MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	November 13, 2024
ATTENTION:	Members, Medical Board of California (Board)
SUBJECT:	Discussion and Possible Action on a New Legislative Proposal to Establish a Physician Health and Wellness Program
FROM:	Kerrie Webb, Attorney III

REQUESTED ACTION:

After review and consideration of the new legislative proposal to establish a Physician Health and Wellness Program (PHWP) and the public comments received in response to the proposal, staff recommends the Board approve a motion to:

1) Direct staff to work with the Legislature to find an author for a bill to carry the proposal; and

2) Authorize President Lawson and Vice President Healzer to work with staff, the Legislature, and stakeholders to move forward with the proposal.

BACKGROUND

Diversion Program Authorized in 1980

The Legislature first authorized the Board to establish a Diversion Program in 1980, stating:

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

This program was one of few in the country that was operated within a state medical board by employees of the board, as most other states and other boards under the Department of Consumer Affairs (DCA) contracted out all functions of their diversion program.

The Board contracted out some components of its program, including its drug testing, laboratory, and group meeting components, but the case management component and all aspects of the administration were performed by Board staff.

The Diversion Program was audited several times by the Auditor General of California, who issued the following reports:

- *Review of the Board of Medical Quality Assurance* (No. P-035) (August 1982)

- *The State's Diversion Programs Do Not Adequately Protect the Public from Health Professionals Who Suffer from Alcoholism or Drug Abuse* (No. P-425) (January 1985)

- *The Board of Medical Quality Assurance Has Made Progress in Improving Its Diversion Program; Some Problems Remain* (No. P-576) (June 1986)

Each of these reports was critical of the Diversion Program and found that it failed to adequately monitor substance-abusing physicians while permitting them to practice medicine, and that the Board had inadequately supervised the Program.

The Board's 2002 sunset bill, SB 1950 (Figueroa, Chapter 1085, Bills of 2002), required the Department of Consumer Affairs (DCA) to appoint an Enforcement Program Monitor for a period of two years. Among other responsibilities, the Enforcement Monitor was tasked to:

> … evaluate the effectiveness and efficiency of the board's diversion program and make recommendations regarding the continuation of the program and any changes or reforms required to assure that physicians and surgeons participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired due to alcohol or drug abuse or mental or physical illness.

Julianne D'Angelo Fellmeth, who at that time was the administrative director and supervising attorney for the Center for Public Interest Law at the University of San Diego School of Law, was appointed as the Enforcement Program Monitor. The Initial Report of the Enforcement Monitor, issued on November 1, 2004, identified serious problems with the Diversion Program. The findings, included, but were not limited to, the following:

- All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures.

    - The Program's urine collection system is fundamentally flawed.
    - It is unclear whether the case managers are attending group meetings as required by Diversion Program policy.
    - Worksite monitoring and reporting is deficient.
    - Treating psychotherapist reporting is deficient.

- The Program is so understaffed that staff could not correct the failures in its monitoring mechanisms even if they knew about them.

- The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held.

  - The Diversion Program's statutes and regulations are skeletal at best, and set forth few enforceable rules, standards, or expectations for either the Program or its participants.
  - The *Diversion Program Manual* — which is unenforceable — sets forth no clear rules and no mechanisms to ensure standardized and consistent decision making about potentially dangerous physicians.
  - There is no consistently applied and enforceable rule regarding consequences for relapse.
  - The Diversion Program's statutes permit repeat offenders "too many bites of the apple."

- Contrary to statute, the [Board] has never taken "ownership" of or responsibility for the Diversion Program.

- The Diversion Program is isolated from the rest of the [Board]; its management has not been consolidated into enforcement management or general [Board] management.

- The Program's claim of a "74% success rate" is misleading.

The Enforcement Monitor made the following recommendations regarding the Diversion Program:

1. Based on the information contained in this and prior reports on the Diversion Program, the [Board] must reevaluate whether the "diversion" concept is feasible, possible, and protective of the public interest.

2. If the Board determines that it is possible to implement the "diversion" concept consistent with the public interest (which is presently demanded by sections 2001.1, 2229, and 2340), the Board must then determine whether to house that diversion program within the [Board] or contract it out to a private entity.

3. If the [Board] decides that "diversion" is feasible and that administration of the Diversion Program should remain within the [Board], the [Board] must spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that limit the Program's effectiveness both in terms of assisting participant recovery and in terms of protecting the public.

4. The [Board] must reclaim its authority and jurisdiction over the Diversion Program by abolishing the Liaison Committee as it is currently structured.

5. The [Board] must determine whether Program participation should be an "entitlement" for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Diversion Program.

6. Regardless of whether Diversion Program participation is deemed an entitlement or is capped to accommodate staffing and protect the public, the Diversion Program's budget should be earmarked and separated from other [Board] program budgets.

7. The [Board] must establish enforceable standards and consistent expectations of participants and Diversion Program staff through legislation or the rulemaking process, oversee a comprehensive revision of the Diversion Program's policy manual, and ensure that Diversion Program management is integrated into overall [Board] management.

8. The [Board] should explore various methods of assessing the long-term effectiveness of the Diversion Program in assisting physicians in recovering from substance abuse.

9. The [Board] should continue its efforts to replace and upgrade the Diversion Tracking System.

10. The [Board's] Diversion Program should undergo a full performance audit by the Bureau of State Audits every five years.

The Enforcement Monitor's Final Report, issued on November 1, 2005, included the Board's and the Legislature's responses to the concerns raised in the Initial Report.

Through SB 231 (Figueroa, Chapter 674, Statutes of 2005), the Legislature expressed its intent to request an audit of the Diversion Program to be completed by June 30, 2007, to evaluate the program, make recommendations regarding the continuation of the program, and any changes required to assure that participants are appropriately monitored, and the public is protected from physicians who are impaired. This bill also placed a sunset date on the Diversion Program, making the article inoperative on July 1, 2008, and repealing it as of January 1, 2009, unless the Legislature extended the Diversion Program.

The California State Auditor issued its report in June 2007, titled *Medical Board of California's Physician Diversion Program: While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public*, and made the following recommendations:

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

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

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

3. To provide adequate oversight of participants' random drug tests, the diversion program should ensure that both the case manager and group facilitator approve all vacation requests and should establish a more timely and effective reconciliation of scheduled drug tests to actual drug tests performed by comparing the calendar of randomly generated assigned dates to the lab results.

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

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

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

7. The [Board] should ensure that areas of program improvement recommended by the enforcement monitor are completed within the next six months.

Thereafter, at the July 26 – 27, 2007 Quarterly Board Meeting, the Board determined that operating the Diversion Program as it was structured and operated was inconsistent with consumer protection and voted to allow the Diversion Program to Sunset not later than June 30, 2008.

Development of the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees

In 2008, SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) was enacted, and required, among other things, that a Substance Abuse Coordination Committee (SACC) be established in the Department of Consumer Affairs to develop the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees (Uniform Standards). The failure of the Board's Diversion Program was cited in this bill as one of the reasons for the Legislature requiring the development of the Uniform Standards.

SB 1441 included various declarations of legislative intent, including:

> "Various health care licensing boards have inconsistent or nonexistent standards that guide the way they deal with substance-abusing licensees. Patients would be better protected from substance-abusing licensees if their regulatory boards agreed to and enforced consistent and uniform standards and best practices in dealing with substance-abusing licensees."

While the SACC conducted open meetings to receive public comment on the proposed Uniform Standards, these standards were adopted in 2011 by the SACC without going through the formal regulatory process. The healthcare boards were then required to adopt the Uniform Standards as developed by the SACC through their own rulemaking process. The Board's rulemaking to implement the Uniform Standards became operative on July 1, 2015. Thereafter, the SACC met and made very minor changes to drug/alcohol testing requirements which addressed limited circumstances under Uniform Standard #4, effective March 2019.

Existing Statutes Authorizing the Development of the Physician Health and Wellness Program (PHWP) and the Related Rulemaking

SB 1177 (Galgiani, Chapter 591, Statutes of 2016), under Business and Professions Code (BPC) section 2340, authorized the Board to establish the PHWP with the goal of providing early identification of and appropriate interventions to support physicians' rehabilitation from substance abuse. The purpose of the PHWP is to ensure licensees remain able to practice medicine in a manner that will not endanger the public and that will maintain the integrity of the medical profession.

BPC sections 2340.2, 2340.4, and 2340.6 generally set forth the PHWP program requirements. BPC section 2340.2(e) specifies that the PHWP shall comply with the Uniform Standards adopted by the SACC.

BPC section 2340.8 establishes the PHWP Account within the Contingent Fund of the Board and requires the Board to adopt regulations to determine the appropriate fee a participant in the PHWP shall pay to the Board. Additionally, this section provides that the Board may use money from its Contingent Fund, subject to appropriation by the Legislature, to support the initial costs for establishing the PHWP, but these moneys shall not be used to cover any costs for individual licensees participating in the program.

At the August 25 - 26, 2022 Quarterly Board Meeting, the Board reviewed and approved proposed regulations to establish the PHWP, and authorized staff to proceed with the rulemaking process.

The Board received numerous public comments from a wide variety of stakeholders in writing, as well as through oral testimony at the November 14, 2023 hearing on the proposed regulations. The comments were overwhelmingly negative and discouraged the Board from proceeding with the proposed rulemaking.

At the February 28 - March 1, 2024 Quarterly Board Meeting, the Board discussed the negative comments received on the proposed rulemaking to establish the PHWP, including from subject matter experts, and heard further public comment. The Board voted to postpone deciding on the proposed rulemaking until the May 2024 Board meeting, when the members could hear from speakers with expertise on best practices for physician health programs.

At the May 23 - 24, 2024 Quarterly Board Meeting (see Agenda Item #11), Christopher Bundy, M.D., Executive Medical Director of the Washington Physicians Health Program and Past President of the Federation of State Physician Health Programs, and Paul Earley, M.D., Medical Director of the Georgia Professionals Health Program, Inc., and Past President of the

Federation of State Physician Health Programs, presented to the Board on best practices for physician health programs.

The Board was advised that a physician health program developed under the current authorizing statutes would not follow nationally recognized best practices and would not encourage individuals with impairing or potentially impairing conditions to self-refer (or be referred by others) into the program to seek help. Dr. Bundy, Dr. Earley, and other subject matter experts who commented at this meeting, encouraged the Board not to proceed with the proposed rulemaking, and to pursue new authorizing legislation, instead, that would, among other recommended changes, not require the PHWP to impose the Uniform Standards on voluntary participants.

Many consumer advocates stated that the Board should not seek to establish a physician health program, and that physicians should seek help on their own. They further contended that, given the Board's history with the past Diversion Program, any future program must comply with the Uniform Standards. After considering the materials, presentations, and public comments, the Board unanimously voted to withdraw the proposed rulemaking and to develop a new legislative proposal to establish a PHWP that meets nationally recognized best practices.

New Legislative Proposal to Establish the PHWP

Based on the presentations and comments from subject matter experts on physician health programs, review of model language from the American Medical Association, and review of several authorizing statutes from existing physician health programs, Board staff developed the attached legislative proposal to establish a PHWP that meets nationally recognized best practices (Attachment 1).

In brief summary, the proposal contains the following sections:

- **2340. Establishment of the Physician Health and Wellness Program**
  - Sets forth the authority for the Board to establish the PHWP and the purpose of the PHWP.
  - Sets forth the definitions for relevant terms.

- **2340.2. Program requirements.**
  - Requires the Board to contract with an administering entity to implement the PHWP.
  - Sets forth what the PHWP shall be required to do.
  - Exempts the Board and program from being mandated to impose or follow the Uniform Standards for voluntary participants.

- **2340.4 Third-party independent administering entity qualifications.**
  - Requires the administering entity to be a 501(c)(3) nonprofit.
  - Requires the Board to select the administering entity pursuant to a request for proposals pursuant to the Public Contract Code.
  - Exempts the Board from having to obtain approval from various state agencies to justify a multiyear contract term.

- Sets forth the requirements for the administering entity in administering the program, including required communications with the Board.
- Requires the administering entity to submit to periodic quality and compliance evaluations by an independent third-party approved by the Board.

- **2340.6 Procedures.**
  - Sets forth the topics that must be addressed in the contract with the administering entity.

- **2340.8 Voluntary evaluation, treatment, and monitoring; Required reports.**
  - Authorizes the Board to divert a licensee to the program, rather than pursue disciplinary action, if the Board determines the unprofessional conduct may be the result of an impairing or potentially impairing condition.
  - Indicates that diversion is not an option for avoiding disciplinary action if the unprofessional conduct involves allegations of patient or client harm or sexual misconduct with a patient, client, or any other person.
  - Sets forth various requirements for payment of costs, providers, and required reports to the Board.
  - Specifies that the Board has the authority to take disciplinary action against a licensee or to deny a license to an individual who withdraws or is terminated from the program without completing the program's requirements or for any other unprofessional conduct.

- **2340.10. Participant's written agreement.**
  - Specifies what must be included in the participant's written agreement to ensure the participant understands the program requirements and the consequences for non-compliance.

- **2340.12 Confidentiality of records; exceptions.**
  - Specifies that program records are confidential, are exempt from disclosure under the Public Records Act, and are not subject to discovery by subpoena or admissible as evidence except in limited, specified circumstances.

- **2340.14 Immunity.**
  - Indicates that a person who, in good faith, reports information or acts in connection with this proposed law is immune from civil liability for those acts.
  - Encourages courts to impose sanctions when allegations are not made in good faith.

- **2340.16. Advisory committee.**
  - Authorizes the Board to establish one or more advisory committee(s) to assist in carrying out its duties under the article.
  - Sets forth who may be appointed to the committee and details for the committee's operation.

- **2340.18. Advisory committee duties.**
  - Sets forth the duties of the advisory committee, including their role in making recommendations to the executive director or their designee on which

individuals should be diverted into the program, rather than disciplined, and which self-referred participants should be reported to the Board for non-compliance.

- **2340.20. Physician Health and Wellness Program Account established; Funding and fees.**
  - Creates a placeholder for future funding provisions.

- **2340.22. Mandatory reporting of licensees with potential impairment.**
  - Establishes a requirement for a licensee to report to the PHWP or the Board the name and current contact information of another licensee if they, in their good faith judgment, believe that the other licensee may have a condition that impacts the ability of that licensee to practice medicine or their profession in a safe, competent, and professional manner.

- **2340.24. Exclusion.**
  - Specifies that this article shall not apply to the Osteopathic Medical Board of California nor to its licensees.

President Lawson appointed Dr. Yip and Ms. Torres to the PHWP Task Force to assist staff with an interested parties meeting on the proposed legislation and to make recommendations to the Board.

The PHWP Task Force held the PHWP Interested Parties Meeting on October 24, 2024, which was well attended. Most of the public comments at the interested parties meeting were very positive and supported the Board's efforts. Additionally, the Board received five letters in response to the proposed legislation. A brief summary of the letters is included below, and full copies of the letters are provided under Attachment 2.

1) Marcus Friedman, Administrative Director, Consumer Protection Policy Center (CPPC), University of San Diego School of Law:

- Described CPPC's history with the Board, including with their former administrative director, Ms. Fellmeth being appointed as the Board's Enforcement Monitor.
- Recounted the Board's history with the previous Diversion Program, and the development of the Uniform Standards.
- Discussed the presentations from Dr. Bundy and Dr. Earley and the PHWP rulemaking that the Board withdrew at the May 2024 Board meeting.
- Stated that the new legislative proposal is very similar to the previous PHWP rulemaking with a few differences.
- Pointed out that the advisory committee(s) would not be composed of Board members and expressed concern that the Board would not be exercising meaningful oversight of the program.
- Indicated that the mandate for licensees to report other licensees who are impaired to the Board or the PHWP is fairly meaningless, as the requirement is effectively unenforceable.
- Expressed concern that the proposal exempts the PHWP from the Uniform Standards.

- Expressed concern over the proposed exemption from having to seek approval to enter into a multi-year contract with a vendor to administer the PHWP.
- Expressed concern over the requirement that the vendor be a 501(c)(3) nonprofit, which would limit for-profit vendors with experience from applying for the contract.
- Emphasized that funding is a critical component of the PHWP and is not addressed in the proposed legislation.
- Asked why participants should not be required to pay their participation fees and the overhead costs of administering the program.
- Urged the Board not to proceed with establishing a PHWP, and to focus on addressing the recommendations contained in the recent Enforcement Monitor Report (Final Report issued August 2023).

2) **Shannon Udovic-Constant, M.D., President, California Medical Association (CMA):**

- Expressed appreciation for the proposed legislation and supports its continued development.
- Indicated that CMA would need additional time to provide detailed feedback.
- Recommended that the proposed language include flexible authority to allow for subsidization of the costs to participants if such funds are available and allocated for that purpose.
- Recognized that the proposal introduces a new statutory mandatory reporting requirement for physicians to report a colleague's suspected impairment to the PHWP or the Board and indicated they will be reviewing this provision further.

3) **John G. Rosenberg, M.D., Chair, California Public Protection & Physician Health, Inc. (CPPPH):**

- Expressed support for the approach, the intent, and many of the provisions in the legislative proposal.
- Suggested a minor amendment to section 2340(b)(5) to the definition of "Impaired," "impairing," or "impairment."
- Suggested a substantive change section 2340.2(a)(1) to expand and reword the requirement for the PHWP to provide education.
- Indicated that the elements of the program require further study from CPPPH before providing further comments.

4) **Deena Shin McRae, M.D., Associate Vice President, Academic Health Sciences, University of California Health (UC Health):**

- Expressed gratitude for the Board's efforts to establish a program and its commitment to safeguarding physician well-being and patient safety.
- Acknowledged that the proposed language introduces a new statutory mandatory reporting requirement for physicians to report a colleague's suspected impairment to the PHWP or the Board, which requires their further review.
- Emphasized that there must be a reliable process that guarantees confidentiality except in cases of clear non-compliance that could pose risks to patient safety, or physicians may be discouraged from seeking the care they need from the program.

- Advised that there must be careful consideration to the composition of the advisory committee so that it includes health professionals knowledgeable in behavioral health, among other recommendations.
- Suggested the inclusion of flexible funding language to allow for subsidization of the costs to participants if such funds are identified.

5) Federation of State Physician Health Programs (FSPHP):

- Applauded the proposed legislation and indicated that it includes critical elements of the FSPHP PHP model.
- Indicated that they support the introduction of mandatory requirements to report impairment, so long as the PHWP has a diversionary track, and the PHWP has the statutory authority as a diversionary program to receive referrals in lieu of individuals being required to report impaired colleagues to the Board, absent patient harm.
- Recommended that section 2340.22 (Mandatory reporting of licensees with potential impairment) be reframed and retitled to clearly provide the PHWP with the authority to receive such referrals, and to clarify that the PHWP is exempt from any mandated reporting to the Board when the licensee is adherent to program requirements and does not pose a risk to patient safety.
- Recommended that the Board include a requirement that the referent under section 2340.22 must receive confirmation that the individual they have referred to the PHWP is compliant with the program within 30-60 days or their obligations to report would remain.
- Recommended minor changes to section 2340.2 (Program requirements), to ensure that the PHWP is available to those prior to their health condition reaching impairment and for those individuals who may not meet criteria for monitoring.
- Cautioned against stating that the Uniform Standards may be applied to voluntary participants, as they are concerned that this could eliminate referrals of voluntary participants.
- Supported the plan for a multi-year contract under section 2340.4 (Third-party independent administering entity qualifications)
- Recommended clarifying that the periodic quality and compliance evaluations shall be conducted by an evaluator with a demonstrated history and expertise in PHWPs, safety sensitive care, and without any bias or conflict of interest.
- Recommended clarifying the advisory committee duties under section 2340.18.
- Advised that state funding for a PHWP is essential to protect public health and ensure the well-being of medical professionals, and they are available to assist with providing budget information and sources of funding from other PHWPs.

STAFF RECOMMENDATION:

Make and approve the motion suggested on page 1 of this memo.

Approval of the motion will allow the Board's leadership and staff to continue working with interested parties to refine the proposed language where appropriate, and to attempt to find a legislator to author the bill.

Attachment 1: New Legislative Proposal to Establish the PHWP
Attachment 2: Five (5) Letters Received in Response to New Legislative Proposal to Establish the PHWP

ATTACHMENT 1

ARTICLE 14. Physician Health and Wellness Program [2340 - 2340.24]

This proposal would repeal and replace all of the existing language under Article 14 (Business and Professions Code section 2340 – 2340.8).

2340. Establishment of the Physician Health and Wellness Program

(a) The board may establish a Physician Health and Wellness Program for the early identification of, and appropriate interventions to support, treat, monitor, and rehabilitate physicians and surgeons and allied healthcare professionals licensed by the board, as well as applicants, prospective applicants, trainees, and students, with impairing or potentially impairing physical or mental health conditions, including substance use disorders, that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner.

(b) For purposes of this article, the following definitions apply:

(1) "Administering entity" means a 501(c)(3) non-profit, third-party independent administering entity that has expertise in mental health disorders including substance use disorders and other potentially impairing health conditions and that has been designated pursuant to a request for proposals to perform any or all of the activities set forth consistent with this article, any applicable regulations, and via contract with the board.

(2) “Applicant” shall mean an individual who has applied for licensure with the board. “Prospective applicant” shall mean an individual who has graduated from a school approved by the board and is contemplating applying for licensure with the board.

(3) “Board” shall mean the Medical Board of California or its designee. Additionally, if the board establishes one or more committees pursuant to this article, “board” may also refer to a board committee to the extent duties have been delegated to the committee, or to its designee.

(4) “Disruptive behavior” shall mean aberrant behavior exhibited through personal interaction with others, including, but not limited to, healthcare professionals, facility staff, or patients, clients, or their family members, which interferes with patient or client care or could reasonably be expected to interfere with the process of delivering health care in a reasonably safe, competent, and professional manner.

(5) “Impaired,” “impairing,” or “impairment” shall mean the inability to practice medicine or other healthcare profession regulated by the board in a reasonably safe, competent, and professional manner due to 1) mental illness; 2) physical illness; 3) disruptive behavior; or 4) excessive use or abuse of drugs or alcohol.

(6) “Licensee” shall mean an individual licensed by the board.

(7) “Mental illness” shall mean an illness or condition characterized by a clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior, including disruptive behavior, that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

(8) “Participant” shall mean a licensee, applicant, prospective applicant, trainee, or student who was or is enrolled in the program for evaluation, treatment, and/or monitoring pursuant to an agreement between that person and the program, including voluntary participants and those referred by the board pursuant to an order of probation.

(9) “Physical illness” shall mean an illness or condition that would adversely affect cognitive, motor, or perceptive skills, including, but not limited to, deterioration through the aging process.

(10) “Physician Health and Wellness Program,” “PHWP,” or “program” shall mean the confidential resource operated by the administering entity for licensees, applicants, prospective applicants, trainees, and students suffering from impairing or potentially impairing health conditions.

(11) “Student” shall mean an individual enrolled in a school approved by the board studying to enter a profession regulated by the board. For such an individual participating in the program, the program shall make any required reports pursuant to this article to the individual’s oversight entity, such as the individual’s school, program, and/or supervisor as specified in the individual’s participation agreement, instead of to the board, unless otherwise specified in this article.

(12) “Substance use disorder” shall mean a disease in which the essential feature is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

(13) “Trainee” shall mean an individual who has graduated from a school approved by the board who is in training to enter a profession regulated by the board, and who is currently unlicensed to practice in California, including, but not limited to, those who are practicing during the exemption period under Section 2064.5 or 2065. For such an individual participating in the program, the program shall make any required reports pursuant to this article to the individual’s oversight entity, such as the individual’s training program and/or supervisor as specified in the individual’s participation agreement, instead of to the board, unless otherwise specified in this article.

(14) “Treatment” shall mean a course of in-patient or out-patient care, treatment or rehabilitation services provided or supervised by the administering entity, or its designee authorized to provide such services.

(15) “Voluntary participant” shall mean a participant who voluntarily enrolled in the program for evaluation, monitoring, and/or treatment services, including an individual referred by the board in lieu of the board pursuing disciplinary action, and is not required by the board to participant in the program pursuant to an order of probation.

2340.2. Program requirements.

(a) If the board chooses to establish a program, the board shall enter into a contract with the administering entity to implement the program. The program shall do all of the following:

(1) Provide for the education of licensees, applicants, prospective applicants, trainees, and students with respect to the early identification and prevention of disruptive behavior, mental illness, physical illness, and substance use disorders.

(2) Enter into relationships supportive of the program with professionals experienced in working with healthcare providers to provide education, evaluation, monitoring, and/or treatment services.

(3) Receive and assess reports of suspected impairment from any source.

(4) Intervene in cases of verified impairment, or in cases where there is reasonable cause to suspect impairment.

(5) Upon reasonable cause, refer suspected or verified impaired participants for evaluation, treatment, and/or monitoring.

(6) Provide consistent and regular monitoring and care management support of program participants.

(7) Advocate on behalf of participants, with their consent, to the board to allow them to participate in the program as an alternative to disciplinary action, when appropriate.

(8) Offer guidance on participants' fitness for duty with current or potential workplaces, when appropriate.

(9) Perform other services as agreed between the program and the board.

(b) Notwithstanding any other law, the board and program shall be exempt from being mandated to impose or follow the requirements of the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees adopted by the Substance Abuse Coordination Committee of the department pursuant to Section 315 (Uniform Standards), for those who are voluntary participants. Nothing in this section shall be construed as preventing the board or program from exercising its discretion to impose some or all requirements of the Uniform Standards on a voluntary participant.

(c) A participant who is subject to a board order of probation, including, but not limited to, an order imposing the Uniform Standards, shall comply with the terms of their probation, and the program shall provide the required evaluations, treatment, monitoring, and reports to the board consistent with the participant's order of probation. A participant who commits a violation of their order of probation shall be subject to the consequences required by such order.

2340.4 Third-party independent administering entity qualifications.

(a) If the board establishes a program, the board shall contract for the program's administration with a 501(c)(3) non-profit, third-party independent administering entity pursuant to a request for proposals. The process for procuring the services for the program shall be administered by the board pursuant to Article 4 (commencing with Section 10335) of Chapter 2 of Part 2 of Division 2 of the Public Contract Code. However, Section 10425 of the Public Contract Code shall not apply to this subdivision. The board is authorized to enter into a multiyear contract with the administering entity without having to obtain the approval of the Department of General Services, the Office of Legal Services, or other state entity to justify such a multiyear term.

(b) The administering entity shall have expertise and experience in the areas of impairment and rehabilitation in healthcare providers. The leadership of the administering entity shall have at least one medical director, who is specialty trained

and/or board-certified in addiction and/or psychiatry and has expertise in health programs for healthcare providers.

(c) The administering entity shall identify and use a national treatment resource network that includes in-person and tele-based evaluation and treatment programs and support groups and shall establish a process for evaluating the effectiveness of those resources and programs.

(d) The administering entity shall identify participants and other individuals affiliated with the participant who would benefit from counseling and shall refer them to services appropriate for the circumstances.

(e) The administering entity shall make the program services available to all board licensees, applicants, prospective applicants, trainees, and students, including those who self-refer to the program.

(f) The administering entity shall make prompt and diligent efforts to contact and conduct an appropriate assessment and referral for an independent evaluation, when indicated, with each licensee, applicant, prospective applicant, trainee, and student who has been referred to the program. The program shall attempt to enroll the referred individual if, in the good faith judgment of the program, the individual has a condition that impairs or may impair their ability to practice their profession in a reasonably safe, competent, and professional manner.

(g) The administering entity shall have a board-approved system for immediately reporting a participant to the board when required by this article, including, but not limited to, a participant who withdraws or is terminated from the program prior to completion. This system shall ensure absolute confidentiality in the communication to the board. The administering entity shall not provide this information to any other individual or entity unless authorized by the participant or this article.

(h) The administering entity shall provide regular communication to the board, including, but not limited to, the following:

(1) Participate at board meetings, which may include presenting at meetings and/or providing reports, as requested by the board on matters relevant to the program and participants.

(2) Provide annual reports to the board with program statistics requested by the board.

(3) Provide reports regarding participants and other individuals as required by this article.

(4) Reports provided during an open meeting or published in open meeting materials, including to provide program statistics, shall not disclose any personally identifiable information relating to any participant without the express written consent of the participant.

(i) The administering entity shall submit to periodic quality and compliance evaluations of all or select operations, fund conditions, records, and management related to the program to ensure compliance with the requirements of this article, applicable regulations, and the contract with the board upon request of the board at the program's expense. The evaluation shall be conducted by an independent third-party approved by the board. Any report on the evaluation conducted pursuant to this section shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the evaluation and shall not disclose any information identifying a program participant.

2340.6 Procedures.

(a) A contract entered into pursuant to this article with the administering entity shall include procedures on all of the following topics:

(1) Regular participation at board meetings, which may include presenting at meetings and/or providing reports as requested by the board.

(2) Regular reporting of statistical information related to the program and participants, including for the board's annual report.

(3) Periodic disclosure and joint review of such information as the board may deem appropriate regarding referrals, including the contacts, evaluations, and investigations made, and the disposition of each referral. However, with respect to non-board referrals, the administering entity shall not disclose any personally identifiable information to the board except as provided in subdivisions (a)(4), (a)(5), and when required by the board following consideration of information provided under (a)(6) of this section.

(4) Immediate reporting to the board the name, last known contact information, and a factual summary of events and findings regarding any suspected or verified impaired licensee, applicant, or trainee practicing during the exemption period under Section 2064.5 or 2065, who, in the opinion of the program, is probably an imminent danger to themselves or to the public. Other program records pertaining to the participant shall be confidential and not accessible to the board, unless the individual is participating in the program pursuant to an order of probation.

(5) Timely reporting to the board the name, last known contact information, and a factual summary of events and findings regarding any suspected or verified impaired licensee, applicant, or trainee practicing during the exemption period under Section 2064.5 or 2065, who fails to cooperate with the program, fails to submit to an evaluation, treatment, or monitoring, or whose impairment is not substantially alleviated through treatment, or who, in the opinion of the program, is probably unable to practice their profession in a reasonably safe, competent, and professional manner. Other program records pertaining to the participant shall be confidential and not accessible to the board, unless the individual is participating in the program pursuant to an order of probation.

(6) Timely reporting to the board, when required under the criteria established pursuant to subdivision (a)(5) of Section 2340.10, for the board's evaluation and direction, deidentified voluntary participants who commit a program violation. After consulting with the program, if the board requests that the individual be identified, the program shall provide to the board the name, last known contact information, and a factual summary of events and findings relating to the individual's participation in the program. Other program records pertaining to the participant shall be confidential and not accessible to the board.

(7) Informing each participant of the program procedures, the responsibilities of participants, and the possible consequences of noncompliance with the program.

(8) Qualifications and requirements for individuals and entities providing services to participants, including, but not limited to, treatment facilities, evaluators, testing locations, laboratories, treatment providers, support group facilitators, and monitors.

(9) Prevention of personal, financial, business, or professional conflicts of interests that may compromise the program's responsibilities, including, but not limited to, conflicts that may unduly influence decisions regarding the selection of treatment options, evaluators, testing locations, laboratories, treatment providers, support group facilitators, or monitors.

(10) Quality assurance and quality improvement principles.

(11) Confidentiality and maintenance of program records.

(12) Identification of the full names of program staff who are available to certify records regarding individuals participating pursuant to an order of probation and be the person most knowledgeable to explain the program's records, if needed.

(13) Standardized data collection to allow for data analysis and research.

(14) Research processes and methodologies.

(15) Education and outreach to stakeholders.

(16) Interstate monitoring to support communication and accountability of program participants across jurisdictions.

(17) Notification of program evaluations, compliance with evaluations, and opportunities to cure deficiencies.

(18) Any other topic pertinent to the program as determined by the board.

2340.8 Voluntary evaluation, treatment, and monitoring; Required reports.

(a) In lieu of disciplinary action, and if the board determines that the unprofessional conduct may be the result of an impairing or potentially impairing condition, the board may refer the licensee to the program. If the unprofessional conduct involves allegations of patient or client harm or sexual misconduct with a patient, client, or any other person, diversion shall not be an option for avoiding disciplinary action.

(b) Referral of the licensee to the program in lieu of disciplinary action shall be done only with the consent of the licensee. If the licensee does not consent to be referred to the program, or does not successfully complete the program, the board may take appropriate disciplinary action.

(c) The cost of evaluation and treatment shall be the sole responsibility of the participant, and this responsibility does not preclude payment by an employer, insurer, or other sources.

(d) Evaluation, monitoring, and treatment shall be conducted by providers with expertise in working with healthcare professionals with impairing or potentially impairing conditions approved by the administering entity or the board. The administering entity or the board may also approve the use of out-of-state programs with expertise in working with healthcare professionals with impairing or potentially impairing conditions.

(e) Upon receiving a report from the program that is required under the criteria established pursuant to subdivision (a)(5) of Section 2340.10 that a deidentified voluntary participant committed a program violation, the board shall have the option to 1) encourage continued program participation with additional conditions, in lieu of disciplinary action, when the board determines that the licensee is able to continue to practice in a reasonably safe, competent, and professional manner; 2) to request the participant’s identity, last known contact information, and a factual summary of events and findings relating to the individual’s participation in the program so that the board

may investigate and pursue disciplinary action, as warranted; or 3) take other action consistent with the agreed upon procedures.

(f) Each participant shall sign a waiver allowing the program to release information to the board as required by this article or their program agreement, including, but not limited to, if the participant does not comply with their program agreement, or, in the opinion of the program, is unable to practice in a reasonably safe, competent, and professional manner. The program shall report to the board any participant who fails to comply with their program agreement, when required under the criteria established pursuant subdivision (a)(5) of Section 2340.10, or who, in the opinion of the program, is unable to practice their profession in a reasonably safe, competent, and professional manner.

(g) The program shall report to the board any licensee, applicant, or trainee practicing during the exemption period under Section 2064.5 or 2065, who fails to enter into a program agreement, and who, in the opinion of the program, is unable to practice their profession in a reasonably safe, competent, and professional manner.

(i) Licensees, applicants, or trainees practicing during the exemption period under Section 2064.5 or 2065, shall notify the board in writing on a form approved by the board within three (3) calendar days from the date they withdraw or are terminated from the program without completing the program's requirements.

(j) Licensees, applicants, or trainees practicing during the exemption period under Section 2064.5 or 2065, who previously withdrew or were terminated from the program without completing the program’s requirements may, upon the agreement of the program and the board, reenter the program.

(k) This section does not restrict the authority of the board to take disciplinary action against a licensee or to deny a license to an individual who withdraws or is terminated from the program without completing the program's requirements, and/or for any other unprofessional conduct, including, but not limited to, its authority under Section 820.

2340.10. Participant’s written agreement.

(a) A participant shall, as a condition of participation in the program, enter into an individual agreement with the program. The agreement shall include but not be limited to all of the following, to the extent they are applicable to the services to be provided by the program to the individual participant:

(1) A jointly agreed-upon plan and mandatory conditions and procedures for monitoring of compliance with the program. For individuals who are referred to the program pursuant to an order of probation, the program’s written agreement

shall require compliance with the terms of their order of probation, in addition to any other program requirements.

(2) Criteria for compliance with terms and conditions of evaluation, treatment, and/or monitoring.

(3) Criteria for program completion.

(4) Criteria for termination from the program.

(5) Criteria for when the participant will be reported to the board for non-compliance with the program requirements.

(6) Agreement to maintain an active release authorizing communication between the program and the board, and other entities and individuals as required by the program.

(7) Acknowledgment that withdrawal or termination prior to completion of program requirements shall be reported to the board. Such a report shall include the participant’s name, last known contact information, and a factual summary of events and findings relating to the individual's participation in the program.

(8) Acknowledgment that the program shall report to the board if the program determines that the participant is unable to practice their profession in a reasonably safe, competent, and professional manner. Such a report shall include the participant’s name, last known contact information, and a factual summary of events and findings relating to the individual's participation in the program.

(9) Acknowledgement that participation in the program shall not be a defense to any disciplinary or licensing action that may be taken by the board.

(10) Acknowledgment that expenses related to evaluation, treatment, monitoring, laboratory tests, and other activities specified by the program shall be paid by the participant or other sources available to the participant.

2340.12 Confidentiality of records; exceptions.

(a) Program records including, but not limited to, case notes, progress notes, laboratory reports, evaluation and treatment records, electronic and written correspondence within the program, and between the program and the participant, board, or other involved entities including, but not limited to, employers, credentialing bodies, referents, or other collateral sources, relating to participants are confidential and exempt from disclosure

under the California Public Records Act (Gov. Code sections 7920.000, et seq.) and shall not be subject to discovery by subpoena or admissible as evidence except:

(1) To defend program professionals in any civil or administrative action involving a participant regarding the restriction or revocation of that individual's clinical or staff privileges, or termination of the individual's employment, or from a school or training program. In such an action, the program will, upon subpoena issued by any party to the action, and upon the requesting party seeking a protective order for the requested disclosure, provide to the parties to the action written disclosure that includes all of the following information:

(A) Verification of the individual's participation in the program as it relates to aspects of program involvement at issue in the action.

(B) The dates of participation.

(C) Whether or not the program identified an impairing or potentially impairing health condition.

(D) Whether the individual was compliant with their program agreement.

(E) Whether the individual successfully completed the program.

(2) Records provided to the board as required by this article.

(b) Records held by the board under this section are also exempt from the California Public Records Act (Gov. Code sections 7920.000, et seq.) and are not subject to discovery by subpoena. Such records are available to the individual only pursuant to Government Code section 11507.6, and the board may use such records as evidence in a licensing or disciplinary action against the individual.

2340.14 Immunity.

(a) A person who, in good faith, reports information or takes action in connection with this article is immune from civil liability for reporting information or taking the action.

(1) The immunity from civil liability provided by this section shall be liberally construed to accomplish the purposes of this section. The persons and entities entitled to immunity shall include:

(A) The approved program, board, and committees.

(B) Members, employees, and agents of the program, board, and committees.

(C) Persons reporting a licensee, trainee, applicant or prospective applicant for licensure as being possibly impaired or providing information about the subject's impairment to the board or program.

(D) Professionals supervising or monitoring the course of the program participant's treatment or rehabilitation, including when they report progress or noncompliance to the board as warranted.

(2) The courts are strongly encouraged to impose sanctions on program participants and their attorneys whose allegations under this section are not made in good faith and are without either reasonable objective or substantive grounds, or both.

(3) The immunity provided in this section is in addition to any other immunity provided by law.

(b) Nothing in this section shall require the board to defend or indemnify a person in an action under subdivision (a), unless otherwise required by law.

2340.16. Advisory committee.

(a) If the board establishes a program pursuant to this article, the board may establish one or more advisory committees to assist it in carrying out its duties under this article. A committee created under this article operates under the direction of the board's executive director or their designee.

(b) Appointments to a committee shall be by the affirmative vote of a majority of members appointed to the board. Each appointment shall be at the pleasure of the board for a term not to exceed four years. In its discretion, the board may stagger the terms of the initial committee members appointed, and also may remove a committee member for any reason.

(c) Any committee established by the board shall have at least three members, who are unaffiliated with the program or any contractors thereof, including at least one member who is not licensed by the board and who is knowledgeable in a board-recognized field relating to substance use disorders, mental illness or physical illness. Each licensee appointed shall have experience in the evaluation or management of healthcare professionals who are impaired due to substance use disorders, mental illness, or physical illness. At least one licensee appointed shall specialize in the diagnosis and treatment of substance use disorders in healthcare professionals.

(d) A majority of the members of a committee shall constitute a quorum for the transaction of business. Any action requires an affirmative vote of a majority of those

members present at a meeting constituting at least a quorum, or a majority of the members on the committee if a decision is made through electronic voting. Each committee shall elect from its membership a chairperson and a vice chairperson.

(e) Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, relating to public meetings, a committee may convene in closed session, in person or remotely, to review information relating to any participant, any licensee being considered for diversion, or any individual the program is required to report to the board pursuant to this article. A meeting which will be convened entirely in closed session need not comply with Section 11125 of the Government Code. A committee shall only convene in closed session to the extent that it is necessary to protect the privacy of individuals being reviewed.

(f) Each member of a committee shall receive a per diem and shall be reimbursed for expenses as provided in Section 103.

2340.18. Advisory committee duties.

(a) Each committee may have the following duties and responsibilities as determined by the board or its designee:

(1) To evaluate licensees who request participation in the program through diversion and to make recommendations to the executive director or their designee. In making recommendations, a committee shall consider any recommendations from professional consultants on the admission of licensees to the diversion program.

(2) To review information concerning individuals participating in the program, and any individual the program is required to report to the board pursuant to this article, and to make recommendations to the executive director or their designee.

(3) To consider information provided by the program and make recommendations to the executive director or their designee as to whether the program should report the participant to the board for noncompliance or continue to evaluate, treat and/or monitor the participant, and under what conditions.

(4) To call meetings as necessary to consider the requests of licensees to participate in the diversion program, to consider reports regarding participants in the program or regarding any individual the program is required to report to the board pursuant to this article, and to consider any other matters referred to it by the board.

(5) To periodically hold open public meetings to evaluate the program's progress, to prepare reports to be submitted to the board, to consider proposals for changes in the program, and to consider other matters as requested by the board.

(b) For the purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, any member of a committee shall be considered a public employee. No board or committee member, contractor, or agent thereof, shall be liable for any civil damage because of acts or omissions which may occur while acting in good faith pursuant to this article.

2340.20. Physician Health and Wellness Program Account established; Funding and fees.

(a) The Physician Health and Wellness Program shall have its own fund under the control of the board. Any funds collected by the board for the support of the program shall be deposited into the Physician Health and Wellness Program account and shall be available, upon appropriation by the Legislature, for the support of the program.

(b) Subject to appropriation by the Legislature, the board may use moneys from the Physician Health and Wellness Program account to support any costs incurred by the board related to the program established under this article, except these moneys shall not be used to cover any costs for individual participants in the program.

2340.22. Mandatory reporting of licensees with potential impairment.

(a) If the board establishes the program, a licensee shall report to the program or the board, the name and current contact information of another licensee if they, in their good faith judgment, believe that the other licensee may have a mental or physical illness, including a substance use disorder, that impacts the ability of that licensee to practice medicine or their profession in a safe, competent, and professional manner.

(b) The program or board shall not disclose the name of the referring individual to the referred licensee under any circumstances, except with the express written permission of the referring individual, or if otherwise required by law.

2340.24. Exclusion.

This article shall not apply to the Osteopathic Medical Board of California nor to its licensees.

ATTACHMENT 2

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November 1, 2024

Hon. Medical Board Members
Medical Board of California
2005 Evergreen St., Ste. 1200
Sacramento, CA 95815
By email: phwp.comments@mbc.ca.gov

Re: Testimony of the Consumer Protection Policy Center – Physician Health and Wellness Program

Dear Hon. Medical Board Members:

On behalf of the Consumer Protection Policy Center (CPPC) at the University of San Diego School of Law, I am pleased to submit the following testimony to the Medical Board of California regarding draft legislation creating a Physician Health and Wellness Program (PHWP).

CPPC Expertise Regarding the Medical Board of California

CPPC is a nonprofit, nonpartisan academic and advocacy center based at the University of San Diego School of Law. For 44 years, CPPC has examined and critiqued California's regulatory agencies that regulate business, professions, and trades, including the Medical Board of California (MBC) and other Department of Consumer Affairs (DCA) health care boards. CPPC's expertise has long been relied upon by the Legislature, the executive branch, and the courts where the regulation of licensed professions is concerned. For example, after numerous reports of problems at MBC's enforcement program were published in 2002, the DCA Director appointed CPPC's then-Administrative Director, Julianne D'Angelo Fellmeth, to the position of MBC Enforcement Monitor pursuant to Business and Professions Code section 2220.1 (now repealed). Over a two-year period, she directed an in-depth investigation and review of MBC's enforcement program and its so-called "diversion program," which purported to monitor substance-abusing licensees. In two exhaustive reports,[1] CPPC's Administrative Director made 65 concrete recommendations to strengthen the Board's programs.

[1] Julianne D'Angelo Fellmeth and Thomas A. Papageorge, *Initial Report of the Medical Board Enforcement Program Monitor* (Nov. 1, 2004); Fellmeth and Papageorge, *Final Report of the Medical Board Enforcement Program Monitor* (Nov. 1, 2005).

also the overhead costs of administering the program. Neither MBC nor CMA have explained why that funding mechanism is no longer appropriate.

As such, CPPC believes the draft PHWP legislation is completely inadequate to establish a program that protects patients from substance-abusing physicians and the dangers they present (as recognized by the Senate Business and Professions Committee in SB 1441's intent language quoted above). In fact, the draft legislation would inevitably lead to the establishment of a program almost identical to the Board's previous "diversion program," except that it would be administered by an outside vendor instead of MBC employees. Further, it is almost identical to the PHWP rulemaking that MBC itself voted to abandon earlier this year.

CPPC's Suggests MBC Step Away from a PHWP and Instead Focus on More Important Issues

At MBC's March 1, 2024, meeting, MBC's second enforcement monitor, Les Lombardo, gave his presentation on the Final Report of the Enforcement Monitor. Mr. Lombardo summarized key issues and recommendations MBC should address. The issues included [1] Central Complaint Unit (CCU) serious injury or death complaints closed without Health Quality Investigation Unit (HQIU) investigation and problems with the complaint tracking system project; [2] lack of collaboration between Health Quality Enforcement (HQE) prosecutors and HQIU investigators that significantly impacted efficient, effective, and timely adjudication, as well as problematic medical expert analysis and the imposition of sanctions/discipline in accordance with disciplinary orders/guidelines; [3] physician and surgeon demographic data analysis; and [4] additional enforcement program issues such as critical issues of program funding shortages and complaint outreach interviews.

Mr. Lombardo gave recommendations as well at the March 1, 2024, meeting. These recommendations included [1] MBC's need to collaborate with Complaint Tracking System (CTS) stakeholders to ensure legally allowable public visibility to CTS information; [2] establish structured collaboration between HQIU investigation and HQE prosecution to ensure necessary, appropriate, and timely communication throughout a complaint investigation (and restructuring the MBC enforcement program if the communication cannot be achieved); [3] recruiting, training, compensation, and feedback of medical experts in adjudication proceedings; [4] review the disciplinary guidelines and procedures for departing from identified disciplines relative to associated violations; and [5] MBC to establish a formal process for self-identified race/ethnicity information to be periodically extracted, analyzed, and reviewed by the Board to provide insight on demographic trends. The enforcement monitor did NOT identify a wellness program for physicians and surgeons as an appropriate MBC focus.

None of these issues highlighted by an independent enforcement monitor has been the subject of a major discussion by the Board. None of these issues led to special meetings to be discussed outside of regular MBC quarterly meetings. Yet the Board has dedicated time and resources to have presenters on a PHWP, and even a special meeting for interested parties on October 24, 2024,

Issues With the Previous MBC Diversion Program

With regard to the diversion program, the Enforcement Monitor found that all of the monitoring mechanisms by which it purported to monitor substance-abusing physicians — including required biological fluid testing, required group therapy meeting attendance, worksite monitor requirements and reporting, and treating psychotherapist reporting — were failing; that the program lacked sufficient internal controls to alert program staff to these failures; and that the program had been so under-resourced and understaffed that staff could not have corrected these failures even if they detected them. Of critical importance, the Monitor also found that the program suffered from an absence of enforceable rules or standards to which participants and personnel were consistently held because MBC itself — contrary to applicable provisions in the Business and Professions Code — had failed to exercise any meaningful oversight over the program. These findings echoed the results of three earlier audits of the program by the Auditor General.[2]

Following the publication of the Enforcement Monitor's reports in 2004 and 2005, the Legislature directed the State Auditor to re-audit MBC's diversion program. In June 2007, the Auditor released Report 2006-116R, which concluded that while the program had improved since the 2005 Enforcement Monitor report, many of the problems identified by the Enforcement Monitor had not been corrected. Specifically, the program failed to ensure that all participants were randomly drug tested; failed to adequately monitor and/or require reporting from its various contractors (including urine specimen collectors, group meeting facilitators, and worksite monitors); did not respond to potential relapses in a timely and adequate manner; and did not always require a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug. Lastly, the Auditor found that MBC — which was charged with overseeing the diversion program — "has not provided consistently effective oversight."

Following receipt of the Auditor's Report, MBC—at its July 2007 meeting—unanimously voted to abolish the diversion program and seek a repeal of the statutes creating it. The program was abolished effective July 1, 2008. Thus, MBC has not had a program to monitor substance-abusing licensees for 16 years.

After MBC's Failed Diversion Program

In 2008, the Legislature enacted SB 1441 (Ridley-Thomas) (Chapter 548, Statutes of 2008), which added section 315 *et seq*. to the Business and Professions Code. Section 1 of SB 1441 succinctly stated the Legislature's unmistakable intent regarding the use of substance abuse monitoring programs by health care licensing boards:

[2] Auditor General of California, *Review of the Board of Medical Quality Assurance* (No. P-035) (August 1982); Auditor General of California, *The State's Diversion Programs Do Not Adequately Protect the Public from Health Professionals Who Suffer from Alcoholism or Drug Abuse* (No. P-425) (January 1985); Auditor General of California, *The Board of Medical Quality Assurance Has Made Progress in Improving its Diversion Program; Some Problems Remain* (No. P-576) (June 1986).

> Substance abuse is an increasing problem in the health care professions, where the impairment of a health care practitioner for even one moment can mean irreparable harm to a patient. … Substance abuse monitoring programs, particularly for health care professionals, must operate with the highest level of integrity and consistency. Patient protection is paramount. The diversion program of the Medical Board of California, created in 1981, has been subject to five external audits in its 27-year history and has failed all five audits, which uniformly concluded that the program has inadequately monitored substance-abusing physicians and has failed to promptly terminate from the program, and appropriately refer for discipline, physicians who do not comply with the terms and conditions of the program, thus placing patients at risk of harm. The medical board's diversion program has failed to protect patients from substance-abusing physicians, and the medical board has properly decided to cease administering the program effective June 30, 2008. … Various health care licensing boards have inconsistent or nonexistent standards that guide the way they deal with substance-abusing licensees. Patients would be better protected from substance-abusing licensees if their regulatory boards agreed to and enforced consistent and uniform standards and best practices in dealing with substance-abusing licensees.

SB 1441 required the Department of Consumer Affairs to convene a "Substance Abuse Coordination Committee" (SACC) to develop "uniform and consistent standards" in 16 specified areas that "each healing arts board ***shall use*** in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program." Bus. & Profs. Code section 315(c) (emphasis added). DCA convened the SACC in 2010, and — following extensive public hearings — it released the original version of the "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees" (Uniform Standards) in 2011. The current version of the Uniform Standards is available on DCA's website.

MBC's Previous Physician Health and Wellness Program Rulemaking

On September 21, 2023, MBC published notice of its intent to adopt proposed PHWP rulemaking. CPPC provided written comment in opposition to the PHWP rulemaking. On March 1, 2024, the Board discussed the PHWP at its quarterly meeting. There was strong opposition not only from CPPC but also from other patient and public interest groups. Among many other objections, CPPC noted that the proposal failed to require MBC to establish a Board committee to oversee the activities of the PHWP, to ensure that MBC meaningfully oversees the program's activities. After a lengthy discussion, MBC voted to postpone any action on the PHWP until the next quarterly board meeting to hear from other states on similar programs.

At MBC's May 24, 2024, meeting, Christopher Bundy, M.D., from Washington, and Paul Early, M.D., from Georgia, gave presentations on their own state's programs. Both presenters demonstrated how their state's programs run independently from the state's medical board. Washington's program is governed by a separate board of directors, approved by the Washington State Medical Association, and created as an independent, nonprofit 501(c)(3) organization. Dr. Early demonstrated a program that functions separately from Georgia's medical regulatory board

and suggested that MBC should have "evolving trust" in the program. Neither presenter suggested that MBC create its own PHWP. After further discussion and public comment, the Board agreed that the proposed PHWP rulemaking was insufficient and voted to terminate the rulemaking.

MBC's Draft PHWP Legislation

On October 14, 2024, MBC published agenda materials for an interested parties meeting on PHWP legislation. The materials included draft legislative language for the PHWP. Despite MBC's agreement that the previous PHWP rulemaking was insufficient, this newly proposed PHWP legislation is very similar to the previous PHWP rulemaking with a few differences. One difference in the draft legislation states that MBC *may* establish one or more advisory committees to assist in the program. The advisory committee would consist of at least three members who are unaffiliated with the program or any contractors thereof, including one member not licensed by MBC and knowledgeable in a board-recognized field relating to substance use disorders, mental illness, or physical illness. Incredibly, and contrary to CPPC's comments during MBC's 2023 rulemaking, the language of draft section 2340.16 does not even require that any advisory committee be composed of MBC members to ensure that – as urged by Enforcement Monitor Fellmeth and the 2007 report of the State Auditor — the Medical Board itself exercise meaningful oversight of the program.

A second difference is mandatory reporting of licensees with potential impairment. An MBC licensee must report to the program or MBC the name and contact information of another licensee if the other licensee is believed in good faith judgment to have a mental or physical illness, including a substance use disorder, that impacts the practice of medicine. The addition is fairly meaningless. The statutes creating other DCA healing arts boards include a similar so-called "snitch law" — these are so vague as to be effectively unenforceable. It is almost impossible to prove when a licensee knew that another licensee suffered from "potential impairment."

Most critically, the current draft actually exempts any PHWP created by MBC from the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees adopted by DCA's Substance Abuse Coordination Committee after a laborious two-year public process. The Uniform Standards directly responded to Enforcement Monitor Fellmeth's finding that MBC's prior monitoring program suffered from an absence of any enforceable rules or standards to which program participants and personnel were consistently subject, and whose violation(s) were accompanied by definable consequences. The Enforcement Monitor's findings were echoed in SB 1441's intent language quoted above ("[v]arious health care licensing boards have inconsistent or nonexistent standards that guide the way they deal with substance-abusing licensees. Patients would be better protected from substance-abusing licensees if their regulatory boards agreed to and enforced consistent and uniform standards and best practices in dealing with substance-abusing licensees.") The Uniform Standards set forth, for example, specific deadlines for the reporting of **all** violations of a participant's contract to the applicable regulatory agency (not just program withdrawals and terminations, as would be required under draft section 2340.4(g)); further, they establish consistent consequences for major and minor violations of a participant's contract (such consequences appear nowhere in the draft legislation); and they prohibit participants who have

repeatedly violated their contract and have been terminated from the program from regaining entry into the program (as would be permitted by draft section 2340.8(j)).

This draft legislation exempts the program from complying with the Uniform Standards as to "voluntary participants" (whose definition is anything but clear under draft sections 2340(b)(15) and 2340.8). The legislation further includes many undefined terms that are defined in the Uniform Standards (from which this program would be exempt). As such, they are unenforceable and unacceptable. The draft legislation's specifications, for example, that the administering entity submit "immediate reporting to the board" of "suspected or verified" impairment (section 2340.6(a)(4), and "timely reporting" to the board under section 2340.6(a)(5) are vague, unenforceable, meaningless, and totally unnecessary. Reasonable and responsible deadlines for all of these events are established in the Uniform Standards. There is no reason why MBC and MBC alone should be exempt from the Uniform Standards when constructing a new PHWP, nor has any reason been proffered by MBC or whoever drafted the document.

CPPC further observes several somewhat unprecedented abnormalities concerning awarding a program contract to an outside vendor to administer the PHWP. For example, draft section 2340.4(a) exempts MBC, in contracting for an outside administering entity, from section 10425 of the Public Contract Code. Further, the draft language would allow MBC to enter into a multiyear contract "without having to obtain the approval of the Department of General Services, the Office of Legal Services, or other state entity to justify such a multiyear term." This language does not even specify that the Department of Consumer Affairs must approve and oversee the contract. This conflicts with existing precedent under which DCA has entered into a master contract with an outside entity (Maximus) to administer substance abuse monitoring programs for six of its healing arts boards. Finally, under the draft legislation, MBC would be limited to extending a program contract to a 501-c-3 nonprofit administering entity. This requirement would preclude Maximus and other experienced companies that are not nonprofits from being able to apply for the contract, and would open the door for MBC to enter into a multiyear contract with a nonprofit created by the California Medical Association shortly after MBC voted unanimously to discontinue the diversion program. The board of that nonprofit, California Public Protection & Physician Health, Inc., contains several individuals who assisted MBC in administering its prior monitoring program, which MBC voted to end after it failed five independent external audits.

Finally, and as admitted by MBC in its interested parties meeting announcement, the draft legislation fails to identify the source(s) of funding for the PHWP. The overhead costs of MBC's prior diversion program were funded by an entirely inadequate portion of MBC licensing fees assessed to all California-licensed physicians, while program participants were required to pay their "participation fees" (including drug testing fees, group meeting fees, and required inpatient/outpatient treatment and psychotherapy (if any)). That level of funding was so inadequate that the Program was forced to turn away participants in 2003-04 because the caseloads of existing program staff doubled, and staff could not adequately monitor program participants. *Initial Report*, *supra* note 1, at 253–54. In 2016, CMA sponsored SB 1177 (Galgiani) (Chapter 591, Statutes of 2016). That statute authorized MBC to create a new monitoring program for substance-abusing physicians so long as (1) the program fully adhered to the Uniform Standards and (2) it required participating physicians to pay not only their participation fees but

to discuss the new proposed PHWP legislation. MBC staff has put time and resources into two separate PHWP proposed implementations, and yet none of the above recommendations by the enforcement monitor have been given the same amount of time and resources. CPPC believes MBC should focus on the issues highlighted by the enforcement monitor instead of dedicating time and resources to a PHWP designed to benefit doctors more than to protect patients and the public interest.

If physicians want a rehabilitation program (outside of the various rehabilitation programs already in existence throughout California), then interest groups should advocate without the aid of MBC resources. The creation of a governing agency to directly oversee rehabilitation programs could provide sufficient oversight, as in the programs in Washington and Georgia. Of course, the program would need to be in contact with MBC to ensure the enlisted physicians are not in violation of their treatment program. A mandatory reporting requirement by the new governing agency would be necessary for MBC to uphold its enforcement obligations.

CONCLUSION

CPPC urges the Board to reject the proposed PHWP legislation and instead focus on matters that truly and appropriately concern the legitimate regulatory functions of the Medical Board of California. When MBC seeks to create a rehabilitation program, it is the Board's burden to ensure that patients are protected above all else. This Board previously rejected a similar PHWP proposal in the form of rulemaking, and there are identical similarities to this new proposed PHWP legislation. There is no need for the MBC to be concerned in physician and doctor rehabilitation in light of the Board's enforcement obligations. If California needs a rehabilitation program for substance-abusing physicians and surgeons, the California Medical Association should look elsewhere outside of the Medical Board of California to establish a PHWP. The MBC needs to dedicate its time and resources to matters that genuinely risk public safety, such as the adjudication issues highlighted by the previous enforcement monitor.

CPPC cannot stress enough that MBC's obligations are to protect patients and the public. Time and resources dedicated to a physician rehabilitation program would be designed to benefit physicians first, with the protection of the public only being an auxiliary side effect if the program is successful.

Sincerely,

Marcus Friedman
Administrative Director
Consumer Protection Policy Center

Cc: Kristina D. Lawson, J.D., President, Medical Board of California
Reji Varghese, Executive Director, Medical Board of California
Senator Angelique Ashby, Chair, Senate Business, Professions & Economic Development Committee
Assemblymember Marc Berman, Chair, Assembly Business & Professions Committee
Kimberly Kirchmeyer, Director, California Department of Consumer Affairs

CALIFORNIA MEDICAL ASSOCIATION

November 01, 2024

Marina Torres, J.D.
Board Member
Medical Board of California
2005 Evergreen St #1200
Sacramento, CA 95815

Felix Yip, M.D.
Board Member
Medical Board of California
2005 Evergreen St #1200
Sacramento, CA 95815

Sent via email to PHWP.comments@mbc.ca.gov

RE: Proposed Language to Establish a Physician and Surgeon Health and Wellness Program aligning with National Best Practices.

Dear Ms. Torres and Dr. Yip:

On behalf of the California Medical Association (CMA) and our more than 50,000 physician and medical student members, CMA writes to comment on the Medical Board of California's (Board's) proposed language to establish a Physician Health and Wellness program which aligns with national best practices.

First, CMA would like to extend our appreciation to the Board for embarking on this effort. The language released for comment reflects a sea change. CMA views this proposal as one which recognizes that impairment is not a personal failing and seeks to provide meaningful ways for licensees of the Board to access help in the furtherance of consumer protection, in alignment with its mission to protect healthcare consumers and prevent harm.

CMA appreciates the provisions to allow for confidentiality of participants who come to the program voluntarily and the provision for confidentiality of records, which aligns with existing protections for confidentiality of medical information. Ensuring physicians trust that they can access the program's services confidentially is foundational to ensuring the program's success. We are also pleased a mechanism was included to allow for referral by the Board to the program in lieu of discipline when there has not been patient harm.

CMA acknowledges and appreciates the amount of work required by Board staff to develop such a robust proposal. CMA will need additional time to fully analyze and

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provide detailed feedback. Before we complete our full analysis, we would like to highlight two key high-level considerations.

Recognizing the significant cost associated with participating in a physician health program, we would like to suggest that the proposed language include flexible authority to allow for subsidization of the costs to participants if funds are identified and allocated to allow for that. Next to confidentiality, high cost to the physician stands as a consideration that we believe would discourage participation. Allowing the program the flexibility to subsidize the cost of participation would allow the program to alleviate a major barrier to participation.

Additionally, the proposed language introduces a new statutory mandatory reporting requirement that warrants further internal review. While physicians are already familiar with their ethical duty, as articulated by the AMA, to intervene when a colleague's impairment endangers patient safety, establishing a statutory requirement raises questions that should be thoughtfully considered to maintain the balance between professional responsibility and clinical judgment. CMA looks forward to providing additional feedback after having the opportunity to complete our review.

CMA requests that the discussion continue and supports continued development of the legislative proposal to create a Physician Health and Wellness program aligned with national best practices. We appreciate that the current language incorporates concepts from these national best practice standards. We look forward to continuing to work with the Board and Board staff on the details of the proposal. If any further information is needed, please do not hesitate to contact us at levensen@cmadocs.org.

Sincerely,

Shannon Udovic-Constant, M.D.
President
California Medical Association

cc: Reji Varghese, Executive Director
Kristina D. Lawson, J.D., President
Members of the Medical Board of California

CALIFORNIA PUBLIC PROTECTION & PHYSICIAN HEALTH, INC.

CPPPH

November 1, 2024

TO the Medical Board of California by email to phwp.comments@mbc.ca.gov

RE: Feedback on the proposed legislation

ARTICLE 14. Physician Health and Wellness Program [2340 - 2340.24]
This proposal would repeal and replace all of the existing language under Article 14 (Business and Professions Code section 2340 – 2340.8).
2340. Establishment of the Physician Health and Wellness Program

CPPPH welcomes the opportunity to provide our viewpoints and to recommend specific changes in some areas of the proposed legislation.

CPPPH is a not-for-profit organization dedicated to patient safety by supporting medical staffs and medical groups as they carry out their responsibility for patient safety with their roles in identifying, referring, and monitoring physicians with potentially impairing conditions.

We are very eager for an effective Physician Health & Wellness Program (PHWP) to be established in our state, and we support the approach, the intent and many of the provisions in the MBC proposed language. We also have concerns about some of the provisions as described, and we plan to submit additional information at a later date.

In today's letter, we offer these recommendations:

We recommend this wording in 2340(b)(5).:

(5) "Impaired," "impairing," or "impairment" shall mean the inability to practice medicine or other healthcare profession regulated by the board in a reasonably safe, competent, and professional manner due to 1) mental illness; 2) physical illness; 3) disruptive behavior; or 4) substance use disorder. ~~excessive use or abuse of drugs or alcohol~~.

We recommend expanded wording of section 2340.2(1) to make it read:

(1) Provide for the education of licensees, applicants, prospective applicants, trainees, ~~and~~ students, hospitals and medical groups and all that privilege physicians to provide patient care; provide ~~with~~ information with respect to the early identification ~~and prevention of disruptive behavior,~~ of threats to patient safety that may be due to potential impairment because of the provider's mental illness, physical illness, behavior, and/or substance use disorders, and provide information on how to apply to or refer to the program.~~.~~

We plan to submit other comments for your consideration. We understand that the proposed legislation does not make any reference to source(s) of funding for the administrative costs of the proposed program. We see the note that says that the MBC would welcome comments on potential funding options, and we plan to address options in further written comments. CPPPH maintains that options must be explored that will provide sufficient, consistent funding, independent of a per-capita amount charged to the participant, in order to minimize the potential financial barriers to participation in the program.

These and other elements in the current proposed language require our further study before we can comment on them, and we ask for your consideration of additional comments as you move forward with this new, very promising approach.

Thank you for your attention to the points we make in this statement. We would appreciate the opportunity to answer questions you may have.

Sincerely,

John Rosenberg

John G. Rosenberg, MD
Chair, CPPPH Board
johngrosenberg@gmail.com

UNIVERSITY OF CALIFORNIA
HEALTH

November 1, 2024

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Re: Recommended Changes to Proposed Language for Physician Health and Wellness Program

Dear Members of the Medical Board of California,

The University of California Health (UC Health) appreciates the opportunity to provide comments on the Medical Board of California's draft legislation that would establish authority for the Board to create a physician health and wellness program.

UC Health's mission is to improve the health and well-being of all people living in California now and in the future by educating and training the diverse workforce of tomorrow; delivering exceptional and equitable care; and discovering life-changing treatments and cures. UC Health is comprised of six academic medical centers and 21 health professional schools. As one of the largest health professional instructional programs in the nation, UC Health trains 6,000 medical residents and fellows, making up 40% of California's total trainees.

UC Health would like to extend its gratitude to the Board for its efforts into establishing a program and its commitment to safeguarding physician well-being, as well as patient safety. As the Board and Board staff continue to work on the details of the proposal, we would like to highlight four key considerations:

1. The proposed language introduces a new statutory mandatory reporting requirement that warrants further internal review. While physicians are already familiar with their ethical duty to intervene when a colleague's impairment endangers patient safety, establishing a statutory requirement raises questions that should be thoughtfully considered to maintain the balance between professional responsibility and clinical judgment.

2. There must be a reliable process that guarantees confidentiality, except in cases of clear non-compliance with assessment or treatment plans that could pose risks to patient safety. It is essential that program participants have genuine trust in the confidentiality process. Without a guarantee of confidentiality, physicians may inadvertently be discouraged from seeking the care they may need.

3. UC Health recommends careful consideration of the composition of the advisory committee. While it is not desirable for committee members to serve as diagnosticians nor treatment providers in this capacity, it is crucial to include health professionals knowledgeable in behavioral health and substance misuse. Furthermore, committee members should possess an understanding of the importance of destigmatizing behavioral health challenges and actively promoting physician well-being, thereby fostering safe avenues for seeking assistance.

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HEALTH

4. UC Health asks that the Board consider how the cost of the program may pose a barrier to physicians' participation in the program and unintentionally decrease utilization of necessary services for our students, residents, and attending physicians. It may be helpful to include language that allows for more flexible authority regarding subsidization of the participants' costs if funds are identified.

Thank you again for the opportunity to provide input on the Board's draft legislative proposal that would authorize the establishment of a physician health and wellness program. We welcome any future opportunities to collaborate on implementing this program in alignment with national best practices. If any further information is needed, please feel free to contact me.

Sincerely,

Deena Shin McRae, MD
Associate Vice President, Academic Health Sciences, University of California Health
Clinical Professor, Department of Psychiatry, UCI School of Medicine
Deena.McRae@ucop.edu

FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS, INC.
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To: **California Medical Board**
From: **Federation of State Physician Health Programs (FSPHP)**
Comments for the California Medical Board
Subject: **ARTICLE 14: Physician Health and Wellness Program Comments**

November 1, 2024
On behalf of the Federation of State Physician Health Programs (FSPHP), we extend our gratitude for the board's dedication and hard work in advancing the needs of California's public by forging a pathway for physicians and trainees to safely address health matters. We look forward to the day when California can join the other 47 states that have an authorized physician health program (PHP) operating in accordance with best practices as set forth in the FSPHP PHP Guidelines. FSPHP draws on its members' 50-year track record of serving the health of the profession and ensuring public safety by providing the support and commentary below.

The proposed regulation aligns with the FSPHP's triad of confidentiality, which ensures that a physician or trainee can navigate health concerns through a private, expertly supported process. This model supports physician health and well-being in a safe and confidential manner. It has been shown to be highly effective in rehabilitating the professional, proactively protecting patient safety, and retaining needed physicians in the healthcare workforce. The proposed language in Article 14 reflects thoughtful research of models of PHP approaches across the country. It includes critical elements of the FSPHP PHP model that drive the unparalleled outcomes that PHPs have demonstrated over time.

For example, this legislation is to be applauded for including:

- Clear parameters for those who may need to be reported to the board for further action
- A pathway for confidential referrals, separate from the medical board, when patient harm has not occurred
- A structure in which a health and wellness program can independently operate in connecting the physician to expert treatment

To accomplish patient safety, we believe that this drafted legislation codifies protection for those who make good faith referrals to the PHWP. In addition, it also provides physicians, trainees, and licensees the ability to come forward and receive confidential care in a health and wellness program. In other words, participants who are compliant with the PHWP program and monitoring agreements, and who do not pose a risk to patient safety, should not be known or reported to the board unless they are deemed unsafe to practice or pose a danger to themselves or others.

The marker of a successful program is a cohort of participants upstream of impairment who are not known to their medical board because their conditions were appropriately addressed and rehabilitated before an event occurred that would require or result in board notification. .
To clarify what we mean, your new PHWP should include a clear pathway for three lines of referrals:

- Those never known to the board (voluntary and/or referred by the workplace)
- PHP referrals from the medical board
- PHP referrals (notifications) to the medical board for participants who fail to meet program requirements AND who, in the opinion of the program, pose a reasonable concern for patient safety.

Thank you for designing what can become a state-of-the-art physician health program, which could serve as a model not only for other state programs but also for other California healthcare professionals. This is truly a pivotal moment for California.

A. Comments regarding the proposed mandated reporting requirement in this legislation:

FSPHP supports legislation authorizing a PHP to accept referrals in lieu of the medical board. FSPHP supports revisions to this section to clarify there is legal authority for a referral to the PHP when a colleague's illness may result in unsafe care. This ethical obligation is made explicit in Opinion 9.3.2 of the American Medical Association's Code of Medical Ethics. FSPHP holds that there be PHP enabling legislation with language that allows referral to the PHP in lieu of notification to the medical board, and as an alternative for healthcare organizations to refer to the PHP instead of the medical board. The proposed language should accomplish the dual goals of strengthening legal requirements to report impairment (and thus patient safety), while also directing those referrals to the confidential, non-disciplinary pathway afforded by the PHWP.

If introducing mandatory reporting requirements, there should be equitable considerations and mechanisms implemented to ensure intended outcomes of the reporting process, particularly a confidential alternative to discipline. In other words, a mandatory reporting requirement's effectiveness goes as far as the ability to provide a diversionary track.

Diversionary Status/Exception for Reporting to the Medical Board:

We recommend this section be reframed and titled "**Exception for Reporting to PHWP instead of the Medical Board**" to provide the PHWP with statutory authority as a diversionary program, to receive referrals in lieu of any report relating to concerns for impairment that would be made otherwise to the medical board absent patient harm. In addition, the language should also highlight that the PHP is exempt from any mandated reporting when the licensee is adherent to program requirements and does not pose a risk to patient safety.

Mandatory reporting may provide a mechanism for licensees and healthcare organizations to help recognize individuals at risk of impairment before it occurs, in so far as there are concurrent assurances to the referrer that not only a concern for patient safety is addressed but also that a

physician is appropriately assessed for the PHWP pathway. In our opinion, it is effective in encouraging referrals to seek help. **Studies show healthcare professionals under-report, so it is prudent to provide an exception that allows for reporting to the PHWP Program in lieu of the medical board when there are concerns of mental health or substance use achieves patient safety.**
FSPHP recognizes the importance of weighing the interests of both the California consumer and those of organized medicine and other stakeholders.

Immunity:

- Equally critical is the protection of the referring individual, which is delineated in the proposed legislation.

Further clarifying language in this section of the legislation:

- "A licensee or participant who is fully compliant with the PHWP should be permitted to continue active participation with the codified protections of confidentiality."
    - For added clarity on the process, we encourage revised language that explains what you are trying to achieve. For example, include that there is an intended "**exception to reporting the state medical board**" which would legally authorize the PHWP program to allow **healthcare organizations and healthcare providers to report to PHWP instead of the medical board in certain defined circumstances**.
    - Specifically, the following requirements must be met for a diversionary report to be made to PHWP:
        - The circumstances involve a mental health condition and/or a drug or alcohol problem
        - There must be no allegation of patient harm
        - The physician must agree to participate in PHWP
        - The referent must receive confirmation of that the individual they have refer to the PHWP is compliant, within 30-60 days or their obligations to report would remain.
    - The PHP must be exempt from any mandated reporting when the licensee is adherent to program requirements and does not pose a risk to patient safety.

We further advise that if the Board receives a report that would otherwise qualify for non-disciplinary referral to the PHWP, there should be a mechanism for the advisory committee to refer the participant to the PHWP with the PHWP program providing confirmation that the health concern resulting in the complaint has been adequately addressed by the PHWP (either through case resolution or enrollment in a health monitoring agreement). Boards should strongly consider closing cases in which the sole basis of a complaint relates to a health condition that is being adequately addressed by the PHWP. However, it is also recognized that

other matters of competence or professionalism may attend the complaint and require Board action.
The PHWP would be required to uphold its duty for reporting concerns to the board advisory committee, as stated in the proposed regulation.

B. Section-specific Recommendations:

- **2340.2 Program Requirements**
  - (4) intervene in cases of verified impairment and those at risk of impairment **FSPHP recommends the program is available to those prior to their health condition reaching impairment.**
  - (6) Provide consistent and regular assessment, referral to evaluation, treatment and remedial resources (such as therapy, education and professional coaching when monitoring is not indicated**).**
    FSPHP recommends that the program is available to individuals who may not meet criteria for monitoring.
  - **(b) We recommend against the requirement that Uniform standards can be applied to voluntary participants. This will eliminate referrals of voluntary participants.**

- **Section 2340.4**
  - We strongly support the plan for a multiyear contract which allows the established program to maintain continuity of care and expertise. Once the approved program is selected, we encourage annual reporting of aggregate data to re-affirm the commitment of PHWP program that exists in perpetuity while meeting the set benchmarks for quality, and annual reporting. An ongoing RFP process interferes with the resources needed to provide care. Moreover, it is widely recognized that it takes a PHP years of dedicated effort to develop stakeholders, build relationships with referral resources, and engender the trust required to be an effective PHP. In short, a strong PHP is one that should be nurtured and preserved as a state supported resource, not subject to the perpetual existential threat of turnover with each RFP cycle. Many states have contracting mechanisms to renew a high-functioning program's contract without the need for an RFP process at the end of the renewal period.
  - (8) We strongly support this section which outlines excellent parameters for an ongoing collaborative relationship with the medical board that also protects patient safety while assuring the health and wellness needs of the profession are met.
  - (3) We recommend clearly delineating that this section is meant for reports regarding anonymized data of participants who are not known to the medical board.
  - (i) Add a requirement to this section that the medical board's chosen "evaluator" of the program has a demonstrated history and expertise in PHWPs, safety sensitive care without any bias or conflict of interest. We see this is covered under section (9) as well, excellent! We also advise that the FSPHP has a review program for PHPs (the FSPHP

PEER™ program) that might serve the evaluative spirit of this section.

- **Section 2340.8**
  - (d) Advisory Committee Duties: Referral to evaluation, and referral to treatment would typically be done by the PHWP, who would then engage the participant in monitoring as well.
  - Advisory Committee Duties
    - (1) **The Advisory Committee should refer individuals to the PHWP for evaluation rather than evaluate themselves** unless "evaluation" in this context refers to the process by which the Advisory Committee determines eligibility for referral to the PHWP. Evaluation in the PHP model conveys a clinical service that would not be appropriately navigated at the level of a board advisory committee
    - (5) Clarify the reporting periods of the PHWP to be evaluated so it does not become a burden to the PHWP (annual reporting, or quality evaluating?)

- **Section 2340.20 Funding**
  - **34 State Physician Health Programs receive funding from their state, typically through a licensure surcharge fee.**
    - By its nature the funds of a 501(c)3 cannot be controlled by another entity but will need to be controlled by the 501(c)3 Board.
    - Change this section to be that the state has a fund that is to be delegated to the PHWP.
    - FSPHP is available to assist with supplying budget information, and sources of funding from other PHPs.
    - FSPHP can provide, upon request, example statutory surcharge language representing best practice including ensuring that the collected funds are allocated to a protected account, paid to the PHWP, and deemed solely to support the PHWP.
    - **State funding for a physician health program is essential to protect public health and ensure the well-being of medical professionals.** These programs help doctors address issues such as burnout, mental health challenges, and substance use disorders—problems that, if left untreated, can compromise patient care and safety. By providing support and rehabilitation, state-funded programs maintain a healthier, more effective healthcare workforce, reduce medical errors, and lower the overall cost of healthcare through early intervention and prevention. This investment safeguards both physicians and the communities they serve.