November 14, 2023

To:
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Please accept these comments submitted on behalf of the Federation of State Physician Health Programs. The Federation of State Physician Health Programs, Inc. (FSPHP) evolved from initiatives taken by the American Medical Association (AMA) and individual state physician health programs, focused on the need for the creation of confidential programs as an alternative to discipline that are dedicated to the rehabilitation and monitoring of physicians with psychoactive substance use disorders as well as mental and physical illness. Currently, programs meeting the FSPHP State PHP criterion exist in 47 States, all but California, Nebraska, and Wisconsin.

The FSPHP is vested in seeing leading-edge practices put forth by State PHPs. These comments are submitted by Dr. Edwin Kim, on behalf of FSPHP. Dr. Kim is a board-certified addiction psychiatrist who serves as a medical director of Pennsylvania's Physician Health Program, director of Addiction Treatment Services at the Palo Alto VA health system, and as a Clinical Assistant Professor Affiliated with Stanford University. He is one of 15 FSPHP Board of Directors who lead Physician Health and Health Professional Programs across the US.

In accordance with Government Code section 11346.5 subdivision (a)(13), we implore members of the Board to consider a reasonable alternative to the proposed regulation concerning Physician and Surgeon Health and Wellness Programs as presented to you in written format here, accompanied by a copy of the FSPHP Physician Health Program Guidelines, and in verbal summary by Dr. Kim.

We want to acknowledge the eloquent change of language from a now-defunct impaired physician or diversion program to the newly minted Physician Health and Wellness Program signifies the board's and California’s forward thinking in balancing the needs of protecting public safety and assisting physicians with a substance use disorder which is impairing or potentially impairing. The FSPHP considers the next natural step in this change of nomenclature to be the careful consideration that physician health

programs not only assist in matters related to substance use disorders but also -- as seen in nearly all states with PHPs -- that programs are being asked to apply the proven PHP model -- in which the PHWP is rooted -- to other potentially impairing illnesses such as psychiatric disorders or even behavioral concerns. In essence, it is a matter of designing a program befitting to the excellent name.

We urge you to read carefully through these proposed alternatives submitted by the Federation of State Physician Health Programs as well as the organization's PHP Guidelines to consider reasonable amendments to the proposed regulation. This written comment brings to the Board's attention the leading-edge thoughts and recommendations by state PHPs with years of experience in protecting the public while concurrently promoting the health and well-being of their physicians.

The written submission outlines what is considered to be the most effective and least burdensome method to carry forth a state physician health program.

From this submission, we emphasize the following important points:

- Consider that individuals be permitted to seek assistance confidentially while also protecting the public. This CAN be accomplished and this truly is the RECOGNIZED way in which physicians can receive early intervention, and meaningful connection to care.
- Consider that with the transition to a newly minted HEALTH and WELLNESS PROGRAM that the Board and its proposed program CAN help protect public safety by expanding the scope of early intervention, connection to treatment, and monitoring… to conditions not strictly in the category of substance use disorders.
- Consider that PHPs are well-designed to assist with psychiatric disorders that are impairing or potentially impairing as well.
- Next, the costs for the program are largely projected onto the participant for evaluations, treatment, support groups, drug testing, and workplace monitor fees. The plan for $168,000 for 5 years with all expenses to be paid by the participants is unfortunate and, in our opinion, underfunded. Furthermore, the struggling physician cannot be left to bear the weight of these substantial fees without assistance.
- Lastly, the anticipated 50 referrals annually with no plans for growth demonstrates a mistaken projection of prevalence. For a state with one of the highest number of actively licensed physicians, the penetrance of the proposed program is grossly underestimated considering the proportion of those who may be suffering.

Thank you for your time and consideration.

Additional Comments

- The Program includes the term “Wellness” while the purpose is strictly limited to those with a substance use or misuse related concern. Notably, current nomenclature suggests against the use of the term “abuse,” and rather promotes updated language such as: individual with a substance misuse or use disorder, the presence of a substance use disorder which is impairing or potentially impairing.

- Provisions for concerns related to mental health or psychiatric disorders better describe the proposed scope of a named “Wellness program”. Nomenclature today in the space of physician health, wellness, and well-being is of the utmost importance. The program as it is named infers a physician can reach out to the Program for concerns related to mental health or psychiatric disorder assistance.

- State Physician Health Programs often work with individuals who are mandated for monitoring as well as those physicians who voluntarily seek assistance for an illness. The current proposed Program appears more aligned with a licensing board monitoring program for substance use disorders for those physicians who are mandated. In its current construct, there are limited reasons for physicians to come forward preventively for well-being or wellness. In other words, the early intervention component will be lacking.

- Excessive costs for each monitoring provision are projected directly on the participant (evaluation, treatment, support group, testing, and workplace monitor fees).

- The plan is for $1680000 for 5 years, with all expenses shouldered by the participants. This is unfortunate and underfunded.

- Revisit adequate funding such that the vendor provides support groups, and monitoring with the program funding, including evaluation and treatment resources that can have some opportunity for some insurance and workplace reimbursement for treatment of SUD medical conditions.

- There is a stated requirement to be out of work for 30 days with reference to this being “unpaid.” Alternative language might include the use of medical leave of absence only when indicated and may be paid or unpaid depending on the individual’s circumstance.

- The plan projects for severely underestimated penetration, to the extent that these numbers fall below thresholds for those likely with illness. There are an anticipated 40-50 referrals a year in your plan, with no plans for growth. This will not meet the needs of those predicted to be suffering from an illness.

- The estimated costs to participants for evaluation, treatment, drug testing, workplace monitoring, and group attendance listed do not contain any information about the fees that would be imposed by the monitoring vendor on the participants. Additionally, in the sections about the required 3-year external audits of the monitoring program, there is language that the costs of the audits will be paid by the monitoring vendor and those same costs can be factored

into monitoring fees of the participants of the program. The fees for which participants are responsible are too high to bear upon themselves.

- State Physician Health and Wellness Programs must consider methods to offset costs for residents, fellows, and unemployed physicians (many of these practitioners may be suffering from more severe health conditions including but not limited to co-occurring psychiatric and substance use disorders). This is an issue of inequity, likely will impact vulnerable/underserved populations more severely, and may result in continued loss of physician workforce in California. It behooves the Board and the Program to account for increased risk of physician suicide, which is exacerbated by loneliness and hopelessness. Financial burdens in the context of possible license action may severely impede physicians' ability to seek assistance.

- A novel Health and Wellness Program, with all that is known about Physician and Surgeon well-being, cannot ignore that healthcare workers are not only impaired or potentially impaired by substance use disorders. At minimum, the Board and Program must prevent inequitable or discriminatory attention towards individuals with substance use disorders. The should account for the undeniable prevalence of underlying mental health conditions or co-occurring disorders. Furthermore, the monitoring vendor should ensure the participant has access to and is engaged in treatment for these other conditions.

- Feedback and transparency are paramount in the realm of physician health. Include language about seeking monitoring participants' feedback as well as outlining the expected method by which the Board, the Program, the Vendor addresses complaints about the monitoring vendor. This should augment the proposed 3-year audits, and serve as a continuous platform for participants to provide confidential feedback – both positive and negative, suggestions for improvement, privacy violations, and complaints about the monitoring vendor.

- Include language about how potential monitoring vendors will be selected/vetted.

- Outline requirements for the monitoring vendor to maintain policies and procedures for addressing informed consent, privacy, nondiscrimination, and a process for vetting complaints/appeals.

- Consider careful definitions of licensed supervision when determining drug testing frequency. Clarify who fits the role of "licensed supervisor" in the documentation that drug testing frequency can be reduced to 24 times yearly for those participants who have 50% supervision per day by a licensed supervisor. Further clarify the meaning of 50% supervision i.e. in treatment 50% of the time or working with a clinical/educational supervisor 50% in the workplace (as seen with medical trainees).

- Section 1357.12(d) states that if the CA Board initiates an investigation, the monitoring vendor has 3 days to notify the Board about whether the physician is in monitoring and compliance status. Clarify the circumstances in which non-compliance can be reported to prevent retaliatory or discriminatory reporting by the monitoring vendor. The Board and Program should consider thresholds for reporting which may include notifying participants which forms of non-compliance require reporting, and differentiating from those which do not. For example, non-payment of fees may be construed as non-compliant just as not attending groups or working

with a workplace monitor as being non-compliant.

- Consider that most state PHPs are a resource for self-referring physicians who are seeking assistance for a substance use or psychiatric concern. The current proposal requires the monitoring vendor to report any positive drug testing to the Board indiscriminately. This opens an unnecessary and intrusive method of reporting a physician who has self-referred to the Program. Furthermore, to account for false positives, environmental contamination, or a medical reason that someone might test positive, when it is not a return to use, the language should read "**confirmed" return to use**. For example, poorly controlled diabetes can increase the risk of having a positive alcohol metabolite (EtG) in urine, not due to consumption of beverage alcohol. Reporting any positive will have huge impacts on willingness to self-refer and could be seen as discriminatory.

- The Board should reconsider the requirement for immediate cessation of practice for a single positive drug test, without any language about confirmation of return to use or concerns about current impairment. This could be considered discriminatory and a heavy-weighted approach which does not account for a state PHP's ability to help the Board and the participant navigate a positive test result. Mandating a physician to stop practice in the middle of the day , for someone who is otherwise doing well, compliant in monitoring, and likely not impaired, poses a risk for patient safety by preventing receipt of timely care. Consider updated language that the monitoring vendor will evaluate the positive test result with other data like testing history, workplace monitor reports, treatment provider reports, or in consultation with an evaluator or medical review officer before making a determination for ceasing practice.

- The currently proposed requirement for the monitoring vendor to report practice restrictions to the Board, and concurrent documentation on the public website indiscriminately includes both board-mandated participants and self-referred participants. This section should specify that practice restrictions imposed by vendor or treatment providers are due to the underlying health condition being monitored or impairment. It would be unreasonable that a participant that takes a leave of absence or is recommended for time away from work related to another non-impairing health issue or personal/family health issues will need to be reported. Reporting any restriction, especially in self-referred participants, will further limit participants to self-refer and could be seen as discriminatory.

- Consider that required reporting non-excused missed groups, even in self-referred participant to board within 2 business days resulting in disclosure of protected health condition can be inappropriate. This opens the possibility of a participant's information being exposed when they were merely tending to an emergent family or personal health issue. Consider amending the language to allow for monitoring vendor to confirm it was unexcused absence.

- Nail testing should be a provided option for testing as some participants cannot produce samples for hair testing due to any variety of physiological, social, cultural or religious reasons.

Additional Comments to specific sections:

Title 16 of CCR (California Code of Regulations)

§ 1357.12. "(b) The vendor shall report in writing to the Board each minor violation by a participant. as defined in section 1361.52(c) within five (5) business days of the vendor's finding that the participant committed a minor violation, and shall identify the name and license number of the participant. and a detailed description of the violation(s), including the type and date of each occurrence."

Comment: This pertains to Uniform Standard #10, Specific consequences for major and minor violations. The reporting requirement for minor violations ensures that virtually 100% of self-referred participants will lose their confidential status with the Board, which will disincentive self-referrals and increase the likelihood that a licensee with a substance use disorder will not seek help.

1361.5. Uniform Standards for Substance-Abusing Licensees. Amendment only to section 1361.5, subdivision (c)(3) as follows:

(3) **Biological Fluid Testing.**

(A) The Board shall require biological fluid testing of substance-abusing licensees.

(B) For the purposes of this section, the terms "biological fluid testing" and "testing" mean the acquisition and chemical analysis of a licensee's urine, blood, breath, or hair.

(C) The Board may order a licensee to undergo a biological fluid test on any day, at any time, including weekends and holidays. Additionally, the licensee shall be subject to 52-104 random tests per year within the first year of probation, and 36-104 random tests per year during the second year of probation and for the duration of the probationary term, up to five (5) years. If there has been no positive biological fluid tests in the previous five (5) consecutive years of probation, testing may be reduced to one (1) time per month.

Comment: This corresponds to #4 Uniform Stand Frequency of Testing. This frequency of testing will benefit the lab and third-party vendors, because of increased revenue, however, there is no basis for this increased rate of testing frequency. 52-104 tests in the first year seems excessive and will decrease the likelihood of self-referrals. 24-36 tests in years 2-5 seems reasonable. Having an informed PHWP, with expertise commensurate with other state-voting members of the Federation of State Physician Health Programs, utilizing treatment recommendations from a treating entity with expertise in treating physicians (safety-sensitive workers) is the best way to guide decisions regarding testing frequency.

BPC section 2340.2(e) requires the PHWP to comply with the Uniform Standards. Uniform Standard #1 sets forth the requirements for clinical diagnostic evaluations for substance abusing licensees. The Board's regulations implementing the Uniform Standards became effective on July 1, 2015.

Additionally, BPC section 2340.2(d) requires the PHWP to provide for the confidential participation by a licensee who does not have a practice restriction based on substance abuse issues. Therefore, for individuals who self-refer into the PHWP and remain compliant, this proposed section

ensures their confidentiality by clarifying that the references to the "Board" in existing regulation, 16 CCR section 1361.5(c)(1)(A)-(D), shall mean the vendor. Thus, a self-referred participant will only provide notice of their employers and consent to communicate to the vendor, and not the Board.

Comment: Describes confidentiality. This is good.

Adopt 16 CCR section 1357.100) Purpose: The purpose of proposed section 1357 .1 0G) is to indicate that if a participant is required to attend support group meetings, the requirements set forth under existing regulation, 16 CCR section 1361.5(c)(4), shall apply. This proposed section also provides for the confidential participation by a licensee who does not have a practice restriction based on substance abuse issues.

Existing regulation, 16 CCR section 1361.5(c)(4), sets forth the criteria to determine the frequency of group meeting attendance and to verify that the meeting facilitators are experienced, objective, and licensed mental health professionals.

Adopt 16 CCR section 1357.10(k) Purpose: The purpose of proposed section 1357 .1 0(k) is to specify that if a participant is required to have a worksite monitor, the requirements set forth under existing regulation, 16 CCR section 1361.5(c)(5), shall apply.

Rationale: BPC section 2340.2(e) requires the PHWP to comply with the Uniform Standards. Uniform Standard# 7 and #13(2)(c) set forth requirements for worksite monitors.

Under existing regulation, 16 CCR section 1361.5(c)(5), the worksite monitor must meet specified qualifications and must not have had a financial, personal, or familial relationship with the participant, but if it is impractical for anyone but the participant's employer to serve as the monitor, then this requirement may be waived by the Board, as appropriate.

This section prohibits employees of the participant from serving as their worksite monitor. Additionally, the worksite monitor must affirm that they have reviewed the terms and conditions of the participant's order and agree to monitor the participant as required. The worksite monitor must have face-to-face contact with the participant at least once a week, interview other staff in the office about the participant's behavior, if applicable, and review the participant's work attendance.

Comment: This seems very reasonable and is consistent with best practices.

Adopt 16 CCR section 1357.10(1)

Purpose: The purpose of proposed section 1357 .10(1) is to ensure the participant meets the requirements set forth under existing regulation, 16 CCR section 1361.53, prior to returning to full-time or part-time practice. This proposed section also provides for the confidential participation by a licensee who does not have a practice restriction based on substance abuse issues.

Adopt 16 CCR section 1357.11

Adopt "Report and Public Disclosure of Practice Restrictions for Participants" as Title for 16 CCR section 1357.11

Purpose: The purpose of adopting 16 CCR section 1357.11 is to set out reporting requirements for program vendors and give participants notice regarding public disclosure of practice restrictions in a regulation section with a clear title.

Add section 1357(i) Practice restriction definition. "means a restriction from practicing medicine for any period of time or limiting the number of hours the participant can practice medicine; the locations where the participant can practice; or the types of services or procedures they may perform. The PHWP may impose practice restrictions on the participant, and under BPC 2027(a)(3)(C), practice restrictions must be reported to the Board and posted on the licensee's profile." P. 7/46

Comment**:** See next Recommended adoption comment**.**

Adopt 16 CCR section 1357.11 (p.28/46)

Purpose: The purpose of proposed section 1357 .11 is to require the vendor to report a participant's practice restriction to the Board and require the Board to post the practice restriction on the participant's profile on the Board's website. If the participant self-referred to the PHWP, then the public disclosure will not indicate that the status is the result of enrollment in the program. Further, this proposed section provides for timely notification of the vendor to report a participant's practice restriction within one business day of imposition and requires the Board to remove the practice restriction from the participant's profile within one business day of being notified that the practice restriction has been lifted.

Anticipated Benefits: The Board anticipates that this proposed section will benefit interested parties by providing for transparency and ensuring that the public is notified timely if a participant has a practice restriction, regardless of whether the participant is Board-referred or self-referred, consistent with Uniform Standard #14. This proposed section also benefits interested parties by requiring the Board to remove the posting of the practice restriction within one business day of being notified it has been lifted.

Rationale: BPC section 2340.2(e) requires the PHWP to comply with the Uniform Standards. This proposed section complies with Uniform Standard #14. Specifically, pursuant to Uniform Standard #14, the vendor is required to notify the Board of the participant's name; whether the participant's license is restricted or in a non-practice status; and a detailed description of each restriction imposed. The vendor will be required to make this report to the Board within one business day of imposing a practice restriction on a participant, regardless of whether the participant is Board-referred or self-referred so that the Board may alert the public to the practice restriction. Such timely notification is necessary for consumer protection. To protect the privacy of a self-referred participant, however, the Board will not indicate that the practice restriction has been imposed by the PHWP.

Comment: Every licensee with a moderate or severe substance use disorder (SUD) diagnosis will likely require residential SUD treatment, requiring cessation of practice. The mandated reporting to Med Board and public posting will further stigmatize addiction and disincentivize self-referrals to PHWP. ANY DECREASE in referrals will contribute to higher likelihood of a licensee practicing with an untreated potentially impairing illness.

Adopt 16 CCR section 1357.12(b)

Purpose: The purpose of proposed section 1357.12(b) is to require the vendor to report participants' minor violations, as defined in existing regulation 16 CCR section 1361.52(c), in writing to the Board within five business days of finding that the participant committed a minor violation, along with the licensee's name, license number, and a detailed description of the violation.

Anticipated Benefits: The Board anticipates that this proposed section will benefit interested parties by ensuring the Board is notified in a timely manner about a participant's minor violation of the program requirements. Timely notification of a minor violation will allow the Board to investigate the matter and take enforcement action as warranted. Such reporting mandates also serve as an incentive to participants to comply with the program requirements.

Comment: The reporting requirement for minor violations ensures that virtually 100% of self-referred participants will lose their confidential status with the Board, which will disincentive self-referrals, and increase the likelihood that a licensee with a substance use disorder will not seek help. All of the other reporting requirements seem reasonable to me.

Amend 16 CCR section 1361.5(c)(3) (p.41/46)

Purpose: The purpose of the proposed amendments to section 1361.5(c)(3)(G) is to implement changes to the Uniform Standards relating to biological fluid testing adopted by the SACC and made effective as of March 2019. These amendments indicate that licensees subject to biological fluid testing require Board approval for any changes to testing frequency and any alternative testing schedule and testing locations.

Anticipated Benefits: The Board anticipates that this amendment will provide clarity to interested parties that prior Board approval is required for changes to testing frequency and alternative testing schedules and locations. Further, this amendment will make the Board's regulations implementing the Uniform Standards consistent with the Uniform Standards adopted by the SACC, effective March 2019.

Rationale: This proposed amendment is necessary to update the Board's Uniform Standards relating to biological fluid testing under section 1361.5(c)(3)(G) to be consistent with modifications the SACC made to Uniform Standard #4, effective March 2019. Existing law indicates that prior to changing testing locations for any reason, alternative testing locations must be approved by the Board. This section does not allow for an alternative testing frequency, however, which creates problems for licensees who are traveling, but who are subject to being required to test on any day, including while traveling outside of California or the country. Current law can risk an otherwise compliant licensee becoming non-compliant with the terms of their probation, because of their travel schedule and the wording of existing law.

Consequently, the proposed amendment modifies section 1361.5(c)(3)(G) to indicate that prior to changing the testing frequency for any reason, including during vacation or other travel, any alternative testing schedule and testing locations must be approved by the Board. This allows the Board flexibility to alter the testing frequency and locations to accommodate vacation and other travel, if approved, without putting the public at risk, as the Board can require the licensee to submit to a test on any day, including upon the licensee's return from travel.

Comment: See #4 Uniform Standard, below.

Add 16 CCR section 1361.5(c)(3)(I)(6) (p.42/46)

Purpose: The purpose of this proposal is to implement changes to the Uniform Standards relating to biological fluid testing adopted by the SACC and made effective as of March 2019, by amending section 1361.5(c)(3)(I) to add subdivision (6) to provide for a new exception to the biological fluid testing frequency schedule. This proposal would allow the Board to reduce testing frequency to a minimum of 24 times per year for a practicing licensee who receives a minimum of 50 percent supervision per day by a supervisor licensed by the Board.

Anticipated Benefits: This proposed addition will make the Board's regulations implementing the Uniform Standards consistent with the Uniform Standards adopted by the SACC, effective March 2019, and will provide for an additional exception to the biological fluid testing frequency schedule for those practicing individuals being supervised at least 50 percent per day by a supervisor licensed by the Board.

Comment: What is “being supervised at least 50% per day by a supervisor licensed by the Board”

Cost Impact on Representative Private Person or Business: (p.44/46)

These costs will apply to licensees subject to discipline by the Board as a substance abusing licensee, or who self-refer into the PHWP.

“…the Board estimates 40 licensees will be placed in the PHWP per year for the duration of their five-year probation period. As a result, PHWP participation is anticipated to increase in the first five years before leveling off as probation periods expire.”

Out of these 40 probationers each year, approximately eight participants will be required to undergo a 30-day in-treatment program and may be subject to lost wages during this time.

Comment: In Mississippi, and other states, PHPs will monitor 1-2% of actively practicing physicians in the state. Considering California has more active physicians in 2023 than any other state, this is a significant underestimate.

Cost Impact on Representative Private Person or Business

These costs will apply to licensees subject to discipline by the Board as a substance abusing licensee, or who self-refer into the PHWP.

Biological Fluid Testing: Participants will be required to be tested between 52 to 104 times and pay $6,948 (flat-fee) during the first year and be tested between 36 to 104 times per year thereafter and thus pay $5,439 (flat-fee) per year in years two through five, which results in total biological fluid testing costs ranging from $277,920 to $1.15 million per year and up to $9.3 million over a ten-year period.

Comment: this frequency of testing will benefit the lab and third-party vendors, because of increased revenue, however, there is no basis for this increased rate of testing frequency. 52-104 tests in the first year is excessive, and will decrease likelihood of self-referrals. 24-36 tests in years 2-5 seems reasonable. Having an informed vendor, such as a state-voting member PHP of the Federation of State Physician Health Programs, utilizing treatment recommendations from a treating entity with expertise in treating safety-sensitive workers, such as physicians is the best way to guide decisions regarding testing frequency.

Group Support Meetings: Participants may be required to attend monthly support group meetings and pay estimated fees of $5,460 per year, which results in estimated annual costs ranging from $218,400 to $1.5 million per year and up to $9.5 million over a ten-year period.

Comment: $5,460 per year for a monthly support group meeting is excessive. This amounts to $455/month. Typical costs for facilitated groups range from $25-75/session.

Worksite Monitoring: Licensees may be required to have a worksite monitor and pay estimated costs of $15,600 per year, which results in estimated annual costs ranging from $624,000 to $3.1 million and up to $24.96 million over a ten-year period.

Comment: This requirement will make it very difficult to practice medicine. Hopefully the Board will elect to waive this requirement, when indicated.

#1 Uniform Standard Refers to Board ordered evaluations (p.4/44)

#2 Uniform Standard "…specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis." (p.6/44)

While awaiting the results of the clinical diagnostic evaluation required in Uniform Standard #1, the licensee shall be randomly drug tested at least two (2) times per week.

After reviewing the results of the clinical diagnostic evaluation, and the criteria below, a diversion or probation manager shall determine, whether or not the licensee is safe to return to either part-time or full-time practice. However, no licensee shall be returned to practice until he or she has at least 30 days of negative drug tests.

#4 Uniform Standard Frequency of testing (p.8/44)

The following standards shall govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance use:

Level I Year 1 Minimum Range of Number of Random Tests 52-104

Level II* Year 2+ Minimum Range of Number of Random Tests 36-104

*The minimum range of 36-104 tests identified in level II, is for the second year of probation or diversion, and each year thereafter, up to five (5) years. Thereafter, administration of one (1) time per month if there have been no positive drug tests in the previous five (5) consecutive years of probation or diversion.

Comment: this frequency of testing will benefit the lab and third-party vendors, because of increased revenue, however, there is no basis for this increased rate of testing frequency. 52-104 tests in the first year seems excessive, and will decrease likelihood of self-referrals. 24-36 tests in years 2-5 seems reasonable. Having an informed PHWP, with expertise commensurate with other state-voting members of the Federation of State Physician Health Programs, utilizing treatment recommendations from a

treating entity with expertise in treating physicians (safety-sensitive workers) is the best way to guide decisions regarding testing frequency.

#5 Uniform Standard group support meetings (p. 12/44)

#7 Uniform Standard Worksite Monitoring (p.14/44). Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

A board may require the use of worksite monitors. If a board determines that a worksite monitor is necessary for a particular licensee, the worksite monitor shall meet the following requirements to be considered for approval by the board.

Comment: Seems reasonable.

#10 Uniform Standard Specific consequences for major and minor violations. (p.18/44)

Minor Violations include, but are not limited to:

1. Untimely receipt of required documentation;

2. Unexcused non-attendance at group meetings;

3. Failure to contact a monitor when required;

4. Any other violations that do not present an immediate threat to the violator or to the public.

Consequences for minor violations include, but are not limited to:

1. Removal from practice;

2. Practice limitations;

3. Required supervision;

4. Increased documentation;

5. Issuance of citation and fine or a warning notice;

6. Required re-evaluation/testing;

7. Other action as determined by the board.

Comment: The reporting requirement for minor violations ensures that virtually 100% of self-referred participants will lose their confidential status with the Board, which will disincentive self-referrals, and increase the likelihood that a licensee with a substance use disorder will not seek help. All of the other reporting requirements seem reasonable to me.

#12 Uniform Standard "Petition for Reinstatement" as used in this standard is an informal request (petition) as opposed to a "Petition for Reinstatement" under the Administrative Procedure Act. (p.21/44).

The licensee must meet the following criteria to request (petition) for a full and unrestricted license.

1. Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.

2. Demonstrated successful completion of recovery program, if required.

3. Demonstrated a consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.

4. Demonstrated that he or she is able to practice safely.

5. Continuous sobriety for three (3) to five (5) years.

Comment: Continuous sobriety for 3-5 years.

#13 Uniform Standard (p.22/44).

1. A vendor must report to the board any major violation, as defined in Uniform Standard #10, within one (1) business day. A vendor must report to the board any minor violation, as defined in Uniform Standard #10, within five (5) business days.

#14 Uniform Standard – disclosure (p.26/44).

If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

The board shall disclose the following information to the public for licensees who are participating in a board monitoring/diversion program regardless of whether the licensee is a self-referral or a board referral. However, the disclosure shall not contain information that the restrictions are a result of the licensee's participation in a diversion program.

• Licensee's name;

• Whether the licensee's practice is restricted, or the license is on inactive status;

• A detailed description of any restriction imposed.

Comment: This Uniform Standard effectively eliminates the possibility of offering legitimate confidentiality for self-referred participants. Additionally, every licensee with a moderate or severe substance use disorder (SUD) diagnosis will likely require residential SUD treatment, requiring cessation of practice. The mandated reporting to Med Board and public posting will further stigmatize addiction and disincentivize self-referrals to PHWP. ANY DECREASE in referrals will contribute to higher likelihood of a licensee practicing with an untreated potentially impairing illness.

Summary of Comments:

The proposed regulatory changes in regard to implementation of SB1177.

The provisions of SB1177 clearly describe a Physician Health Program with provisions for confidentiality, providing services that are in line with requirements for State Voting membership in the Federation of State Physician Health Programs. However, the proposed language in the regulations referenced below, as well as the language in the Uniform Standards contradict the language in SB1177, and support a

Medical Board operated monitoring program that does not enable confidentiality, or incentivize early intervention and treatment for self-referred participants.

CCR section 1357.11 regarding mandated reporting of practice restrictions. Every licensee with a moderate or severe substance use disorder (SUD) diagnosis will likely require residential SUD treatment, requiring cessation of practice. The mandated reporting to Med Board and public posting will further stigmatize addiction and disincentivize self-referrals to PHWP. ANY DECREASE in referrals will contribute to higher likelihood of a licensee practicing with an untreated potentially impairing illness.

CCR Section 1357.12. (b) regarding consequences and reporting requirements for minor violations are concerning. Corresponds to #10 Uniform Standards Specific consequences for major and minor violations. Minor violations will likely occur in the vast majority of participants. The reporting requirement for minor violations ensures that virtually 100% of self-referred participants will lose their confidential status with the Board, which will disincentive self-referrals, and increase the likelihood that a licensee with a substance use disorder will not seek help. All of the other reporting requirements seem reasonable to me.

CCR Section 1361.5. Uniform Standards for Substance-Abusing Licensees. Biological Fluid Testing. This corresponds to #4 Uniform Standard Frequency of Testing. This frequency of testing will benefit the lab and third-party vendors, because of increased revenue, however, there is no basis for this increased rate of testing frequency. 52-104 tests in the first year seem excessive, and will decrease likelihood of self-referrals. 24-36 tests in years 2-5 seems reasonable. Having an informed PHWP, with expertise commensurate with other state-voting members of the Federation of State Physician Health Programs, utilizing treatment recommendations from a treating entity with expertise in treating physicians (safety-sensitive workers) is the best way to guide decisions regarding testing frequency.

Cost Impact estimates 40 licensees will be placed in the PHWP per year for the duration of their five-year probation period. In Mississippi, and other states, PHPs will monitor 1-2% of actively practicing physicians in the state. Considering California has more active physicians in 2023 than any other state, this is a significant underestimate. The estimated cost impact of monthly support group meetings of $5,460 per year for a monthly support group meeting is excessive. This amounts to $455/month. Typical costs for facilitated groups range from $25-75/session.

#14 Uniform Standard – Disclosure. "The board shall disclose the following information to the public for licensees who are participating in a board monitoring/diversion program regardless of whether the licensee is a self-referral or a board referral. However, the disclosure shall not contain information that the restrictions are a result of the licensee's participation in a diversion program. Licensee's name; Whether the licensee's practice is restricted, or the license is on inactive status; A detailed description of any restriction imposed." This Uniform Standard effectively eliminates the possibility of offering legitimate confidentiality for self-referred participants. Additionally, every licensee with a moderate or severe substance use disorder (SUD) diagnosis will likely require residential SUD treatment, requiring cessation of practice, and mandated reporting to Med Board and public posting, which will further stigmatize addiction and disincentivize self-referrals to PHWP.

2019 FSPHP Physician Health Program Guidelines

4/16/19
The Federation of State Physician Health Program Guidelines have been designed by FSPHP members with subject matter expertise to assist State Physician Health Programs (PHPs) in achieving accountability, consistency, and excellence. An earlier version of these Guidelines was developed and accepted by the Federation of State Physician Health Programs (FSPHP) in 2005. The new 2019 FSPHP PHPs Guidelines expand upon the original Guidelines, reflecting developments in the science, practice, and scope of PHP services over the past decade. Many PHPs assist healthcare professionals in addition to physicians, such as dentists, nurses, veterinarians, and/or pharmacists. The use of the Guidelines for other professionals is left to the discretion of the individual PHP.

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