program. Major requirements of a standard agreement include:

1. A certain number of random toxicology tests per year, depending upon the year in the Program and progress made in the recovery process.
2. Weekly group facilitation meetings with an approved HPP counselor, for at least the first two years of the Program.
3. A certain number of weekly 12-step meetings, such as AA, NA, or Caduceus.
4. Monthly or quarterly meetings with a monitoring consultant.
5. At least one annual meeting with the Medical Director (or designee), participant, and treatment team members to assess progress and modify treatment as necessary.
6. A certain amount of CME while in the Program.
7. Identify workplace contacts for all participants and a formal workplace monitor, when appropriate, along with personal contacts and treatment provider to contact when concerns arise.

Random Toxicology Testing

Toxicology testing is one of the most effective ways of ensuring participants are complying with their agreements with HPP. However, even this method has shortcomings. Licensees are medically trained, and as such, understand how testing works and would likely know better than most of the general population how to effectively manipulate tests to assure a desired result. Therefore, the randomness and frequency of the tests is highly important.

As indicated in the 2006 Audit, HPP has had problems with its toxicology service provider. Not only has the provider not collected enough tests for some of the participants to satisfy the agreement between HPP and the licensee, the randomization of these tests has been flawed. The audit found that most tests fell on Tuesdays through Thursdays, with minimal testing occurring on Mondays and Fridays and very little testing on Saturdays.

Since the 2006 Audit, HPP has made attempts at improving the service provider performance. HPP requested participant schedules and offered to assist in the generation of random testing but this did not occur. Monthly deficiency reports were provided to the service provider through 2006 and the first half of 2007. However, in late 2007, HPP lost two employees to retirement resulting in limited ability to provide thorough monitoring. Once additional staff was hired, Program personnel contacted the contractor regularly, to rectify deficiency issues, determine how the provider was performing, and to request that the summary information be received in a timely manner.

Toxicology reports requested by the Supervisory Council and other statistical information compiled by HPP were reviewed. The following is a summary of the information received.

In 2007, the Program tracked the number of tests that were performed on target (or above), and under target per participant:

| 2007 | | | | |
|---------------------|---------------------|---------------------|---------------------|---------------------|
| | 1 st QTR | 2 nd QTR | 3 rd QTR | 4 th QTR |
| On or Over Target | 58 (70%) | 71 (84%) | 33 (36%) | 33 (36%) |
| Under Target | 25 (30%) | 14 (16%) | 59 (64%) | 59 (64%) |
| Participants Tested | 83 | 85 | 92 | 92 |

The average collections on or over target for 2007 was 56.5%.

In 2008, the Supervisory Council asked the Program to compare the total tests actually performed (total tests ordered) against expected collections based on the total number of tests that should have been performed for all of the participants:

| | 2008 | | | | 2009 |
|------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| | 1 st QTR | 2 nd QTR | 3 rd QTR | 4 th QTR | 1 st QTR |
| Expected Collections | 456 | 471 | 476 | 549 | 400 |
| Total Tests Ordered | 354 | 536 | 385 | 432 | 208 |
| Percentage of Expected | 78% | 114% | 81% | 85% | 52% |

The average percentage of collections taken from expected collections in 2008 was 89.5%.

The information above indicates that the contractor was unable to meet the targeted tests expected for 2007, 2008, and the first quarter of 2009.

The 2006 Audit analyzed the day of the week toxicology testing occurred during the first quarter of 2005. Since that time, HPP has periodically tracked the day of the week tests were performed, by quarter.

| | 1 st QTR 2005 ⁴ | 3 rd QTR 2006* | 4 th QTR 2007 | 4 th QTR 2008 | 1 st QTR 2009 |
|--------------|--|------------------------------|-----------------------------|-----------------------------|-----------------------------|
| Mondays | 40 (11%) | 97 (22%) | 44 (10%) | 96 (22%) | 40 (19%) |
| Tuesdays | 95 (26%) | 65 (15%) | 124 (27%) | 73 (17%) | 34 (16%) |
| Wednesdays | 100 (28%) | 80 (19%) | 66 (14%) | 101 (23%) | 33 (16%) |
| Thursdays | 80 (22%) | 125 (29%) | 135 (29%) | 66 (15%) | 39 (19%) |
| Fridays | 45 (13%) | 63 (15%) | 75 (16%) | 78 (18%) | 62 (30%) |
| Saturdays | 0 (0%) | 0 (0%) | 18 (4%) | 20 (5%) | 0 (0%) |
| Total | 360 | 430 | 462 | 434 | 208 |

* Months tracked were actually August, September, and October 2006.

⁴ Per 2006 Audit.

It appears, based on the above results that the service provider was able to test more on Mondays, Fridays, and to some extent Saturdays, for at least part of the time HPP tracked performance in this area. However, the results do not provide assurance that participants are being tested adequately. According to HPP staff and counselors that provide weekly group meetings, participants are aware and upset about the shortcomings of the contractor. Participants are the ones that pay for this service, and having a toxicology service provider that tests as required helps prove that these participants are complying with the terms of their contract.

Although HPP staff have made efforts in addressing these shortcomings, they have not proven effective. Two and one-half years after the prior audit, the results of toxicology testing have not shown significant improvement. The Medical Director requested that a new service provider be used for this service at the first Supervisory Council meeting of 2009. At that time, since the results of the first quarter had not been received, the Council rejected the request. When the service provider provided the results of the first quarter, it was clear that performance had severely declined. The results showed that the contractor had only performed 52% of the expected tests for that period instigating the Council's decision to begin steps for replacing the provider.

Although a new provider was recently identified and has agreed to timely and electronic reporting of information, previous testing did not achieve the level of assurance required by the Program to *protect the public from practitioners who are impaired due to alcohol or drug abuse*. In addition, the new provider will generate a random schedule for each participant. Toxicology testing is one of the most important aspects of this Program, provided it is conducted in accordance with Program guidelines and requirements. Therefore, HPP should monitor the new service provider's performance closely.

Group Facilitation Meetings

Group meetings are lead by an experienced group facilitator and are attended by a number of HPP participants. Ideal group size is five to eight participants. Participants

are expected to have 100% attendance of group facilitation meetings for the first 90 days in the Program and at least 90 meetings in the first two years, with no more than six absences. In addition, the facilitators of these meetings are expected to complete a monthly group report for each participant within their care.

Feedback from a recent participant survey and the group facilitators indicated that these sessions provide support for participants who have a common interest in staying sober.

Based on case files reviewed, group facilitators, with only a few minor exceptions, completed and sent monthly reports for each participant within their care. We noted that the forms used over time have improved. However, in some cases, the handwriting was difficult to read. Reports received from consultants should be typed instead of handwritten whenever possible to assure that the information being provided is easily understood and does not require institutional knowledge when case files are reviewed in the future.

In addition, it appeared that HPP has not been strict about the 100% attendance of group meetings for the first 90 days or ensuring that at least 90 meetings in the first two years were attended. However, in several cases, we noted that group meetings were continued until the participant attended at least 90 meetings.

Monitoring Consultant Reports (Monthly or Quarterly)

Monitoring consultants provide independent verification of a participant's recovery progress. Participants are expected to meet with a monitoring consultant monthly at the beginning of their involvement with HPP and quarterly, thereafter. Based on case files reviewed, it appeared that participants generally met with the consultants as scheduled, the information was consistent with group facilitation reports, and the consultants provided the reports to HPP as instructed. As with the Group Facilitator's Monthly Reports, the handwriting on some of the reports was difficult to read.

Annual HPP Evaluations

Participants are expected to have an official annual meeting with HPP’s Medical Director (or designee) to assess progress and modify the terms of the treatment plan as necessary. Quarterly Monitoring Report forms are used for annual evaluations. During our review of case files, we noted that some annual evaluations had “Annual” written on the top of the form. Otherwise, the only ways we could determine whether it was a quarterly report or an annual evaluation was by identifying who completed the form, which was often difficult because the signature was hard to read, whether there were two reports completed within the same quarter, or if the space for the next meeting was completed, indicating either the next quarter or the next year. As with the other reports discussed above, the reports were handwritten, often making them difficult to read.

Continuing Medical Education Credits

Continuing Medical Education Credits (CME) for HPP participants has been required since 2004. Substance use disorder participants are required to complete at least 20 hours of CME in addictive medicine or HPP-approved courses. Mental health disorder participants are required to complete at least 20 hours of CME approved by HPP in studies related to their illness. Dual-diagnosed participants are to complete 10 hours in each category.

Program participants are encouraged to wait until the last two years of their contract to obtain CME to provide a “refresher course” and alternate perspective on the disease process prior to leaving the monitoring program. Based on cases reviewed, no concerns were noted regarding CME requirements.

Workplace Monitors

All participants identify workplace associates that HPP periodically contacts to determine the status of their progress. On agreements to participate, workplace monitors are identified, depending upon the reason the participant is in the Program. For instance, if a participant is in the Program for driving while under the influence of intoxicants and

there is no evidence of substance abuse in the workplace, a workplace monitor is most likely not needed.

Workplace monitors are being utilized to prevent and detect typical signs of relapse such as increasingly being late to work or a practitioner being unusually moody. Most are not expected to complete monthly or quarterly reports, but to contact HPP when concerns arise about the performance or behavior of a participant. HPP contacted each of the monitors at the end of 2008 to obtain status reports.

Until recently, workplace monitors have not been utilized very often in the treatment plan. HPP or their consultants have not typically visited the workplace to observe the participant's surroundings and to ensure that safeguards are in place to help alleviate risks associated with relapse. HPP relies on the workplace monitoring mechanisms in place such as peer review or quality assurance, for all licensees and the additional oversight of the identified workplace contact to identify workplace problems. When a relapse does occur, HPP contacts the employer to discuss workplace restrictions but does not visit the workplace to review and assure those restrictions are in place. Although actual visits may be counter to the confidential nature of the Program, they may be helpful in the recovery of a participant.

Monitors have not received documentation or formal training to help them identify signs of relapse. Workplace reintegration meetings may be held with the employer, staff, or supervisor in cases of particular concern or when otherwise indicated. At these meetings, specific information applicable to the licensee returning to work will be provided to attendees which will include information on licensee-specific warning signs and any modifications which are recommended. HPP is in the process of preparing materials and will be able to track which monitors have received these materials within the techMed system.

Workplace monitors could play a significant role in the Program by having another individual looking out for participants functioning within the workplace. HPP should ensure that monitors are properly trained to identify relapse behavior, understand their responsibilities as a workplace monitor, and provide regular updates about the behavior of the participant.

In cases where impairment has occurred at the workplace, HPP, or one of its consultants, should observe the workplace to ensure safeguards are in place to mitigate the risk of relapse.

Other Observations

Many of the progress notes, especially those in some of the older case files, are handwritten and difficult to decipher. It appears that HPP is moving to typed progress notes, although not in all cases. Institutional knowledge of the staff administering the Program should not have to be relied upon to determine what had occurred. In order to ensure someone not directly involved with the case can follow and understand the progress of a participant, progress notes should be typed.

A summary of significant events would be helpful to quickly understand what had occurred in relation to treatment and compliance. Case files did not have a section identifying when relapses occurred. In many cases, we had to review the entire file or ask HPP personnel to determine whether a person had relapsed and how this was addressed. Currently, significant events, such as relapses are buried in progress notes or recorded on consultant reports that were sometimes illegible. Relapses could also be identified from the toxicology reports, and in some cases, the date on a treatment report would provide insight that the participant received additional treatment during the course of their continuing care contract. However, all relapses are recorded and tracked in a database to allow staff to look in one place for relapse information. It is anticipated that a report within techMed will be able to sort the information included in a case file by date

to identify when significant events, such as relapses, have occurred and how they were addressed.

Managing the Operations of the Program

Administratively, the HPP has two primary management components – the Supervisory Council and the Medical Director. The Council is charged with directing policies and procedures, supervising clinical decisions, and developing and implementing a program for chemically dependent licensees of the OMB. The Medical Director is responsible for oversight of all Program services including case identification, intervention, initial assessment, referral, post treatment monitoring, and relapse management. The Director also manages HPP personnel and operations by developing and implementing policies and procedures in compliance with State requirements and all legal regulations.

The Oregon Medical Board also plays a part in the management of the Program's operations. In addition to appointing members of the Supervisory Council, the Board develops specific rules and practices to achieve its mission to: *protect the health, safety, and well being of Oregon citizens by regulating the practice of medicine in a manner that promotes quality care*. The implementation of those rules and practices has, at times, dictated how the HPP manages its operations.

Supervisory Council Meetings

The Supervisory Council meets six times a year with additional emergency meetings called to address immediate concerns about the Program or its participants. Case reviews are conducted in closed sessions and Program business, such as HPP updates, discussions and approvals of policies and procedures, and legislative and OMB updates, is discussed in public session.

Council members are provided an agenda and summary information several days prior to a meeting. For cases that will be discussed, treatment evaluations and/or letters from participants are reviewed to determine whether to report the participant to the Board,

modify their relationship with HPP, or grant successful completion of the Program.

Consultants may be asked to attend meetings occasionally to discuss a particular case or to provide input regarding the Program. In addition, a representative of the Department of Justice attends the meetings to provide legal advice. The OMB Executive Director is also present during public session to discuss OMB and legislative updates, as well as any pertinent issues relating to the Board. Council members do not review entire case files or invite participants to come before it to discuss recovery progress or to appeal a Council decision.

During closed sessions, new admissions, assessments, case reviews, and discharges are discussed. The status of new evaluations, continuing care agreements, transfers, OMB referred cases, various discharges and case closures are discussed. Cases where decisions must be made are discussed in detail and clinical consensus is reached by the Council. HPP staff is instructed to carry out their decision, whether it be reporting a participant to the Board for non-compliance or addressing a participant request.

Administratively, the HPP provides statistical information and updates on marketing efforts and office issues, such as techMed status and toxicology contractor updates. The Council reviews and approves policies and procedures drafted by HPP and provides guidance on administrative questions about the Program. Some of the recent issues that the Council addresses include how information should be shared between the HPP and the Investigations Department, legal/policy issues, and how legislation affects the Program.

Efficiency and Effectiveness of the Program

Opportunities for improved efficiency and effectiveness occur in all organizations. As mentioned previously, the implementation of previous recommendations coupled with modifications to areas such as participant monitoring and case file organization will help improve overall operations. However, our review of the HPP identified two primary

areas that extensively impact Program operations and effectiveness: the relationship of HPP with the OMB and Program management.

The HPP and OMB have recently had a difficult relationship. Views have been so divergent that HPP has elected to use separate DOJ attorneys. Although both entities have similar missions, a cooperative approach to achieving their ultimate goals is not always present.

The HPP provides Program updates and statistical information at quarterly Board meetings and reports a participant for non-compliance or when public safety may be at stake. However, the Program is not required to provide detailed case information relating to participants who are in compliance with the Program and participating in good faith. An ongoing disagreement exists about what information can be shared when OMB Investigations is investigating a Program participant. When the Supervisory Council determines that a participant is non-compliant or a safety risk and reports to the Board, all information relating to that case is available for review. However, when Investigations is informed of a possible violation of the Medical Practices Act and opens an investigation that is unrelated to substance use disorders or mental health conditions, 42 CFR, Section 2, restricts how confidential treatment records can be used by the licensing board. Opinions differ regarding how this law should be interpreted.

Conflicting perspectives also appear to impact how the Supervisory Council approaches some decisions. During our observations of two recent Supervisory Council meetings, it was apparent that, in several instances, the Council had tried to anticipate what the Board would decide instead of considering what was right for the Program or case that was being considered. This is contrary to the direction given to the Council, which is supposed to run the Program independent of the Board.

The strained relationship is also evident with the Medical Director and extends both to the OMB and the Supervisory Council. The Medical Director is a strong advocate for

diversion programs in general, and the HPP in particular. To that end, the passion and commitment shown by the Medical Director appears to have sometimes alienated others. In an attempt to make a point or persuade others to see things a different way, the Medical Director has essentially caused others to believe that she is inflexible and uncompromising. This drive and focus has caused some to question whether public safety is weighed adequately when considering the maintenance of the health of licensees. In addition, some Supervisory Council members have lost confidence in the Medical Director's performance.

Program management has also been impacted by this relationship. The OMB and HPP Medical Director differ on policies, rules, and decisions that are shaping the Program. The OMB is tasked with a very specific mission that includes helping to evaluate disciplinary actions imposed on licensees and considering whether the licensee should be referred to HPP for evaluation and potential entry into the Program. The Board is not kept informed of who has entered the Program voluntarily, only learning about a participant when independently investigated and incidentally discovers that the licensee is in the Program or when HPP reports a participant for non-compliance or safety risk. In an effort to ensure licensees self-report impairment or competency issues, the Board has modified certain Administrative Rules. HPP personnel see this as detrimental to voluntary participation.

The BME-HPP Administrative Consultation Report, issued September 19, 2007, also indicated that the reporting relationship between OMB and HPP/Supervisory Council was not conducive to running the Program effectively. Many of the 23 individuals from the medical community interviewed favored HPP remaining a part of the state government in a more autonomous status. Some believed that the HPP should be run by an independent, not-for-profit organization, but did not have sufficient knowledge about how that would work.



HPP Supervision of Toxicology

Objective: Reassess the degree and quality of toxicology testing enrollees arranged and supervised by HPP, and make recommendations with regard to the adequateness of this supervision.

Our analysis and conclusions relating to the supervision of toxicology testing can be found in the *Managing the Monitoring of Participants* section, above.