

# **Contract Compliance and Performance Audit of The Department of Consumer Affairs contract with Maximus, Inc. for the Health Professionals Diversion Program**

Contract # 014-0511-3

Audit No. 2009-101  
June 2010

**INTERNAL AUDIT OFFICE**

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April 30, 2010

Brian Stiger, Director  
Department of Consumer Affairs  
1625 North Market Blvd. Ste. S-308  
Sacramento, CA 95834

Dear Mr. Stiger,

Enclosed is the DCA Internal Audit Office's report on the DCA's contract with Maximus, Inc. for the Health Professionals Diversion Program, contract # 014-0511-3. The audit period was 7/1/2007 through 6/30/2009. We issued our draft report on April 15, 2010. We received Maximus' response to the draft audit report on April 22, 2010 and have incorporated the reply into this report. If you have any questions, please call me at (916) 574-8190.

Sincerely,

*Original signed by:*

Cathleen Sahlman  
Audit Chief

Attachment

cc: Virginia L. Matthews, Maximus Program Manager

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## Report Summary

### Results in Brief

Since 2003 Maximus is the contractor that has provided Diversion services on behalf of six healing arts boards and one committee that fall under the administrative authority of the Department of Consumer Affairs (DCA). The purpose of the Diversion contract was to implement a confidential, comprehensive chemical dependency and mental illness monitoring and referral program for health care professionals. There are six boards and one committee authorized by statute to administer a Diversion program for eligible licensees. The six boards and one committee covered under the contract are:

- Board of Pharmacy
- Board of Registered Nursing
- Dental Board of California
- Osteopathic Medical Board
- Physical Therapy Board
- Veterinary Medical Board
- Physician Assistant Committee

The audit was conducted pursuant to Senate Bill 1441, chaptered September 28, 2008. The purpose of the audit was to review Maximus' effectiveness, efficiency, and overall performance in managing Diversion programs. The audit test period was from July 1, 2007 through June 30, 2009. The audit was performed in accordance with the *Standards for the Professional Practice of Internal Auditing*.

The audit scope closely followed the audit requirements set forth in SB 1441, and included detailed interviews with Maximus personnel to describe all processes, and subsequent case file testing to determine if Maximus had complied with provisions of the contract and had performed in accordance with these provisions. We tested a sample of 177 case files, representing all six boards and one committee.

Although we noted a number of areas for improvement, overall, we concluded that Maximus is operating in compliance with contract provisions. Senate Bill 1441 also asked that the audit "make recommendations regarding the continuation of the **programs...**" It should be noted that the scope of the audit encompassed only contract compliance and performance of the administrative vendor, Maximus, and not the DCA boards' performance as a broader aspect of the DCA's overall Enforcement **program**. It follows that the recommendations in the report address only the administrative vendor and not the program as a whole. Decisions regarding the continuation of the programs are policy level decisions appropriately made by DCA management and the legislature once audits of the boards' Enforcement programs taken as a whole have been completed, and are beyond the scope of this review.

We noted the following areas for improvement:

- Maximus currently provides the individual boards/bureaus with monthly and quarterly summary reports of the overall Diversion program, however, the DCA executive management team does not currently receive comparable reports. With the current emphasis on standardizing enforcement practices and the interrelated nature of the Diversion program with the enforcement process, it follows that the executive management team would benefit from customized reports providing high level detail that reflect their needs related to executive management decisions regarding these programs.

Recommendation: Maximus should work with DCA's executive management team to develop high level summary reports of the program that provides executive management with the information most useful in making department-wide decisions related to the Diversion program.

- Maximus Diversion records in some cases lack the required documentation of treatment, aftercare, and monitoring services received by recipients. Of the thirty or so individual participant contract terms found in any participant's case file, two items were not well documented. Documentation was missing for outpatient programs (mainly aftercare) and quarterly reports from therapists in 65% of files tested. Maximus was accepting monthly self-reports provided by the participants themselves as proof that these terms had been fulfilled.

Recommendation: Maximus should require reliable third party documentation proving that 100% of individual contract terms are compliant. Maximus should increase its monitoring of all required reports for individual recovery contracts for all participants, ensuring aftercare and therapist reports are included in the case file documentation.

- Maximus' timeliness could be improved for positive urine test results reporting to the boards. Maximus subcontracts with FirstLab for laboratory testing services. Maximus assigns each participant a unique identifying number which they are supposed to provide to the collection site at the time of testing. Some participants are not using the unique identifier and instead provide the collection site with their social security numbers. This creates a situation in which FirstLab must manually reconcile the different identifiers before providing Maximus with positive test results. This results in about a one-day delay in Maximus receiving positive test results.

Recommendation: Maximus should work with FirstLab to speed up the reporting of positive test results. Maximus and FirstLab should consider the use of donor identification cards to provide collection sites with official

information regarding the participants and would eliminate the extra day required to match identifiers and social security numbers.

- Maximus failed to adequately monitor one participant's compliance with bodily fluid testing, resulting in a participant who was not testing for more than two months. This participant was terminated from the program for ceasing to call and test. A note in the Maximus case log stated "no one knew he had not called in or tested for two months."

Recommendation: Maximus should ensure it adequately monitors each and every participant in accordance with the Diversion contract.

- Maximus had combined some of the records for certain licensees with multiple participations within the program, in one case, resulting in the erroneous purging of treatment records. Because there were no identifiers in these cases distinguishing old from new case files, a new file could be purged along with old information.

Recommendation: Maximus should ensure it keeps separate files for each participation when a participant has been in the program more than one time.

- Worksite monitoring (WSM) needs to be improved. Worksite monitor agreements do not provide enough information to determine if Worksite monitors meet required criteria. Worksite monitors are supposed to be in a position to observe the participant at work, and it is essential that the WSM not be a subordinate of the program participant.

Recommendation: Maximus should increase its oversight over worksite monitoring. No WSM should be a subordinate of the participant.

- Clinical Assessments may not be done timely due to limited availability of licensed therapists. One participant's clinical assessment was not done within four weeks of application to the program. Some participants are in inpatient programs during this 4 week time frame and Maximus has relied upon the in-house clinical staff to provide the required assessment. However, this could be viewed as a conflict of interest if the treating clinician were to recommend further treatment in its own facility.

Recommendations: Maximus should have alternate licensed therapists in cases where a licensed therapist assigned to a participant is unavailable.

Maximus should ensure the completion of the clinical assessment required for proper treatment. Maximus should limit the reliance on treatment facility in-house therapists to conduct the clinical assessment to avoid the appearance of conflict of interest.

- Discrepancies were noted in participant's initial call dates existing in Maximus' database. The audit found 12% of initial call dates did not match the date noted in the case log and what was recorded in the participant's history and profile (H & P) report. It may appear that the participant called earlier or later than noted in the H & P report. For participants who are board-ordered into the program, the report may not accurately reflect the correct date when the participant applied for the program.

Recommendations: Maximus should better define what date to use for the initial call date when preparing the History & Profile report for each participant.

## **Background**

Maximus, Inc. was the contractor chosen in 2003 by the Department of Consumer Affairs (DCA) to provide Diversion services on behalf of six healing arts boards and one committee that fall under its administrative authority (Contract # 014-0511-3 and eight amendments extending the contract through December 31, 2009). The purpose of the contract was to implement a confidential, comprehensive chemical dependency and mental illness monitoring and referral program for health care professionals. The contract was originally designed to accommodate approximately 700+ participants. The six boards and one committee are:

- Board of Pharmacy
- Board of Registered Nursing
- Dental Board of California
- Osteopathic Medical Board of California
- Physical Therapy Board of California
- Physician Assistant Committee
- Veterinary Medical Board

Each of the above entities is authorized by statute to administer a Diversion program for their eligible licensees. As described by the Request for Proposal (RFP) for the contract, the goal of each Diversion program is to protect the public by early identification of these licensees and by providing them access to appropriate intervention programs and treatment services so they can return to practice in a manner that will not endanger the public health and safety. Since there were features, standards, and services common to each of the six boards and one committee, the contract with Maximus was chosen to address all seven entities as one client. The contract also specifies board specific requirements for each board and the committee. We also reviewed these board specific requirements to determine whether or not Maximus had appropriately addressed each board's specific requirements. The contract with Maximus covers the period July 1, 2003 through December 31, 2009 over 6.5 years.

The DCA Internal Audit Office (IAO) performed an audit of the DCA's contract with Maximus to fulfill the audit requirement in Senate Bill 1441, chaptered September 28, 2008. The purpose of the audit was to review Maximus' effectiveness, efficiency, and overall performance in managing diversion programs for substance abusing licensees. The audit test period was from July 1, 2007 through June 30, 2009. Case files selected for testing within the audit period extended both before and after the initial period of audit due to the multiple year nature of the program (i.e. if an active case file from 2008 was selected for testing, relative case file information may have extended as far back as the late 1990's, and may have extended forward to current day if still an active case).

**Objectives, Scope and Methodology**

The audit was performed in accordance with the *Standards for the Professional Practice of Internal Auditing*. The objective of the audit was to provide DCA management, boards and the California legislature with an audit of the effectiveness, efficiency, and overall performance of the vendor chosen by the department to manage diversion programs for substance-abusing licensees of health care licensing boards, as required by Senate Bill 1441. The Senate Bill also requested the audit make recommendations regarding the continuation of the programs and any changes or reforms required to ensure that individuals participating in the programs are appropriately monitored, and the public is protected from health care practitioners who are impaired due to alcohol or drug abuse or mental illness.

The audit scope has been designed to closely follow the audit requirements set forth in SB 1441. The following grid identifies the applicable SB 1441 audit requirement, a cross-reference to the applicable report narrative addressing the senate bill requirement, and a cross-reference to any related findings and recommendations addressing the requirement.

| Senate Bill 1441 Requirement   | Report Narrative Location  | Related Finding # If applicable |
|--|--|---------------------------------|
| Identify percentage of participants that were: <ul style="list-style-type: none"> <li>• Self-referred</li> <li>• Board-referred</li> <li>• Board-ordered</li> </ul>  | Exhibit A, page 6  | N/A                             |
| Describe all aspects of bodily fluids testing <ul style="list-style-type: none"> <li>• Frequency of testing</li> <li>• Randomnicity</li> <li>• Method of notice to participants</li> <li>• Number of hours between the provision of notice and the test</li> <li>• Standards for specimen collectors</li> <li>• Procedures used by specimen collectors</li> <li>• Location of testing</li> <li>• Average timeframe from date of the test to the date the result becomes available</li> </ul> | Begins on page 9<br>Pgs. 10-11<br><br>Pg. 10<br><br>Pg. 11<br><br>Pg. 12<br><br>Pg. 13<br><br>Pg. 13 | Finding 2                       |

| Senate Bill 1441 Requirement  | Report Narrative Location    | Related Finding # If applicable |
|---|------------------------------|---------------------------------|
| Describe group meeting attendance <ul style="list-style-type: none"> <li>• Required qualifications for group meeting facilitators</li> <li>• Frequency of required meeting attendance</li> <li>• Methods of documenting and reporting attendance or non-attendance by program participants</li> </ul>   | Pg. 14<br>Pg. 14<br>Pg. 14   |                                 |
| Describe standards used in determining whether inpatient or outpatient treatment is necessary   | Pg. 15                       |                                 |
| Describe worksite monitoring requirements and standards   | Pg. 15                       | Findings 5,6                    |
| Timeliness of diversion services provided by the vendor   | Pg. 16                       | Findings 8,9                    |
| Thoroughness of <i>documentation</i> of treatment, aftercare, and monitoring services received by participants  | Pg. 17                       | Finding 1                       |
| Thoroughness of <i>documentation of the effectiveness</i> of the treatment and aftercare services received by participants  | Pg. 17                       | Finding 1                       |
| Evaluate vendor’s approval process for providers or contractors that provide diversion services, including specimen collectors, group meeting facilitators, and worksite monitors   | Pg. 17<br>Pg. 14<br>Pg. 15   | Finding 6                       |
| Evaluate the vendor’s disapproval of providers or contractors that fail to provide effective or timely diversion services   | Pg. 17                       |                                 |
| Evaluate the vendors promptness in notifying the boards when a participant fails to comply with the terms of his or her diversion contract or the rules of the board’s program  | Pgs. 20-33 case file testing | Finding 2                       |
| Recommend whether the vendor should be more closely monitored by the <b>department</b> , including: <ul style="list-style-type: none"> <li>• Whether the vendor should provide the <b>department</b> with periodic reports demonstrating</li> <li>• the timeliness and thoroughness of documentation of non-compliance with diversion program contracts; and,</li> <li>• Its approval and disapproval of providers</li> <li>• and contractors that provide diversion services.</li> </ul> | Pg. ii, Page 19              | Report Summary                  |
| Recommendations regarding continuation of the programs and any changes or reforms necessary.  | Pg. ii, Pg. 19               | Report Summary                  |

We applied the following specific procedures in conducting this audit:

1. Reviewed the RFP and contract, including all amendments, between the DCA and Maximus.
2. Reviewed each board's specific contract provisions and incorporated this into our audit testing.
3. Interviewed each board and committee's Diversion Program Manager (DPM) to obtain an understanding of their interaction with Maximus, and any concerns they felt should be addressed in the audit.
4. Reviewed each board's statutes and regulations applicable to the Diversion program.
5. Interviewed the Maximus Diversion Program Manager and Operations Manager regarding all aspects of the program. Also interviewed clinical case managers and compliance monitors working for Maximus. Tested case files to validate procedures described during the interview process.
6. Observed a Diversion Evaluation Committee meeting of the Dental board in order to understand how a DEC works.
7. Obtained and reviewed Department of Transportation Drug Testing Standards required by the contract.
8. Interviewed the client business manager for FirstLab, the sub-contractor that administers laboratory testing services for Maximus.
9. Visited a First Lab collection site and interviewed staff on-site about their procedures to determine compliance with contract requirements.
10. Interviewed a clinical assessor under contract with Maximus.
11. Interviewed a group meeting facilitator under contract with Maximus.
12. Obtained read-only access to the Max-CMS computer system containing the automated case files for all participants. Tested a sample of case files (both automated and hard copy) for all six boards and one committee. Case files were tested for timeliness of critical services, completeness, and accuracy, compliance with contract terms and conditions, and thoroughness of documentation of treatment. A more detailed description of the case file testing is found prefacing the Findings and Recommendations section of this report.

## **Description of the Diversion Program**

As discussed in the background section of this report, the Diversion program was designed to be a confidential, comprehensive chemical dependency and mental illness monitoring and referral program for health care professionals.

There are six boards and one committee participating in the Maximus contract. Each board and committee has its own statutes and is organized according to these statutes. Exhibit A shows each board or committee, what statutes apply, and whether or not a Diversion Evaluation Committee (DEC) is utilized (some boards have statutes authorizing a DEC, but do not use one). In addition, the exhibit shows the percentages of self-referred participants, board-referred participants, and board-ordered participants, as required by SB 1441.

Exhibit A provides an overview of each board's program.

Exhibit A – Board summaries

|   | B & P Codes pertaining to Diversion/ Recovery Program | Number of applicants/ participants during period of review | Self-referrals | Board referrals*** | Board Ordered referrals**** | Unknown referral method***** | Authorized Diversion Evaluation Committee |
|---|---|--|----------------|--------------------|-----------------------------|------------------------------|---|
| Dental Board of CA  | 1695-1699   | 75   | 7 (9%)         | 36 (48%)           | 32 (43%)                    | 0                            | Yes                                       |
| Osteopathic Medical Board of CA   | 2360-2370   | 17   | 10 (59%)       | 1 (6%)             | 6 (35%)                     | 0                            | Yes                                       |
| Pharmacy, Board of  | 4360-4373   | 122  | 30 (25%)       | 20 (16.33%)        | 64 (52%)                    | 8 (6.66%)                    | No  |
| Physical Therapy Board of CA  | 2662-2669   | 20   | 0              | 19 (95%)           | 1 (5%)                      | 0                            | Yes                                       |
| Physician Assistant Committee   | 3534-3534.10  | 30   | 11 (37%)       | 9 (30%)            | 10 (33%)                    | 0                            | Yes                                       |
| Registered Nursing, Board of  | 2770-2770.14  | 853  | 280 (33%)      | 566 (66%)          | 0                           | 7 (1%)                       | Yes                                       |
| Veterinary Medical Board and Registered Veterinary Technician Examining Committee | 4860-4873   | 12   | 7 (58.3%)      | 3 (25%)            | 1 (8.3%)                    | 1 (8.3%)                     | Yes                                       |

\*\*\*Board Referrals are Informal Board Referrals.

\*\*\*\*Board Ordered Referrals are known as Probation Referrals, which are mandated referrals to the Diversion Program with successful completion as a term and condition of probation.

\*\*\*\*\*Unknown referral method- unable to determine how participant was referred to the program. This may account for those participants who were in the program before 2003 (the year Maximus took over as Diversion vendor). However, Maximus should make every attempt to classify the type of referral as self, board-referred, or board-ordered, contacting each board as necessary to obtain the information.

The audit period was July 1, 2007 through June 30, 2009, but includes many cases that started before 2007 due to the multi-year nature of participation in the program.

As shown in exhibit A, there are three methods of entry into the Diversion program. The first is self-referral. A participant is designated as a self-referral when the licensee contacts the contractor directly and is not in the program as a result of disciplinary action by the board. A self-referral is confidential, and is not disclosed to the public. Some self-referrals become board referrals or board-ordered referrals at a later date.

The second type of admission to the Diversion program is board-referred. In a board referral, the board may refer a licensee to the Diversion program, but it is not yet a condition of formal probation.

The third type of referral is a board-ordered referral. This occurs usually as a condition of probation.

Regardless of the method of entry or type of referral, the process followed by Maximus is the same. The potential participant does a phone intake with Maximus, reached through their 24-hour telephone number, which is manned by clinical case managers (CCMs). The CCM mails the participant program information and sets them up for immediate urine screening. An appointment is scheduled for a clinical assessment.

### **Clinical Assessment**

After the initial intake assessment is completed, a face-to-face meeting is scheduled between the applicant and a Clinical Assessor (CA). The CA is required to provide a comprehensive assessment, including a complete psychosocial history, drug history, and a five Axis diagnosis per standards of the DSM IV-TR Multiaxial Assessment Clinical Evaluation. They are also asked to provide treatment recommendations.

The written assessment is due to Maximus within 30 calendar days of completing the assessment. A CA will set an appointment with an applicant, review intake notes and collect history information during a diagnostic interview. With this information, the CA will identify any concerns for the applicant's safety, or recommend immediate inpatient treatment if necessary, as well as provide any specific recommendations for treatment. Although CAs do not make the ultimate determination whether an applicant is fit for the program, their assessment is considered in the decision-making process. Clinical judgement is never made by only one person. It is always done in conjunction with the DEC or DPM. Dental Board requires all participants to go into inpatient treatment (95% do go into inpatient treatment but for various reasons the other approximate 5% do not; sometimes insurance will not cover it, etc.). These participants go to a treatment center that specializes in health care professionals, such as Betty Ford in Southern California or Hazelden in Oregon. For the Nursing Board, almost 100%

go into inpatient treatment at first. Other boards vary. If a participant is actively using at the time of entry into the program they need a medically supervised detoxification. Some have already checked themselves into one; if this is the case, then Maximus needs to determine whether or not the program is adequate. Some participants have already started treatment based upon what their insurance coverage will cover.

Intensive outpatient treatment is for those further along in their program. It is 9 hours per week for 9 weeks minimum. Aftercare is usually 1 hour per week, normally at the same facility where the participant received their inpatient or intensive outpatient treatment.

If a determination is made that an applicant seek immediate inpatient treatment, the CA is required to notify Maximus within one business day. At that time a Clinical Case Manager will contact the applicant immediately to facilitate entry into the appropriate level of care. The Diversion Program Manager (DPM) or the Diversion Evaluation Committee if also notified with 24 hours of the CA's recommendation.

Once out of initial inpatient or intensive outpatient treatment, a participant is set up for either a DEC meeting or board committee meeting to determine acceptance to the program (if not already previously accepted). An initial intake with the Clinical Case Manager will be held, in which the terms of a pre-entry agreement are determined by the applicant's individual case. The applicant is given an opportunity to respond, clarify, and is asked to agree to the terms. The agreement is then mailed to the applicant, and they are asked to sign and return it. Once the DEC or committee meets, a customized agreement is prepared and signed by the participant. There are normally about thirty terms to the agreement, including random drug testing, group therapy, individual therapy, Alcoholics Anonymous or 12 step meetings, quarterly DEC or committee meetings, aftercare, intensive outpatient treatment, worksite monitoring, monthly self-reporting, etc. In addition, the agreement will place restrictions on the participant's ability to work. The customized terms are based upon the DEC or DPM's assessment of the participant's needs, as well as public protection. As of January 1, 2009 Business and Professions Code was amended to state that the Diversion Program Manager has primary responsibility to review and evaluate recommendations of the DEC, so that all decisions rest with the DPM.

### **Ongoing Monitoring by Clinical Case Managers and Compliance Monitors**

Once the participant's program has been set up, there is ongoing monitoring and assessment of progress provided by Maximus. Each participant is assigned to a Clinical Case Manager (CCM). The CCM is supported by one or more compliance monitors (CM). Clinical Case Managers are experienced clinicians. Many hold certifications in addiction nursing specialties. CCMs work in teams

with CMs and are assigned to the Boards and groups of participants. The CMs provide support to the CCMs and are dedicated solely to a CCM when the caseload exceeds 100 participants.

We interviewed both a Clinical Case Manager and a Compliance Monitor about their roles, and also reviewed their job descriptions found in the Maximus contract. The CCM position requires a licensed psychologist, social worker or registered nurse. Primary duties include conducting assessment and reassessment of impaired health professional licensees, including evaluating incoming information submitted by treatment providers, facilities, participants, and labs to monitor participant's progress and compliance with the recovery contract. They develop the immediate plan of care for each participant, then monitor how it is going by obtaining feedback from all parties. Initially, they set up the clinical assessment, set up drug testing with FirstLab, and require the participant to call once per week. If the participant fails to call, they are considered non-compliant. They also set up the participant with support group meetings. They consult with the DEC on the recovery contract terms. In the event the participant has a positive drug test or relapse, it is the CCM who makes the call to notify the board DPM and/or DEC.

The compliance monitor position requires a bachelor's degree in Behavioral Science or a related field, plus three years of experience in a behavioral health care setting related to chemical dependency or mental illness. Their primary responsibilities are to collect incoming data and reports from treatment providers, facilities, participants, labs, worksite monitors, support group facilitators, and other team members. They input necessary information into the case management system (Max-CMS). Auditors noted there could be multiple case log notes for each participant during a single day. They alert the CCM of any issues of non-compliance or special circumstances on a prompt basis. They produce the monthly compliance/non-compliance letters, as well as other reports and correspondence. It is the CM who initially (7 a.m. each morning) logs into Max-CMS to see any missed calls, missed tests, etc. One of the CMs runs a report each morning of the Random bodily fluids testing results and sends the information to all other CMs. They also fax the boards when there is non-compliance.

### **All Aspects of Random Bodily Fluids Testing (RBFT)**

At the end of 2008 and the beginning of 2009, Maximus found performance issues with the vendor contracted to perform drug testing on participants. As a result, in February 2009, Maximus changed drug testing vendors. FirstLab is the subcontracted vendor responsible for the arranging, collecting, processing and accounting for all drug testing related to this program. Included in the services provided by FirstLab are the random selection of participants, notification, specimen collection, testing, electronic reporting and billing of participants. First

Lab only uses certified labs. First Lab is a third party contractor to the actual labs, and provides neutral oversight of these facilities.

### **Frequency/Randomicity**

FirstLab has a random selection system that can generate customized test frequencies based on the monitoring needs of any given participant. The tests are scheduled by computer annually and the frequency of the testing can be changed if necessary. Also, the Board Diversion Program Manager (DPM) and/or the Clinical Case Manager (CCM) have the ability to add additional tests or revise the schedules as the need arises. Under the contract audited, the “default” or minimum number of tests conducted was 18 times per year. Any board or DEC could request a different frequency if warranted. Some participants’ frequency has been as high as 52 times per year (Dental, Pharmacy participants).

FirstLab is responsible for the call-in notification system. That is, participants are required to call-in each day to find out if they are required to be tested. Not only is a call-in system available, but also an online log-in system. If a participant is unable to go to their regular site due to work schedule conflicts, arrangements can be made for the participant to test at an alternate site.

Although the call-in and log-in systems are available 24 hours a day, participants are limited to calling or logging in between the hours of 5 a.m. and 8 p.m. No notice is given before 5 a.m. or after 8 p.m. Participants must test the **same business day** they call in. This means that if a participant called in at 5 a.m. and determined they had to test that day, they would have at most 19 hours to get the test done, in order to meet the same business day requirement, because they would have to test before midnight. This measure was put into place in order to limit the participants’ ability to flush his or her system before testing and also to meet the schedule of most collection sites. Maximus limits the number of hours between provision of notice of the test and the test itself by utilizing limited call-in hours and the requirement to test the same business day.

The program uses a standardized lab panel on all participants that includes the use of Ethyl Glucuronide (EtG), a direct metabolite of alcohol, to detect alcohol ingestion. EtG testing can detect the ingestion of alcohol for up to 72 hours after consumption. Since alcohol has the highest frequency of relapse (due to its availability) the urine test using EtG is the preferred alternative. Urine testing also picks up drug metabolites for several days after use. There are exceptions, such as very short-acting drugs that can only be detected on the same day. If the use of such drugs is suspected by the CCM, they can recommend additional tests to the DEC for a particular individual.

A participant can not be excused from testing on a given day without the approval of the DPM, Diversion Evaluation Committee (DEC) or DEC Consultant.

If a participant is traveling for some reason, approval must be obtained in advance and an alternate testing site identified in the locale traveled to.

Testing provided by FirstLab is for the basic panel. This consists only of urine testing. If other non-standard testing is required, such as hair follicle, Maximus will obtain approval of the DPM. One board requires the hair follicle test as a condition of graduation from the program. The hair test will show evidence of drug use if used in the past 90 days (window of results). The test is performed by taking a sample of hair close to the scalp that is about the diameter of a drinking straw. Several panels are available to test the hair, and Maximus uses the panel with the most capability. There is no provision in the contract under audit requiring Maximus to do this, nor is it in the new contract now in effect (after January 1, 2010), however Maximus provides this service as an add-on.

### **Specimen Collection**

Specimen collectors are approved by the sub-contractor for lab service, FirstLab.

Specimen collectors used by FirstLab are certified according to the most recent version of the Mandatory Guidelines for Federal Workplace Drug Testing Programs. Specimen collectors employ the standards and procedures as outlined in the DOT Urine Specimen Collection Guidelines for the U.S. Department of Transportation (DOT) Workplace Drug Testing Programs. The DOT does not allow anyone else to use its chain of custody forms however, the chain of custody form utilized by FirstLab contains the same information as the federal form.

Collection sites are located throughout the United States, making it convenient for participants to be tested when required. Also, field staff is available to perform collections on the weekend if necessary.

Auditors selected a collection site in Sacramento to do a site visit, view the facilities and speak to the personnel on-site about their procedures applicable to the Maximus contract. All drug testing procedures were confirmed to conform to DOT drug testing standards. The site selected was an urgent care center. The site, as is typical, served many other customers besides FirstLab. They provided a sample of the chain of custody form used by FirstLab, which contained specific instructions as to how the collection should be handled. A participant reporting to provide a specimen is required to provide positive identification with a picture ID.

The manager on-site described how the form is used, and how the facilities are prepared for specimen collection. The lab must place a bluing agent into the toilet used, and also secure the faucets so that no source of liquid is available to the participant.

If a collection is required to be observed, collections are observed by same-gender collectors. Participants are notified by FirstLab that they will be subject to observed collections as a condition of monitoring. Under the contract currently under audit, not all collections had to be observed, but many were.

Approximately 50% of dental board collections were observed, and 100% of Pharmacy collections. The new contract effective in 2010 now requires all collections to be observed.

To ensure that a specimen has not been adulterated, substituted or diluted, the laboratory will conduct specimen validity testing on every specimen. A Chain of Custody form accompanies every specimen and is initialed by the participant and the collector. If for some reason the chain of custody has been broken, the specimen is discarded. A participant is considered noncompliant if it is found that his or her specimen has been adulterated, substituted or diluted.

The following procedures are employed at the time of specimen collection:

- After washing hands, the donor shall remain in the presence of the observer and not have access to any water fountain, tap, soap dispenser, cleaning agent or any other materials that might be used to adulterate the specimen.
- The donor shall provide the specimen under the direct supervision of an observer (partially applicable under contract audited).
- Upon receiving the specimen, the observer shall determine that there is sufficient sample to enable all required testing to be performed. If a nonsufficient sample is provided, the participant will be asked to provide another sample of sufficient volume.
- After the specimen is collected, the observer shall inspect the urine specimen to determine its color and look for any indication of adulterants or dilutents. The specimen temperature is taken and should be in the range of 33°C and 38°C. Any unusual findings should be noted in the observer's record.
- When it has been determined that the specimen is valid, the observer will ask the donor to observe the transfer of the specimen and the placement of the tamper-proof seals over the bottle cap and down the sides of the bottles. The donor will sign the seals.

The specimen is prepared using the following procedures:

- Both the observer and the donor shall be present.
- The observer shall place labels on the bottle. The label should note the date of collection and a minimum of two identifiers for the donor, such as a name and date of birth.
- The observer shall enter the date and time of the supervised collection into their record and sign the record.
- The donor shall be asked to read and counter-sign the record.

- The observer shall complete the chain-of-custody form.
- All specimens are shipped to the laboratory via secure, overnight courier service as soon as possible after collected and will be securely stored in a refrigerated environment until it is shipped.

Audit observation at the collection site determined the collection is being performed according to the contract requirements. FirstLab reports to Maximus on monitoring regarding lab turn around times, errors, and broken chain of custody as these conditions occur. FirstLab maintains a log of collection site errors and provide immediate written and verbal corrective action in the event of a flaw. In the event that problems are identified at a collection site, FirstLab may recommend a change in the site.

### **Specimen Processing**

Specimens are processed within two business days of receipt by Clinical Reference Laboratories or other subcontracted laboratory. If a specimen is received on a Friday, it may not be tested until the following Tuesday allowing the participant to work as many as 5 or 6 additional days before a positive test is determined.

Presumptive positive tests will be confirmed by gas chromatography/mass spectrometry (GC/MS). Each specimen will be examined for the presence of compounds at the detection levels indicated in each panel. Positive screening results will be confirmed prior to reporting. This is a provision of laboratory certification. Positive test results must be confirmed by GC/MS prior to being reported as a positive. Thus for a confirmed positive test, average timeframe from the date of the test to the date the result becomes available will be longer than the time taken to report a negative result.

### **Testing Results and Information**

Certified Medical Review Officers are made available by FirstLab to review and evaluate drug testing results, if deemed necessary. FirstLab is able to provide web-based result retrieval, management reports and early warning indicators of participant noncompliance.

Audit testing of lab results imported to Maximus identified a recommendation for improvement in the timeliness of drug testing results. The issue is due to program participants using social security numbers rather than the Maximus unique identifier number at the collection site. Maximus no longer uses social security numbers due to federal requirements (HIPAA). Many collection sites still accept the SSN as the unique identifier for a participant. When a program participant gives a collection site their SSN, rather than their Maximus unique identifier number, a difficulty is created until First Lab manually reconciles the

results, matching up the SSN used with the Maximus unique identifier number. This can create a one-day delay in importing lab results to the Maximus system. A more complete description of this issue is found in Finding # 2 on page 22.

### **Support Groups**

There are approximately 70 nurse and health professional support group providers in California. Maximus maintains a list of support groups throughout the state. The list is used to refer participants to support group meetings which are required as a part of their recovery contracts. Providers of Nurse Support Groups are required to hold a California license as a registered nurse. Health Professional Support Group providers must hold a California license as a registered nurse, a marriage family therapist, a clinical social worker, a psychologist or psychiatrist. Providers must be clinically competent and have at least 3 years of experience providing chemical dependency, mental illness treatment, and referrals and monitoring for health care professionals. Group meeting facilitators have been selected by the boards. The Board of Nursing already had group meeting facilitators selected and Maximus has continued with the use of these, adding only one since taking over the contract. The approval process consists of verifying the facilitator's credentials, and the other components of the application.

All participants are required to attend health support groups or nurse support groups at least weekly until they enter the transition phase, which is typically the final year of program participation. Registered nurses are required to attend 1 time per week and health professionals are required to attend either 1 or 2 times per week. Although Maximus is not responsible for the delivery of the support group content (program), Clinical Case Managers make site visits to the meeting locations at least once per year. During the visits, the CCM completes an evaluation of the site and reports on any feedback obtained. These evaluations are maintained by Maximus and the information is summarized and provided to the Diversion Program Managers on a monthly basis. A support group may be subject to removal from the referral list if evaluations find that they are noncompliant, ineffective or have quality of care issues. The final decision to remove a support group from the referral list is made in conjunction with the Board(s). Support group sites may be visited more often if problems or concerns are identified.

The support group facilitators provide monthly reports to Maximus that indicate a participant's progress and attendance. Group facilitators will contact Maximus within 24 hours if a participant is absent from a meeting without having contacted the facilitator or if the facilitator suspects a participant has relapsed. Group facilitators do not determine if a participant's absence is excused or not. Non-attendance at group support is cause for a letter of non-compliance to be sent to the participant.

## **Determination of Inpatient/Outpatient Treatment**

As discussed in the Clinical Assessment Section of this report, starting on page 7, recommendations for inpatient or outpatient treatment are made by the clinical assessor, based upon their diagnostic tools and assessment of the participant's needs. Maximus makes a recommendation for treatment based upon these factors. Admission criteria at each treatment facility is generally standardized. However, it is possible for Maximus to make a referral which is then rejected by the treatment facility. Maximus is sometimes forced to accept another alternative which is not as preferable. The "old" standard for inpatient treatment was 28 days; however, many insurance companies stopped paying for the full 28 days. Therefore, a participant's insurance coverage may determine what type of treatment they receive. If it is found that intensive outpatient treatment does not result in any benefit, Maximus will recommend inpatient treatment. Inpatient treatment may be recommended to an applicant after the initial intake has been completed. In making this determination, the standard criteria that is followed includes whether an applicant is a danger to himself/herself, is a danger to others, or is unable to care for himself/herself.

The contract in force during the audit period contained no criteria for whether a participant should go into inpatient or outpatient treatment, and it would appear Maximus does not have full control over which type of treatment a participant receives.

## **Worksite Monitoring**

In order to ensure the safety of the public, as well as ensure compliance from participants, the Maximus Diversion Program uses Worksite Monitors (WSM) to monitor and document how participants conduct themselves in the workplace. A worksite monitor is a person who is also employed at the participant's worksite. The WSM is an observer of the participant's personal behavior and professional performance. A WSM is required to be in a position to have regular daily and ongoing contact with the participant and a willingness to contact Maximus to discuss any concerns. Reportable concerns would include attendance, behavior, and general attitude or competency. Likewise, a WSM will be notified by the clinical case manager that a participant must stop working if he or she tests positive for alcohol or drugs. Furthermore, the WSM must maintain confidentiality in the work environment.

As a condition of the participant returning to the workplace, a WSM must be designated by the participant and approved by Maximus. To become a WSM, the WSM applicant must be in a position to provide supervision for the Diversion Program participant. Qualification requirements may vary from board to board. Additionally, supervision requirements may vary from participant to participant

depending upon their perceived level of need during a given period of time. Maximus has established the following minimum criteria for approving Worksite Monitors:

1. The WSM must be available to the applicant or participant, preferably working the same shift/hours, for randomly scheduled contact.
2. The WSM must be a colleague or in a supervisory capacity to the participant, at least one management step above on the organization chart.
3. If no such person is available in the current work setting, the board can approve another person, perhaps within the same building.
4. The WSM must be comfortable with and willing to confront the participant when addressing unusual or outstanding behaviors.
5. This person must also be willing to notify Maximus immediately if a suspected relapse or unusual behavior is exhibited by the participant and comfortable knowing that these concerns will be immediately discussed with the participant.
6. If a WSM is in recovery, they should have at least five years of current and continuous sobriety.
7. The WSM may not be a current participant in the Diversion program. If the WSM was a previous Diversion participant, they shall have successfully completed the Diversion program.
8. The WSM may not be a relative of the participant.
9. Reports must be submitted to Maximus monthly for the first three months and quarterly thereafter.

A WSM is notified within 10 business days that they have been approved by the Clinical Case Manager. The new WSM is educated on their responsibilities and the process for identifying relapse behaviors and detecting whether an applicant or participant is a danger to themselves or the public. The WSM is also provided information about reporting. WSMs were required to submit quarterly reports to Maximus under the contract audited.

The audit determined that not all of the above criteria have been enforced. WSMs do not always work the same shift as the program participant. Worksite monitors are not always in a supervisory capacity. We also found, during the case file testing portion of the audit, weaknesses existed in some cases in the worksite monitoring area. See Finding 6 on page 29 for a description of the issues.

### **Timeliness of Diversion Services Provided by the Vendor**

Timeliness is covered in the case file testing, described on page 17 of the report. Findings 7 and 8, on pages 30 and 31 describe timeliness issues found.

### **Review the Thoroughness of Documentation of treatment, aftercare and monitoring services received by participants**

Thoroughness of Documentation of treatment, aftercare and monitoring services received by participants was determined during case file testing, described on page 17 of the report. Finding 1 describes a thoroughness of documentation issue found.

### **Maximus' Process for Approval/Disapproval of Providers/Contractors**

SB 1441 required the audit cover the vendor's disapproval process of providers or contractors that fail to provide effective or timely diversion service. During the period under audit Maximus replaced the sub-contractor providing lab services. The reason given is that the lab did not have national certification. Therefore, Maximus replaced the subcontractor with FirstLab, who uses only certified labs to conduct testing. First Lab is a third party contractor to the actual labs, and provides neutral oversight of these facilities.

Maximus also sub-contracts with about 70 clinical assessors. They apply and Maximus validates their licenses and ensures they have malpractice insurance. Typically these positions are licensed by the Board of Behavioral Sciences or the Board of Psychology as marriage and family therapists, licensed clinical social workers, or psychologists. All clinical assessors are evaluated quarterly in written reports based upon the parameters of 1) adhering to the scope of their contracts 2) the quality of their services, and 3) their communication with clients. Every two years, Maximus checks to re-certify each provider's license is current and insurance is up to date.

### **Case File Testing**

#### Max-CMS Tracking System

Maximus created the Max-CMS computer system to assist with monitoring each participant. Creation of this database was a condition of the original contract, and has been fully complied with. This comprehensive database tracks all activity of a participant in the program. All board/committee Diversion program managers have access to the system, and can use it to monitor participant activity. The system contains many useful reports, including a history and profile report, clinical information, the customized recovery compliance terms, the compliance recovery plan, report of compliance/non-compliance, work restrictions, DEC reassessments, monthly self-reports, fee payments, whether or not phone check-in for drug testing is compliant, transition information, and more. Max-CMS capability has been enhanced continuously since Maximus took over the Diversion contract, and can produce some customized reports useful for monitoring. Max-CMS was created in 2004 therefore, for some long-term

Diversion participants there are some documents that needed to be accessed through the old, paper case files.

Case file testing was performed for all six boards and one committee as follows:

- Board of Registered Nursing (43)
- Physical Therapy Board of California (10)
- Board of Pharmacy (16)
- Osteopathic Medical Board (7)
- Veterinary Medical Board (6)
- Physicians Assistant Committee (25)
- Dental Board (26)

Files were selected using a random selection method. All files were subjected to the same procedures, including an examination of:

- Timeliness of diversion services provided by Maximus
- Determination that each board's specific contract provisions were incorporated into each board's cases and are appropriately documented as addressed by Maximus
- Documentation of the clinical assessment
- Date the DEC or committee met to consider applicant's entrance
- Whether or not applicant was accepted and why
- Documentation of non-compliance
- Whether or not the participant was deemed a public threat
- Whether or not the participant was terminated, is currently participating, or completed the program
- Evidence of ongoing monitoring by clinical case manager and/or compliance monitor
- Thoroughness of documentation of treatment, aftercare, and monitoring services received by participants
- Thoroughness of documentation of effectiveness of the treatment
- Compliance with each participant's individual contract terms, such as worksite monitoring, group meeting attendance, 12-step program attendance, aftercare, etc.
- Maximus' promptness in notifying the boards when a participant failed to comply with the terms of his or her individual Diversion contract or the rules of the board's program

Results of the case file testing follow in the Findings and Recommendations section. The Findings and Recommendations section also includes some issues applicable to contract performance without regard to any specific case or board, intended to provide changes or reforms necessary, as required by SB 1441.

## **SB 1441 Recommendations**

SB 1441 required this audit make recommendations regarding the continuation of the programs and any changes or reforms required to ensure that individuals participating in the programs are appropriately monitored. The scope of the audit encompassed only contract compliance and performance of the administrative vendor, Maximus, and not the DCA boards' performance as a broader aspect of the DCA's overall Enforcement program. Therefore, the recommendations in this report address only the administrative vendor and not the program as a whole. Decisions regarding the continuation of the programs are policy level decisions appropriately made by DCA management and the legislature once audits of the boards' Enforcement programs taken as a whole have been completed, and are beyond the scope of this review.

Maximus' monitoring of participants is described in the preceding several pages describing the Diversion program in general. Monitoring was specifically evaluated during the case file testing. Any instances in which participants were not adequately monitored are found in the Findings and Recommendations section of this report, beginning on page 20.

SB 1441 also required the audit to determine whether Maximus should provide the Department with periodic reports demonstrating the timeliness and thoroughness of documentation regarding non-compliance with the program. While Maximus currently provides the individual boards/bureaus with monthly and quarterly summary reports of the overall Diversion program, the DCA executive management team does not currently receive comparable reports. With the current emphasis on standardizing enforcement practices and the interrelated nature of the Diversion program with the enforcement process, it follows that the executive management team would benefit from customized reports providing high level detail customized to reflect their needs related to executive management decisions regarding these programs. Further, these reports should be structured to provide a mechanism to alert DCA management, first hand, to changes and issues as they arise, rather, than having to rely on board management to relay this information. Maximus' Diversion Program management has expressed a willingness to work with DCA's executive management to develop reports that would meet their specific needs.

Maximus should work with DCA's executive management team to develop high level summary reports of the program that provides the executive management with the information most useful in making department-wide decisions related to enforcement and Diversion programs.

Copies of the Diversion Program Manager monthly meeting agendas and minutes should be provided to the DCA executive management to allow them the ability to attend a meeting if necessary and to review the issues and concerns raised during the meetings.

## **Findings and Recommendations**

### **Finding 1 - Maximus Diversion records in some cases lack the required documentation of treatment, aftercare, and monitoring services received by participants.**

Samples of participants requiring aftercare were randomly selected for testing. Participant files were reviewed for specific recovery contract requirements. Some simply required aftercare or other treatment, whereas others required aftercare or treatment with reporting from the treatment provider at regular intervals. We noted an exception whenever there was a requirement and no documentation existed. A total of 63 files were tested for the attributes noted above, covering all 7 boards. Of the 63 tested, 41 (65%) files were found to have exceptions to the requirements. Many of the files requiring quarterly reports from treating therapists did not contain all required reports. Further, Maximus has acknowledged that they have been accepting the monthly self reports in which the participants state that they are participating in the aftercare programs or therapy sessions in lieu of the quarterly status reports from the providers as required by the respective contracts.

As a result, some of the participants' required treatment is not documented in accordance with the individual contracted terms. Further, Maximus cannot fully monitor the participant's treatment if they are not requiring updates from the treatment providers. Relying on the word of the participants does not adequately replace the status updates from these providers.

Senate Bill 1441 required this audit to review "...the thoroughness of documentation of treatment, aftercare, and monitoring services received by participants..."

Contract # 014-0511-3, contract term 7/1/03 – 12/31/09 Scope of Work, general requirements section 1.5, states that the contractor should, "Reassess and evaluate participants' recovery, and monitor compliance with recovery contracts."

It should be noted that additional treatment and aftercare are not required of all participants. The requirement is specific to each participant recovery contract, and there may be various requirements in any given recovery contract (i.e., Aftercare is just one of possibly 30 terms in a recovery contract). Within the contracts progress reports may not be required in the same intervals for all participants.

Although Maximus does in many cases require the documentation through the contractual agreements, they have admittedly not been enforcing the reporting requirements.

**Recommendation:**

Maximus should collect all required reports and information as required by the individual recovery contracts for all participants. Maximus should consider standardizing this requirement in participant recovery contracts to increase the efficiency of Maximus' monitoring of the participant treatment, as currently not every recovery contract requires written status reports for treatment provided.

## Finding 2 – Positive Lab Result Reporting- Timeliness Issues

Compliance information contained within the participant files regarding the out of range, dilute, or positive urine tests were mostly Maximus' own internally generated documents, consisting of non-compliance letters and "occurrence reports". Maximus was using the occurrence reports to document the date they received notification from FirstLab of a positive test result. The contract in force during our testing period of 7/1/2006 through 6/30/2009 requires Maximus to report to the board within one business day of the receipt of the results by Maximus, cases in which bodily fluid results were positive.

To test the timeliness of the reporting of positive urine results by Maximus to the boards we had to first ascertain whether we could obtain reliable third party information documenting when lab results were actually available to Maximus.

We contacted FirstLab, Maximus' subcontractor for laboratory testing. FirstLab told us that there is an "import date" that can be easily accessed by Maximus on FirstLab's website. The import date is the date the testing lab imports the results into FirstLab's system. However, upon testing the dates in the system, we noted that some test results seemed to be one day off. In some cases Maximus clearly did not have access to the results data on the "import date" but rather about one day later. FirstLab's account manager in charge of the Maximus account stated that there are exceptions in the system when a participant profile does not exactly match up with the information given by the participant, and this causes a delay in the viewing of results on the system by Maximus. The exceptions are commonly caused by the participant using a social security number at the collection site rather than their unique Maximus identifier. When this happens FirstLab must manually match up the participants SSN to the Maximus identifier before results are available to Maximus on the system. FirstLab does this at least once per day, which may account for the one day delay seen in the dates results were available to Maximus.

We tested 100% of positive results for a six month period for each board (except BRN, for which we tested only one month due to the larger volume of participants). The chart below identifies the number of positive test results for the six month (or one month in the case of BRN), and the time frames it took for the board to receive notification of the positive result.

Because the contract requires Maximus to report within one business day **after** obtaining the results, we took exception to all positive tests that were reported to the boards more than two days after the "import date". This threshold provided Maximus with the one business day requirement and one additional day to account for the lag between the import date and their ability to view the information. Our specific testing to determine Maximus' timeliness in reporting positive tests results to the boards are as follows:

| Board                           | Number of Positive Results | Exceptions | % of Exceptions to Total Tested | Could Not Determine <sup>1</sup> |
|---------------------------------|----------------------------|------------|---------------------------------|----------------------------------|
| Dental Board                    | 10                         | 0          | 0%                              | 2                                |
| Physicians Assistants Committee | 6                          | 2          | 33%                             | 2                                |
| Board of Pharmacy               | 2                          | 0          | 0%                              | n/a                              |
| Veterinary Medicine Board       | 4                          | 0          | 0%                              | n/a                              |
| Board of Osteopathic Medicine   | 1                          | 0          | 0%                              | n/a                              |
| Physical Therapy Board          | No + results               | 0          | 0%                              | n/a                              |
| Board of Registered Nursing     | 13                         | 2          | 15%                             | n/a                              |

<sup>1</sup> Could Not Determine represents those files reviewed that did not have fax receipt dates confirming the actual delivery of the test results to the board on the date noted as the "Date Board Notified" on the occurrence reports.

As shown in the chart above, notification of positive test results contained exceptions for the Physicians Assistant Committee and the Board of Registered Nursing for the sample months selected. In the case of the Board of Registered Nursing, the two exceptions consisted of one that took one extra business day to notify, and one that took three extra days to notify. For the Physicians Assistant Committee, one exception took one extra business day to notify, and one exception took 3 extra business days to notify. The Physical Therapy Board had no positive results during the period selected for testing.

Further, we met with a clinic manager for a collection site used by Maximus participants. This manager stated that the normal practice for their facility is to require social security numbers unless the donor has a donor ID card. She stated that they do not feel comfortable accepting donor IDs without one. As noted above, this is likely a contributing factor to the delay in Maximus' ability to view the results as soon as they are imported. Providing participants with a donor ID card will provide official information to the collection sites to check against the information on the collection forms and serve to reduce the number of data exceptions that cause delays in Maximus actually obtaining the results.

Contract # 014-0511-3, contract term 7/1/03 – 12/31/09, Scope of Work, general requirements section 1.6, states that the contractor should, "Report in writing, within one business day, to the DEC and/or DPM any applicant or participant

who is unsuccessful in maintaining recovery, is non-compliant with contract requirements, or presents a threat to the public health and safety or themselves.”

The current process does not provide the boards with the source information needed to monitor compliance with the reporting timeframes required by the contract. Further, participants providing their SSNs rather than their Maximus unique identifier numbers to the collection sites are causing delays in Maximus’ ability to view lab results.

**Recommendations:**

The boards should be provided with regular reports similar to those provided to us by Maximus that allowed us to choose our sample for testing. With these reports and the occurrence reports already provided to the boards upon a non-negative test result by a participant, the boards will be better equipped to monitor Maximus’ compliance with the contract terms related to timely reporting on an ongoing basis.

Additionally, Maximus should carefully monitor its reporting of test results to the boards to ensure they are meeting the reporting timeframes.

Maximus and FirstLab should consider utilizing donor ID cards to provide collection sites with official information regarding the participant, including the unique identifier used in the FirstLab system, in an effort to reduce the number of exceptions in the system, which will allow Maximus to view the results earlier.

**Finding 3 - Maximus failed to adequately monitor one participant's compliance with the bodily fluid testing, resulting in a participant who was not testing for more than two months, being allowed to continue in the program unabated.**

One participant was terminated for non-compliance for ceasing to call and test for more than two months. A note on the participant's case log by Maximus' compliance monitor assigned to the board stated that "no one knew he had not called in or tested for two months." There were no non-compliance letters regarding this situation until more than two months after the participant stopped calling in and testing. Maximus is normally notified of missed calls and tests by the laboratory subcontractor shortly after the missed call or test via the internet site that Maximus says they check daily, so the lack of information does not make sense and presents a concern regarding the effectiveness of Maximus' monitoring of this participant's case.

As a result, a participant was allowed to continue virtually un-monitored as far as urine testing is concerned for over two months.

The contract in force during our testing period of 7/1/2006-6/30/2009 requires Maximus to report within one business day participant non-compliance with contract terms. Maximus stated in its bid that missing more than two tests within any three month period will be considered chronic and will be reported the next business day after the third missed test.

The cause is unknown, however, it seems that there was a lapse in monitoring for this particular participant.

This severe non-compliance was noted in only 1 of the 177 case files tested.

**Recommendation:**

Maximus should ensure that it adequately monitors each of its participants in accordance with the diversion contract.

**Finding 4 - Maximus has combined some of the records for certain licensees with multiple participations within the program, in one case, resulting in the erroneous purging of treatment records.**

There were several licensees that have participated in the program previously, and in some of these cases information from previous participation was included in the current files. This blending of files becomes a problem if Maximus begins to purge old cases. Because there are no identifiers on the case files distinguishing an old participation from the current, a new file could be purged along with the old information. In fact, this happened in two of the tested files. In one instance, the participant had been in the program previously and the old case had been flagged to be purged. Initially, Maximus could not find the current file with the exception of some of the very recent information. After some searching they were able to find part of the current case file which had been erroneously placed in the archived storage boxes. However, even this information was not complete. The support group reports, self reports, treatment information, and 12-step cards have seemingly been purged from the physical files. However, this information is still contained in the max-cms system.

In the other case, a case log note from the wrong participant was placed into another participant's case log. This compromises participant confidentiality and increases the risk that case decisions could be made based upon inaccurate information, as both case files were affected. One was missing a case log note it should have had, while the other included erroneous information.

Further, another case that was closed as a public risk contained information on all three participations in the program, when only the most current was relevant to the public risk closure. This case is sent to the board, whose enforcement investigators use the information for the enforcement action to be taken on the licensee.

As a result, each participation in the program is not being provided with separate case files, making the chances of erroneous purging, file misplacement, and improper disclosure of information more likely.

Maximus has acknowledged this problem and has stated they are already taking steps to correct it.

The contract in force during our testing period of 7/1/2006-6/30/2009 requires Maximus to maintain documents and records for a period of three years after final payment under the contract.

In some cases, Maximus' staff has combined case files, for unknown reasons, however, Maximus stated they will devise a procedure to prevent this from happening.

This exception occurred in 3 (2%) of the 177 case files tested.

**Recommendation:**

Maximus should ensure that it keeps separate files for each participation when a participant has been in the program more than one time.

**Finding 5 - A participant had multiple noncompliance issues**

One participant's 12-step meeting cards for May-July 2006 were received late in mid-August 2006. There was no signed copy of the pre-entry agreement in the file. The participant did not have a Worksite Monitor Agreement in place. There was no documentation of timely notification to the Board of these issues.

There was no indication of the reason that the noncompliance occurred or that the noncompliance was not timely reported to the Board.

All noncompliance should be monitored and the participant should be compelled to comply or be terminated from the program.

**Recommendation:**

We recommend that Maximus document noncompliance and report noncompliance to the Board in a timely manner. In addition, if a participant's contract calls for a worksite monitor and none is obtained, the participant should not be allowed to practice.

**Finding 6: One participant initially did not have a worksite monitor in place. When a worksite monitor was subsequently put in place, the worksite monitor agreement did not provide enough information to determine if the worksite monitor was not a subordinate employee of the participant.**

A participant's case log notes initially stated that the participant does not have a worksite monitor in place. When a new worksite monitor was put in place, it was noted that a "new Employee" is the participant's new worksite monitor. Because the Worksite Monitor Agreement does not require a worksite monitor to indicate a license number or a job title, it is difficult to determine whether the worksite monitor was a superior or a subordinate employee of the participant.

Business and Professions Code Section 4870 states that, "Each veterinarian and registered veterinary technician who requests participation in a diversion program shall agree to cooperate with the treatment program designed by a diversion evaluation committee. Any failure to comply with the provisions of a treatment program may result in termination of the veterinarian's or registered veterinary technician's participation in the program."

Maximus stated that a job title is not required at this time on the worksite monitoring agreement. However, the new contract effective January 2010 requires that a worksite monitor agreement include the worksite monitor's job title as well as a copy of the organizational chart.

A worksite monitor that is independent and not a subordinate employee of the participant helps ensure that worksite monitor activities and reports are accurate and unbiased.

**Recommendation:**

Worksite Monitor agreements should have the monitor's official title stated on the form to document they are not a subordinate of the participant.

**Finding 7: Clinical assessments were not done timely due to limited availability of licensed therapists, and for some participants entering inpatient treatment facilities upon application into the diversion program.**

In one case, we found a participant's clinical assessment was not done within four weeks of application into the program. It appears that the delay was due to the assigned licensed therapist. The case log shows that Maximus made numerous attempts to contact the licensed therapist to schedule the clinical assessment. However, because the licensed therapist did not return the phone call timely, the clinical assessment was not done within four weeks of the participant's application. Maximus may not have had an alternate licensed therapist available to conduct the required clinical assessment.

Additionally, we found that in 16 of the 98 cases (16%) reviewed, the participant's clinical assessment was not done within four weeks after the initial intake interview. However, we note that in some cases, the participant was in an inpatient treatment facility. Therefore, the participant's availability to schedule the clinical assessment may have been problematic.

Contract #014-0511-3-8, contract term 7/1/03 – 12/31/09, General requirements, section 1.3 requires that Maximus conduct comprehensive, confidential, in-person assessments of applicants within four weeks of application. Further, Scope of Work, general requirements section 2.2 requires that Maximus evaluate and monitor treatment providers and other resources for adherence to the Diversion Program's criteria.

**Recommendation:**

We recommend that Maximus have alternate licensed therapists in cases when the licensed therapist assigned to a particular participant is not available.

For board referred participants, Maximus should institute procedures addressing when the assessor or participant is unreachable, so that the lack of progress in scheduling the clinical assessment is reported to the board.

**Finding 8: Maximus placed reliance on a third party administrator to conduct the required clinical assessment; however, it was not done. As a result, the participant’s recovery contract may not properly reflect the treatment required for a successful recovery.**

An applicant was in a 90-day in-patient treatment facility when the applicant initially applied to enter the Diversion program. During the intake interview, Maximus decided that because the facility has a licensed therapist, it would rely on the facility to conduct the clinical assessment. However, we found that the clinical assessment that includes the required diagnosis was not provided by the facility.

Contract #014-0511-3-8, contract term 7/1/03 – 12/31/09, Scope of Work, general requirements section 2.2 states that Maximus evaluate and monitor treatment providers and other resources for adherence to the Diversion Program’s criteria. Moreover, a board specific requirement, section 1.3 states that a comprehensive in-person assessment will be completed within four weeks of the initial intake.

Maximus relied on the treatment facility to conduct the required clinical assessment. However, it appears that Maximus did not ensure that the clinical assessment was performed.

As a result, the participant’s clinical assessment was not done timely. Moreover, because the clinical assessment is a factor in determining appropriate treatment, the participant’s recovery contract may not properly reflect the treatment required for a successful recovery. In addition, it may represent a conflict of interest for a third party administrator to conduct a clinical assessment and recommend treatment to be provided, when in fact they are being paid to provide treatment to a participant.

**Recommendation:**

Maximus should follow-up timely with any third party/sub-contractors to ensure completion of the clinical assessment required for proper treatment and successful recovery.

To limit the appearance of conflict of interest issues, Maximus should limit reliance on in-house licensed therapists to conduct the clinical assessment. Because the assessment could recommend continual treatment in the facility where the licensed therapist is employed, it might be interpreted by someone from outside the facility that the licensed therapist is recommending such treatment for continual employment or continued business for its employer (treatment facility).

**Finding 9: Discrepancy in participant's initial call dates exist in Maximus' database.**

Maximus' database keeps track of all correspondence with either the board or participant. During our review, we found 36 instances of 133 cases reviewed (27%) where the initial call date with the participant did not match the date noted in the case log and what was reported in the participant's History & Profile report.

Contract #014-0511-3-8, contract term 7/1/03 – 12/31/09, Scope of Work, general requirements section 3. the contractor should, "Provide, maintain and upgrade as necessary a computer database system for the effective and efficient monitoring of Diversion Program applicants and participants and production of statistical reports."

The difference in when the initial call was received by Maximus could be due to a programming error.

It may appear that the participant called to apply for the program earlier or later depending on what was reported in their History & Profile report. As a result, for those participants who are board ordered to be in the program, the report may show that the participant called Maximus later than they should have.

**Recommendation:**

Maximus should better define what date to use for the initial call date when preparing the History & Profile report.

Maximus should ensure the database reporting function is programmed correctly to ensure correct dates are reported on the participant's History & Profile report.



# **ATTACHMENT I**

## **Maximus' Response to the Draft Report**

## **MAXIMUS Response to the DCA audit of the California Health Professionals Diversion Program April 2010**

### **EXECUTIVE SUMMARY**

MAXIMUS appreciates the opportunity to participate in this audit and respects the decision of the Department of Consumer Affairs (DCA) to conduct such an audit. We understand the importance of an agency to audit and confirm that an Administrative Vendor is in compliance with contract requirements and the program is operated as designed. This audit includes the start of the MAXIMUS and DCA partnership which began in 2003 and continues today. Most recently, we are pleased to be working closely with the respective Diversion Program Managers (DPMs) to implement the terms of the new agreement beginning on January 1, 2010.

We applaud the DCA for the incorporation of key elements contained in SB1441 into the program before the legislation was enacted. As noted in our responses, the new contract has resulted in several improvements to processes and procedures that further strengthen the program. Quality and continuous improvement are core tenets of the services MAXIMUS provides to its clients and stakeholders. We continue to stand ready to work closely with the DCA to continue to improve the processes which protect the safety of the healthcare consumers of California.

### **FINDING #1**

**MAXIMUS diversion records in some cases lack the required documentation of treatment, aftercare, and monitoring services received by participants.**

### **RECOMMENDATION:**

MAXIMUS should collect all required reports and information as required by the individual recovery contracts for all participants. MAXIMUS should consider standardizing this requirement in participant recovery contracts to increase the efficiency of MAXIMUS monitoring of the participant treatment, as currently not every recovery contract requires written status reports for treatment provided.

### **MAXIMUS RESPONSE:**

Thank you for the recommendation for standardization in the requirements and collection of reports and information in support of the elements in the participant's *Recovery Contract*. In response to the recommendation, MAXIMUS has initiated a preventative action plan. Effective December 23, 2009 revisions were made to the *Recovery Contract* to include a participant contract term for the requirement for providing the *Treatment Provider Reports*, when appropriate, to their Clinical Case Manager. Additionally, a blank *Treatment Provider Report* is now mailed to the participants on a quarterly basis so they have it readily available. While the inclusion of this information is not a contractual requirement for MAXIMUS under the agreement with the Department of Consumer Affairs, if provided, the documentation increases consistency in monitoring participant treatment, standardization to the collection of reports and improves the communication between the MAXIMUS Clinical Case Manager and the Treatment Provider. *Treatment*



*Provider Reports* are one of many elements of recovery that are monitored to determine compliance with the terms of the Recovery Contract.

**FINDING # 2**

**Finding #2 was not summarized in the audit report.**

**RECOMMENDATION:**

The boards should be provided with regular reports similar to those provided to us by MAXIMUS that allowed us to choose our sample for testing. With these reports and the occurrence reports already provided to the boards upon a non-negative test result by a participant, the boards will be better equipped to monitor MAXIMUS compliance with the contract terms related to timely reporting on an ongoing basis.

Additionally, MAXIMUS should carefully monitor its reporting of test results to the boards to ensure they are meeting the reporting timeframes.

MAXIMUS and FirstLab should consider utilizing donor ID cards to provide collection sites with official information regarding the participant, including the unique identifier used in the FirstLab system, in an effort to reduce the number of exceptions in the system, which will allow MAXIMUS to view the results earlier..

**MAXIMUS RESPONSE:**

Thank you for the recommendations. MAXIMUS is always open to suggestions that further strengthen the communication between the Department of Consumer Affairs and the Diversion Program. We support this recommendation regarding the reports and view as a continuous improvement opportunity. We are prepared to initiate discussion with the department regarding their report needs. MAXIMUS will coordinate specifically with the Diversion Program Managers regarding this program enhancement via our regularly scheduled Status Meetings.

Beginning with the new contract term starting January 1, 2010, MAXIMUS has adopted new reporting requirements for positive lab results as prescribed by the Department of Consumer Affairs. These new requirements are monitored via an independent Quality Assurance review.

Donor ID cards are provided to applicants and participants at the time of registration with FirstLab. As an enhancement to the registration process, the applicants and participants are to be encouraged to use their Donor ID card, and not their Social Security Numbers. Additionally, MAXIMUS has opted to move away from the use Social Security Numbers in the program in an effort to further protect the Personal Health Information (PHI) of our program participants.

**FINDING #3**

**MAXIMUS failed to adequately monitor one participant's compliance with the bodily fluid testing, resulting in a participant who was not testing for more than two months, being allowed to continue in the program unabated.**

**RECOMMENDATION:**

MAXIMUS should ensure that it adequately monitors each of its participants in accordance with the diversion contract.

**MAXIMUS RESPONSE:**

MAXIMUS recognizes the importance of program monitoring specific to bodily fluid testing and agree that participant compliance is to be closely monitored. In this particular circumstance, the participant was in recovery from surgery and as a result unable to work. During recovery he was not working and was monitored by his Clinical Case Manager for the other applicable elements of his compliance terms. The participant did not call in for testing as he perceived he was not required to do so during the surgery recovery period and until active engagement in the program resumed.

Based on the circumstances of this participant as it relates to the finding, we respectfully submit that we do not concur that the participant was allowed to continue in the program unabated. We are also pleased to note that the audit identified only one case in a sample size of 177 that was noteworthy. We do, however, acknowledge that program monitoring in the area of bodily fluid testing should be periodically reviewed for opportunities to increase controls and the effectiveness of monitoring. As recent as August 2009, we have further refined our processes in response to participants who fail to call or test. This is also an aspect of the program that is discussed regularly with the Diversion Program Managers and we will continue to do so in efforts to further strengthen the monitoring of testing.

**FINDING #4**

**MAXIMUS has combined some of the records for certain licensees with multiple participations within the program, in one case, resulting in the erroneous purging of treatment records.**

**RECOMMENDATION:**

MAXIMUS should ensure that it keeps separate files for each participation when a participant has been in the program more than one time.

**MAXIMUS RESPONSE:**

Periodically, there are participants that return to the Diversion Program. In this case, the participant already has both an electronic and hard copy file. Upon return to the program, it is best to create a new hard copy file to ensure the purging cycle is appropriately applied. Upon the identification of this finding, MAXIMUS immediately implemented a corrective action plan that includes the paper file being sealed and filed in a separate location from active files within 30 days of the closure of the case. This practice was fully implemented on October 1, 2009.

**FINDING #5**

**One participant's 12-step meeting cards for May-July 2006 were received late in mid-August 2006. There was on signed copy of the pre-entry agreement in the file. The participant did not have a Worksite Monitor Agreement in place. There was no documentation of timely notification to the Board of these issues.**

**There was no indication of the reason that the noncompliance occurred or that the noncompliance was not timely reported to the Board.**

**All noncompliance should be monitored and the participant should be compelled to comply or be terminated from the program.**

**RECOMMENDATIONS:**

We recommend that MAXIMUS document noncompliance and report noncompliance to the Board in a timely manner. In addition, if a participant's contract calls for a worksite monitor and none is obtained, the participant should not be allowed to practice.

**MAXIMUS RESPONSE:**

MAXIMUS recognizes the critical nature of adequate supervision when a participant returns to work. The case circumstances associated with this finding are from one participant in 2006, therefore, we do not believe that this finding is representative of a systemic concern related to case documentation in need of a formal corrective action plan. However, we believe in continuous improvement in the operations of the Diversion program and in our role as your Administrative Vendor and we have recently enhanced our Diversion Quality Assurance (QA) program for the new contract period and its new requirements. We took this opportunity to also review the manner in which we review case documentation and reporting from a quality perspective. We have enhanced our QA checklist to increase the focus on this important element of the case record.

The Department of Consumer Affairs and its respective Boards has our commitment to continue the use our Quality Assurance methodology and continuous improvement initiatives to increase the effectiveness of the Diversion program in the new contract period.

**FINDING #6**

**One participant initially did not have a worksite monitor in place. When a worksite monitor was subsequently put in place, the worksite monitor agreement did not provide enough information to determine if the worksite monitor was not a subordinate employee of the participant.**

**RECOMMENDATION:**

Worksite Monitor agreements should have the monitor's official title stated on the form to document they are not a subordinate of the participant.

**MAXIMUS RESPONSE:**

As a component of the new contract implementation, the Worksite Monitor Agreement is being revised to include the information regarding position and license number of the Worksite Monitor. The approval

process for the Worksite Monitor now includes a request for the Organizational Chart to verify the position of the participant in relation to the Worksite Monitor.

**FINDING #7**

**Clinical assessments were not done timely due to limited availability of licensed therapists, and for some participants entering inpatient facilities upon application into the diversion program.**

**RECOMMENDATION:**

We recommend that MAXIMUS have alternate licensed therapists in cases when the licensed therapist assigned to a particular participant is not available.

For board referred participants, MAXIMUS should institute procedures addressing when the participant is unreachable, so that the lack of response is reported to the board.

**MAXIMUS RESPONSE:**

While we believe that these cases do not represent a systemic concern with delays in conducting assessments, MAXIMUS does agree there is a continuous improvement opportunity to review the current resource level of Assessors for any adjustments warranted.

The audit records show 16 findings of 98 cases reviewed. All 98 participants had an assessment completed; however, 16 were identified as not completed timely. One of the 16 cases met the contract requirement with an assessment completed 15 days after intake. With regard to six of the cases with this finding, the delays were related to participants who were in treatment. When in treatment, the participant is legitimately unavailable for the Assessment. In two additional cases, the assessment was conducted by an independent assessor while the participant was in treatment, either on a pass or as an excused absence from an intensive outpatient program. As a result, we respectfully submit that these cases were not findings in which a MAXIMUS response is required.

Concerning the remaining seven cases, in three of the seven, an assessment was conducted within 31 calendar days; the requirement is within four (4) weeks. During this timeframe the MAXIMUS staff was making contact with the Clinical Assessor to secure an appointment. The remaining three cases all had assessments conducted; however, delays were related to rescheduling the appointment times.

MAXIMUS understands the importance of the timely clinical assessments. In response to the new contract period, we engaged in securing the new Subcontractor Agreements for Clinical Assessors. This process creates an opportunity for MAXIMUS to further review timely response requirements when securing appointments for the participants.

**FINDING #8**

**MAXIMUS placed reliance on a third party administrator to conduct the required clinical assessment; however; it was not done. As a result, the participant's recovery contract may not properly reflect the treatment required for a successful recovery.**

**RECOMMENDATION:** MAXIMUS should follow up timely with any third party/sub contractors to ensure completion of the clinical assessment required for proper treatment and successful recovery.

To limit the appearance of conflict of interest issues, MAXIMUS should limit reliance on in-house licensed therapists to conduct the clinical assessment. Because the assessment could recommend continual treatment in the facility where the licensed therapist is employed, it might be interpreted by someone from outside the facility that the licensed therapist is recommending such treatment for continual employment or continued business for its employer (treatment facility).

**MAXIMUS RESPONSE:**

In the one case noted for this finding, MAXIMUS provided the auditor a copy of the treatment provider report dated 7/9/09. The report included a 5-Axis diagnosis, as is required. This report fulfills the requirement for timely completion of clinical assessment, and therefore, was accepted by the program.

With the terms of the contract beginning January 1, 2010, MAXIMUS agrees to obtain a clinical assessment from an independent third party for all new applicants.

**FINDING #9**

**Discrepancy in participant's initial call dates exist in MAXIMUS database.**

**RECOMMENDATION:**

MAXIMUS should better define what date to use for the initial call date when preparing the History and Profile report.

MAXIMUS should ensure the database reporting function is programmed correctly to ensure correct dates are reported on the participant's History and Profile report.

**MAXIMUS RESPONSE:**

During the time of the audit, which coincided with the start date of the new contract period, MAXIMUS identified that there were conflicting definitions and/or conditions being applied to the use of the data elements *date of initial contact* and *intake date*. As a result, date variances occurred. Please note, the database reporting functionality is correct, only the application of the definition of terms is applicable to the findings noted. MAXIMUS initiated discussion with the Diversion Program Managers (DPMs), on behalf of their respective Boards, to determine how best to proceed and obtain their direction. MAXIMUS has received clarification from the Boards and the Department of Consumer Affairs legal counsel regarding the definition of the point of initial contact. The History and Profile Report will be revised to meet the requirements related to initial call date as directed. We will keep the DPMs apprised of the progress of this effort during the regularly scheduled Status Meetings.



# **ATTACHMENT II**

## **Internal Audit Office Comments on Maximus' Response to the Draft Report**

## Internal Audit Office Comments on Maximus' Response to the Draft Report

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To provide our perspective on Maximus' response to our draft audit report, we are commenting on the issues below.

**Finding 3** - To ensure the proper context of this finding we must reiterate that Maximus stated in its case log notes that no one was aware that this participant had not called into the lab or tested for over two months. If Maximus is monitoring compliance with the drug testing requirements daily, it does not make sense that this issue would go unnoticed for over two months. Regardless of the reason the participant was not compliant with the testing requirements, this is still a non-compliance situation and should be dealt with in a timely manner.

**Finding 8** - The progress report provided to the auditor by Maximus dated 7/9/09 was not for the required clinical assessment, but was presumably for the aftercare treatment provided by the same facility to the participant. The dates of treatment did not correspond to the patient's in patient treatment period, and could not have fulfilled the requirement for the time period in question.