

# Department of Consumer Affairs

## Contract and Performance Audit of the DCA Diversion Program provided by Maximus Health Services

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## Executive Summary

The California Business and Professions Code provides enabling legislation to various health care licensing Boards under the auspices of the Department of Consumer Affairs (DCA) to identify and rehabilitate licensees whose competency may be impaired due to substance abuse and/or mental illness. In part, this legislation establishes a Diversion Program as a voluntary alternative approach to traditional disciplinary actions. The Boards that have implemented Diversion Programs include: Dental, Osteopathic Medicine, Physical Therapy, Physician Assistant, Pharmacy, Registered Nurses and Veterinary Medicine.

Since 2003, DCA has contracted with Maximus Health Services, Inc. (Maximus) to provide Diversion Program services for approximately 700 licensee participants.

Business and Profession Code Section 156.1 (c) authorizes the DCA Director or Chief Deputy Director to request an examination and audit by the Department's internal auditor of all performance under the contract. In January 2010, the DCA Internal Audit Office (IAO) audited the period from July 1, 2003 through December 31, 2009 and found that overall, Maximus is effectively and efficiently providing the program services.

In October 2015, the DCA IAO engaged CPS HR Consulting (CPS) to conduct an audit of the Diversion Services provided by Maximus for the contract period from January 1, 2010 through December 31, 2014. This audit was performed in compliance with Uniform Standard 15 that requires an external independent audit at least once every three years.

### Overall Conclusion

Overall, this audit found Maximus is effectively and efficiently managing the various Board diversion programs and recommends the program be continued under the vendor. This audit identifies a variety of non-compliant instances and opportunities for improvement, but nothing of a systemic nature that materially affects program effectiveness and efficiency.

### Findings and Recommendations

This report includes a program description section that covers the Diversion Program goals, enabling legislation, uniform standards, and distinguishing program elements; and an audit section that presents findings and 30 recommendations in the following areas:

#### Historical Program Statistics, Trends and Costs

- Over the audit period, approximately 67% of the program participants were female; 80% were Caucasian, and the average age increased from 30-34 years old to 45-49 years old.
- Approximately 67% of the participants entered the program through a Board referral.
- Slightly over 50% successfully completed the program.
- Most relapses were in the first year of the program and primarily due to abuse of alcohol, narcotics and other opiates, and benzodiazepine. The relapse rate has improved over time.

- Only seven of the 20 DCA healing arts licensing Boards are included in the Diversion Program, and the Board of Registered Nursing (BRN) does not include nurses on probation in the program.
- Some program participants lose their health insurance, but there are insurance benefits available for substance abuse and mental health treatment.

## Recommendations

1. If applicable and warranted, other DCA healing arts Boards should consider participating in the Diversion Program, and in particular, the Medical Board of California and Board of Vocational Nursing and Psychiatric Technicians.
2. The BRN should consider making probationers attend the Diversion Program as a condition of probation.
3. Maximus should identify a program staff member whose sole responsibility is to become knowledgeable about health insurance coverage benefits and referral sources, and periodically update the Clinical Case Managers and Compliance Monitors.
4. Program participants should assume personal responsibility to contact and research coverage options and costs with the health insurance companies listed on the Covered California website.

## Diversion Program and Shared Services Staffing

No negative findings or recommendations.

## Diversion Program Manager Survey Results

- In lieu of observing DEC and Board Participant Review meetings, CPS surveyed the DPMs and attended a monthly DPM meeting resulting in the following observations:
  - All receive information timely from Maximus before a meeting.
  - They all have remote access to the Max-CMS and most reported the information is generally complete and accurate, and the system is easy to use.
  - Decisions and outcomes are well documented based on standardized templates.
  - They receive materials timely (within 7 days) after the meetings.
  - The DPMs rated as high: Program effectiveness for licensees, Maximus knowledge and expertise, and Program efficiency.
  - The DPMs offered a number of improvement recommendations.

## Recommendation

5. Maximus should consider and evaluate all of the Diversion Program Manager (DPM) recommendations and, at a minimum, provide the DPMs with recovery training.

## Treatment Provider Survey and Credential File Audit Results

- Treatment Providers (Clinical Assessors, Health and Nurse Support Group Facilitators and Worksite Monitors) were surveyed to identify obstacles/challenges that hinder their program role and recommendations to improve the program.
- In addition, the auditors reviewed a sample of credential files for compliance with Uniform Standards and found partial compliance.

## Recommendations

6. Maximus should consider and evaluate all of the stated Treatment Provider obstacles/challenges, then prioritize and implement the recommendations accordingly.
7. As evidenced by the success of the auditor's online survey, Maximus should periodically reach out to Treatment Providers and other stakeholders to identify ongoing issues and opportunities for continuous improvement.
8. Maximus and the Boards should ensure each credential review is completed in compliance with the Uniform Standards, including evidence of: a license, experience and insurance; do not accept licensees with whom they have had a personal, financial and business relationship within the last year; and Board approval.
9. Per healthcare standards, perform and document an OIG clearance for each Treatment Provider at <https://exclusion.oig.hhs.gov>
10. Per healthcare standards, require all Treatment Providers with access to records to sign HIPPA confidentiality statements.

## Participant File Audit Results

- The auditors reviewed a statistically-valid random sample of participant files for compliance with applicable Uniform Standards and found a variety of non-compliant instances and opportunities for improvement.

## Recommendations

11. Maximus should consider hiring a part-time CCM to cover vacations, illness and time away at DEC meetings, etc. This will improve the management of multiple calls.
12. Maximus program staff should continue to document reasons for assessment completion delays.
13. All program staff should take advantage of the improved spelling and grammar check feature in the upgraded Max-CMS.
14. The Project Manager should review and revise closing notes as necessary.
15. Use the participant's first or last name rather than pronouns only to prevent misunderstandings with case log entries.

16. Maximus should develop and implement a written policy for making deletions and retractions to case logs. The American Health Information Management Association website (<http://www.ahima.org>) has examples and sample policies Maximus could use.
17. Maximus program staff should track and trend the reasons for program withdrawal to determine the number of participants who withdrew for financial and other reasons.
- 18-20. Maximus program staff should improve or modify the Program Handbook in a variety of ways to provide participants with more valuable information.
21. Maximus should include medicine disposal information from the USFDA website in the Program Handbook.
22. Maximus should consider advising participants to seek out Mental Health Services from their local county government Adult System of Care, when appropriate.
23. Maximus should contact the California Chapter of the American Organization of Nurse Executives and California Hospital Association to speak at a regional or state-wide meeting regarding the prevention and detection of nurses diverting drugs.
24. The Board's should collectively consider identifying an acceptable, but less frequent, random testing schedule that would accomplish the goal and reduce participant cost and loss, then modify Uniform Standard 4 accordingly.
25. The non-DEC Board's should consider evaluating the effectiveness of the participants' non-attendance at Board review meetings, and consider ways to improve interpersonal interaction by Skype, Face Time or other forms of communication.

### **Drug Test File Audit Results**

- The auditors reviewed a statistically-valid random sample of 114 participant drug testing files on the FirstLab website for compliance with applicable Uniform Standards and found all but four participants in the files. The drug test files include the participant name, license number, organization, test start and end dates, testing frequency, whether observed and current status.

### **Recommendation**

26. The Maximus Quality Analyst should periodically audit the FirstLab website files to ensure all program participants being drug tested are included in the database.

### **Program Effectiveness Reporting**

- Each Board is required to report specific information on a yearly basis to the DCA and the Legislature as it relates to licensees with substance abuse problems who are either in the Diversion Program or on Board probation. The auditors identified some minor issues and made the following recommendations for these specific reporting items.

## **Recommendations**

27. Maximus should revise the intake report accordingly to eliminate the confusion between monthly and year-to-date reporting.
28. Maximus should consider tracking and trending major violations and actions taken, and report this information in the annual report.
29. Maximus should consider tracking and trending successful returns to work on a monthly and annual basis, and report this information in the annual report.
30. Participating Boards should attempt to monitor long range participant outcomes after program completion.

## **Planned Technical Improvements**

No negative findings or recommendations.

The auditee responses to these findings and recommendations are contained in Appendix 6. Any inaccuracies the auditees noted in the draft report have been corrected in this final report.

## Introduction

The following provides a brief background about the Maximus Diversion Program since its inception; presents the program staffing as of December 31, 2015, project scope, objective and methodology, constraints and data qualifications; and acknowledges the important role all of the audit participants.

### Background

The DCA Diversion Program provided by Maximus is a voluntary, statewide, confidential, comprehensive, substance abuse disorder and mental illness monitoring and referral program for impaired health care professionals. It is not a treatment program. The primary role of Maximus is to provide case management for program participants during their recovery and to serve as a liaison with the Boards to which they are affiliated. As of December 2014, there were approximately 700 licensee participants in the program.

In 2003, DCA selected Maximus to provide Diversion Services on behalf of six health care licensing Boards and one Committee that fall under DCA administrative authority.

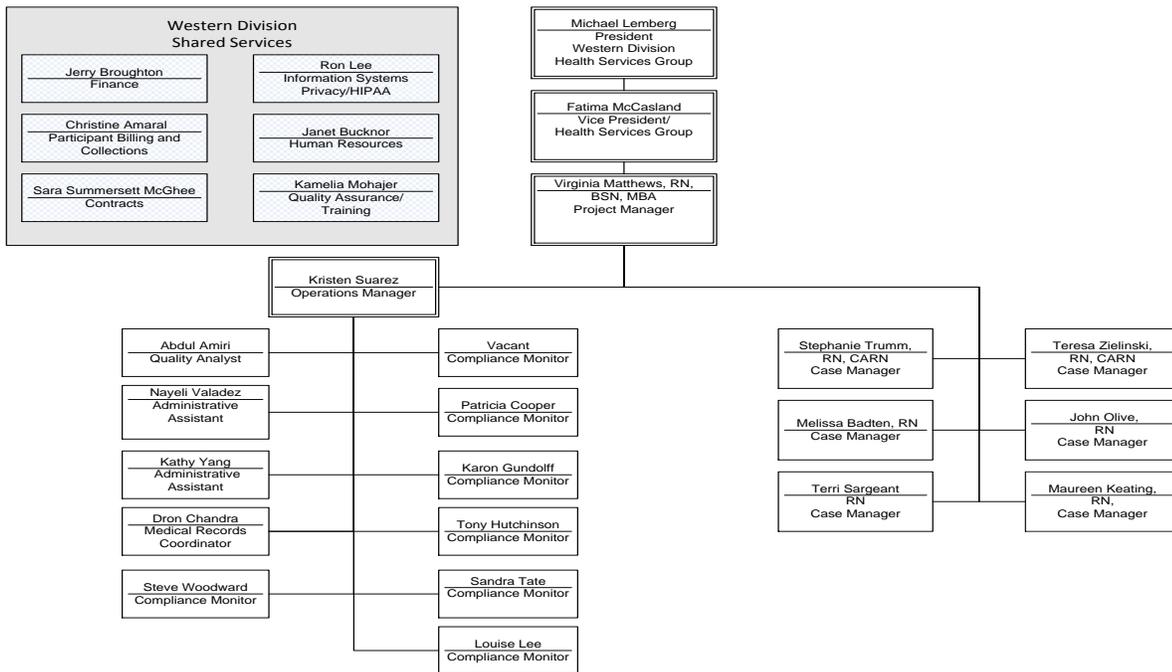
In 2009, the DCA Internal Audit Office (IAO) audited the DCA contract with Maximus to fulfill the audit requirement in Senate Bill 1441, chaptered September 28, 2008. The audit test period covered was July 1, 2007 through June 30, 2009. Overall, the DCA IAO audit concluded Maximus was effectively and efficiently managing the various Board diversion programs and recommended the program be continued with some opportunities for improvement.

In October 2015, the DCA engaged CPS HR to conduct a contract and performance audit of the DCA Diversion Program with an audit test period from July 1, 2010 through December 31, 2014 for up to approximately 700 eligible participants. The Diversion Program contract value for this audit period was \$10,672,884. This audit was performed in compliance with Uniform Standard 15 that requires an external independent audit at least once every three years.

### Maximus Program and Shared Services Staffing

Figure 1 displays the 19 authorized Maximus Diversion Program staff positions (including one vacancy) and the six Western Division Shared Services organizations supporting the program as of December 31, 2015. The staff roles and tasks are discussed in detail in the Audit Results section of this report.

**Figure 1**  
**Maximus Diversion Program Organization Chart as of 12/31/15**



## Project Scope, Objective and Methodology

The scope of this engagement focused on auditing the DCA Diversion Program services provided by Maximus from July 1, 2010 through December 31, 2014 to eligible licensee participants of the following seven Boards:

- Dental Board of California (+ Hygiene Committee) (DBC)
- Osteopathic Medical Board of California (OMB)
- Board of Pharmacy (BOP)
- Physical Therapy Board of California (PTB)
- Physician Assistant Board (PAB)
- Board of Registered Nursing (BRN)
- Veterinary Medical Board of California (VMB)

The project objective is to provide DCA management and the California Legislature with an external audit of the Maximus Diversion Program’s compliance, effectiveness, efficiency and overall performance as required by Senate Bill 1441.

The CPS HR methodology included the following approach:

- Conducted off-site and onsite document reviews of the DCA-Maximus contract and drug screening administer contract (FirstLab); pertinent California program legislative mandates and regulations; Maximus staffing and organization charts, job descriptions, personnel

files, policies, procedures, performance metrics, flowcharts, forms and operating statistics.

- Converted applicable standards to compliance criteria checklists.
- Conducted staff interviews and group facilitation with Maximus program and shared services staff to better understand duties and workload, the as-is business processes used within the program, and document compliance with their own procedures.
- Surveyed Board/Review Committee Program Managers and reviewed applicable meeting minutes.
- In addition, CPS surveyed online:
  - Clinical Assessors to better understand their roles and responsibilities, and review their credential files and assessments.
  - Health Support Group Facilitators (HSGF) and Nurse Support Group Facilitators (NSGF) to better understand their roles and responsibilities, and review their credential files and reports.
  - Work Site Monitors (WSM) to better understand their roles and responsibilities, and review their credentials and reports.
- Audited the treatment program referrals for licensure and accreditation, and licensee participant records per the applicable standards at a statistically valid sample size (attribute sampling with expected error rate not over 5% at a confidence level of 95% with a precision of plus or minus 4%) using the Maximus MAX-CMS case management system.
- Surveyed FirstLab regarding licensure/accreditation; drug screening and laboratory services provided to program participants; audited a statistically valid sample (attribute sampling with expected error rate not over 5% at a confidence level of 95% with a precision of plus or minus 4%) of applicable records for contract compliance and quality controls; and conducted site visits of local laboratory subcontractors.
- Briefed DCA and Maximus periodically as requested.
- Prepared incremental deliverables, monthly status reports, draft and final reports.

The audit as conducted in accordance with:

- The terms and conditions of contract REQ0003674 approved December 27, 2009, including but not limited to, General Requirements (Section 4), Board Specific Requirements (Sections 5-11), Functional Requirements (Section 12), Administrative Requirements (Section 19), and all provisions listed in the Appendices (Section 19); and Amendment #1 approved December 27, 2012 and Amendment #2 approved December 31, 2013, including, but not limited to, section B. Revisions to the Agreement.
- The DCA Uniform Standards as stipulated in Senate Bill 1441, April 2011, and the California Attorney General Decision on Uniform Standards dated April 8, 2015; and

- The US General Accounting Office Government Auditing Standards for performance reviews of government agencies and programs.
- Finally, the audit was managed according to the best practices of the Project Management Institute.

### **Constraints and Data Qualifications**

CPS relied on information received from Maximus staff, Board staff, and program service providers. With the exception of audited Maximus information, conclusions were drawn from unaudited information provided by these other sources.

### **Acknowledgment**

CPS wishes to thank all participants at Maximus Health Services, especially the Program Manager, Operations Manager and the Quality Assurance function that gave so willingly of their time and expertise. In addition, CPS wishes to thank Professional Health Consulting Services (PHCS) for their invaluable health care expertise and services.

## Maximus Diversion Program Services

The following describes the Diversion Program, including a summary of the program goals and enabling legislation; budgeted program participants; program length, entry and confidentiality; program intake and clinical assessment; treatment programs; program requirements, uniform standards and distinguishing program elements; and program billing and reporting.

### Program Goals and Enabling Legislation

The primary Diversion Program goal is to protect the public by early identification of affected health care professionals and immediate access to appropriate intervention programs and treatment services. The secondary goal is to assist licensee participants with their recovery without losing their license to practice. The program intent is not to punish but to rehabilitate and return the health care professional to safe practice.

Table 1 summarizes the California statutes within Division 2 of the Business & Professions Code enable the Diversion Program for the health care licensing boards within the scope of this audit.<sup>1</sup>

**Table 1: Diversion Program Enabling Legislation**

Participating Board	Business & Professions Code Section Division 2
Dental Board of California (+ Hygiene Committee)	Chapter 4, Article 4.7, Section 1695
Osteopathic Medical Board of California	Chapter 5, Article 15, Sections 2360-2370
Physical Therapy Board of California	Chapter 5.7, Article 5.5, Sections 2662-2669
Board of Registered Nurses	Chapter 6, Article 3.1, Sections 2770-2770.14
Physician Assistant Board	Chapter 7.7, Article 6.5, Sections 3534-3534.10
Board of Pharmacy	Chapter 9, Article 21, Sections 4360-4373
Veterinary Medical Board	Chapter 11, Article 3.5, Sections 4860-4873

### Budgeted Program Participants

Table 2 displays the number of program participants, unit cost and total amount budgeted in the DCA contract and two amendments with Maximus for managing the Diversion Program during the audit period. The table indicates total budgeted participants declined over the audit period from 686 to 658, BRN licensees comprised more than 70% of the program participants, the monthly unit cost increased 3% per fiscal year, and the total budgeted cost was \$10,672,884.

<sup>1</sup> Appendix 1 contains, in part, the applicable Business & Professions Code sections.

**Table 2: Diversion Program Participants Budgeted by Board**

FY	FY 2010-11				FY 2011-12				FY 2012-13				FY 2013-14				FY 2014-15 (7/1/14-12/31/14)			
	Board	# Part.	Mo. Unit Cost	Amt	# Part.	Mo. Unit Cost	Amt	# Part.	Mo. Unit Cost	Amt	# Part.	Mo. Unit Cost	Amt	# Part.	Mo. Unit Cost	Amt	# Part.	Mo. Unit Cost	Amt	
BRN	509	\$ 280.16	\$1,711,217.28	509	\$ 288.56	\$1,762,524.48	480	\$ 297.22	\$1,711,987.20	485	\$ 306.14	\$1,781,734.80	485	\$ 315.32	\$917,581.20					
BOP	79	\$ 280.16	\$265,591.68	79	\$ 288.56	\$273,554.88	75	\$ 297.22	\$267,498.00	80	\$ 306.14	\$293,894.40	80	\$ 315.32	\$151,353.60					
DBC	48	\$ 280.16	\$161,372.16	48	\$ 288.56	\$166,210.56	36	\$ 297.22	\$128,399.04	40	\$ 306.14	\$146,947.20	40	\$ 315.32	\$75,676.80					
PAB	22	\$ 280.16	\$73,962.24	22	\$ 288.56	\$76,179.84	25	\$ 297.22	\$89,166.00	20	\$ 306.14	\$73,473.60	20	\$ 315.32	\$37,838.40					
PTB	12	\$ 280.16	\$40,343.04	12	\$ 288.56	\$41,552.64	15	\$ 297.22	\$53,499.60	15	\$ 306.14	\$55,105.20	15	\$ 315.32	\$28,378.80					
OMB	10	\$ 280.16	\$33,619.20	10	\$ 288.56	\$34,627.20	12	\$ 297.22	\$42,799.68	12	\$ 306.14	\$44,084.16	12	\$ 315.32	\$22,703.04					
VMB	6	\$ 280.16	\$20,171.52	6	\$ 288.56	\$20,776.32	10	\$ 297.22	\$35,666.40	6	\$ 306.14	\$22,042.08	6	\$ 315.32	\$11,351.52					
<b>Totals</b>	<b>686</b>		<b>\$2,306,277.12</b>	<b>686</b>		<b>\$2,375,425.92</b>	<b>653</b>		<b>\$2,329,015.92</b>	<b>658</b>		<b>\$2,417,281.44</b>	<b>658</b>		<b>\$1,244,883.36</b>					

Source: DCA contracts

### Program Length, Entry and Confidentiality

The length of participation in the program depends on the licensee participant’s compliance with program requirements and demonstrated recovery progress. There are essentially two program phases: recovery and transition. Most participants remain in the program for three to five years. At a minimum, during the recovery phase participants must demonstrate full compliance with program requirements before they may petition their respective Board to enter the transition phase. However, transition is not guaranteed at the two-year mark. The transition phase lasts at least one year and is designed to ease participants into accepting full responsibility for their recovery. Participants are given more autonomy and responsibility with fewer program requirements and restrictions.

Depending on Board policy, licensee applicants can enter the program in the following ways defined in the contract:

- Board Referral: a licensee referred to the Diversion Program by the Board, based on information or complaint received by the Board, indicating the licensee may be impaired due to a substance abuse disorder or mental illness. (66.6% of referrals)<sup>2</sup>
- Self-Referral: a licensee who voluntarily seeks admission into the Diversion Program may apply to the program directly by calling a 24 hour/7 day a week toll-free phone number [(800) 522-9198]. (19.7% of referrals)
- Probation Referral: a licensee referred to the Diversion Program by their applicable Board as a condition of a Board-imposed disciplinary action. (9.2% of referrals)
- Informal Referral: a licensee of the Dental Board of California (DBC) and/or Board of Pharmacy (BOP) who may have a Board investigation pending, and upon recommendation of a Board inspector/investigator, may voluntarily apply to the program. (4.0% of referrals)
- In Lieu of Discipline: a licensee the BOP investigated and referred into the program to be assessed in order to determine if the licensee has a substance abuse disorder. In cases of a

<sup>2</sup> Based on Diversion Program Annual Reports from FY 2010-11 through FY 2014-15.

serious violation, the BOP may refer to the program in addition to discipline. Approximately 0.5% of program participants are this type of referral. (0.5% of referrals)

Participant confidentiality is protected by law. Licensees become participants after they are accepted into the program. Any and all information gathered to assist in developing a recovery plan, and all other information in their record, is confidential. In general, when participants successfully complete the Diversion Program, their program records are destroyed. However, except for BOP participants, if a participant does not successfully complete the program, the original complaint, if any, is investigated by the respective Board's Enforcement Program.

## **Program Intake and Clinical Assessment**

After verifying the eligibility of the applicant, the assigned Compliance Monitor (CM) contacts the licensee and schedules an initial intake interview with the assigned Clinical Case Manager (CCM). Within 10 days of applying for entry into the program, the CCM conducts an in-depth telephone interview with the licensee. Following the interview, the CCM prepares and mails a Pre-Entry Agreement and recovery plan which may include some or all of the following recovery activities:

- Random drug testing
- 12-step meeting attendance
- Support group meeting attendance
- Outpatient or inpatient treatment
- Psychiatric evaluation
- Individual psychotherapy
- Medication management
- Medical evaluation
- Nephrology evaluation
- Submission of monthly self-reports
- Work site monitor reports
- Temporary work suspension
- Periodic reviews with Board Evaluation Committees or Board Diversion Evaluation Committees

Within five days of completing the intake interview, an Administrative Assistant mails the applicant an application packet. The applicant has 10 days from the intake to complete and return the application.

Within 10 days after completing the intake interview, the CM schedules the applicant to meet with a licensed clinician near their home for a Clinical Assessment. There are 34 Clinical Assessors statewide.

Before the clinical assessment, the applicant completes a self-assessment and takes it to the appointment. The clinician conducts a comprehensive assessment and discusses treatment options with the applicant. The clinician has 30 calendar days to prepare and submit the Clinical Assessment with treatment recommendations to the CCM. However, if the clinician determines there is a safety

concern with an applicant, s/he must notify the CCM within one day and the CCM contacts the applicant for entry into care. Otherwise, upon receipt of the assessment, the CCM notifies the applicant and the applicable Board to schedule the applicant for a Board Review or Diversion Evaluation Committee meeting.

Appendix 2 displays a high level flowchart of initial participant contact, program roles and tasks.

## **Treatment Programs**

Participants discuss outpatient or other treatment options with their Clinical Assessor and CCM. There are literally hundreds of nonmedical alcoholism, drug recovery or treatment facilities licensed and/or certified by the California Department of Health Services (CDHS) covering all 58 counties to choose from.

Program/facility types include, but are not limited to:

- RES and RES-DETOX– 24-hour residential nonmedical alcoholism or drug abuse recovery or treatment facility licensed by the Department of Alcohol and Drug Programs (ADP).
- NON – nonresidential program certified by ADP.
- DETOX – free standing, 24-hour nonmedical detoxification facility licensed by ADP.
- DHS – medical alcohol and drug recovery or treatment facilities licensed by CDHS and certified by ADP. Typically, these are Chemical Dependency Recovery Hospitals.
- DSS – residential facilities licensed by the Department of Social Services and certified by ADP. Typically, these are group homes.

However, the CCM must approve the treatment program the participant selects before s/he can attend. Participants must complete and sign a Consent to Exchange Information for the treatment provider and send it to Maximus.

Maximus cannot require participants to go to any one specific program, a stance influenced by Medicare guidelines that prohibit hospitals from referring to a single provider. Participants must ultimately select from the CDHS list of approved facilities.

## **Program Requirements, Uniform Standards and Distinguishing Elements**

Participants must comply with the following rigorous ongoing requirements incorporated into 16 Uniform Standards implemented in 2011 to successfully complete the program:

- After reading the Diversion Program Handbook, sign and return the signature page to Maximus.
- Call the CCM: weekly at first then monthly after formal acceptance into the program by the appropriate Board PRM or DEC.
- Always notify the CCM of any address or telephone number changes and be reachable.
- Complete a self-assessment, give a copy to the Clinical Assessor and mail the original to Maximus.

- Ensure outpatient or other treatment programs are approved by the CCM.
- Prepare and submit a monthly self-report to Maximus by the 10<sup>th</sup> of the following month.
- Arrange for treatment providers to submit monthly progress reports to Maximus by the 10<sup>th</sup> of the following month.
- Attend appropriate 12-step meetings, obtain one signature per day, and submit the attendance card to Maximus by the 10<sup>th</sup> of the following month.
- Attend the appropriate health or nurse support group and ensure the group facilitator submits a monthly attendance report by the 5<sup>th</sup> of the next month. There are 21 health support groups and 45 nurse support groups statewide.
- Follow individual restrictions on practice, including submitting a Return to Work request, approved by the respective Board.
- Obtain a Maximus-approved worksite monitor before starting work, ensure the monitor files the required consent forms and monthly reports the first three months, then quarterly thereafter with Maximus. There are 436 worksite monitors statewide.
- Participate in the random drug testing program, including registration within five days of the intake interview, check-in daily online or by phone, provide observed specimens at a local collection site, enter post test data online, respond appropriately to test results, and pay for the cost of the test plus collection fee.
- Abide by the unapproved medication list and remains free of mind-altering substances (unless prescribed by a physician for a specific diagnosis and approved by the Board).
- Pay the monthly program fee to Maximus based on applicable Board policy.
- Petition for and be accepted by the applicable Board PRM or DEC into the program's Transition phase, meet the minimum conditions of this phase, complete the Transition Packet and be approved by the CCM, PRM or DEC for successful completion. If approved by the PRM/DEC, the CCM recommends and prepares a successful completion letter within 10 days of the PRM/DEC meeting.

In 2011, Senate Bill 1441 (Ridley-Thomas) established in the Department of Consumer Affairs the Substance Abuse Coordination Committee. This committee was comprised of the 20 Executive Officers of the Department's healing arts licensing boards and a designee of the State Department of Alcohol Drug Programs. The committee no longer exists. The bill required the committee to formulate uniform standards in specified areas that each healing arts board would be required to use in dealing with substance-abusing licensees. The following briefly summarizes the 16 Uniform Standards the committee formulated and implemented in April 2011. There must be:

1. Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.
2. Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in subdivision (a) and any treatment recommended by the evaluator described in subdivision (a) and approved by the board, and specific

criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

3. Specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status or condition.
4. Standards governing all aspects of required testing, including, but not limited to, frequency of testing, noticing the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.
5. Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.
6. Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.
7. Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.
8. Procedures to be followed when a licensee tests positive for a banned substance.
9. Procedures to be followed when a licensee is confirmed to have ingested a banned substance.
10. Specific consequences for major and minor violations. In particular, the committee shall consider the use of a "deferred prosecution" stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency until or unless licensee commits a major violation, in which case it is revived and license is surrendered.
11. Criteria a licensee must meet in order to petition for return to practice on a full time basis.
12. Criteria a licensee must meet in order to petition for reinstatement of a full and unrestricted license.
13. If a Board uses a private-sector vendor that provides diversion services, there must be (1) standards for immediate reporting by the vendor to the board of any and all noncompliance with process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; (2) standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and (3) standards for a licensee's termination from the program and referral to enforcement.
14. If a Board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.
15. If a Board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor's performance in adhering to the standards adopted by the committee
16. Measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

The following discusses other essential and distinguishing program elements concerning random drug testing, health and nurse support groups, and worksite monitors.

## **Random Drug Testing**

According to the American Society of Addiction Medicine (ASAM)<sup>3</sup>, the nation's largest organization of physicians specializing in the prevention and treatment of addiction, drug testing is a primary prevention, diagnostic, and monitoring tool used to identify the presence or absence of drugs of abuse or therapeutic agents related to addiction management in multiple settings.

The ASAM encourages wider and “smarter” use of drug testing within the practice of medicine and broadly within American society. Smarter drug testing means:

- Increased use of random testing rather than scheduled testing;
- Testing not only urine but also other substances such as blood, oral fluid (saliva), hair, nails, sweat and breath; and
- Testing based upon clinical indication for a broad and rotating panel of drugs rather than only testing for the traditional five-drug panel designed by the federal government for government-mandated testing such as that required of commercial drivers.
- Improved sample collection and detection technologies to decrease sample adulteration and substitution, including designing appropriate steps to respond to the efforts of individuals trying to subvert the testing process.
- Giving careful consideration of the financial costs of testing in relationship to the value and in many cases, medical necessity, of the test results. It means considering the advantages and limitations of the many testing technologies available today.

Maximus has contracted with First Hospital Laboratories, Inc. (FirstLab), a third party laboratory administrator, to provide qualitative urine substance abuse testing for each program participant. In turn, FirstLab has subcontracted the laboratory services to DrugScan, a laboratory certified by the US Department of Health and Human Services (DHHS), and to almost 700 program collection sites in California.

## **Health and Nurse Support Groups**

Depending on the participant’s license, each participant is required to attend either a weekly Health Support Group (HSG) or a Nurse Support Group (NSG). According to the contract, HSGs are facilitated by a California licensed registered nurse, marriage family therapist, licensed clinical social worker, psychologist or psychiatrist who has a minimum of three years of experience providing chemical dependency and mental health treatment for health care professionals. The NSGs are facilitated by a California licensed registered nurse with similar experience. HSG’s typically charge more than NSG’s because they are usually led by a licensed clinician.

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<sup>3</sup> Drug Testing: A Whitepaper of the American Society of Addiction Medicine, October 26, 2013

The audit scope of work included observing several HSG and NSG meetings. However, due to participant confidentiality concerns, CPS was unable to observe these meetings but understands the process involves, and is not limited to:

- Facilitating or co-facilitating a weekly hourly group meeting with program participants. Keeps the group focused on the day-to-day professional issues and recovery process and applies interpersonal interaction group process while giving priority to recovery.
- Observing and reporting to Maximus staff any behavior, attitude, demeanor or appearance which may suggest a relapse within twenty-four (24) hours of the observation.
- Recording and reporting weekly attendance to Maximus staff by the 5th of every month. If the participant does not show, or if the excused absence is unreasonable, the facilitator must report to Maximus staff within twenty-four (24) hours.
- Reporting relapses to Maximus staff within twenty-four (24) hours.
- Being accessible to participants twenty-four (24) hours a day for crisis intervention or referral.
- Provides input and recommendations at any time to Maximus staff regarding a participant's recovery.

## **Worksite Monitors**

Worksite monitors (WSMs) assist licensed health professionals return to work in a controlled and safe manner. According to the contract, WSMs observe participants at least once a week or up to a maximum of 100%, verify participant attendance, review work performance, monitor/detect substance abuse, submit monthly worksite monitor reports to Maximus, and report any non-compliant work-related issues or changes in behavior and signs of relapse. The worksite monitoring percentage can be reduced to zero in the transition phase.

WSMs must have knowledge of the provisions or requirements of the applicant/participant's recovery contract and be approved by the Diversion Program's CCM, Board's DPM and/or DEC. WSMs maintain continual communication with the assigned CCM. They are required to notify Maximus within one hour of noticing any signs of relapse or suspicious behavior and submit a written report within 48 hours of the occurrence. In addition, WSMs submit a written monthly or quarterly reports to Maximus by the 10<sup>th</sup> of the following month.

## **Participant Review Process**

Depending on the Board, the initial and recurring participant review process varies. For example, the BRN, DBC, OMB and VMB use a Diversion Evaluation Committee (DEC) meeting to evaluate initial applicants for program entry, approve Recovery Agreements, review participant progress, make Agreement revisions, and approve program discharges for recurring participants. DEC's are unique because they also review participants in person. The DEC composition is mandated by law and is typically composed of three to four Board-appointed members who are licensed by the same Board as the participant, a physician and a public member. The CCM and a Board representative also attend

the meetings. The BRN (has 14 DEC's located throughout the state), DBC and OMB DEC meetings are held quarterly. The VMB DEC meets every four months.

The BOP, PAB and PTBC use Board Participant Review Meetings (PRM) instead of DEC's to review applicants for entry and on a routine recurring basis, but do not meet with participants in person. Typically, a Board representative meets with the CCM to review participant progress, revise the Recovery Agreements and approve program discharges. BOP meetings are held monthly, PTBC meetings are held quarterly, and PTBC meetings are held semi-annually.

In between the various Board meetings and until program completion, six teams of paired CM's and CCM's monitor ongoing participant compliance with the program requirements and specific Board uniform standards to ensure timely, successful completion. The CM/CCM teams will actively monitor for compliance all of the above tasks included in the initial and revised Recovery Agreements in accordance with each Board's uniform standards. Participants must sign and return the Recovery Agreements within 10 days of receipt. The CM monitors each participant daily and submits noncompliance issues to the CCM and the PRM/DEC within five days of discovery. When teams identify non-compliance, they contact participants by phone or email then mail them non-compliance letters within five days. Participants must respond timely to the compliance letters or be subject to program termination.

Appendix 3 displays a high level flowchart of the recurring participant and program responsibilities and tasks.

### **Program Billing and Reporting**

Maximus bills and accounts for the Board and participant administrative co-pay fees on a monthly basis. Boards are billed individually based on their own specific requirements in arrears \$338.15 per participant a month by the 10<sup>th</sup> day of the following month. This expense increases by three percent (3%) annually on January 1. Maximus provides each Board Diversion Program Manager (DPM) with a monthly report of all administrative fees collected from participants, an aged receivable report, and a monthly audit schedule.

Table 3 shows depending on the respective Board requirements, Maximus bills participants varying administrative co-pay amounts by the 20<sup>th</sup> of the current month ranging from \$25 to \$338.15 a month or from \$1,000 to \$2,000 for a one-time fee that may be paid in quarterly installments. Participants may pay by check, cashier's check, credit card, money order or ATM debit with no service charges. Participants are charged fees for non-sufficient funds. Maximus credits the collected participant fees against the fee balance paid by each Board the following month.

**Table 3: Participant Administrative Co-Pay Fees**

Board	Participant Co-Pay	Frequency	Comments
BOP	\$100.00	Monthly	
BRN	\$25.00	Monthly	
DBC (+ Hygiene)	\$100.00	Monthly	
PTBC	\$338.15	Monthly	Increases 3% annually on Jan. 1
PAB (Board referral)	\$338.15	Monthly	Increases 3% annually on Jan. 1
PAB (Self referral)*	\$253.61	Monthly	Increases 3% annually on Jan. 1
OMB**	\$1,600.00	1-Time	Can be paid in qtrly installments
VMB	\$2,000.00	1-Time	Can be paid in qtrly installments
Source: Maximus			
* A regulatory change in 2011 provided a 25% reward for participant self-referral to the program.			
** Plans to make participants pay the full program fee of \$338.15.			

FirstLab bills each participant directly for each drug test performed. Participants are responsible for paying the collection site specimen collection and drug testing fees at the time service is rendered. These fees can range up to \$125.

## Audit Results

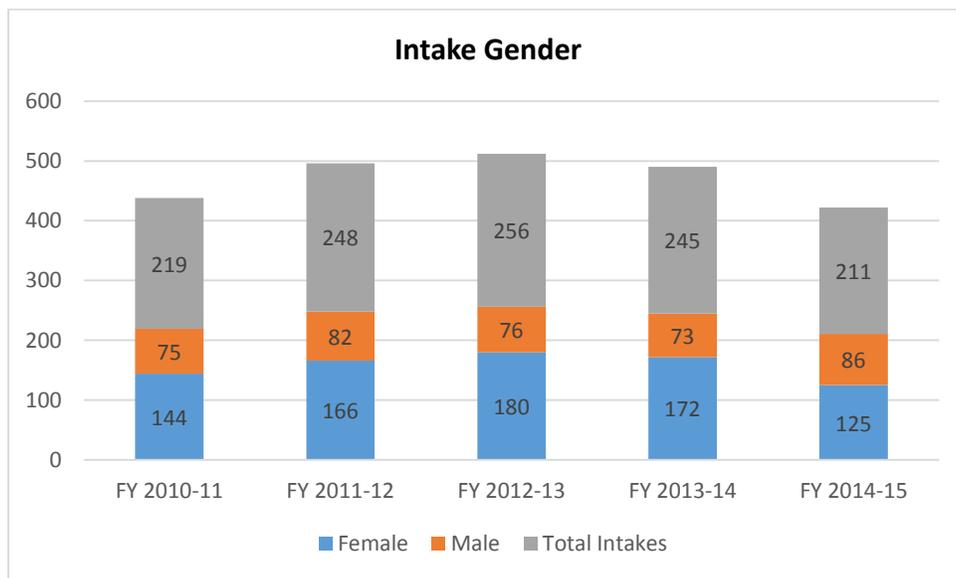
This section of the report presents audit observations, findings and recommendations for improvement based on interviews and information gathered and analyzed from: Maximus Program and Shared Services staff; Board Diversion Program Managers; Treatment Providers (Client Assessors, Health and Nurse Support Group facilitators and Worksite Monitors); drug testing subcontractor FirstLab; and licensee participant and drug test files.

The following presents historical program statistics, trends and costs; Diversion Program staffing, roles and tasks; Shared Services roles and responsibilities; Diversion Program Manager survey results; Treatment Provider survey and credential file audit results; results of participant file and drug test file audits; Program effectiveness reporting and planned technical improvements.

### Program Statistics, Trends and Costs

Based on the Maximus California Diversion Program Annual Reports for FY 2010-11 through 2014-15 (six months beyond the scope of this audit), there were 1,179 intakes (top of stack) into the program. Approximately 66.8% (787) were female (bottom of stack) and 33.2% (392) were male (middle of stack). Figure 2 graphically displays the program intakes by gender and reveals intakes began dropping after FY 2012-13. The program experienced its lowest overall intake level in FY 2014-15 with a significant drop in female intakes.

Figure 2

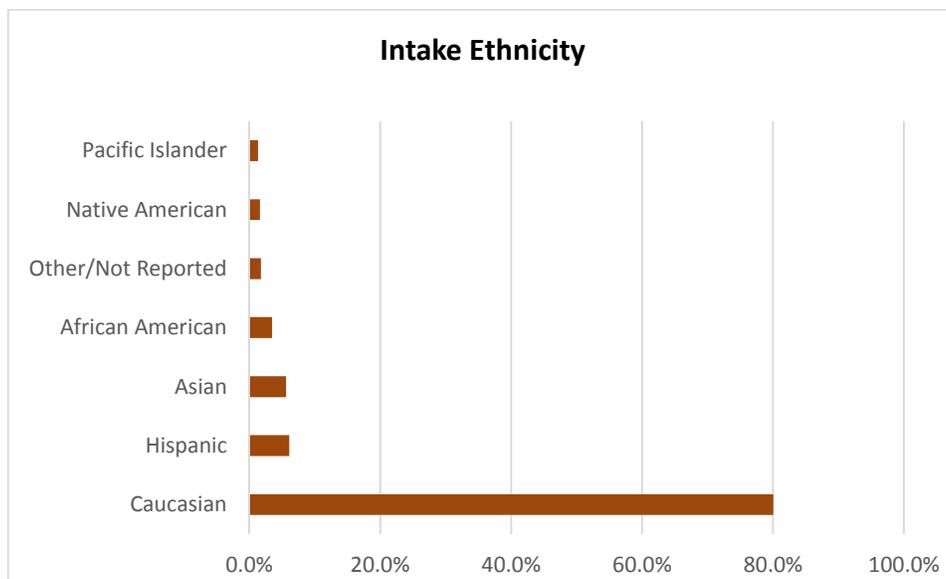


Source: Diversion Program Annual Reports

The average program intake for the five fiscal years by the following ethnicities is shown in Figure 3:

- Pacific Islander (average 1.4%)
- Native American (1.6%)
- Other/Not Reported (1.8%)
- African-American (3.5%)
- Asian (5.6%)
- Hispanic (6.1%)
- Caucasian (80.1%)

Figure 3



Source: Diversion Program Annual Reports

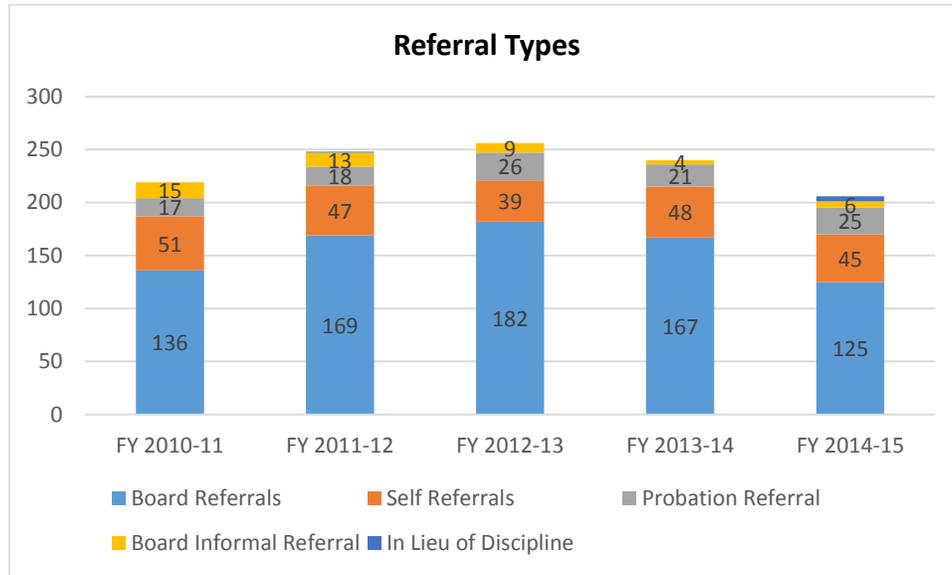
A particularly interesting trend has been the increase in the average age of program participants. In FY 2010-11, the average age range was from 30-34 years old. In FY 2014-15, the average age range increased to 45-49 years old. This is primarily due to the fact most of the program participants are registered nurses who are aging. According to the National Council of State Boards of Nursing, the average age of a nurse is 50 years old and 53% are over the age of 50.

Over the past five fiscal years, program entry has been through the following types of referrals. The leading referral types are Board, self and Probation referrals:

- Board referrals (66.6%)
- Self-referrals (19.7%)
- Probation referrals (9.2%)
- Board informal referrals (4.0%)
- In lieu of discipline referrals (0.5%)

Figure 4 displays the breakdown of referral types over the five fiscal years.

Figure 4



Source: Diversion Program Annual Reports

The Program Annual Reports also present information on 15 program closure types and relapses by eight different substances for the audit period. Table 4 reveals slightly over 50% of participants successfully completed the program, while the rest were terminated for a wide variety of reasons. A closure type that should be considered and is conspicuously absent is financial hardship.

Table 4: Closure Types

	Closure Type	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	Totals	% Total
1	Successful Completion	104	127	144	122	497	50.1%
2	Terminated-Public Risk	32	32	19	23	106	10.7%
3	Applicant Withdrawn-Pre DEC	22	34	21	29	106	10.7%
4	Terminated-Non Compliant	22	14	12	12	60	6.0%
5	Applicant Public Risk	14	20	11	13	58	5.8%
6	Withdrawn-Post DEC	10	20	13	13	56	5.6%
7	Clinically Inappropriate-Pre DEC	6	6	12	14	38	3.8%
8	Terminated-Failure to Derive Benefit	7	9	2	2	20	2.0%
9	Applicant Not Accepted by DEC	4	6	5	3	18	1.8%
10	No Longer Eligible-Post-DEC	3	3	4	3	13	1.3%
11	Clinically Inappropriate-Post DEC	2	2	1	4	9	0.9%
12	No Longer Eligible Pre-DEC	2	1	2	0	5	0.5%
13	Expired	1	1	0	2	4	0.4%
14	Terminated – Moved	0	1	1	0	2	0.2%
15	Sent to Board- Post DEC	0	0	0	0	0	0.0%
	<b>Total Number of Closures</b>	<b>230</b>	<b>276</b>	<b>247</b>	<b>240</b>	<b>993</b>	<b>100.0%</b>

Source: Diversion Program Annual Reports

Table 5 shows over the audit term the number of program participants decreased, but the relapse rate improved over time, with an average relapse rate of 10.6% per fiscal year.

**Table 5: Program Participants and Relapse Rates over the Audit Term**

Program Indicators	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	Avg.
Program participants (high)	682.0	650.0	645.0	652.0	650.0	655.8
Program participants (low)	667.0	632.0	630.0	625.0	571.0	625.0
Program participants (avg)	674.5	640.3	635.8	630.3	611.8	638.5
Total relapses	81.0	76.0	68.0	68.0	47.0	68.0
Relapse rate based on participant avg	12.0%	11.9%	10.7%	10.8%	7.7%	10.6%

Source: Diversion Program Annual Reports

According to a 2012 research guide prepared by the National Institute on Drug Abuse,<sup>4</sup> the disease of substance abuse disorders is estimated at 10 to 14% of the general population and has a relapse rate similar to other chronic diseases. For example, the relapse rate for drug addiction is 40% to 60% versus 30% to 50% for type I diabetes, and 50% to 70% for hypertension and asthma. As table 5 reveals, the DCA Diversion Program average relapse rate is almost four times better than the expected relapse rate of the general public.

Table 6 indicates most relapses reflect the use of alcohol, narcotics and other opiates, and benzodiazepine (drugs primarily used for treating anxiety).

**Table 6: Relapses by Substance**

Relapses by Substance	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	Avg*
Alcohol	29.8%	26.0%	47.0%	31.0%	38.3%	34.4%
Narcotics and other opiates (hydrocodone)	30.6%	26.0%	22.0%	28.0%	25.5%	26.4%
Benzodiazepine	6.0%	9.0%	15.0%	10.0%	19.1%	11.8%
Other	9.5%	12.0%	7.0%	7.0%	2.1%	7.5%
Tramadol	10.5%	2.0%	7.0%	5.0%	12.7%	7.4%
Amphetamines	1.0%	7.0%	3.0%	7.0%	2.1%	4.0%
Marijuana	1.5%	2.0%	4.0%	6.0%	2.1%	3.1%
Cocaine	0.8%	4.0%	4.0%	1.0%	0.0%	2.0%

\* Total do not equal 100% but provides a reasonable indication of the most abused substances

Source: Diversion Program Annual Reports

In summary, most program participants are Caucasian females that enter the program through Board referrals. Approximately half successfully complete the program and most of the relapses involve the use of alcohol, narcotics and other opiates, and benzodiazepine.

<sup>4</sup> Principles of Drug Addiction Treatment: A Research-Based Guide, National Institute on Drug Abuse, December 2012

## Board Participation

It is interesting to note that only eight of the 20 DCA healing arts licensing Boards are included in the program. Notable exceptions with large licensee populations include the Medical Board of California (medical doctors) and Board of Vocational Nursing and Psychiatric Technicians (LVNs and PTs).

In addition, BRN probationers are not included in the Diversion Program as a condition of probation like some other Boards. As of December 2015, BRN had 425 program participants and approximately 1,420 probationers, including 1,125 active and 305 in tolled status which are out of state and require minimum monitoring. It can be reasonably assumed a percentage of the probationers probably suffer from substance abuse or mental issues and do not receive the medical attention the program participants receive. Like other Boards, BRN probationers would probably benefit if they were included in the Diversion Program.

## Recommendations

1. If applicable and warranted, other DCA healing arts Boards should consider participating in the Diversion Program, and in particular, the Medical Board of California and Board of Vocational Nursing and Psychiatric Technicians.
2. The BRN should consider making probationers attend the Diversion Program as a condition of probation.

## Program Costs

Table 7 presents a representative breakdown of the participant monthly cost elements and total program costs by Board for the full five year term. Costs are not exact because every participant is treated based on their individual needs.

Costs vary by Board and, in general, non-nursing Board participants pay substantially more than BRN participants. For example, in Year 1 the range of costs for a BRN participant ranges from \$5,980 to \$27,620, while the low cost for other Board participants start at \$8,800 to \$11,658 and range up to \$31,800 to \$46,400. The total estimated five-year cost for BRN participants ranges from \$18,700 to \$60,900, while the costs for other Board participants range from a low of \$30,400 to a potential high of \$104,289.

Table 7 indicates the primary cost differences between Boards are the participant co-pay fees and the monthly support group fees. The BRN subsidizes most of the participant co-pay fee while the other Boards do not subsidize any portion, or subsidize a smaller portion of the total fee. In addition, the Nurse Support Groups are facilitated by a nurse while the Health Support Groups are facilitated by a licensed therapist, which typically costs significantly more.

**Table 7: Participant Cost Differential by Board for 5 Years**

Year	BRN		BOP		DBC		PTBC		PAB		OMB		VMB	
	Low	High	Low	High	Low	High								
<b>Year 1</b>														
3-day clinical assessment*	\$0	\$0	\$0	\$15,000	\$0	\$15,000	\$0	\$0	\$0	\$15,000	\$0	\$0	\$0	\$0
Participant co-pay fee varies from \$25/mo and up**	\$300	\$300	\$1,200	\$1,200	\$1,200	\$1,200	\$4,058	\$4,058	\$4,058	\$4,058	\$1,600	\$1,600	\$2,000	\$2,000
Drug testing: 52-104 times @ \$100 per	\$5,200	\$10,400	\$5,200	\$10,400	\$5,200	\$10,400	\$5,200	\$10,400	\$5,200	\$10,400	\$5,200	\$10,400	\$5,200	\$10,400
Nurse Support Group @ from \$40 to \$160/mo	\$480	\$1,920	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Health Support Group 1x-2x/wk@ \$200-\$400/mo	\$0	\$0	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800
Treatment cost: \$0 - \$15,000	\$0	\$15,000	\$0	\$15,000	\$0	\$15,000	\$0	\$15,000	\$0	\$15,000	\$0	\$15,000	\$0	\$15,000
<b>Estimated Year 1 Costs</b>	<b>\$5,980</b>	<b>\$27,620</b>	<b>\$8,800</b>	<b>\$46,400</b>	<b>\$8,800</b>	<b>\$46,400</b>	<b>\$11,658</b>	<b>\$34,258</b>	<b>\$11,658</b>	<b>\$49,258</b>	<b>\$9,200</b>	<b>\$31,800</b>	<b>\$9,600</b>	<b>\$32,200</b>
<b>Year 2</b>														
Participant co-pay fee varies from \$25/mo and up**	\$300	\$300	\$1,200	\$1,200	\$1,200	\$1,200	\$4,058	\$4,058	\$4,058	\$4,058	\$1,600	\$1,600	\$0	\$0
Drug testing: 24-36 times @ \$100 per***	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600
Nurse Support Group @ from \$40 to \$160/mo	\$480	\$1,920	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Health Support Group 1x-2x/wk@ \$200-\$400/mo	\$0	\$0	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800
Treatment cost: \$0 - \$5,000	\$0	\$5,000	\$0	\$5,000	\$0	\$5,000	\$0	\$5,000	\$0	\$5,000	\$0	\$5,000	\$0	\$5,000
<b>Estimated Year 2 Costs</b>	<b>\$3,180</b>	<b>\$10,820</b>	<b>\$6,000</b>	<b>\$14,600</b>	<b>\$6,000</b>	<b>\$14,600</b>	<b>\$8,858</b>	<b>\$17,458</b>	<b>\$8,858</b>	<b>\$17,458</b>	<b>\$6,400</b>	<b>\$15,000</b>	<b>\$4,800</b>	<b>\$13,400</b>
<b>Year 3</b>														
Participant co-pay fee varies from \$25/mo and up**	\$300	\$300	\$1,200	\$1,200	\$1,200	\$1,200	\$4,058	\$4,058	\$4,058	\$4,058	\$1,600	\$1,600	\$0	\$0
Drug testing: 24-36 times @ \$100 per***	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600
Nurse Support Group @ from \$40 to \$160/mo	\$480	\$1,920	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Health Support Group 1x-2x/wk@ \$200-\$400/mo	\$0	\$0	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800
Treatment cost: \$0 - \$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000
<b>Estimated Year 3 Costs</b>	<b>\$3,180</b>	<b>\$7,820</b>	<b>\$6,000</b>	<b>\$11,600</b>	<b>\$6,000</b>	<b>\$11,600</b>	<b>\$8,858</b>	<b>\$14,458</b>	<b>\$8,858</b>	<b>\$14,458</b>	<b>\$6,400</b>	<b>\$12,000</b>	<b>\$4,800</b>	<b>\$10,400</b>
<b>Year 4</b>														
Participant co-pay fee varies from \$25/mo and up**	\$300	\$300	\$1,200	\$1,200	\$1,200	\$1,200	\$4,058	\$4,058	\$4,058	\$4,058	\$1,600	\$1,600	\$0	\$0
Drug testing: 24-36 times @ \$100 per***	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600
Nurse Support Group @ from \$40 to \$160/mo	\$480	\$1,920	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Health Support Group 1x-2x/wk@ \$200-\$400/mo	\$0	\$0	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800	\$2,400	\$4,800
Treatment cost: \$0 - \$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000
<b>Estimated Year 4 Costs</b>	<b>\$3,180</b>	<b>\$7,820</b>	<b>\$6,000</b>	<b>\$11,600</b>	<b>\$6,000</b>	<b>\$11,600</b>	<b>\$8,858</b>	<b>\$14,458</b>	<b>\$8,858</b>	<b>\$14,458</b>	<b>\$6,400</b>	<b>\$12,000</b>	<b>\$4,800</b>	<b>\$10,400</b>
<b>Year 5</b>														
Participant co-pay fee varies from \$25/mo and up**	\$300	\$300	\$1,200	\$1,200	\$1,200	\$1,200	\$4,058	\$4,058	\$4,058	\$4,058	\$1,600	\$1,600	\$0	\$0
Drug testing: 24-36 times @ \$100 per***	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600	\$2,400	\$3,600
Nurse Support Group @ from \$40 to \$160/mo	\$480	\$1,920	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Health Support Group (Transition not required)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Treatment cost: \$0 - \$1,000	\$0	\$1,000	\$0	\$1,000	\$0	\$1,000	\$0	\$1,000	\$0	\$1,000	\$0	\$1,000	\$0	\$1,000
<b>Estimated Year 5 Costs</b>	<b>\$3,180</b>	<b>\$6,820</b>	<b>\$3,600</b>	<b>\$5,800</b>	<b>\$3,600</b>	<b>\$5,800</b>	<b>\$6,458</b>	<b>\$8,658</b>	<b>\$6,458</b>	<b>\$8,658</b>	<b>\$4,000</b>	<b>\$6,200</b>	<b>\$2,400</b>	<b>\$4,600</b>
<b>5 Year Total Estimated Costs</b>	<b>\$18,700</b>	<b>\$60,900</b>	<b>\$30,400</b>	<b>\$90,000</b>	<b>\$30,400</b>	<b>\$90,000</b>	<b>\$44,689</b>	<b>\$89,289</b>	<b>\$44,689</b>	<b>\$104,289</b>	<b>\$32,400</b>	<b>\$77,000</b>	<b>\$26,400</b>	<b>\$71,000</b>

\*3-day clinical assessments are only required when a more comprehensive evaluation is needed.

\*\*See Board Participant administrative co-pay fees (Table 3).

\*\*\*12 times per year for mental health diagnosis otherwise 36-104 times per year; 24 times per year for non-working only.

Treatment cost is only required if a participant requires treatment, and mostly at the initial program enrollment or if a participant relapses while in the program.

Table 7 shows the Diversion Program may be cost prohibitive for some, and especially for non-nursing participants. Without insurance or financing, Board subsidies or waivers, it may be financially impossible for some to participate in the program. With some Boards, such as the BOP and PAB, the fee may be waived, reduced or deferred by the DPM if the participant demonstrates financial hardship. Under certain conditions, it would be in the best interest of participants if other Boards consider granting such waivers.

### **Insurance Benefits for Substance Abuse and Mental Health Coverage**

Effective January 1, 2014, the federal Affordable Care Act (ACA) expanded coverage for treatment of substance abuse addictions. Insurance plans are governed by the federal Mental Health Parity and Addiction Equity Act of 2008. In California, the coverage includes both inpatient (residential) and outpatient (day-treatment, individual and group counseling) services.

Those on Medi-Cal that make less than \$16,000 per year are also eligible under the ACA. Under Medi-Cal there is a separately funded program for substance abuse known as DMC, or Drug Medi-Cal, which offers inpatient detox, residential treatment, methadone maintenance, and outpatient counseling. At the state level, the Department of Health Care Services (DHCS) administers the DMC and certifies treatment providers. There are over 1,400 DMC-certified treatment facilities statewide. At the local level, county alcohol and drug programs (Adult System of Care) determine applicant eligibility and are reimbursed by DHCS for the cost of those activities.

The website for the US Centers for Medicare and Medicaid Services (CMMS) (<https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/>) indicates all health plans in the health insurance marketplace must cover substance abuse disorder and mental health services, including behavioral health treatment such as counseling and psychotherapy, prescription drugs and laboratory services. Furthermore, marketplace plans cannot deny coverage or charge more for a pre-existing condition. Moreover, marketplace plans cannot put yearly or lifetime dollar limits on coverage of any essential health benefit, including substance abuse disorder and mental health services.

A review of the Covered California website (<http://www.coveredca.com>) shows there are 12 health insurance companies that are required to provide coverage in compliance with the ACA. A telephone survey of the six largest companies reveals that all provide ACA coverage for substance abuse disorder and mental health treatment. However, under Laboratory Services, the following conditions typically apply to having the cost of random drug testing covered:

- The participant must be a patient of a specific health insurance company/provider that provides such coverage, and
- A physician of the health insurance provider must order a claimable service, and
- The physician must be able to monitor the participant's performance.

The auditors found that all sales agents were not equally knowledgeable about these benefits. Therefore, it behooves program participants to be persistent about getting their questions about Laboratory services covered answered correctly.

### **Recommendations**

3. Maximus should identify a program staff member whose sole responsibility is to become knowledgeable about health insurance coverage benefits and referral sources, and periodically update the Clinical Case Managers and Compliance Monitors.
4. Program participants should assume personal responsibility to contact and research coverage options and costs with the health insurance companies listed on the Covered California website.

### **Diversion Program Staffing, Roles and Tasks**

Based on a review of job descriptions, interviews and observations, CPS confirmed the accuracy of the following Diversion program staff roles and tasks and the six Western Division Shared Services organizations supporting the program

The **Project Manager**, a licensed registered nurse and former hospital administrator, holds a MBA with significant related experience. She is responsible for, but not limited to:

- Ensuring MAXIMUS complies with all applicable contractual requirements, state, and federal regulations.
- Coordinates development of project performance goals, objectives, policies and procedures, and monitors achievements.
- Supervises Clinical Case Managers to ensure requirements are met or exceeded.
- Oversees the Diversion quality assurance program.
- Maintains relationships with the Department of Consumer Affairs (DCA) and the seven Health Professional Boards and Committees
- Maintains effective communications with Clinician Assessors, laboratory subcontractors, and health and nurse support group facilitators.
- Attends, presents and/or chairs meetings and educational programs including, but not limited to: the Diversion Evaluation Committee (DEC) and review committee, the Diversion Liaison Committee, the Diversion Discipline Committee, Board meetings, Quality Improvement Committee, orientations, conferences, and presentations.
- Approves time cards, work plans and schedules, deliverables, contracts, correspondence, billings and invoices, and evaluates staff.
- Performs other corporate responsibilities as required.

The **Operations Manager**, a former Compliance Monitor with substantial program experience, is responsible for day-to-day operations, which include, but are not limited to:

- Assists the Project Manager and ensures the availability of all staff, resources, and Diversion services, are effectively and efficiently delivered throughout California.
- Supervises Administrative Assistants, Compliance Monitors, Quality Assurance, Administrative Assistants and the Medical Records Coordinator.
- Maintains relationships with the Department of Consumer Affairs (DCA) and the seven Health Professional Boards and Committee.
- Maintains effective communications with Clinician Assessors, laboratory subcontractors, and health and nurse support group facilitators.
- In the absence of the Project Manager, attends, presents and/or chairs meetings and educational programs, approves deliverables and signs correspondence.
- Conducts Quality Assurance Testing on the Maximus Case Management System (CMS).
- Updates Diversion Program policies and procedures and provides training as needed.
- Prepares Monthly Status Report, Quarterly Report and Annual Diversion Program Report, and conducts research for special studies.
- Performs other program and corporate responsibilities as required.

The **Clinical Case Managers** (CCMs) are licensed registered nurses with at least three years of experience working in the treatment of substance abuse and/or mental illness. Their educational backgrounds include addiction, psychology and chemical dependency. Until December 2015, they were short-handed one position. CCMs are paired with Compliance Monitors who jointly serve a geographic and Board-specific caseload of up to 130 participants and are responsible for, but not limited to:

- Through continuous communication by phone, mail and email, CCMs manage applicants/participants through intake into the program, clinical assessment, overseeing preparation of initial program entry and recurring recovery agreements, continually monitoring recovery activities and treatment recommendations, and liaising with Boards to ensure overall program compliance and completion success.
- Conduct remote, telephonic assessment and reassessments of impaired licensees to evaluate their overall compliance with program requirements and progress in recovery. Using a standardized template, CCM's conduct a thorough applicant intake telephone interview. In their first contact it is important to set the stage right from the beginning. Participants are generally upset and don't always retain the information given to them the first time. It takes a lot of reinforcement, support and encouragement. After the intake interview, it requires ongoing communications and scheduling of appointments.
- Respond to incoming calls on the toll-free line, as needed, and after-hour, weekend, and holiday calls on a rotating basis with other Diversion Program staff. CCMs are on call

for a week at a time about every 5-6 weeks from Monday to Monday. Most calls are related to lab issues, ER visits or medications.

- Meet with applicant/participant telephonically weekly until seen by the Diversion Evaluation Committee (DEC), and monthly thereafter, to review compliance and progress in recovery. CCMs verbalize the importance of keeping up with all the non-compliant issues daily and the necessity of reviewing all reports daily. In addition, it is necessary to communicate daily with their Compliance Monitor and with the DEC/Diversion Program Manager (DPM) when indicated. All CCMs agree that aside from leaving voice messages and playing phone tag, their biggest obstacle is not having personal interaction face-to-face with a new participant.
- Evaluate incoming information submitted by treatment providers, facilities, participants, and labs to monitor participant's progress and compliance with recovery agreements.
- Ongoing communications with the participant, the appropriate Board/Committee (or their designee) or treatment providers, facilities and labs in response to participant non-compliance with their recovery agreement.
- Enter information into the Maximus CMS (Max-CMS). Compiles, produces, reviews and ensures timely distribution of the History and Profile (H&P) reports before submitting to the DPMs. There is an abundance of paper work compiled several weeks ahead of time. All of the CCM's and CM's are looking forward to the Boards having access to all information on-line so there won't be a need to compile massive paper packets.
- Review Monthly Compliance/Non-Compliance reports and letters, as well as other reports and correspondence, as required. The CCMs' agree it is an ongoing daily process and that the upgraded Max-CMS will be a time saver since all the information will be within one tracking system.
- Produce other reports and letters as requested, including the "Letter of Successful Completion."
- Serve as liaison for assigned Board/Committee and their designee (DPM), DEC Case Consultant, DEC Chair and provide clinical case input.
- Perform other program and corporate responsibilities as required.

The **Compliance Monitors** (CMs) are college-educated with three-to-five years of experience in a behavioral health care setting related to chemical dependency, recovery, and/or mental illness. Their educational backgrounds include biology, chemistry, psychology and pharmacy. They constantly communicate with their paired CCM and are responsible for, but not limited to:

- Respond to incoming calls from participants regarding their program participation, applicants regarding entry into the program, and licensees regarding general program information. Contact participants for additional relevant information.

- The CM's mail the new applicant's package of information within five days of the initial intake and from there the process begins. After the CCM completes the telephone intake and schedules the clinical assessment and first DEC meeting, the CM's begin daily tracking. The CM's all rely on the Maximus daily tracking system that tracks the timelines of due dates of all items to be sent or to be received and lab correspondence. In addition, all mailed and faxed documents are scanned into the record immediately. As a result, the CCMs and CMs are able to access the Case Logs to review up-to-date documentation.
- Prepare initial entry agreements and recurring recovery agreements based on participant case history and forward to the CCM for review and approval.
- Collect and analyze incoming data and reports from participants, treatment providers, labs, and other team members to determine the participant's level of compliance and enter necessary information into the Max-CMS. The CM's check all documents received to ensure they are timely and complete. If items are missing, late, or incomplete, the CM informs the CCM and the issues is entered onto the case log. They also check to see if there are any missed calls into the lab or if there are late fees, etc. They call the participants to inform them of potential violations as related to their agreement. If participants are non-compliant, the CM's reports the non-compliance to the CCM to determine the compliance level. The CM writes a non-compliance letter and the Administrative Assistant mails the documents to the participants and to the Boards. The CMs then enter the findings into the case log and notify the participants. The CM's manage the paper work and CCM's manage the participant's systematic recovery process.
- Make follow-up calls to respond to non-compliance data from providers.
- CMs produce monthly compliance/non-compliance reports and letters based on analysis of information received from participants, treatment providers and the laboratory. The Recovery Contracts are updated at each DEC or Board meeting and more often if needed. The update information is written into the DEC/ Committee minutes by the CCM's. The CM's revise the Recovery Agreement based on the DEC/Committee recommendations. Information is entered into the template and reviewed with CCM's before forwarding the revised contract to administrative assistant for mailing to the participants and the Board.
- Compile, produce, and timely distribute the H&P reports to CCM, Client DPMs, and DEC members.
- Perform other program and corporate responsibilities as required.

The **Administrative Assistants** and **Medical Records Coordinator** possess at least an Associate's degree with at least two years of experience in behavioral health care, call center and/or crisis intervention. They are responsible for, but not limited to:

- Respond to incoming calls from licensees, Boards/Committee and their designee,

applicants/participants and other inquiries. Apply standardized protocol to identify cases requiring immediate crisis or clinical intervention.

- Process incoming faxes and incoming U.S. mail.
- Provide necessary administrative support, including handling correspondence.
- Perform limited direct participant services under supervision.
- Manage and file documents and correspondence received from and sent to participants.
- Maintain participant records in hard copy file format, scan and index documents.
- Prepare H&Ps for mailing.
- Maintain and prepare orders for office supplies for department.
- Perform other program and corporate responsibilities as required.

In summary, the Project Manager reports all assigned work is getting completed but due to a CCM vacancy, CCM/CM workload has increased and will until the position is filled (the position was filled in mid-December 2015). The Project Manager emphasized how critical the CCM/CM teamwork is to program success.

## **Shared Services Roles and Responsibilities**

Based on interviews and documentation reviews, CPS confirmed Diversion Program staff are supported effectively and efficiently by the following Maximus Western Services Division departments displayed in the Figure 1 organization chart. The Project Manager recognizes the cost effective benefits of having full-time departments support this small program which would otherwise be unaffordable. The following briefly discusses the services each department provides, staffing levels, and information CPS reviewed.

### **Quality Assurance/Training Department**

The Quality Assurance/Training Department has a central role in ensuring project operations, quality assurance and training adhere to ISO 9001:2008 standards, resulting in program success. There are 14 Quality Analysts in this department, including one QA Analyst dedicated to the Diversion Program. The QA responsibilities cover eight Maximus programs, including the Diversion Program.

The Maximus Quality Manual, Quality Assurance Plan (QAP) and other written procedures provide the integrated framework and detailed work instructions to ensure contract provisions and quality standards are met, information is reported, corrective and preventive actions are taken, and the process is continually improved. The QA function has its own system (ITG) for identifying, tracking, correcting and reporting on QA problems. The QAP is reviewed and updated annually.

According to the Quality Assurance Plan, ISO 9001:2008 requirements stipulate inspections and testing of critical process inputs and outputs. Inspections take place at four levels: individual, supervisory or quality control, quality assurance, and ISO 9001:2008 audits.

- Quality control is a failure detection system that uses observation techniques and activities to identify and correct errors in products or services to ensure they meet defined requirements.
- Quality assurance is a failure prevention system that uses planned and systematic activities like defined processes and procedures to ensure products or services delivered will be of good quality.

The first level of Quality Control (QC) monitoring activities start with individual staff members. Each employee is required to inspect his or her own work in accordance with the established procedures and standards. Each individual inspects the inputs they receive from another process before sending it forward for further processing.

The second level of QC inspection involves the Program Manager and/or Operations Manager who review and evaluate process outputs based on established requirements and standards. They document their monitoring results and take immediate corrective action for any unacceptable results.

Quality Assurance (QA) Analysts are responsible for the third level of inspection which starts the quality assurance process. They are primarily responsible for sampling processes on a scheduled, monthly basis to ensure Quality Management System controls are operating correctly and that all requirements and standards are met. The analysts retrieve samples from the MAX-CMS using a sampling formula that ensures a 95% confidence level and 5% error rate unless otherwise noted in the Maximus Sampling Procedure.

The monthly QA evaluations use checklists based on criteria extracted from contract requirements, state law and regulations, business rules and internal process standards. The analysts document the evaluation data for trending, research, and quality improvement purposes in the Monthly Quality Management Performance Report per the required procedure.

The following 13 processes or products are subject to monthly QA evaluations.

Process/Product	Evaluation Criteria	QC Sample	QA Sample	Reporting
Initial Intake	Timeliness, accuracy	None	100% of sample	Standard QA Report
Worksite Monitor	Timeliness, accuracy	None	Standard sample	Standard QA Report
Random Drug Test	Timeliness, accuracy	1 positive result per CCM/CM team monthly randomly selected	Standard sample	Standard QA Report & Standard Business Unit Report
Recovery Agreement	Timeliness, accuracy	5/month randomly selected	Standard sample	Standard QA Report
Non-Compliance Letters	Timeliness, accuracy	4/month per CM randomly selected	Standard sample	Standard QA Report

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Monthly Reports/Contacts	Timeliness, accuracy	None	Standard sample	Standard QA Report
Document Scanning	Timeliness, accuracy	10 documents/week randomly selected	Standard sample	Standard QA Report
Billing (Premium) Processing	Timeliness, accuracy	None	Standard sample	Standard QA Report
Physical Therapy Board	Accuracy	None	1 intake/quarter	Monthly Business Unit Report
Call Monitoring	Various call aspects	None	Min of 3 staff/week	Standard QA Report
Case Closures	Info ok and verified	100% of files with public risk	None	Standard Business Unit Report
Clinical Assessors	Various appointment aspects	None	3 per month	Monthly Business Unit Report
Lab Test Results	Cut off levels	1 result daily		Monthly Business Unit Report

Source: Maximus Quality Assurance Plan, DPP-12-01

One result of the work of the QA Analyst is a Monthly Quality Management Performance Report that summarizes and provides details on the results of the 13 processes or products evaluated during the month. This includes a breakdown of the number of items reviewed, errors found, a trend analysis against the specific goal, and a root-cause analysis of the top errors. Monthly meetings are held with the Diversion staff to discuss the findings and corrective action required.

In addition, the QA Analyst monitors and reports monthly on the performance of 45 specific contract provisions (see Appendix 5, Contract Performance Standards Measured). The Diversion Program Performance Standards Analysis Report is referred to as the “red-green” report because items meeting standards are shaded in green while those that are not are shaded in red.

The December 15, 2015 red-green report covers from December 2014 through November 2015. Table 8 shows the number of contracts standards measured every month for the past year varied from month to month, but overall compliance with the standards averaged 94% per month.

**Table 8: Contract Standards Compliance from December 2014 through November 2015**

<b>Month/Year</b>	<b>12/14</b>	<b>1/15</b>	<b>2/15</b>	<b>3/15</b>	<b>4/15</b>	<b>5/15</b>	<b>6/15</b>	<b>7/15</b>	<b>8/15</b>	<b>9/15</b>	<b>10/15</b>	<b>11/15</b>	<b>Avg</b>
Contract Stds Measured	45	45	45	45	45	45	45	45	45	45	45	45	45.0
Contract Stds Not Measured	11	10	9	13	14	9	14	10	7	12	11	9	10.8
Number of Contract Stds Met	31	33	35	32	29	34	30	32	35	32	33	31	32.3
<b>Compliance Rating</b>	<b>91%</b>	<b>94%</b>	<b>97%</b>	<b>100%</b>	<b>94%</b>	<b>94%</b>	<b>97%</b>	<b>91%</b>	<b>92%</b>	<b>97%</b>	<b>97%</b>	<b>86%</b>	<b>94%</b>

Source: Maximus

Both of these monthly reporting activities demonstrate how thorough, yet prescriptive and administrative-intensive the ISO process is. The samples are drawn and analyzed from the Maximus CMS which is efficient and paperless.

In the past before the new scanners were deployed, there was a document scanning backlog. However, the backlog did not impact program participants because staff and used original

hardcopy documents. With the implementation of new scanning equipment and electronic document policy, there is no longer a document scanning backlog.

The fourth level of inspections is an Internal Quality Audit per the required procedure. The purpose of these audits is to verify whether quality activities and related results comply with requirements and to determine the effectiveness of the quality system. The Internal Audit department may conduct 4-5 operational reviews a year of the program based on its policies and procedures. Finally, Bureau Veritas conducts a two-day surveillance audit once a year and an in-depth, end-to-end ISO audit every three years.

The program has been primarily aimed at tracking activities performed and timeliness, and outcomes such as successful completions, terminations and relapses. The QA analyst continually tests for procedural untimeliness that is corrected through the Corrective and Preventive Action (CAPA) Procedure, DPP-12-03 and tracked in the QA ITG database.

All staff receive mandatory corporate training for HIPAA, safety and sexual harassment. The Quality Analysts participate in a formal training program and receive additional in-house on-the-job training based on their education and experience. Maximus also offers a professional development program and staff can request outside training, which is typically granted. Maximus is also taking action to train or hire more certified internal auditors and project managers.

### **Administrative Services Department**

The Administrative Services Department provides the Diversion Program with the following services: budgeting, forecasting, accounting, accounts payable, accounts receivable, and contracts. These services incorporate three of the shared services boxes on the organization chart.

The Senior Director of Administrative Services has one direct report and three other non-direct reports. In addition to the Diversion Program, this unit supports 13 other Maximus programs and projects.

Boards pay Maximus a participant fee and participants pay Maximus a co-pay that is credited back to the Boards. Depending on the Board, Maximus may or may not have a financial risk. Accounts Receivable (AR) bills the Boards (by the 10<sup>th</sup> calendar day of the month) and participants (by the 20<sup>th</sup> calendar day) according to the contract requirements. Payments are received and accounted for through a bank lockbox.

AR also performs the collection function which includes establishing payment plans for delinquent participants. If a participant is delinquent, AR notifies the program and CMs prepare and send non-compliance letters. The Quality Assurance (QA) Analyst ensures non-compliance letters were sent to participants that are more than 60 days in arrears with their payments. The Annual Reports for the last Fiscal Years 2010-11 through 2014-15 reveal there have been about three delinquent participants per fiscal year.

CPS reviewed comprehensive policies and procedures concerning Project Financial Management that include the accounting system of record; budgets, forecasting and variance analysis; accounts receivable (billing and collection) and accounts payable; contracting and management reporting. Execution of these policies and procedures, including billing compliance, is continually monitored by the Quality Assurance Analyst. The only financial performance metrics concern timely billing of the Boards and participants. The QA Analyst reported there are no financial process delays or operational issues with the participant billing process.

To verify the program’s financial reporting process and its financial condition, CPS reviewed end-of-calendar year monthly Project Status Reports as of January 1, 2010, 2011, 2012, 2013 and 2014. Also reviewed were income statements and accounts receivable aging reports for the same time periods.

In our opinion, the monthly Project Status Reports provide the Project Manager with complete and timely information to manage the project. The reports summarize total funded, billed to date and balance due, and track current period revenue and expenses, year to date and contract to date actuals. The reports also contain detailed line items that capture total revenue, labor and non-labor expenses, overhead allocations, total expenses and profit.

The following table 9 shows a summary income statement covering Calendar Years (CY) ending in 2011 through 2014. Since CY 2011, program revenue has been stable but profitability has varied substantially as the number of program participants, direct labor, direct costs and allocations have fluctuated.

**Table 9: Summary Income Statement\***  
**CYs 2011 – 2014**

	12/31/10	12/31/11	12/31/12	12/31/13	12/31/14	Totals	% Total Revenue
<b>Revenue</b>	<b>\$2,190,579</b>	<b>\$2,187,733</b>	<b>\$2,186,800</b>	<b>\$2,241,025</b>	<b>\$2,249,313</b>	<b>\$11,055,450</b>	<b>100.0%</b>
Direct Labor	1,176,211	1,358,249	1,218,332	1,352,691	1,389,331	6,494,814	58.8%
Direct Costs	219,435	276,371	302,080	315,322	285,992	1,399,200	12.7%
Overhead, G&A	315,777	337,521	308,777	310,668	323,936	1,596,679	14.4%
<b>Total Costs</b>	<b>\$1,711,423</b>	<b>\$1,972,141</b>	<b>\$1,829,189</b>	<b>\$1,978,681</b>	<b>\$1,999,259</b>	<b>\$9,490,693</b>	<b>85.9%</b>
Profit	\$479,156	\$215,592	\$357,611	\$262,344	\$250,054	\$1,564,758	14.1%
% Profit	21.9%	9.9%	16.4%	11.7%	11.1%	14.1%	

Source: Maximus (numbers are rounded)\*

As a publicly traded company, Maximus has multiple layers of internal and external controls. In addition to continual review by the QA Analyst, there is a Maximus internal audit team and an outsourced PriceWaterhouseCoopers internal audit team. The external auditors include Ernst & Young and Bureau Veritas (ISO auditor).

The Contracts Unit consists of three staff that maintain copies of subcontract and Clinical Assessor agreements, provide updates to Diversion ISO procedures and policies that pertain to contracts, and compile monthly Supplier Performance Evaluations from various departments. The Diversion Program consumes minimal time.

The unit has detailed written policies and procedures that are subject to the continual QA review process to ensure contract policies, procedures, legal and compliance provisions are being met. The unit manager and the QA Analyst confirmed there are no persistent financial management process delays or operational issues.

### **Information Systems Department**

The Information Systems Department (ISD) supports the Diversion Program Maximus CMS, a mission-critical program component. The Maximus CMS is planned to be updated to further improve operational effectiveness and efficiency in 2016.

The Director of ISD has five staff including two in application development & testing and three in infrastructure, database management and data warehousing. Staff spend less than half their time supporting the Diversion program as they also support a Michigan healthcare project, a Federal background check project, and a Hawaii call center.

The most important performance metric for this department is 100% percent uptime. During 2015, the application, database and web servers' average uptime was 100%, and the Max-CMS database average uptime was 99.5%.

ISD is not required to comply with ISO standards but must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and security policies. CPS reviewed the HIPAA policy contained within the Corporate Employee Manual. CPS found the policy establishes compliance with the national standards for privacy of individually identifiable health information designed to meet HIPAA and contract requirements.

CPS also reviewed the comprehensive Maximus Information Security Policy which covers confidential information handling, storage, reproduction, transport and destruction; system access and privileges; internet connections; use of Maximus electronic communications systems; application development; business continuity and disaster recovery; encryption; portable computers and remote printing; privacy and personal use; software copying; physical security and violations. CPS found the policy meets contract requirements.

In addition, CPS reviewed the Maximus Server Security Policy, Application Security Statement and Physical Security Policy and found them to be comprehensive and compliant with contract requirements. CPS did not test the effectiveness or efficiency of the various policies.

Furthermore, CPS reviewed the master services agreement with Iron Mountain to provide storage of records and media, document scanning and shredding services, and found it to be compliant with contract requirements.

## Human Capital Department

The Human Capital (HC) Director manages three professional and three support positions. The department supports all HC functions for the Diversion Program including:

- **Recruitment/Selection** - maintains recruiting database including job postings, resumes, background checks, offer letters, and electronic on-boarding, etc. Trend data for CY 2014 shows program turnover at less than one percent annualized. New positions are posted internally first. Program administrative positions are commonly filled by internal candidates. Recruitment/selection issues for Program openings include highly specific skillset for RNs which requires specialized sourcing of nurses more suited to the alcohol/chemical dependency aspects of this program.
- **Classifications** - Personnel Requisitions are submitted to the corporate compensation team to confirm selected classification/job titles, etc. Maximus does not “impose” corporate-wide job descriptions/classifications on work sites with differing needs.
- **Employee Relations** - Human Capital Director works directly with Project Manager and/or Operations Manager to address employee matters.
- **Performance Management** – The annual review of employees is done in April and they are eligible for quarterly bonuses.
- **Benefits Administration** – The local HC supports open enrollment and answers questions while Corporate Total Rewards administers the benefit program.

HC training responsibilities include: state-mandated sexual harassment training (AB 1825) for management and mandatory annual supervisor training for: EEO Compliance, Corporate Compliance Refresher, Employee Disclosure, and Workplace Harassment Refresher. HC provided CPS with a compliance training matrix showing that Diversion Program staff received required training.

## Diversion Program Manager Survey Results

In lieu of observing DEC and Board Participant Review meetings, CPS surveyed the DPMs and attended a monthly DPM meeting resulting in the following opinions and observations.

The DPMs represented both DEC (4) and PRM Non-DEC (3) Boards. The DPMs averaged almost eight years of experience in the position and ranged from nine months to 30 years on the job. The survey results indicated the following:

- All receive information timely from Maximus before a meeting.
- They all have remote access to the Max-CMS but only 4 of 7 use the system extensively.

- Of those using the Max-CMS, all experienced a high (>98%) percentage of uptime and most reported the information is generally complete and accurate, and the system is easy to use.
- Decisions and outcomes are well documented based on standardized templates (100%).
- They receive materials timely (within 7 days) after the meetings.
- On a scale of 1 to 5 with 5 being the highest, the DPMs rated the following:
  - Program effectiveness for licensees: average 4.6
  - Maximus CCM knowledge and expertise: average 4.6
  - Program efficiency: average 4.8
- Some DPMs felt cost was not a factor, but most indicated the total program cost to the participant is expensive.

As a result of the DPM meeting, CPS learned the following:

- Issues or obstacles that affect program efficiency include phone “tag” between program staff and participants, lost paperwork and participant delays.
- There is a perception that DEC Boards provide a better recovery process, but there are insufficient data to support the hypothesis. DEC advocates feel their process advantage is face-to-face interaction with participants, Board and DEC members. It is an effective way to see changes in participants which is better than just reviewing hard data. Non-DEC advocates contend they can make more timely decisions that benefit participants without requiring Board approval. DEC DPMs claim the same decision-making advantage and can override a health care professional, but are reluctant to do so because they don’t possess the same level of technical healthcare knowledge.
- Most DPMs claimed they lack formal drug training but would benefit from it.

As a result, many DPMs suggested the following Diversion Program improvements:

1. Hire more CCMs and increase the number of participants.
2. Identify ways to better manage or reduce participant costs.
3. Identify ways to better treat participants suffering from mental illness.
4. Provide DPMs with recovery training.

### **Recommendation**

5. Maximus should consider and evaluate all of the DPM recommendations and, at a minimum, provide the DPMs with recovery training.

## Treatment Provider Survey and Credential File Audit Results

As part of an outreach to key program stakeholders, CPS HR conducted a brief online survey directed to a sample of the following Diversion Program Treatment Providers:

- Clinical Assessors (30)
- Nurse Support Group leaders/facilitators (41)
- Health Support Group leaders/facilitators (19)
- Worksite Monitors (20)

The purpose of the survey was to both solicit general information on program stakeholder experience as well as identify ways to improve program effectiveness and efficiency. The following summarizes the survey findings and recommendations. The complete results are presented under separate cover.

### Response Rates

A total of 60 of 110 invitees responded to the survey. With the exception of Worksite Monitors, the survey response rate exceeded the 50% target for the respondent sub-groups.

Stakeholder Group	# Responding	% Responding of those Invited
Clinical Assessors (CA)	20	66.7%
Nurse Support Group leaders/facilitators (NSG)	22	53.7%
Health Support Group leaders/facilitators (HSG)	12	63.2%
Worksite Monitors (WSM)	6	30.0%

Table 10 summarizes Treatment Provider respondent experience and their participation in the Diversion Program. Based on their collective experience, it appears the Boards and Maximus should pay attention to the results of this survey.

**Table 10: Treatment Provider Experience and Program Participation**

Experience and Program Participation	CA	NSG	HSG	WSM
Avg. years evaluating health care professionals?	21.6 yrs.	15.4 yrs.	21.0 yrs.	NA
Avg. years working with the Diversion Program?	12.3 yrs.	10.9 yrs.	15.6 yrs.	2.1 yrs.

### Clinical Assessor Responses

Clinical Assessors indicated the following about key aspects of their practice:

- They assess up to three participants a month, but average one per month.
- An assessment appointment ranges from one to two hours, but averages one hour.
- All respondents indicated they were able to submit an assessment report within the required 10 days after the assessment is completed.

Clinical Assessors claim the following obstacles/challenges (not inclusive of all responses) hinder their role in the Diversion Program:

1. Participants miss appointments or cancel late.
2. Participants misunderstand the program requirements.
3. Untimely receipt of material for the assessment
4. There is a lack of treatment options in the area they work.
5. They are unable to complete the assessment on a computer.
6. Lost billings delay payment.

Many Clinical Assessors recommend the following improvements (not inclusive of all responses) to the Diversion Program:

1. Simplify and clarify the participant administrative requirements.
2. Provide for online transmission of program forms.
3. Update the clinical assessment tool.
4. Institute DEC's for all professions.
5. Increase DEC training.
6. Pay for assessments cancelled with less than 48 hours' notice and for no show appointments.

### **Nurse Support Group Facilitator Responses**

NSG facilitators indicated the following about key aspects of their practice:

- They facilitate up to three groups per week, but average about two per week.
- Participants range from 6 to 21 per session, but average about 12 per session.
- Session costs range from free to \$40, but average \$19 per session.
- On average, about 66% of group participants are in the Diversion Program; the balance are in the Probation Program.

NSG facilitators claim the following obstacles/challenges (not inclusive of all responses) hinder their role in the Diversion Program:

1. Lack of direct communication with Maximus about participants and changes in program policies and procedures, including untimely call backs and an inability to email case managers.
2. The implementation of SB 1441 has changed the program focus from rehabilitation to punitive discipline. The rules and regulations are often too rigid and inflexible, and there is an unreasonable, high frequency of drug testing.
3. Lack of adequate in-service training.
4. Access to the Maximus website can be frustrating and cumbersome.

5. When probationers exceed program participants, the group tends to become more negative.

NSG facilitators recommend the following improvements (not inclusive of all responses) to the Diversion Program:

1. Improve direct communication with Maximus case managers, including written notification of policy and procedure changes, and email notification of participant non-compliance, transition or completion.
2. Provide participants with more information about the Diversion Program and what to expect at their first Board or DEC meeting.
3. Maximus staff should observe more group sessions.
4. Provide more opportunities for facilitators to receive training, such as an annual, offsite conference.
5. Provide more mental health options.

### **Health Support Group Facilitator Responses**

HSG facilitators indicated the following about key aspects of their practice:

- They facilitate up to eight groups per week, but average about three per week.
- Participants range from 2 to 14 per session, but average about 8 per session.
- Session costs range from \$21 to \$75, but average \$47 per session.
- 92% of respondents indicated they are able to complete and submit the monthly attendance and participation report by the required 10<sup>th</sup> of the following month.

Many HSG facilitators claim the following obstacles/challenges (not inclusive of all responses) hinder their role in the Diversion Program:

1. The Maximus case manager caseload is too high to be effective, resulting in inadequate and untimely communication between all parties.
2. Maximus does not give enough consideration to HSG facilitator feedback.
3. The punitive manner in which participants are treated by their respective Boards.
4. Lack of program training.
5. Except for BRN, the participant census from the other Boards is low.

HSG facilitators recommend the following improvements (not inclusive of all responses) to the Diversion Program:

1. Reduce Maximus case manager caseloads.
2. Provide HSG facilitators with access to intake summary, evaluations and treatment reports.
3. Coordinate treatment decisions with HSG facilitators before implementation.

4. Maximus case managers should attend more HSG sessions.
5. Maximus should provide more diversion training through area meetings.
6. Maximus staff should observe more group sessions.
7. Improve marketing of services through more outreach.

### **Worksite Monitor Responses**

WSMs indicated the following key aspect about their practice:

- They can monitor up to two participants at any time, but the average is one at a time.

WSMs claim the following obstacles/challenges (not inclusive of all responses) hinder their role in the Diversion Program:

1. They lack the ability to contact the Maximus CCM or CM by email.
2. Due to early diversion-related meetings, participants leave early from work.
3. Difficult to contact Board Diversion Program Managers.
4. They have limited time to observe in a clinical setting.
5. Often have to wait for mailed participant evaluations.

WSMs recommend the following improvements (not inclusive of all responses) to the Diversion Program:

1. Establish email communication with Maximus staff.
2. Provide the ability to either fax or submit online monthly and quarterly reports.
3. Provide improved access to Board Diversion Program Managers.
4. Provide participant evaluations by email.

### **Recommendation**

6. Maximus should consider and evaluate all of the stated Treatment Provider obstacles/challenges, then prioritize and implement the recommendations accordingly.
7. As evidenced by the success of this online survey, Maximus should periodically reach out to Treatment Providers and other stakeholders to identify ongoing issues and opportunities for continuous improvement.

### **Credential File Audit Results**

CPS reviewed a 10% sample of Maximus and Board treatment provider credential files to ensure compliance with Uniform Standards 1, 5, 7 and 13. Except for WSMs with no files, all other credential files were found to partially comply with the Uniform Standards. Most files provided evidence of license/credential verification, experience and insurance. However, most lacked evidence of Board approval and a disclaimer to not accept licensees with whom they have had a personal, financial or business relationship within the last year.

Specifically, a review of four Clinical Assessor credential files revealed evidence of a valid license was independently verified through the state website ([www.breeze.ca.gov](http://www.breeze.ca.gov)) 100% of the time. However, evidence of three years' experience in providing evaluations of health professional with substance abuse disorders, and \$1 million of malpractice and general liability insurance was present only half the time.

The review of four Health Support Group Facilitator credential files discovered that a valid license was independently verified through the state website or by hardcopy credential, and the three years' experience was documented 100% of the time. But, there was no evidence documenting whether there was a financial, personal or business relationship with the licensee within the last year.

The review of six Nurse Support Group Facilitator credential files exposed evidence of the three years' experience and a Board-signed document 100% of the time. However, in most cases there was no documentation of independent verification of the license or whether a financial, personal or business relationship existed with the licensee within the last year.

The review of WSMs disclosed almost a total absence of required documentation. CCMs report verifying WSM licenses, when applicable, but there aren't any WSM folders. Consequently, there is no evidence of license verification of licensed healthcare professionals, and a signed affirmation including a statement the WSM agrees to not accept licensees with whom they have had a financial, personal or business relationship within the last year.

Finally, PHCS noted the absence of two documents commonly found in healthcare credentials that are not covered under the Uniform Standards. These include an Office of the Inspector General (OIG) exclusion clearance and a HIPPA confidentiality statement.

## Recommendations

8. Maximus and the Boards should ensure each credential review is completed in compliance with the Uniform Standards, including evidence of: a license, experience and insurance; do not accept licensees with whom they have had a personal, financial and business relationship within the last year; and Board approval.
9. Per healthcare standards, perform and document an OIG clearance for each Treatment Provider at <https://exclusion.oig.hhs.gov>
10. Per healthcare standards, require all Treatment Providers with access to records to sign HIPPA confidentiality statements.

## Participant File Review Results

The following presents the participant file review methodology PHCS used and the audit findings and recommendations.

## Participant File Review Methodology

The Maximus participant file review was based on the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees dated April 2011, specific requirements of each Board, and the 2010 – 2014 Maximus contracts with the Department of Consumer Affairs.

PHCS selected and reviewed a random, statistically-valid sample of 103 Participant files spanning the audit period of 2010-2014. Files were reviewed for every Board, and for all 14 BRN DEC's across the state. The files were reviewed by two PHCS registered nurses with master's degrees who have extensive experience reviewing patient charts.

Table 11 reveals most reviews were done on BRN participants (77.7%), followed by BOP (9.7%), PTB (4.9%), PAB (2.9%), DBC and OMB (1.9% each) and VMB (1%).

The cases reviewed contained 40 BRN participants who diverted drugs and four in the BOP. There were three participants in the BRN program who falsified prescriptions and one in the DBC program who self-prescribed.

**Table 11**  
**Summary of Program Closures of Participant Cases Reviewed**

Board	SELF WITHDRAWALS				BOARD CLOSURES						Totals	% Total
	Pre/Post DEC	Moved out-of-state	Financial hardship	Not clinically appropriate	Terminated: public risk	No longer eligible	Terminated: non-compliant	Continues in program	Continues in transition	Successful completion		
BRN	7	2	0	1	8	0	4	22	18	18	80	77.7%
BOP	0	0	0	0	3	1	0	3	3	0	10	9.7%
PTB	0	0	1	1	0	0	0	1	2	0	5	4.9%
PAB	0	0	0	1	0	0	0	1	1	0	3	2.9%
DBC	0	0	0	1	0	0	0	0	1	0	2	1.9%
OMB	2	0	0	0	0	0	0	0	0	0	2	1.9%
VMB	0	0	0	0	0	0	0	0	1	0	1	1.0%
<b>Totals</b>	<b>9</b>	<b>2</b>	<b>1</b>	<b>4</b>	<b>11</b>	<b>1</b>	<b>4</b>	<b>27</b>	<b>26</b>	<b>18</b>	<b>103</b>	<b>100.0%</b>
<b>% Total</b>	<b>8.7%</b>	<b>1.9%</b>	<b>1.0%</b>	<b>3.9%</b>	<b>10.7%</b>	<b>1.0%</b>	<b>3.9%</b>	<b>26.2%</b>	<b>25.2%</b>	<b>17.5%</b>	<b>100.0%</b>	

## Participant File Review Findings and Recommendations

PHCS found Maximus complied with all of the Uniform Standards and protocols for each participant file reviewed. In some cases, original supporting documents were not available for review, but the case logs summarized the document contents in compliance with the applicable Uniform Standards. Most participants had a history of drug and/or alcohol addiction. One BRN participant was in the psychiatric diversion program and two other participants had histories of mental illness with alcohol and chemical dependency. PHCS also identified opportunities for improvement.

### Participant Contact

In compliance with Uniform Standard 14, because the participating Boards use a private-sector vendor to provide diversion services, they must and do publicly disclose their involvement in the Diversion Program and provide restricted licensee information on their websites.

According to the Maximus Annual Report, all test telephone calls made to the toll-free 24/7 telephone line were answered by Maximus within the five-minute standard. The auditor's tests confirmed this practice. However, it was not uncommon for participants to spend a prolonged amount of time trying to reach CCMs for routine calls.

Participant concerns documented in the case log and interviews with CCMs confirmed a problem with returning calls promptly. Until December 7, 2015, one CCM position had been vacant since June 2015. With all positions filled, the problem should improve and routine calls should be answered more promptly, but this should continue to be monitored.

For those employed participants, PHCS found evidence of written participant consent to communicate with employers in compliance with Uniform Standard 3.

### **Recommendation**

11. Maximus should consider hiring a part-time CCM to cover vacations, illness and time away at DEC meetings, etc. This will improve the management of multiple calls.

### **Participant Orientation Documentation Lacking**

In an isolated incident in 2011, one clinical case review did not show evidence of a licensee orientation. Maximus identified the problem and soon thereafter implemented an orientation template to ensure adequate documentation.

### **Clinical Assessments**

PHCS found the summaries of the clinical assessment reports documented in the case logs revealed:

- The report contents meet the requirements of Uniform Standard 1;
- Uniform Standard 2, the temporary removal of the licensee from practice pending the results of the clinical assessment was met; and
- Treatment considered the clinical diagnostic evaluation recommendation required by Uniform Standard 6.

The auditor also found there was a slight delay occasionally in completing the clinical assessment within the standard 20 business days of the initial intake. In general, delays exceeding the standard were due to the participant being occupied in an inpatient treatment center or unable to keep the appointment. There was only one delay that was not explained in the case logs or participant's profile. Maximus staff should continue to work to diminish the obstacles and document reasons for delay.

### **Recommendation**

12. Maximus program staff should continue to document reasons for assessment completion delays.

## **Participant File Maintenance Issues**

PHCS found multiple instances of incorrect or unclear entries in case files, misspellings and incorrect use of pronouns.

A few participant entries were found in the wrong case logs. The errors were usually found several days later, but the wrong entry stayed in the case log. It is common practice for an error in an electronic record to be flagged to indicate it has been corrected.

Maximus currently lacks a written procedure for making deletions or retractions to case logs. The current informal practice is to correct the case log without marking the incorrect entry as an error.

There were also multiple misspelled words in the case logs which can lead to the wrong interpretation or meaning of the notes. The current Max-CMS version allows spell check capability for only a few employees. However, the upgraded version in 2016 will make spell check available to all employees and treatment providers and should correct much of this problem.

Some of the case log notes entered by one CCM were unclear due to fragmented sentence structure or imprecise documentation. This particular staff member is highly regarded for her ability to communicate with participants, but should use the improved spelling and grammar check feature in the upgraded Max-CMS. The Project Manager should also review and revise closing notes as necessary.

Finally, PHCS frequently found the incorrect use of 'he/she' pronouns. The wrong pronoun may cause the reader to question whether the entry in the case log is correct. Using the participant's first or last name rather than pronouns only will prevent misunderstandings concerning entries.

## **Recommendations**

13. All program staff should take advantage of the improved spelling and grammar check feature in the upgraded Max-CMS.
14. The Project Manager should review and revise closing notes as necessary.
15. Use the participant's first or last name rather than pronouns only to prevent misunderstandings with case log entries.
16. Maximus should develop and implement a written policy for making deletions and retractions to case logs. The American Health Information Management Association website (<http://www.ahima.org>) has examples and sample policies Maximus could use.

## **Program Understanding and Obstacles to Compliance**

Program participants face many obstacles on their road to recovery. Based on file reviews and interviews with Maximus program staff, applicants often have a difficult time comprehending all

the rules and expectations specified in Uniform Standard 10 early in the program due to high anxiety and/or their addiction/disease conditions.

PHCS identified obstacles including, but not limited to: financial hardships; temporary disability with less pay; loss of health insurance, car and/or driver's license, and home. Some participants ended up living in their car or in a sober living facility that was not always safe. Others suffered from guilt and anxiety, fear of failure, low self-esteem and relationship problems that made it difficult to comply with all aspects of the program. It was not clear how many participants withdrew due to these obstacles and others.

Some participants did not understand they needed to discard the drugs they were not allowed to use. Some participants gave their unused drugs to others and did not understand that this is a violation of the Nurse Practice Act.

CCMs and CMs continually reminded participants of their responsibilities and advised them that part of the recovery program is being accountable for their own actions and inactions.

### **Recommendations**

17. Maximus program staff should track and trend the reasons for program withdrawal to determine the number of participants who withdrew for financial and other reasons.
18. Maximus program staff should improve the Program Handbook in the following ways:
  - Explain in the Handbook how to properly dispose of drugs according to the US Food and Drug Administration web site, and emphasize that participants may not give the drugs they are discarding to other persons for their use.
  - Attach a letter to the applicant's packet to encourage reading/re-reading the Handbook until they are familiar with the rules and expectations (participants are required to sign, date and return the Handbook Acknowledgment Signature Sheet), and consider giving applicants a pre-DEC test to validate their understanding.

### **Major Compliance Violations**

The file reviews revealed the most common avoidable **MAJOR** violations were generated because participants failed to call the lab on a daily basis, missed a random drug test, or had a non-negative or positive drug test. It appears many participants have difficulty organizing their required daily and monthly tasks to comply with the program requirements. They reported posting notes all over the house so they would not forget to call the lab on a daily basis. However, they sometimes forgot and suffered the consequences.

Missed daily calls and/or missed tests result in immediate removal from work and at least an additional two urine drug screens. According to program policy, participants must pass two consecutive negative tests results before Maximus will allow them to return to work.

## Recommendation

19. Maximus should modify the Program Handbook in the following ways:

- Add an index so applicants/participants can easily find needed information.
- Modify the drug testing information to include stronger language about the consequences of missing a call into the lab and missing a random drug test.
- Use **bold letters** or **highlight** the essential compliance information.
- Insert the Maximus Diversion Program Random Body Fluid letter into the Handbook and include additional information regarding caffeine and protein. For example: “Please be aware that any confirmed positive, dilute or out of range random body fluid testing (RBFT) may result in **immediate suspension of work privileges**.”

Tips to ensure test results fall within acceptable ranges include:

- Do not use any mind-altering substances.
- Test before 10:00 AM.
- Avoid the use of caffeine before testing, including coffee and caffeinated drinks like energy drinks and sodas.
- Limit fluid intake before the test.
- Consume some protein in the morning before the test, such as an egg or protein bar, plain yogurt with fruit and nuts, breakfast burrito with black beans and cheese, whole wheat bread with 2 tablespoons of peanut butter, etc.
- Avoid exercise before testing.”
- Include information about how participants can prove they followed the protocol at the collection site, such as taking a photo of the specimen, and/or post test data.
- Many participants with an upper respiratory infection unknowingly took over-the-counter (OTC) medications without thinking of the consequences of taking a banned substance. CCM’s suggest Mucinex **without** DM for coughs. Participants might also consider using home remedies such as hot tea and honey, saline gargles, humidifiers and ‘Nedi” pots with saline water for nasal cleansing rather than other OTC drugs than contain prohibited ingredients.
- Include information on ways to remember to call the lab, such as setting alarms and/or always calling at the same time every day.
- Suggest possible call reminder tools, including but not limited to: paper calendars, check lists, Google calendar or similar smart phone applications.

## Minor Compliance Violations

The most common non-compliance letters with **MINOR** violations were for receipt of late reports including:

- Monthly Self Report (MSR) and specifically the first page;
- 12-Step attendance cards;
- Health/Nurse Support Group Facilitator attendance reports; and
- Work Site Monitor reports.

Participants have control over the submission of MSR and 12-Step cards and should be able to submit them timely if they are organized. MSRs were often returned without the first page causing participants to be non-compliant with the required submission time lines. The first page of the MSR has a bar code but participants do not have to complete any information on this page. Therefore, participants often don't think they need to submit this page.

The Handbook does not currently include information about returning the first page. However, it would be beneficial if there was a note in the Handbook indicating "it is necessary to return the first page with the entire report." The updated Max-CMS system will allow participants to enter their MSR on-line which should improve timely submission of the completed report.

While sometimes submitted late, PHCS found the templates for reporting Health/Nurse Support Group attendance and the WSM monitor report comply with Uniform Standards 5 and 7. Maximus often received the initial WSM information and attestations late due to various reasons. This caused a delay in return to work for participants. PHCS also found some monthly WSM reports were received late because they were not mailed timely, resulting in late receipt and a non-compliance letter for the participant.

The upgraded Max-CMS system will allow WSMs to complete and submit pertinent forms and monthly reports online, which will have the potential to improve document timeliness, reduce non-compliance for participants, and delays to return participants to work.

However, to have any control over the submission of these other reports, participants must proactively request on a regular basis that WSMs, treatment providers and nurse/health support group facilitators submit the reports timely. PHCS noted some participants called their CCM or CM to find out if the forms had been submitted timely.

A review of the Handbook revealed there is little information regarding how to avoid non-compliance letters for these issues.

## Recommendations

20. Maximus should modify the Program Handbook in the following ways:

- Remind participants that multiple minor violations hinder progress in the program and that 100% compliance is expected before being allowed to move to the transition phase.
- Revise the MSR information on page 8 to indicate the first page of the MSR must be submitted with the rest of the report and include a notation regarding the same on the first page.
- Revise the WSM information on page 9 to advise participants to check with their WSM by the first of the month to ensure their report is submitted timely.
- Revise the Treatment Provider Progress Report information on page 7 to advise participants to check with their treatment provider by the first of each month to ensure their reports are submitted timely.
- Revise the Support Group Facilitator information on pages 7-8 to advise participants to check with their group leader by the first of each month to ensure their reports are submitted timely.
- Include reminder tools such as, but not limited to: paper calendars, check lists, Google calendar or similar smart phone applications.
- Suggest participants call or email the Maximus CM or CCM monthly to verify that all reports have been received in a timely manner.

21. Maximus should include the following information from the USFDA website in the Handbook:

- Mix medicines (do not crush tablets or capsules) with an unpalatable substance such as dirt, kitty litter, or used coffee grounds;
- Place the mixture in a container such as a sealed plastic bag;
- Throw the container in your household trash; and
- Scratch out all personal information on the prescription label of the empty pill bottle or packaging to make it unreadable, then dispose of the container.

### **Participants with Mental Health Issues**

Participants with mental health issues need groups for support. The usual groups, such as Alcoholics Anonymous (AA), Al-Anon and Narcotics Anonymous (NA) and are helpful but not specific to mental health participants. Emotions Anonymous (EA) groups are not as readily available as AA-type groups. A review of DEC notes indicated participants with a mental illness appear to take longer in recovery.

The options for participants with mental illness seem to be limited. The DPM survey includes a comment from the BRN representative that improved care for participants with mental health issues is needed. California county governments offer Adult System of Care services which

typically include Mental Health Support Services and authorization for Medi-Cal Mental Health Services.

### **Recommendation**

22. Maximus should consider advising participants to seek out Mental Health Services from their local county government Adult System of Care, when appropriate.

### **Drug Testing**

The file review revealed there were 40 BRN participants with a history of drug diversions who entered the program during the audit period. Most of the drug diversion was done by removing drugs from a Pyxis automated medication dispensing system and/or removing discarded medications from the hazardous waste container. The Pyxis MedStation or Omnicell systems were implemented to decrease medication error and improve inventory control. Currently, most hospital pharmacies run a monthly reconciliation report to identify narcotic users by determining if anyone has an unusual narcotic dispensing practice. If someone is identified as a high user, the management team will conduct an internal audit. In previous years, narcotics were counted by one nurse from the off-going shift and one nurse from the oncoming shift so it was more difficult to divert drugs.

PHCS found one positive test for morphine that was later rescinded after Maximus requested an investigation by the FirstLab Medical Review Officer (MRO). Fortunately, the participant was not working at the time. This incident proved to be an example of how the Maximus test results notification process identified the issue early and resolved the concern with the assistance of the MRO without effecting the participant's progress in the program.

### **Recommendation**

23. Maximus should contact the California Chapter of the American Organization of Nurse Executives and California Hospital Association to speak at a regional or state-wide meeting regarding the prevention and detection of nurses diverting drugs.

### **Uniform Standards**

The 2011 Uniform Standards are comprehensive, highly prescriptive, administratively-intense, and provide excellent criteria and procedures for managing the DCA Diversion Program. However, some of the drug testing standards appear to be overly prescriptive which limit the effectiveness and efficiency of random drug testing, resulting in increased participant time and cost which may be viewed as punitive.

Specifically, Uniform Standard 4 stipulates the following testing frequencies:

- Level 1 in year 1: 52 to 104 times for the year
- Level 2 in years 2 through 5: 36 to 104 times per year

According to the Board's DPMs, the implementation of the high testing frequency requirements contained in the Uniform Standard has reduced the benefits and flexibility of random testing and increased the cost. As a result, some DPMs claim self-referrals into the program have almost stopped and participant levels have dropped by 18% from approximately 690 in 2010 to 585 in 2015.

### **Recommendation**

24. The Board's should collectively consider identifying an acceptable, but less frequent, random testing schedule that would accomplish the goal and reduce participant cost and loss, then modify Uniform Standard 4 accordingly.

### **Board Review and DEC Meetings**

As previously mentioned, the BOP, PAB and PTB hold periodic review meetings to discuss participant progress, transition and completion without the individual being present, while participants are present at the BRN, DBC, OMB and VMB DEC meetings. Board and DEC actions concerning participant treatment, testing, and petitions for modification and reinstatement are compliant with Uniform Standards 4, 6, 8, 9, 10, 11 and 12.

The audit work plan included visiting several Board Review and DEC meetings. However, due to participant confidentiality reasons, the auditors were able to attend only one Board Review Meeting without any participants. The auditors did not attend a Board meeting or a DEC meeting. However, through reading the Board meeting minutes, PHCS was left with the following perceptions:

- The participants who did not attend a DEC meeting, or see the Diversion Program Manager during their meeting, appear to lack a connection to the program and are more negative in their comments about the program.
- DEC participants, however, expressed gratitude to the DEC, CCM's and CM's for their guidance throughout the program, their assistance in helping changing their life, teaching organization skills and feeling better about themselves. Following are a sample of participant quotes taken from the meeting minutes:
  - "I am so grateful for this program, it saved my life;"
  - "I am living and enjoying today;"
  - "I am so grateful for this program. I had lost my way spiritually and now I'm back in my life;"
  - "I am so proud and happy...you have given me a new life;"
  - "She reports doing well despite having her house burn down. She is working and doing well."

- The participant “is doing very well. She is back at work and loves it. She has come a long way from the first 6 months of her program. She turned the corner and never looked back. She is very happy and grateful to the DEC and the Diversion Program.”

Additionally, Maximus program staff shared their feelings of satisfaction at hearing the participants tell their stories to the DEC meetings.

### **Recommendation**

25. The non-DEC Board’s should consider evaluating the effectiveness of the participants’ non-attendance at Board review meetings, and consider ways to improve interpersonal interaction by Skype, Face Time or other forms of communication.

### **Health and Nurse Support Facilitated Groups**

The audit work plan included visiting several health and nurse support facilitated groups. However, due to similar concerns about participant confidentiality, the auditors were unable to attend any groups. Instead, PHCS reviewed the CCM notes from their visits to the support groups.

During the file reviews, PHCS noted the support group facilitators helped participants understand the consequences of their failure to follow the program rules and how to deal with their addictions and other concerns. Only one participant asked for a different group leader and only one group leader asked to change a participant to another group.

The following table shows the evaluation ratings for six nurse and one health support group facilitators. The evaluation rating values are:

- Strongly disagree (1)
- Disagree (2)
- Neutral (3)
- Agree (4)
- Strongly agree (5)

As Table 12 indicates, attendees ranged from eight to 19 per session and evaluation ratings ranged from 3.9 to 5.0, with four of the facilitators earning perfect scores. The miscellaneous comments are generally positive, with two recommendations for a smaller group size.

**Table 12: Nurse and Health Support Group Attendance and Facilitator Ratings**

Group	NSGF #1	HSGF #2	NSGF #3	NSGF #4	NSGF #5	NSGF #6	NSGF #7
Location	Galt	Rancho Cucamonga	Folsom	Ranch Cucamonga	LA	Sacramento	Sacramento
Total Attendees	8	12	9	12	15 - 17	10	19
Diversion	2	NA	2	NA	NA	8	15
Probation	6	NA	8	NA	NA	2	3
	Rating	Rating	Rating	Rating	Rating	Rating	Rating
Location of group matches address on record	5	5	5	5	5	5	5
Location of group is easy to locate and access	5	5	5	5	5	4	4
Parking is available within 2 blocks	5	5	5	5	5	4	5
Location of group meets ADA standards	5	5	5	5	5	4	5
Location of group is clean and free from hazards	5	5	5	5	5	4	5
Group begins on time	5	5	5	5	5	4	5
New members are welcomed into group	5	5	5	5	5	3	5
Diversion Program standards are met	5	5	5	5	5	4	5
Sobriety and recovery are supported	5	5	5	5	5	4	5
Group members appear comfortable in speaking freely	5	5	5	5	5	4	5
Confidentiality is stressed	5	5	5	5	5	3	4
Group ends on time	5	5	5	5	5	4	5
<b>Rating Average</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>3.9</b>	<b>4.8</b>	<b>4.8</b>
<b>Miscellaneous Comments</b>							
HSGF group leader set appropriate boundaries.							
BOP applicant in HSGF was upset about diversion rules, but was re-directed.							
NSGF group leader set a supportive and approachable tone.							
NSGF was approachable warm and professional.							
A smaller group size is recommended for a NSGF. Disruptive activity happening in room with people							
A smaller group size is recommended for a NSGF. Need to consider another room for nurses who are working during the day.							

Source: Maximus

**Policies and Procedures**

PHCS also reviewed the Diversion Program policies and procedures. They are based on ISO principles and standards and provide detailed, step-by-step procedures. The policies and procedures are maintained in a current manner with frequent updates as changes occur.

As previously mentioned, PHCS discovered Maximus lacks a policy for deleting and retracting incorrect information from case logs and made recommendation 15 to correct this problem.

**Maximus Educational and Outreach Presentations**

	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	Total	Average
Educational & Outreach Presentations	9	9	12	12	42	8.4

Source: Maximus Diversion Program Annual Reports

Maximus is contractually required to conduct community education. Over the term of the audit period, Maximus has been increasing the number of educational programs they present each fiscal year.

Maximus has developed an excellent PowerPoint presentation entitled, “The Health Professional with Substance Abuse Disorders,” and is giving the presentation to hospitals and other organizations.

Recommendation 22 specifies Maximus should contact appropriate California healthcare associations to make presentations concerning the prevention and detection of nurses diverting drugs.

## **Random Drug Testing Review**

The following describes the Maximus contract with First Hospital Laboratories, Inc. (FirstLab), FirstLab subcontractors, FirstLab Quality Plan, customer satisfaction with FirstLab services, and the results of the random testing review.

### **Maximus Contract with FirstLab**

FirstLab reports being in the drug and alcohol testing business for over a quarter century, serving approximately 2,500 clients, and averages over 800,000 medical services/tests per year. They also report having long term relationships with the majority of their clinics and collection sites.

Since 2010, Maximus has contracted with FirstLab as the third-party administrator for random body fluid testing and results reporting for the Diversion Program. Pursuant to the contract's Prime Contract Flow-Down provision, all work and/or deliverables produced and performed by the subcontractor (FirstLab) and its subcontractors (DrugScan and clinics/collection sites) shall be done in accordance with the Maximus prime contract.

Specifically, FirstLab is required to provide qualitative urine substance abuse testing for each participant. Specimen testing is to be performed by sub-contractor laboratories certified by the US Department of Health and Human Services (DHHS) and/or College of American Pathologists - Forensic Urine Drug Testing Program (CAPFUDT). All laboratories used to perform testing shall provide analytical services according to the protocols established by the US Department of Health and Human Services (DHHS) or to Maximus specifications on a per test fee basis.

The per test fees set forth in the 2010 contract escalates over time, covers the following services and allows for testing of additional drugs and panels upon client request for an extra cost:

- On-line Participant registration, Participant Tools and Case Manager Tools
- Create Random Testing Schedule Customized For Each Participant
- Web-Based Participant Login And Random Notification System and/or Toll Free Call-In Random Notification System
- Toll-Free Helpline
- Direct Participant Billing
- All Chain-of-Custody and Specimen Collection Supplies
- Collection Site Quality Assurance
- Overnight Delivery of Specimens to Lab
- Confirmation of All Positive Drug Screening Results
- Negative Results Available Within 24-48 Hours of Receipt of Specimens By Laboratory
- Positive Results Available Within 3-7 Business Days of Receipt of Specimens By Laboratory
- Internet Based Result Retrieval System

- Various Web-Based Program Management Reports
- Unlimited Telephone Consultation
- Administrative Services including Tracking of Test Results
- Dedicated Account Manager
- West Coast Customer Service Office

Required testing parameters include:

- FirstLab will provide for specimen collections within 50 miles of the participant's address or home of record, observed specimen collections performed by collectors of the same gender as the donor, and testing by alternative methods including expanded hair testing panels, oral fluid testing, blood and sweat.
- FirstLab will certify each collection site for use before permitting a participant to use it and will maintain an error correction log for each site.
- FirstLab subcontractors will test for drugs identified in, but not limited to "Description of Non-Regulated Testing Protocol" as directed by the Boards (see Appendix 4: FirstLab Drug Testing Panel). These panels are subject to change.
- The initial screen will be by immunoassay and gas chromatography/mass spectrometry (GC/MS).
- Presumptive positive results obtained on the initial screen will be confirmed by GC/MS or a more sensitive methodology with the exception of alcohol and Ethyl Glucuronide (EtG) positives. EtG testing is performed by liquid chromatography-tandem mass spectrometry/ mass spectrometry (LC-MS/MS).
- FirstLab will ensure all test results are legally defensible and will also have available a Medical Review Officer (MRO) to evaluate drug screen test results and to serve as an expert in this area upon the request of the participant or the DPM/DEC. In addition, FirstLab will provide access to industry experts and laboratory toxicologists to provide testimony at hearings or legal proceedings for an additional fee.

The contract includes the following drug testing critical service levels categories:

- **Drug Test Result Turnaround:** Negative screening results will be reported to Maximus within 2 business days of receipt of specimen by the lab 90% of the time. Non-negative results will be reported to Maximus within 4 business days of receipt of specimen by the lab 90% of the time. Compliance of this Service Level will be measured by reports generated by the FirstLab Account Manager and made available to Maximus after service is rendered.
- **New Participant Enrollment:** New participants in the program can be enrolled in the FirstLab program on-line immediately or receive start up package information by mail from FirstLab. FirstLab will have the participant enrolled (including the approval of their

chosen collection site) within 48 hours of receiving their enrollment and payment information via online communication or by return mail 95% of the time.

- **Collection site Selection and Approval:** When a participant needs a new collection site or requests the use of a collection site that does not already exist in FirstLab's data base, FirstLab will locate and approve a site within the State of California for usage within 24 hours 98% of the time.
- **Testing Accuracy:** Standard for accuracy in specimen testing is 100%.
- **Measurement and Evaluation:** The measurement of these Service Levels will be provided by FirstLab to Maximus based on the timely receipt of appropriate paperwork and documentation. The evaluation of these Service Levels will be done by the Maximus Vendor Manager in coordination with the Maximus Drug Program Manager.

FirstLab is also responsible for arranging, collecting directly from participants, processing, and accounting for all drug testing and all fees associated with drug testing. The BRN nor MAXIMUS will reimburse the FirstLab for any drug testing fees owed by participants.

Based on a review of the contract between Maximus and FirstLab and participants files, the program random drug testing process appears to meet the ASAM criteria and Uniform Standards 4, 8, 9 and 10.

### **FirstLab Subcontractors**

FirstLab reports contracting with DrugScan, Inc. for over 20 years to provide analytical laboratory services for approximately 13,000 clinics and collection sites throughout the United States that are FirstLab subcontractors. There are about 900 sites in California and 689 for the Diversion Program.

Initially, FirstLab vets each collection site is through a phone interview which covers the Program collection policies and procedural requirements. Once the phone interview is completed and the site is willing to follow the requirements, FirstLab sends each clinic/collection site a client specific operating protocol/questionnaire. Once the protocol is satisfactorily completed and the site agrees to the terms, they are added to the client's approved collection site list in the FirstLab system.

FirstLab reports the collection site listing/directory is current, maintained and updated in real time. This is imperative because all FirstLab divisions use this information. Account Managers interface with the many clinics/collection sites and clients each day. During this interaction, data are validated and updated when required. The Provider Contracting Team, a dedicated unit that maintains, develops and negotiates with clinics and collectors, also provides oversight. In addition, as a condition of the Maximus contract, FirstLab conducts an annual audit of all assigned California clinics and collection sites.

## FirstLab Quality Plan

The following briefly describes the FirstLab Quality Plan and explains how it monitors ongoing contractual compliance of DrugScan and the hundreds of clinics and collections sites used.

- FirstLab reports using only laboratories that are DHHS, SAMHSA (formerly NIDA) and/or CAP certified. This means the labs are physically inspected several times a year and their policies and procedures are subject to approval by those agencies. In addition, these labs receive blind proficiency specimens that are known negatives or non-negatives and they must perform with 100% accuracy or risk losing their certification. FirstLab reports being partially reliant on the clinic/collector's contractual obligations as well as state and federal certifications required to operate.
- FirstLab ensures specimen collection is observed by the same gender in the following manner: The FirstChoice provider database indicates those locations that do observed collections and for what gender, along with gender availability. When setting a participant up with a collection site, the participant is encouraged to call and verify availability of gender observation for when they anticipate being at the site. If there should be any issue when at the site either the participant or the collector will call FirstLab for instructions. FirstLab then takes appropriate steps to accommodate the Participant.

In addition, the Account Manager receives automated alerts daily of any collections that were not marked as directly observed by the collector. The Account Manager conducts research on every result not marked as observed to determine whether the result was truly not observed or whether the collector simply neglected to check the "observed" box on the CCF. Then, the Account Manager updates the comments in the CaseNotes application to indicate the true observed status of the result, for the benefit of the Maximus Case Manager.

- FirstLab reports verifying the initial screen for all drugs is conducted by immunoassay technique in the following manner: All HealthCare Professional panels from Maximus are built into the LIS (Laboratory Information System) to create an initial screening aliquot (sample of a total amount of liquid). The order code directs the sample to the immunoassay screening instrument. This is an automated process that is followed, reviewed and certified by trained and experienced scientists. Part of the review and certification process is to ensure all testing protocols and quality assurance procedures are followed from initial accessioning through reporting.
- FirstLab reports verifying presumptive positive results are confirmed by gas chromatography/mass spectrometry (GC/MS) in the following manner: Every presumptive positive screen is automatically reflexed by the LIS to the corresponding mass spectrometry confirmation method for the respective presumptive positive analytes. This is an automated process that is followed and reviewed and certified by trained and

experienced scientists. Part of the review and certification process is to ensure all testing protocols and quality assurance procedures are followed from initial accessioning through reporting.

- FirstLab reports verifying EtG testing is based on Maximus requests built into the LIS to create an aliquot that is directed by the order code to an LC-MS/MS method. This is an automated process that is followed and reviewed and certified by trained and experienced scientists. Part of the review and certification process is to ensure all testing protocols and quality assurance procedures are followed from initial accessioning through reporting.

- FirstLab reports lab contractor staff are trained in each NIDA/US DOT standard operating procedure they are required to perform and a training record is maintained. Training in accordance with regulatory requirements including SAMHSA (formerly NIDA) which includes an initial, six-month and yearly recertification.

In addition, the DrugScan Quality Assurance Department performs rotating monthly audits on all test systems which includes the “tracer” technique that follows samples from accessioning through reporting. This process involves observation of individual performance and review of training records to ensure all documentation and procedures within the scope of an individual’s job description are up to date and compliant.

- FirstLab reports using the following the procedure to correct the actions of significant or repeated contractor violation of NIDA/DOT standards:

- 1) Any critical errors identified at the lab are discussed with the Certifying Scientist and/or reported to the appropriate certifying organization for additional follow up, (SAMHSA etc.).
- 2) Any ongoing critical errors identified at the collection site are handled in accordance with all applicable regulatory requirements (DOT SAMHSA, CA DOH etc.). The site would also be removed from the FirstLab FirstChoice network and replaced with a compliant organization. Due to the volume of testing conducted, FirstLab reports constantly monitoring the quality of collection services on behalf of all our clients to ensure a high quality product.
- 3) In addition, FirstLab has quality review standards that couple both the lab and collection site output in the following manner:

When FirstLab receives negative results and before reporting to the client, the Account Manager or Assistant Account Manager performs an administrative review on a sampling of negative results to ensure both the electronic result and the laboratory hard copy results are consistent with the test panels that have been signed off by the lab, the client and FirstLab. The results are also checked to make sure they are consistent with each other.

For positive results, the Account Manager or Assistant Account Manager again performs an administrative review on 100% of all positive results to ensure both the electronic result and the laboratory hard copy results are consistent with the test panels that have been signed off by the lab, the client and FirstLab. The results are also checked to make sure they are consistent with each other. If any discrepancies are found, the Account Manager will immediately notify the lab and begin corrective action.

FirstLab also reports that when it has chosen to discontinue the use of a clinic or collection site for quality or other issues that did not meet the expected level of services, it is important to note they were not in violation of applicable regulatory requirements. FirstLab indicated it has never reported a lab for not meeting standards.

Although the auditor was unable to field test the above FirstLab assertions, it is evident that between FirstLab and Maximus, there are sufficient controls in place to ensure the effectiveness and efficiency of program substance abuse testing.

### **Customer Satisfaction with FirstLab Services**

In terms of this audit, customer satisfaction refers to the contentment of program participants and Maximus with FirstLab services.

For the most part, FirstLab does not interact with participants, so it must rely on collection site customer service to ensure program participants are treated courteously and respectfully by lab contractors. To monitor customer service practices, FirstLab reports that constant communication with customers is their key focus. This communication comes from the following sources:

- Participants who provide both positive and negative feedback.
- Day-to-day interaction with their Account Managers.
- Interaction with the Finance Department to facilitate payment for services.
- Interaction with the Provider Contracting Team.

FirstLab reports any issues are dealt with swiftly and definitively. Notes as to any issues are placed directly into the Provider database and the issue is reported to Provider Contracting. Any significant issue is reported to the Executive Vice President & CAO whose staff contacts the clinic/collection site. If the issue cannot be reasonably explained, the site will be deactivated for all FirstLab clients. If the issue can be reasonably explained, FirstLab notes the instance. If there is a second instance, the site will be deactivated.

From the perspective of Maximus, there is sufficient evidence the terms and conditions specified in the Maximus contract are being met. The monthly Maximus scorecard reports the results of critical services levels, service level requirements, monthly performance tracking and the

attainment of key performance indicators. The following table 13 summarizes the Maximus scorecard through December 2015.

**Table 13: Maximus Scorecard Summary through December 2015**

Critical Service Levels	Service Level Requirements	Monthly Performance Tracking	9-month Avg.
<b>Drug Test Turnaround</b>	Negative results reported within 2 business days of receipt by lab- 90% of the time	Negative results threshold achieved except for mass test days. For mass test days, FirstLab will work with lab to add staff	99.03%
	Non-negative results reported within 4 business days of receipt by lab – 90% of the time	Non-negative threshold achieved	98.97%
<b>New Participant Enrollment</b>	New participants enrolled within 2 business days of receiving information – 95% of the time	Thresholds achieved	100.00%
	FirstLab will locate and approve a travel site within 24 hours – 98% of the time	In-state travel collection sites within 24 hours	100.00%
		Out-of-state travel collections sites within 24 hours	100.00%
<b>Testing Accuracy</b>	Standard for specimen testing is 100%	DrugScan & FirstLab QA procedure ensures 100% accuracy	99.99%
		Incorrect Date	3.2
		Incorrect Substance	0
		Incorrect Participant	0.25
		Incorrect Value	0
		Other	0.11
<b>FL Daily Result Reports</b>		Low C results not reported	2.00
		Results reported late (10 mins or more)	1.10
		Result status not changed before reporting	0.38
<b>Specimens Lost in Transit</b>			0.38
<b>Collection Site Errors</b>		Cancelled at lab due to site error	0
		Urine	1.78
		Hair	0
		Phosphatidylethano (Peth)	0.38
<b>Key Performance Indicators</b>	<b>Service Level Requirements</b>	<b>Notes</b>	
Process Time	95% of time participants will be seen in less than 1 hour		
Participant/Maximus Satisfaction	Overall average rating of neutral or better		
Quality Adherence	100% adherence to Maximus quality standards	FirstLab policy is zero exceptions. Any exceptions are promptly reported to Maximus.	
Customer Service Inquiries	90% of time inquiries are responded to on same day	Agreed. Same day response subject to after business hours calls.	
Error Resolution	Resolution or plan for same to Maximus within 7 days	Agreed.	

Notification/Consultation Adherence	Respond to Maximus request with MRO within 24 hours	Agreed.	
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Source: Maximus

**Random Drug Testing Results**

CPS reviewed a statistically-valid random sample of 114 participant drug testing files on the FirstLab website for compliance with applicable Uniform Standards. The drug test files include the participant name, license number, organization, test start and end dates, testing frequency, whether observed and current status. CPS found all but four participants in the files. After further review, it was determined the four omitted participants all withdrew or declined to join the program and did not register with FirstLab.

**Recommendation**

- 26. The Maximus Quality Analyst should periodically audit the FirstLab website files to ensure all program participants being drug tested are included in the database.

**Program Effectiveness Reporting**

Uniform Standard 16 concerns the use of measurable criteria and standards to determine whether each Board’s method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting them in recovering from substance abuse in the long term. Each Board is required to report specific information on a yearly basis to the DCA and the Legislature as it relates to licensees with substance abuse problems who are either in the Diversion Program or on Board probation. If the data indicates licensees in specific licensing categories or with specific substance abuse problems have either a higher or lower probability of success that information shall be taken into account when determining program success. The data may also be used to determine the risk factor when a board is determining whether a license should be revoked or placed on probation. The following indicates the PHSC observations, findings and recommendation for these specific reporting items.

**Number of Intakes**

Maximus tracks program intakes on a monthly basis and prepares an annual report for stakeholders. The information is tracked for all Boards by county and includes applicant interviews and acceptance into the program. The intake report is confusing because the monthly statistics are based on actual intakes but the year-to-date total is based on Maximus’ July 1 - June 30 schedule.

**Recommendation**

- 27. Maximus should revise the intake report accordingly to eliminate the confusion between monthly and year-to-date reporting.

### **Number of Probationers**

Maximus tracks the number of probation referrals whose conduct was related to a substance abuse problem on a monthly basis and prepares an annual report for stakeholders.

### **Number of Referrals to Treatment Programs**

There was no evidence of Maximus tracking referrals to treatment programs but Maximus indicated the program will start tracking this indicator in 2016.

### **Number of Relapses (break in sobriety)**

Maximus tracks relapse rates and relapse substance on a monthly basis. PHCS contractors found consistent documentation in the case logs when there was an identified relapse. The annual report summary shows the length of time from intake to relapse and indicates most relapses take place during the first year of enrollment.

### **Number of Cease Practice Orders/License In-activations**

According to Maximus, this is a Board function and not the responsibility of Maximus.

### **Number of Suspensions**

According to Maximus, this is a Board function and a formal process that is not the responsibility of Maximus.

### **Number Terminated for Noncompliance**

Maximus tracks this data on a monthly basis and prepares an annual report for stakeholders.

### **Number of Successful Completions based on Uniform Standards**

Maximus tracks this data on a monthly basis and prepares an annual report for stakeholders.

### **Number of Major Violations, Nature of Violation and Action Taken**

For each participant, Maximus documents each violation and actions taken in the case logs but does not summarize them in the annual report.

### **Recommendation**

28. Maximus should consider tracking and trending major violations and actions taken, and report this information in the annual report.

### **Number of Licensees Successfully Returned to Practice**

Maximus documents each participant's return to practice and follows their progress on an ongoing basis until completion of the program. They do not include this information in the annual report.

## Recommendation

29. Maximus should consider tracking and trending successful returns to work on a monthly and annual basis, and report this information in the annual report.

## Number of Patients Harmed while in the Program

Maximus reports participants have not harmed any patients while in the program. In addition, the Boards are required to use the following criteria to determine if the program protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

- At least 100% of licensees who either entered the program or whose license was placed on probation as a result of a substance abuse problem successfully completed either the program or the probation, or had their license to practice revoked or surrendered on a timely basis based on noncompliance of those programs.
- At least 75% of licensees who successfully completed the program or probation did not have any substantiated complaints related to substance abuse for at least five (5) years after completion.

Regarding the first criterion, the PHCS review of 103 cases indicates 100% of the licensees/participants were all closed for the appropriate reasons and all documentation explained in detail the end status for each participant. Maximus tracks the information on a monthly basis and includes it in the annual report as well.

According to Maximus, the implementation of the second criterion is a Board responsibility and Maximus lacks access to this information after participants have completed the program. B&P code section 156.1 specifies a Board shall retain all participant records for treatment and rehabilitation services for three years from the date of the last treatment or services rendered, or until review for audit by the department. After that time period the documents may be purged. Purging the documents after three years eliminates the ability to measure long range participant outcomes.

## Recommendation

30. Participating Boards should attempt to monitor long range participant outcomes after program completion.

## Planned Technical Improvements

Hallmark technical features of the Maximus Diversion Program effectiveness and efficiency include, but are not limited to, implementation and application of ISO 9001:3015 standards and processes; use of a Client tracking matrix, Max-CMS and ITG Quality Assurance systems; and a mostly paperless environment.

During the course of the audit, the auditors learned Maximus plans to deploy in 2016 a variety of technical improvements that will address some Treatment Provider obstacles and a number of recommendations to improve program effectiveness and efficiency. All parties to the Diversion Program will benefit. These updated technical improvements include, but are not limited to, the following:

#### Improvements for Staff

- Increased efficiency for program staff through one login instead of multiple logins, improved navigation, and reduced data entry time.
- The licensee profile will be streamlined and will enable a participant image to be uploaded into the Max-CMS.
- The case log will be organized to include all notes instead of selective information.
- The applicant intake form will be consolidated into one long form with numbered questions that is auto saved instead of eight separate pages that needed to be saved individually. Users will also be able to add or change questions as needed.
- Staff will be able to add/change or delete recovery agreement terms on the fly and an electronic signature will be allowed.
- Scheduling for Maximus operations and administrative staff will be easier and faster. Staff will be able to drag and drop appointments instead of having to cancel old appointments before entering new appointments.

#### Improvements for Participants

- Participants will be able upload 12-step attendance cards and self-reports instead of faxing or mailing these documents.
- They will also be able to print the intake packet, reports, and the return to work packet. Once data are entered, the Max-CMS will notify the appropriate program staff electronically.
- These improvements should: eliminate paper and lost documents, and reduce mail handling, postage costs, and non-compliance-related tasks and consequences.

#### Improvements for Treatment Providers

- Treatment Providers will have their own portal.
- Clinical Assessors will be able to enter assessments online instead of submitting manual reports.
- HSG/NSG facilitators and WSMs will be able enter or upload monthly reports.

Improvements for Board staff and DEC Members

- Board staff and DEC members will have 24/7 access to all participant and program information. This will reduce time sorting and reviewing records, transit time waiting for hardcopy information, and printing time, materials and other related costs.

## Appendix 1: Diversion Program Business & Professional Code Sections

The following is a partial listing of the enabling Diversion Program statutes within the California Business and Professions Code.

### **CHAPTER 4. Dentistry [1600 - 1976]** (Chapter 4 added by Stats. 1937, Ch. 415.)

#### **ARTICLE 4.7. Diversion Program [1695 - 1699]** (Article 4.7 added by Stats. 1982, Ch. 1261, Sec. 1.)

##### **1695.**

It is the intent of the Legislature that the Board of Dental Examiners of California seek ways and means to identify and rehabilitate licentiates whose competency may be impaired due to abuse of dangerous drugs or alcohol, so that licentiates so afflicted may be treated and returned to the practice of dentistry in a manner which will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Dental Examiners of California shall implement this legislation in part by establishing a diversion program as a voluntary alternative approach to traditional disciplinary actions. *(Added by Stats. 1982, Ch. 1261, Sec. 1.)*

##### **1695.1.**

As used in this article:

- (a) "Board" means the Board of Dental Examiners of California.
- (b) "Committee" means a diversion evaluation committee created by this article.
- (c) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

*(Amended by Stats. 2008, Ch. 548, Sec. 4. Effective January 1, 2009.)*

##### **1695.2.**

One or more diversion evaluation committees is hereby created in the state to be established by the board. The board shall establish criteria for the selection of the committee. No board member shall serve on any committee.

*(Added by Stats. 1982, Ch. 1261, Sec. 1.)*

##### **1695.3.**

Each member of a committee shall receive per diem and expenses as provided in Section 103.

*(Added by Stats. 1982, Ch. 1261, Sec. 1.)*

#### **ARTICLE 15. Osteopathic Physician and Surgeon Diversion Evaluation Committee [2360 - 2370]** *(Article 15 added by Stats. 1988, Ch. 384, Sec. 1.)*

##### **2360.**

It is the intent of the Legislature that the Osteopathic Medical Board of California seek ways and means to identify and rehabilitate osteopathic physicians and surgeons whose competency may be impaired due to abuse of dangerous drugs and alcohol, so that osteopathic physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety. It is also the intent of the Legislature that the Osteopathic Medical Board of California shall implement this legislation by establishing a diversion program as a voluntary alternative approach to traditional disciplinary actions.

*(Amended by Stats. 1991, Ch. 359, Sec. 12.)*

##### **2361.**

As used in this article:

- (a) "Board" means the Osteopathic Medical Board of California.
- (b) "Diversion program" means a treatment program created by this article for osteopathic physicians and surgeons whose competency may be threatened or diminished due to abuse of drugs or alcohol.
- (c) "Committee" means a diversion evaluation committee created by this article.
- (d) "Participant" means a California-licensed osteopathic physician and surgeon.
- (e) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

*(Amended by Stats. 2009, Ch. 140, Sec. 9. Effective January 1, 2010.)*

**2362.**

One or more diversion evaluation committees are hereby created in the state to be established by the board. The board shall establish criteria and appoint the members of the committee pursuant thereto.  
*(Added by Stats. 1988, Ch. 384, Sec. 1.)*

**2363.**

Each member of the committee shall receive per diem and expenses as provided in Section 103.  
*(Added by Stats. 1988, Ch. 384, Sec. 1.)*

**CHAPTER 5.7. Physical Therapy [2600 - 2696]** (Chapter 5.7 added by Stats. 1953, Ch. 1826.)

**ARTICLE 7. Substance Abuse Rehabilitation Program [2662 - 2669]** *(Heading of Article 7 renumbered from Article 5.5 by Stats. 2013, Ch. 389, Sec. 62.)*

**2662.**

It is the intent of the Legislature that the board shall seek ways and means to identify and rehabilitate physical therapists and physical therapist assistants whose competency is impaired due to abuse of dangerous drugs or alcohol so that they may be treated and returned to the practice of physical therapy in a manner which will not endanger the public health and safety.  
*(Amended by Stats. 1996, Ch. 829, Sec. 52. Effective January 1, 1997.)*

**2663.**

The board shall establish and administer a substance abuse rehabilitation program, hereafter referred to as the rehabilitation program, for the rehabilitation of physical therapists and physical therapist assistants whose competency is impaired due to the abuse of drugs or alcohol. The board may contract with any other state agency or a private organization to perform its duties under this article. The board may establish one or more rehabilitation evaluation committees to assist it in carrying out its duties under this article. Any rehabilitation evaluation committee established by the board shall operate under the direction of the rehabilitation program manager, as designated by the executive officer of the board. The program manager has the primary responsibility to review and evaluate recommendations of the committee. *(Amended by Stats. 2013, Ch. 389, Sec. 63. Effective January 1, 2014.)*

**2664.**

(a) Any rehabilitation evaluation committee established by the board shall have at least three members. In making appointments to a rehabilitation evaluation committee, the board shall consider the appointment of persons who are either recovering from substance abuse and have been free from substance abuse for at least three years immediately prior to their appointment or who are knowledgeable in the treatment and recovery of substance abuse. The board also shall consider the appointment of a physician and surgeon who is board certified in psychiatry.

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

(c) A majority of the members of a rehabilitation evaluation committee shall constitute a quorum for the transaction of business. Any action requires an affirmative vote of a majority of those members present at a meeting constituting at least a quorum. Each rehabilitation evaluation committee shall elect from its membership a chairperson and a vice chairperson. Notwithstanding the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code), relating to public meetings, a rehabilitation evaluation committee may convene in closed session to consider matters relating to any physical therapist or physical therapist assistant applying for or participating in a rehabilitation program, and a meeting which will be convened entirely in closed session need not comply with Section 11125 of the Government Code. A rehabilitation evaluation committee shall only convene in closed session to the extent it is necessary to protect the privacy of an applicant or participant. Each member of a rehabilitation evaluation committee shall receive a per diem and shall be reimbursed for expenses as provided in Section 103.

**CHAPTER 6. Nursing [2700 - 2838.4]** (Chapter 6 repealed and added by Stats. 1939, Ch. 807.)

**ARTICLE 3.1. Diversion Program [2770 - 2770.14]** (Article 3.1 added by Stats. 1984, Ch. 865, Sec. 1.)  
**2770.**

It is the intent of the Legislature that the Board of Registered Nursing seek ways and means to identify and rehabilitate registered nurses whose competency may be impaired due to abuse of alcohol and other drugs, or due to mental illness so that registered nurses so afflicted may be rehabilitated and returned to the practice of nursing in a manner which will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Registered Nursing shall implement this legislation by establishing a diversion program as a voluntary alternative to traditional disciplinary actions. *(Added by Stats. 1984, Ch. 865, Sec. 1.)*

**2770.1.**

As used in this article:

- (a) "Board" means the Board of Registered Nursing.
- (b) "Committee" means a diversion evaluation committee created by this article.
- (c) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

*(Amended by Stats. 2008, Ch. 548, Sec. 17. Effective January 1, 2009.)*

**2770.2.**

One or more diversion evaluation committees is hereby created in the state to be established by the board. Each committee shall be composed of five persons appointed by the board. No board member shall serve on any committee.

Each committee shall have the following composition:

- (a) Three registered nurses, holding active California licenses, who have demonstrated expertise in the field of chemical dependency or psychiatric nursing.
- (b) One physician, holding an active California license, who specializes in the diagnosis and treatment of addictive diseases or mental illness.

(c) One public member who is knowledgeable in the field of chemical dependency or mental illness.

It shall require a majority vote of the board to appoint a person to a committee. Each appointment shall be at the pleasure of the board for a term not to exceed four years. In its discretion the board may stagger the terms of the initial members appointed. *(Amended by Stats. 1999, Ch. 655, Sec. 36. Effective January 1, 2000.)*

**2770.3.**

Each member of a committee shall receive per diem and expenses as provided in Section 103. *(Added by Stats. 1984, Ch. 865, Sec. 1.)*

**2770.4.**

Three members of a committee shall constitute a quorum for the transaction of business at any meeting. Any action requires a majority vote of the committee.

**CHAPTER 7.7. Physician Assistants [3500 - 3546]** (Heading of Chapter 7.7 amended by Stats. 1992, Ch. 427, Sec. 5.)

**ARTICLE 6.5. Diversion of Impaired Physician Assistants [3534 - 3534.10]** (Article 6.5 added by Stats. 1988, Ch. 385, Sec. 2.)

**3534.**

It is the intent of the Legislature that the board shall seek ways and means to identify and rehabilitate physician assistants whose competency is impaired due to abuse of dangerous drugs or alcohol so that they may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety.

*(Amended by Stats. 2012, Ch. 332, Sec. 66. Effective January 1, 2013.)*

**3534.1.**

The board shall establish and administer a diversion program for the rehabilitation of physician assistants whose competency is impaired due to the abuse of drugs or alcohol. The board may contract with any other state agency or a private organization to perform its duties under this article. The board may establish one or more diversion evaluation committees to assist it in carrying out its duties under this article. As used in this article, "committee" means a diversion evaluation committee. A committee created under this article operates under the direction of the diversion program manager, as designated by the executive officer of the board. The program manager has the primary responsibility to review and evaluate recommendations of the committee.

*(Amended by Stats. 2012, Ch. 332, Sec. 67. Effective January 1, 2013.)*

**3534.2.**

(a) Any committee established by the board shall have at least three members. In making appointments to a committee the board shall consider the appointments of persons who are either recovering of substance abuse and have been free from abuse for at least three years immediately prior to their appointment or who are knowledgeable in the treatment and recovery of substance abuse. The board also shall consider the appointment of a physician and surgeon who is board certified in psychiatry.

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

(c) A majority of the members of a committee shall constitute a quorum for the transaction of business. Any action requires an affirmative vote of a majority of those members present at a meeting constituting at least a quorum. Each committee shall elect from its membership a chairperson and a vice chairperson. Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of

Division 3 of Title 2 of the Government Code, relating to public meetings, a committee may convene in closed session to consider matters relating to any physician assistant applying for or participating in a diversion program, and a meeting which will be convened entirely in closed session need not comply with Section 11125 of the Government Code. A committee shall only convene in closed session to the extent it is necessary to protect the privacy of an applicant or participant. Each member of a committee shall receive a per diem and shall be reimbursed for expenses as provided in Section 103.

*(Amended by Stats. 2012, Ch. 332, Sec. 68. Effective January 1, 2013.)*

**CHAPTER 9. Pharmacy [4000 - 4426]** (Chapter 9 repealed and added by Stats. 1996, Ch. 890, Sec. 3.)

**ARTICLE 21. Pharmacists Recovery Program [4360 - 4373]** (Article 21 added by Stats. 1996, Ch. 890, Sec. 3.)

**4360.**

The board shall operate a pharmacist's recovery program to rehabilitate pharmacists and intern pharmacists whose competency may be impaired due to abuse of alcohol, drug use, or mental illness. The intent of the pharmacists' recovery program is to return these pharmacists and intern pharmacists to the practice of pharmacy in a manner that will not endanger the public health and safety. *(Amended by Stats. 2005, Ch. 621, Sec. 63. Effective January 1, 2006.)*

**4361.**

(a) "Participant" means a pharmacist or intern pharmacist who has entered the pharmacists' recovery program.

(b) "Pharmacists recovery program" means the rehabilitation program created by this article for pharmacists and intern pharmacists. *(Repealed and added by Stats. 2005, Ch. 621, Sec. 65. Effective January 1, 2006.)*

**4362.**

(a) A pharmacist or intern pharmacist may enter the pharmacists recovery program if:

(1) The pharmacist or intern pharmacist is referred by the board instead of, or in addition to, other means of disciplinary action.

(2) The pharmacist or intern pharmacist voluntarily elects to enter the pharmacists' recovery program.

(b) A pharmacist or intern pharmacist who enters the pharmacists recovery program pursuant to paragraph (2) of subdivision (a) shall not be subject to discipline or other enforcement action by the board solely on his or her entry into the pharmacists recovery program or on information obtained from the pharmacist or intern pharmacist while participating in the program unless the pharmacist or intern pharmacist would pose a threat to the health and safety of the public. However, if the board receives information regarding the conduct of the pharmacist or intern pharmacist, that information may serve as a basis for discipline or other enforcement by the board.

*(Repealed and added by Stats. 2005, Ch. 621, Sec. 67. Effective January 1, 2006.)*

**4364.**

(a) The board shall establish criteria for the participation of pharmacists and intern pharmacists in the pharmacists' recovery program.

(b) The board may deny a pharmacist or intern pharmacist who fails to meet the criteria for participation entry into the pharmacists' recovery program.

(c) The establishment of criteria for participation in the pharmacists recovery program shall not be subject to the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. *(Amended by Stats. 2005, Ch. 621, Sec. 69. Effective January 1, 2006.)*

**4365.**

The board shall contract with one or more qualified contractors to administer the pharmacists' recovery program.

*(Amended by Stats. 2005, Ch. 621, Sec. 70. Effective January 1, 2006.)*

**CHAPTER 11. Veterinary Medicine [4800 - 4917]** (Chapter 11 repealed and added by Stats. 1937, Ch. 933.)

**ARTICLE 3.5. Diversion Evaluation Committees [4860 - 4873]** (Article 3.5 added by Stats. 1982, Ch. 870, Sec. 1.)

**4860.**

It is the intent of the Legislature that the Veterinary Medical Board seek ways and means to identify and rehabilitate veterinarians and registered veterinary technicians with impairment due to abuse of dangerous drugs or alcohol, affecting competency so that veterinarians and registered veterinary technicians so afflicted may be treated and returned to the practice of veterinary medicine in a manner that will not endanger the public health and safety. *(Amended by Stats. 1995, Ch. 60, Sec. 35. Effective July 6, 1995.)*

**4861.**

One or more diversion evaluation committees is hereby authorized to be established by the board. Each diversion evaluation committee shall be composed of five persons appointed by the board.

Each diversion evaluation committee shall have the following composition:

- (a) Three veterinarians licensed under this chapter. The board in making its appointments shall give consideration to recommendations of veterinary associations and local veterinary societies and shall consider, among others, where appropriate, the appointment of veterinarians who have recovered from impairment or who have knowledge and expertise in the management of impairment.
- (b) Two public members.

Each person appointed to a diversion evaluation committee shall have experience or knowledge in the evaluation or management of persons who are impaired due to alcohol or drug abuse.

It shall require the majority vote of the board to appoint a person to a diversion evaluation committee. Each appointment shall be at the pleasure of the board for a term not to exceed four years. In its discretion the board may stagger the terms of the initial members appointed.

The board may appoint a program director and other personnel as necessary to carry out provisions of this article.

*(Added by Stats. 1982, Ch. 870, Sec. 1.)*

**4862.**

Each member of a diversion evaluation committee shall receive per diem and expenses as provided in Section 103.

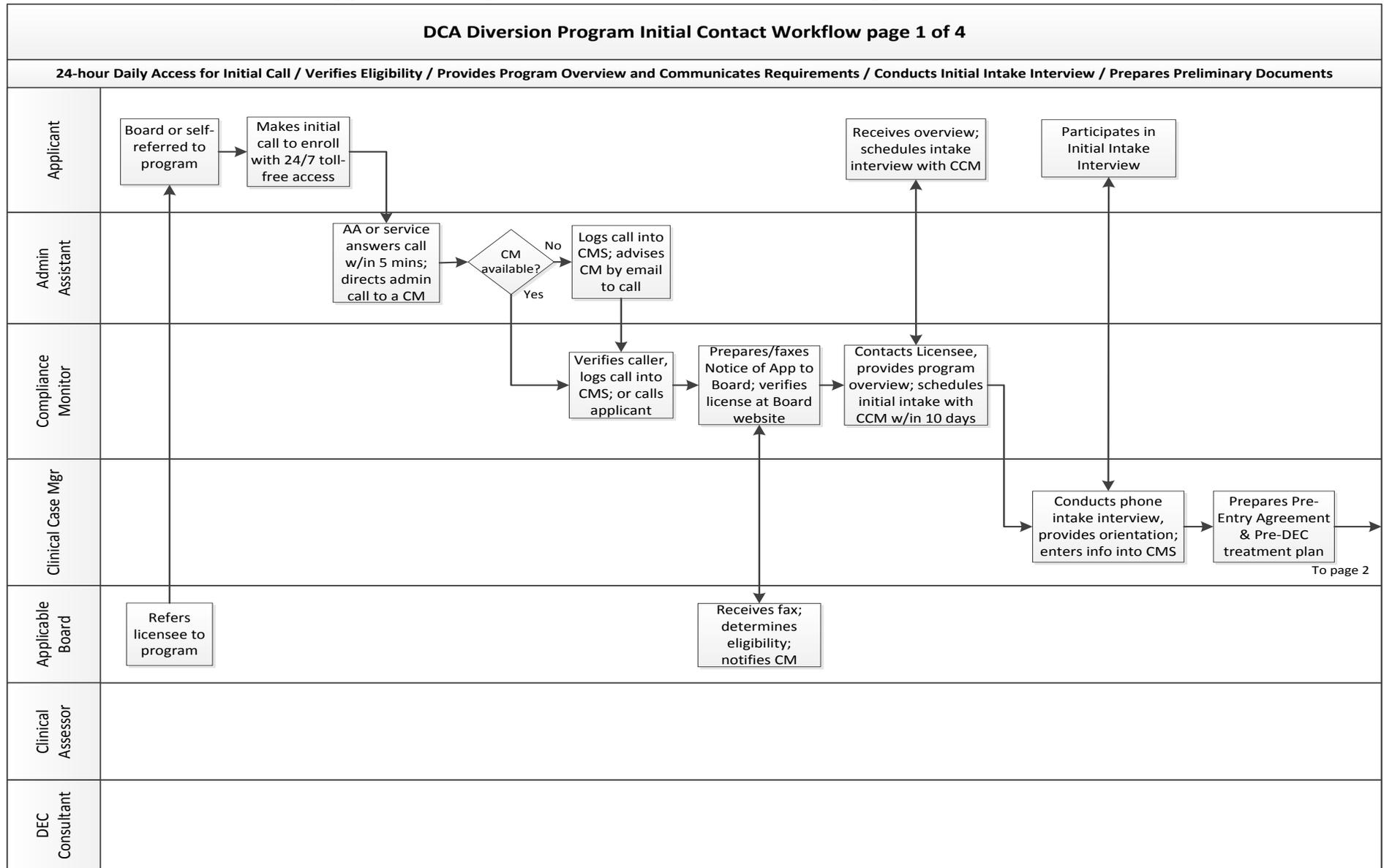
*(Added by Stats. 1982, Ch. 870, Sec. 1.)*

**4863.**

Three members of a diversion evaluation committee shall constitute a quorum for the transaction of business at any meeting. Any action requires the majority vote of the diversion evaluation committee.

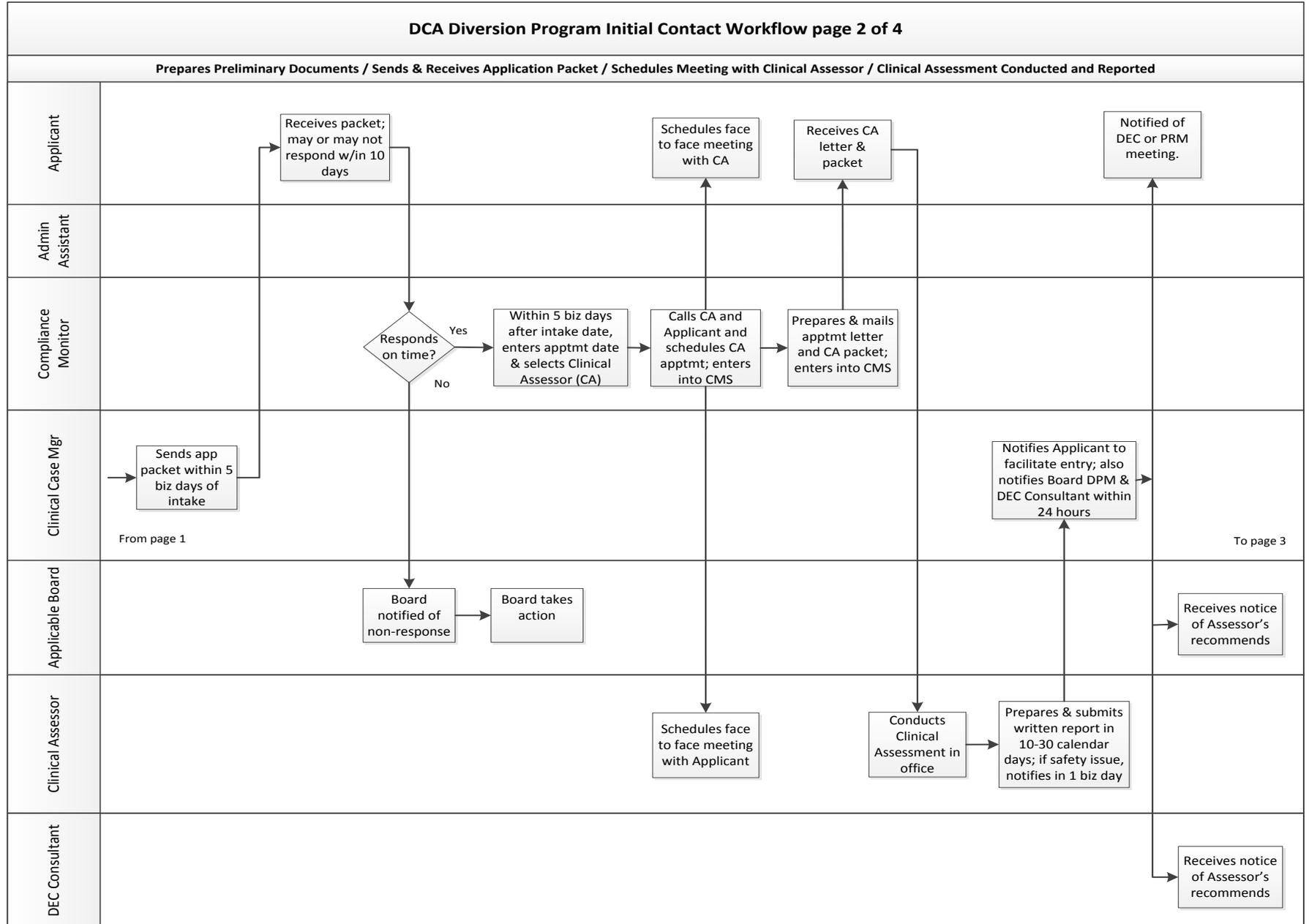
*(Added by Stats. 1982, Ch. 870, Sec. 1.)*

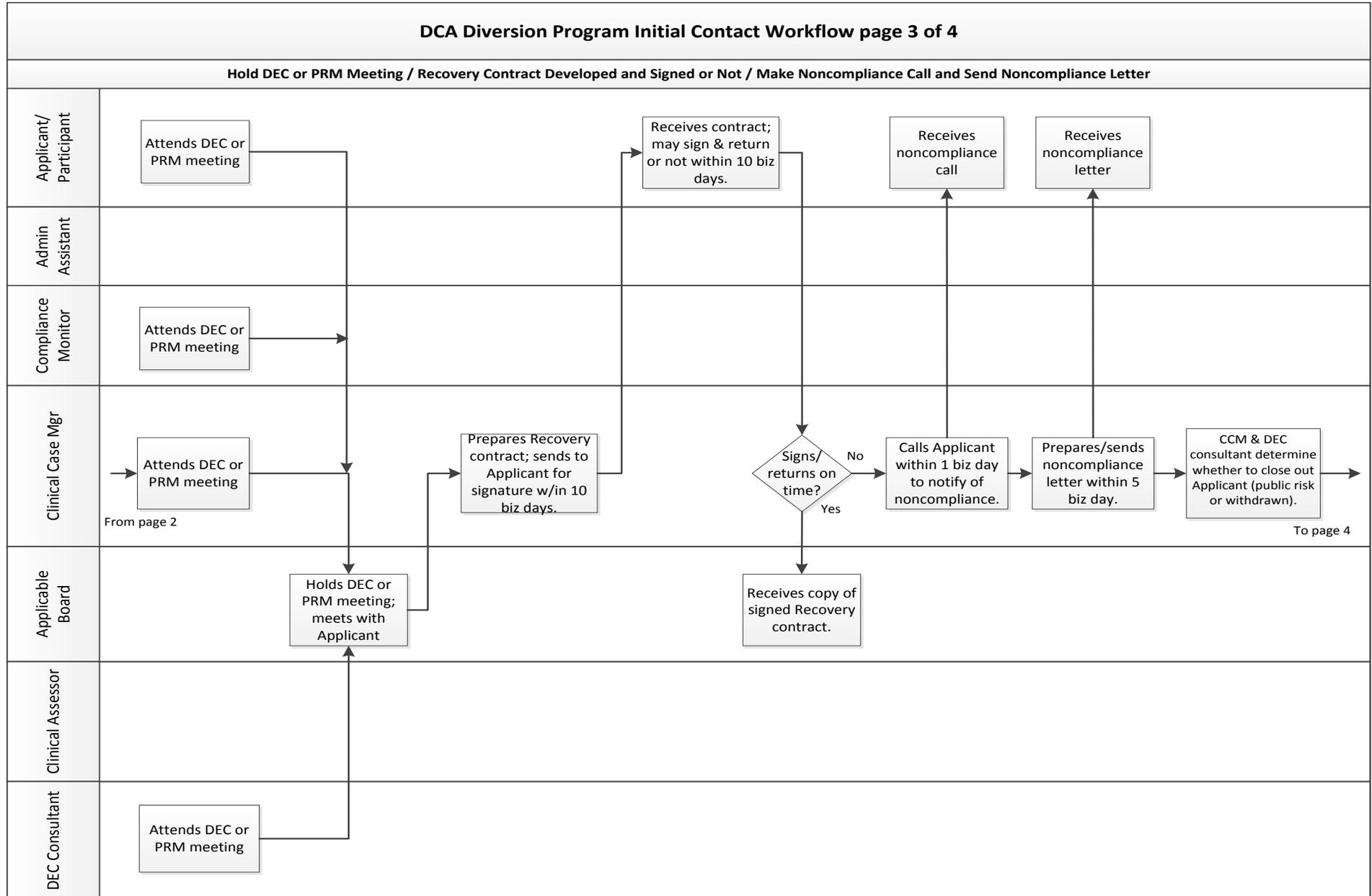
## Appendix 2: High Level Flowchart of Initial Participant Contact

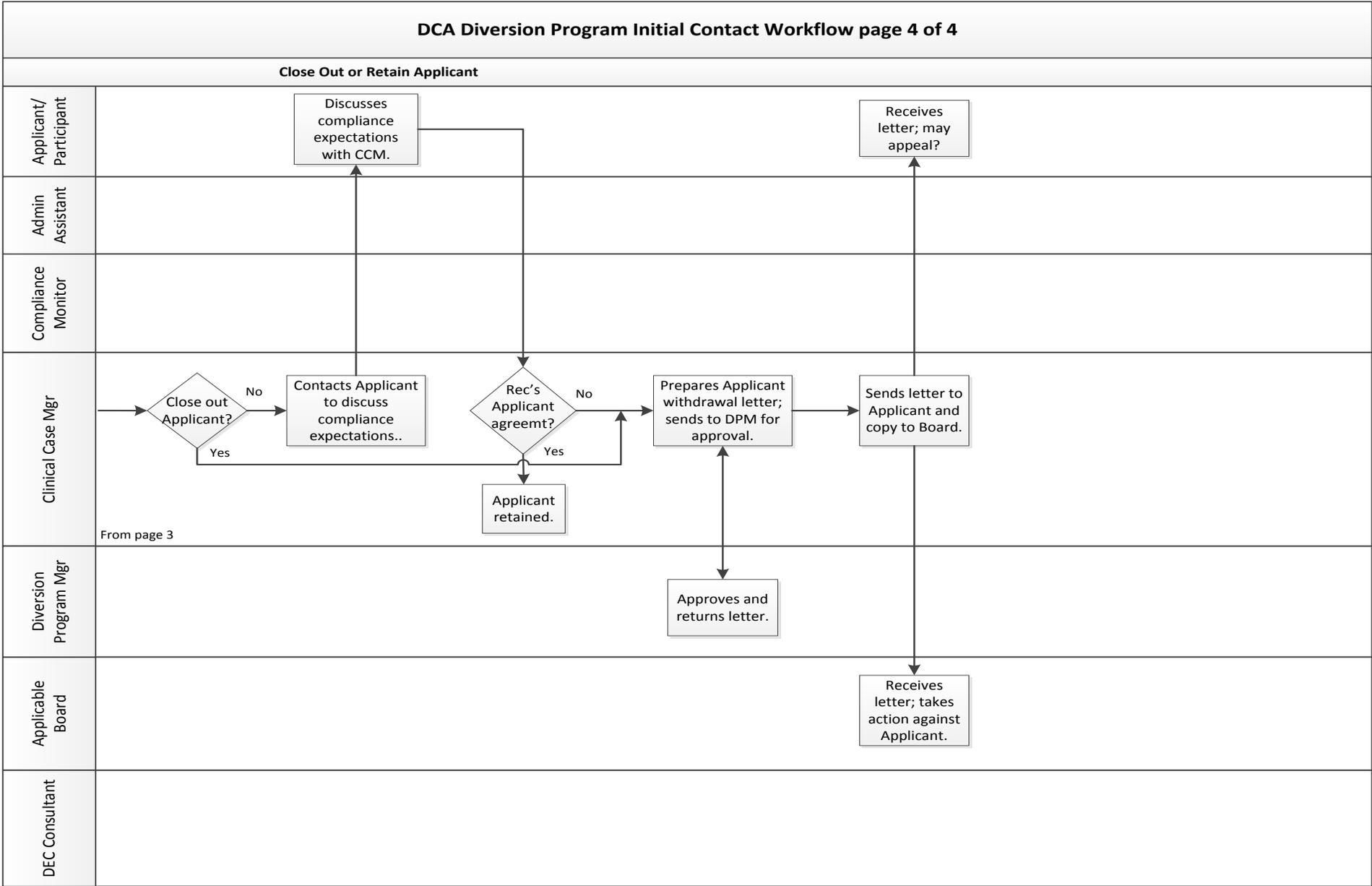


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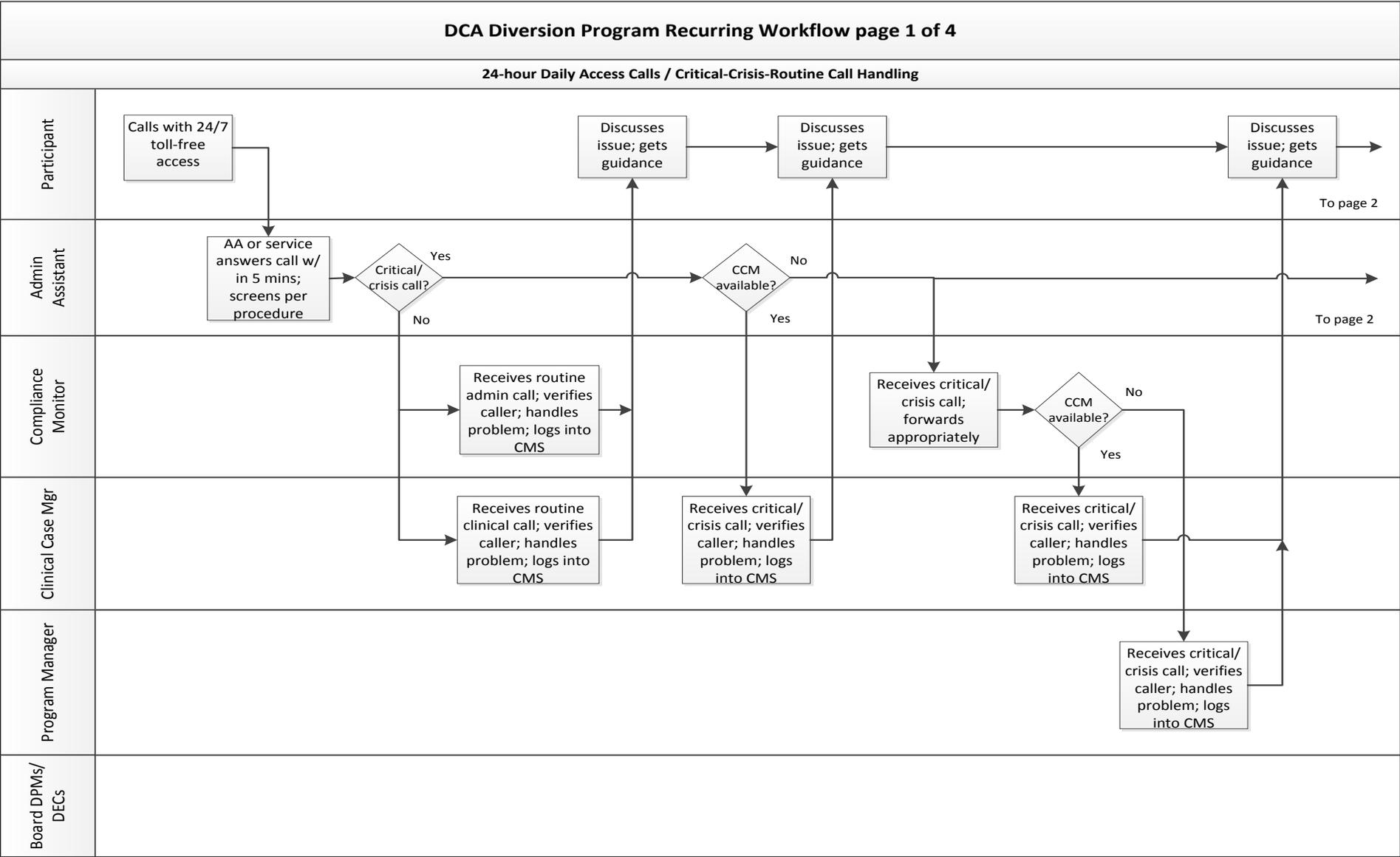
Prepares Preliminary Documents / Sends & Receives Application Packet / Schedules Meeting with Clinical Assessor / Clinical Assessment Conducted and Reported

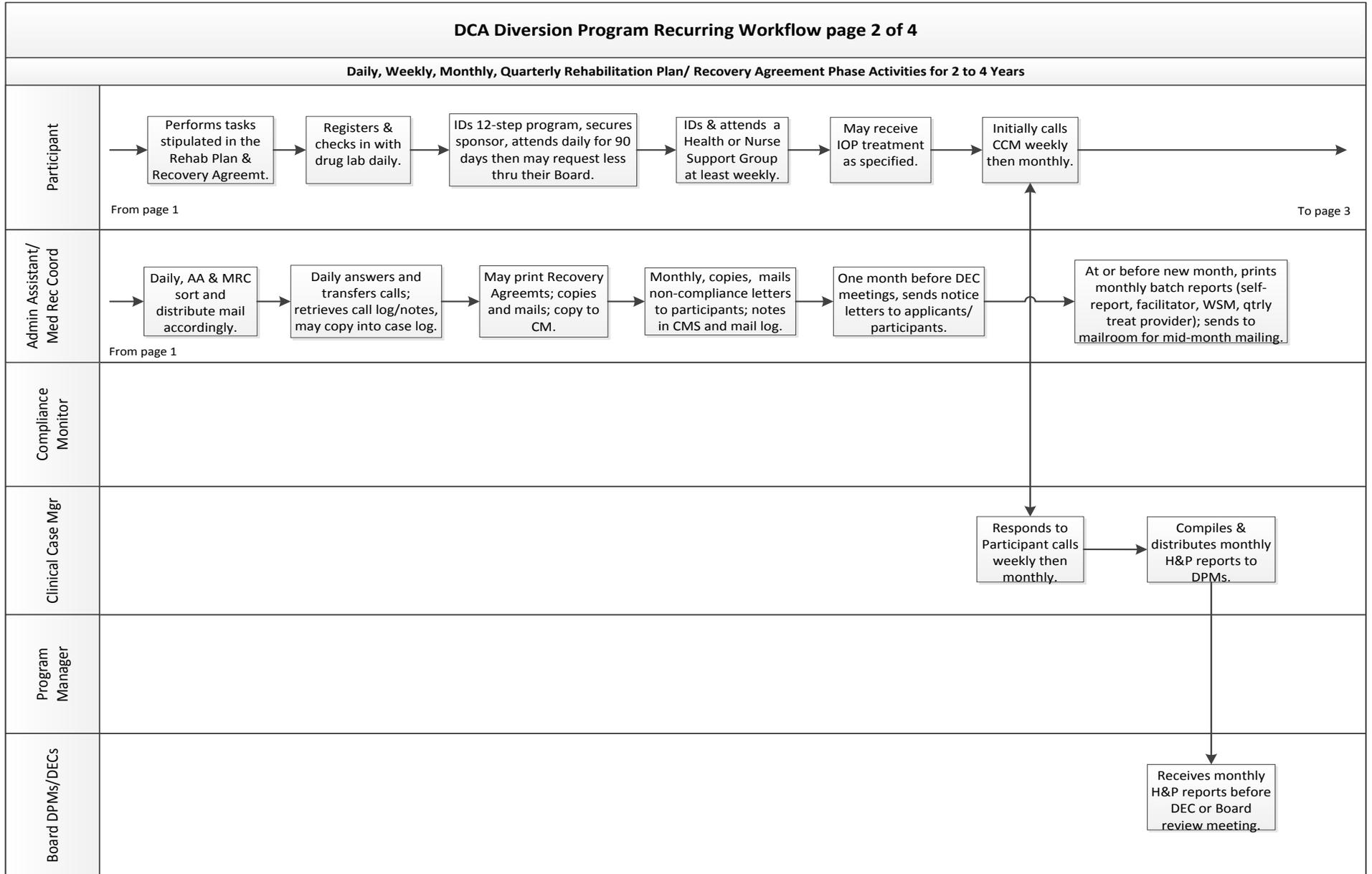


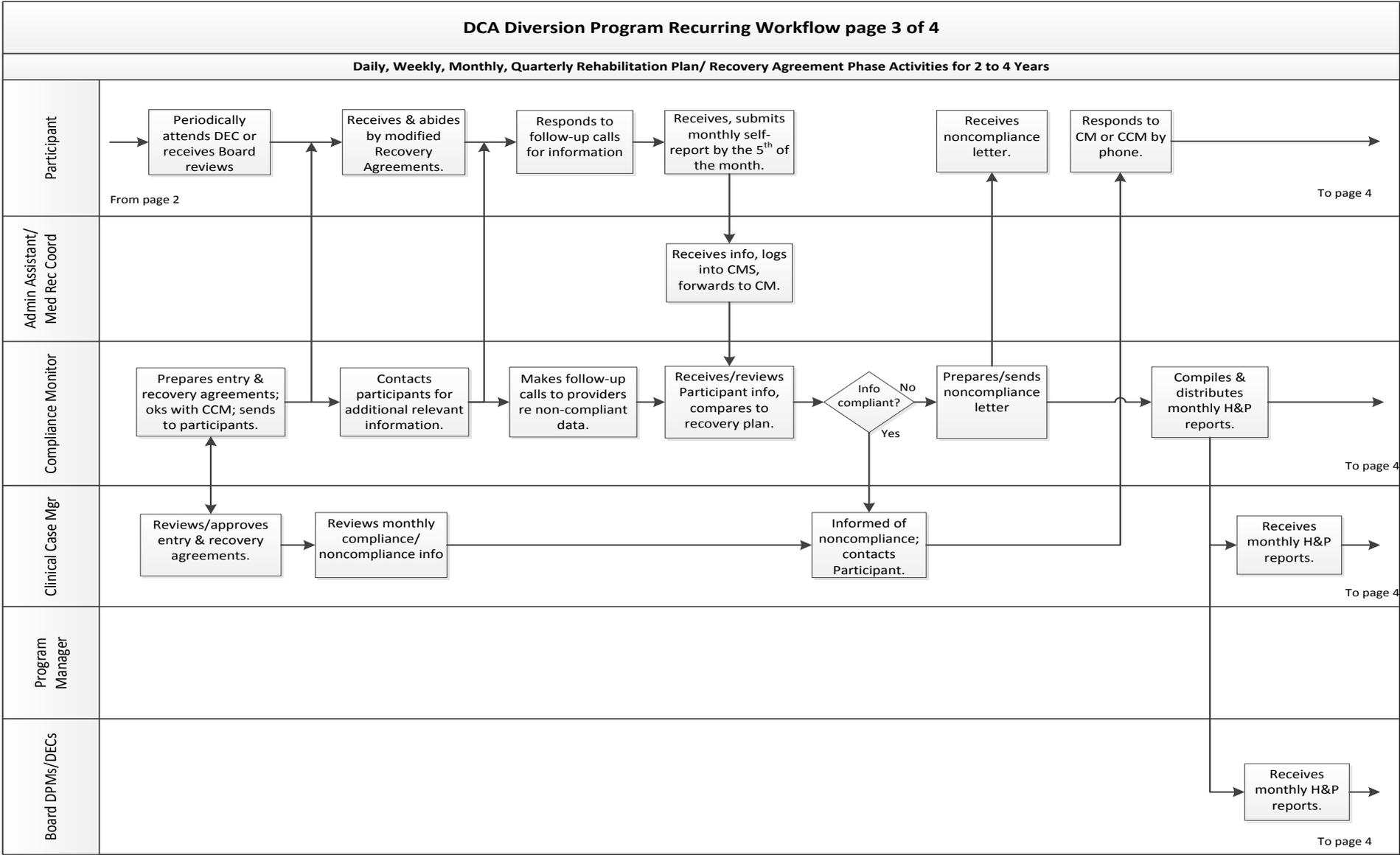


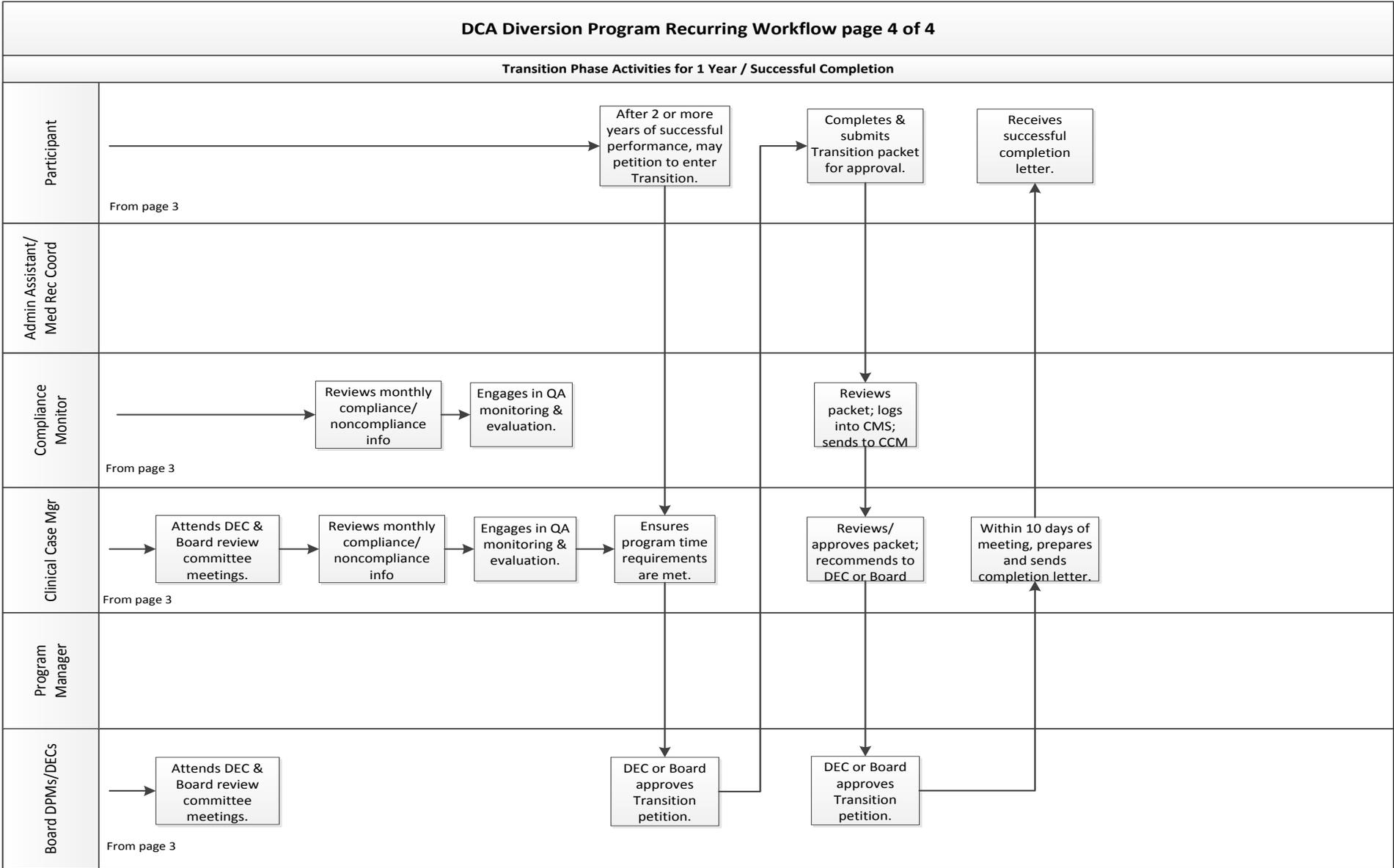


**Appendix 3: High Level Flowchart of Recurring Program Tasks**









### Appendix 4: FirstLab Drug Testing Panel

The following is the drug testing panel used during the audit period.

DRUG GROUP.	SCREEN DETECTION LEVEL* ng/inl**	MASS SPECTROMETRY CONFIRMATION DETECTION LEVEL* na/tml*
Ethanol (Alcohol)	0.02%	0.02%
Ethyl Glucuronide (ETG/ETS)	250	250
Amphetamines (EMIT)	1000	500
Barbiturates (EMIT)	300	200
Benzodiazepines (EMIT)	300	300
Cocaine Metabolites (EMIT)	300	150
Marijuana Metabolites (EMIT)	20	15
Methadone (EMIT)	300	200
Methaqualone (EMIT)	300	200
Opiates/metabolites (EMIT)	300	300
Phencyclidine (EMIT)	25	25
Propoxyphene (EMIT)	300	200

<b>BENZODIAZEPINES (MASS SPECTROMETRY)</b>		
Alprazolam (Xanax)	50	50
Bromazepam (Clectopam)	***LOD	***LOD
Clorazepate (Tranxene)	100	100
Chlordiazepoxide (Librium)	100	100
Clonazepam (Klonopin)	100	100
Diazepam (Valium)	100	100
Flunitrazepam (Rohypnol)	50	50
Flurazepam (Dalmane)	100	100
Halazepam (Paxipam)	100	100
Lorazepam (Ativan)	100	100
Lormetazepam (Noctamid)	100	100
Medazepam (Nobrium)	100	100
Midazolam (Versed)	50	50
Nitrazepam (Somnibel)	100	100
Oxazepam (Serax)	100	100
Prazepam (Centrax)	100	100
Temazepam (Restoril)	100	100
Triazolam (Halcion)	50	50

<b>NARCOTICS (MASS SPECTROMETRY)</b>		
Buprenorphine (Buprenex)	10	10
Butorphanol (Stadol)	***LOD	***LOD
Dextromethorphan (Rornilar)	100	100
Fentanyl	50	50
Hydrocodone (Vicodin)	100	100
Hydromorphone (Dilaudid)	100	100
Ketamine (Ketalar)	***LOD	***LOD
Meperidine (Demerol)	100	100

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Meprobamate/Carisoprodol (Miltown/Soma)	100	100
Nalbuphine (Nubain)	100	100
Naltrexone (Trexan)	***LOD	***LOD
Oxycodone (Percocet)	100	100
Oxymorphone (Numorphan)	100	100
Pentazocine (Talwin)	100	100
Tramadol (Ultram)	***LOD	***LOD

### Appendix 5: Contract Performance Standards Measured

#	
1	The Contractor must prepare a yearly calendar of upcoming DEC and PRM meetings. The calendar must be approved by the DPM for that Board and once approved the Contractor will distribute the calendar to all DEC members and the DPM by November 1st preceding each year. (§4.A.17; page 57) (LD's \$500.00/day)
2	Contractor shall prepare and provide a History and Profile Report, and a current list relevant to the applicant/participant(s) monitored by their respective DEC and/or DPM who have had a Positive Drug Screen, Relapse and/or Public Threat Report(s) on each applicant/participant for their respective DEC and DPM no less than five (5) business days prior to the DEC or PRM. (§4.A.17; page 58)(§4.A.15; page 50) (LD's \$500/day)
3	If a positive drug screen is determined to be a relapse by the CCM or DEC Case Consultant, a copy of the drug screen and a Relapse Report must be mailed or faxed to the DPM and DEC consultant within five (5) business days. (§4.A.13. B; page 43) (LD's \$200/day)
4	Contractor shall prepare and provide a written Board specific Monthly Participant Statistical Profile Report on the applicant/participant(s) in the Diversion Program and distribute the report to each DPM for their respective participant(s) within five (5) business days of the end of each month. (§4.A.12; page 41) (LD \$250/day)
5	Contractor shall prepare and provide to the DPM a Monthly Status Report for their respective Board by the tenth of each month. (§4.F.2; page 127) (LD \$250/day)
6	Contractor shall prepare and provide to the DPM a Quarterly Report for their respective Board by the twentieth day of the month following each quarter. (RFP §4.F.3; page 128) (LD \$250/day)
7	Contractor shall prepare and provide to the DPM an Annual Diversion Program Report within 45 days following the end of the state fiscal year, June 30.(§4.F.4; page 131) (LD \$250/day)
8	If terminated, the Contractor shall provide a Termination Report to the DPM and/or DEC Case Consultant within five (5) calendar days from the termination date.(§4.A.10; page 33)
9	BRN: Contractor shall include a Compliance Report with the Monthly Participant Statistical Profile Report detailing the areas for non-compliance for each applicant/participant that must be distributed to the DPM, DEC Chairperson, and assigned DEC Case Consultant monthly and within five (5) business days of the following month.(§5.A. 12; page 133)
10	BRN: A supplemental report shall be provided to each DEC regarding that particular DEC's applicant/participant cases. This report along with the History and Profile Report (H&Ps) shall be mailed and received by the DEC and DPM. (§5.A. 15; page 141) (per contract, provided at DEC)
11	Contractor shall verify a self-referral participant's license online with the Board's website prior to accepting him or her into the Diversion Program and quarterly to ensure the licensee has a current and valid license. (§6. A. 2; page 149 and §8.A.2; page 165) DBC and PTBC; (§9.A.2.; page 175)
12	DBC: The CCM shall consult with the DPM and DEC Chair to determine if the licensee needs to be removed from practice no more than seven (7) business days after completing the initial intake interview. (§6. A. 5; page 149)
13	A written breakdown of the Diversion Program requirements, the applicant/participant's financial obligation, and the required consent forms shall be mailed to the applicant/participant within five (5) business days of the initial intake interview. The CCM shall inform the applicant/participant to return the consent forms within 10 days of receipt. (§4.A.4; page 19)
14	The CCM... assigned to the applicant/participant's Board shall conduct an applicant/participant initial intake interview within 10 business days of application to the Diversion Program. (§4.A.5; page 20)
15	The clinical in-person assessment(s) shall take place within 10 days from the date of the CCM's initial clinical intake assessment interview. (§4.A.6; page 22)
16	The clinical assessor shall submit his or her written assessment of the applicant/participant to the Contractor within 30 days of the clinical in-person assessment. (§4.A.6; page 22)

17	If the clinical assessor recommends the applicant/participant requires immediate in-patient treatment, the clinical assessor shall notify the Contractor within one (1) business day. Upon notification from the clinical assessor, the CCM shall notify the DPM or DEC Case Consultant within 24 hours of the clinical assessor's recommendation. (§4.A.6; page 22)
18	The DPM must be notified within one (1) business day that the Intake has been completed along with the date and location of the applicant's first DEC meeting. (§5.A. 5; page 133)
19	BRN: The DPM must be notified of the scheduled date of the Intake within one (1) business day of scheduling. (§5.A. 5; page 133)
20	All Pre-Entry and Recovery Contracts shall be prepared and mailed to the applicant/participant and the DPM within 10 business days of approval by DEC or DPM. (§4.A.8; page 24)
21	All applicant/participants must have a designated worksite monitor. The Contractor shall validate that the approved worksite monitor is in place. (§4.A.9; page 29)
22	The CCM assigned to the applicant/participant shall contact the applicant/participant's worksite monitor within 10 business days from receipt of worksite monitor notification to communicate the responsibilities of being a worksite monitor and to review how to identify and detect certain indicators of relapse or threat to themselves or the public and how to report such instances to the CCM. (§4.A.9; page 29)
23	The Contractor shall provide... Successful Completion... Letter to the participant within 10 business days from the date of the DEC or PRM meeting or if terminated, from the date of termination (§4.A.10; page 31)
24	The Contractor shall provide a Termination Letter to the participant within 10 business days from the date of the DEC or PRM meeting or if terminated, from the date of termination (§4.A.10; page 31)
25	If the applicant/participant fails to return a signed copy of the contract as required, the Contractor shall... mail a Non-Compliance Letter within five (5) business days to the DPM and applicant/participant. (§4.A.10; page 31)
26	If the applicant/participant fails to return a signed copy of the contract as required, the Contractor shall verbally notify the applicant/participant within one (1) business day... (§4.A.10; page 31)
27	The Non-Compliance Letter must be prepared and mailed to the applicant/participant within five (5) business days of discovery of non-compliance. (§4.A.11; page 38)
28	The Non-Compliance Letter must be prepared and mailed to the DPM and/or Board's designee within five (5) business days of discovery of non-compliance. (§4.A.11; page 38)
29	For any termination resulting from non-compliance that is not deemed a public risk, the CCM shall provide to the DPM and/or Board's designee within five (5) business days of the termination a Termination Letter. (§4.A.11; page 22)
30	BOP: If the confirmed positive drug screen is positive for any unauthorized substance, the CCM shall verbally notify the Board's DPM within one (1) hour of notification by the drug testing provider either via telephone or email that pursuant to the participant's recovery contract they are prohibited from practicing. (§7.A.13.A; page 158)
31	Non-negative drug screens are reported to the DPM or DEC Case Consultant on a Non-negative Drug Screen Report within one business day (§4.A.13; Page 46)
32	If the confirmed positive drug screen is positive for any unauthorized substance, the CCM shall verbally notify the applicant/participant within one (1) hour of notification by the drug testing provider that he or she has tested positive for an unauthorized substance and they are immediately removed from practicing until further notice. (§4.A.13; page 43)

33	If a confirmed positive drug screen is positive for any unauthorized substance, The CCM shall notify the worksite monitor within one (1) hour of notification by the drug testing provider that pursuant to the applicant/participant's recovery contract they are prohibited from practicing until further notice. (RFP §4.A.13; page 43)
34	If a confirmed positive drug screen is positive for any unauthorized substance, The CCM shall notify and confer with the Board's DPM or DEC Case Consultant within one (1) business day and provide remediation plans. (§4.A.13; page 43)
35	If a confirmed positive drug screen is positive for any unauthorized substance, The CCM must notify the applicant/participant's support group facilitator within one (1) business day. (§4.A.13; page 43)
36	Any treatment contract modifications resulting from a positive or non-negative drug screen or relapse shall be provided to the applicant/participant via telephone within (1) business day (§4.A.13; page 43)
37	A modified Recovery Contract shall be mailed within five (5) business days after consulting with the Board's DEC Case Consultant and/or DPM regarding any treatment contract modifications resulting from a positive or non-negative drug screen or relapse. (§4.A.13; page 43)
38	If the applicant/participant fails to return a signed copy of the modified Recovery contract resulting from a positive or non-negative drug screen or relapse as required, the Contractor shall verbally notify the applicant/participant within one (1) business day and shall mail a Non-Compliance Letter within five (5) business days to the DPM and applicant/participant. (§4.A.13; page 43)
39	In the event that an applicant/participant has been determined by the appropriate authority as designated in the Board Specific Requirements to be a threat to themselves or others, the CCM assigned as the designated consistent team for that applicant/participant must notify the DPM and/or DEC Case Consultant within one (1) business day by sending a Public Threat Report. (§4.A.14; page 48)
40	If the applicant/participant is terminated from the Diversion Program, the CCM shall submit a Termination Letter to the applicant/participant and the DPM within five (5) business days (§4.A.14; page 48)
41	All closure documents, files, and a written in-depth Public Threat Report describing the justification as to why the applicant/participant is being terminated must be mailed only to the DPM, DEC Consultant & Participant within five (5) business days of the closure.(§4.A.14; page 48, § 5.A.14; Page 140)
42	Contractor shall have a CCM attend HSG/NSG support group meetings at a minimum once per year to ensure that the groups are functioning properly and that the facilitator is supporting the goals and objectives of the Diversion Program unless otherwise indicated in Board Specific Requirements. (§4.B.4; page 81)
43	Contractor shall survey the participant who successfully completed or was terminated from the program within thirty (30) days of exiting the program. (§4.F.1; page 120)
44	Contractor shall meet quarterly with the DPMs for a Quality Review Meeting to report verbally and in writing on the quality of the program. (RFP §4.F.1.1; page 122)
45	Contractor shall investigate and resolve complaints made about services provided by Contractor's staff or subcontractors. The Contractor shall provide written documentation to the DPM detailing the initial complaint(s) and corrective action(s) taken within ten (10) days of receiving the complaint. Contractor will develop a standardized complaint resolution process that will be approved by the DPMs. (§4.B.3, page 80)

## Appendix 6: Auditee Responses

The following includes audit responses prepared by Maximus and the seven participating Boards. Inaccuracies identified by the auditees in the draft report have been corrected in this final report.

### MAXIMUS Response to the DCA audit of the California Health Professionals Diversion Program Conducted by CPS-HR Consulting February 10, 2016

#### **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.

We applaud the DCA for the incorporation of key elements contained in SB1441 Uniform Standards into the program before the legislation was enacted. As noted in our responses, the 2015 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 recognize that there were no audit findings, and are responding to the recommendations of the Audit Team. All actions that are described in the responses are the responsibility of the Project Manager to implement.

We continue to work closely with the DCA to continue to improve the processes which protect the safety of the healthcare consumers of California.

#### **RECOMMENDATION #1:**

If applicable and warranted, other DCA healing arts Boards should consider participating in the Diversion Program, and in particular, the Medical Board of California and Board of Vocational Nursing and Psychiatric Technicians.

#### **MAXIMUS RESPONSE:**

Thank you for the recommendation for standardization of services to add the DCA healing arts boards who do not currently participate in the Diversion Program. Although MAXIMUS is not required to respond to this specific recommendation, we do believe in the mission of the Diversion program and support this recommendation for the Boards that are not currently served by the Program. MAXIMUS stands at the ready to assist the Boards in drafting the appropriate legislation to allow for implementation of this recommendation.

#### **RECOMMENDATION #2:**

The BRN should consider making probationers attend the Diversion Program as a condition of probation.

#### **MAXIMUS RESPONSE:**

Thank you for the recommendation for standardization of services to Probationers managed by the BRN Enforcement unit. MAXIMUS is not required to respond to this recommendation, however, wishes to state that several other Boards currently enroll the Probation Participants in the Diversion Program to assist with management of their Substance Use Disorders. This is a very effective partnership for these Boards, assists them to interpret and manage the clinical aspects of Addiction, and allows the Probation Monitors to conduct their enforcement duties without distraction.

**RECOMMENDATION #3:**

Maximus should identify a program staff member whose sole responsibility is to become knowledgeable about health insurance coverage benefits and referral sources, and periodically update the Clinical Case Managers and Compliance Monitors.

**MAXIMUS RESPONSE:**

MAXIMUS recognizes the value of employing an individual whose sole responsibility it is to become knowledgeable about health insurance coverage benefits and referral sources, and periodically update the Clinical Case Managers and Compliance Monitors; however such a position is not contractually required and is beyond what the program can support financially at this point in time.

**RECOMMENDATION #4:**

Program participants should assume personal responsibility to contact and research coverage options and costs with the health insurance companies listed on the Covered California website.

**MAXIMUS RESPONSE:**

MAXIMUS concurs with the recommendation to place personal responsibility for insurance coverage options and costs onto the program participants, however, participants are often overwhelmed and fragile when entering the program, and they need the program's assistance to sort through the many options available to them. In response to this recommendation, and although not contractually required, MAXIMUS will investigate the feasibility of creating a tool to assist participants with referral sources and coverage options.

**RECOMMENDATION #5:**

Maximus should consider and evaluate all of the Diversion Program Manager (DPM) recommendations and, at a minimum, provide the DPMs with recovery training.

1. Hire more CCMs and increase the number of participants.
2. Identify ways to better manage or reduce participant costs.
3. Identify ways to better treat participants suffering from mental illness.
4. Provide DPMs with recovery training.

**MAXIMUS RESPONSE:**

1. MAXIMUS staffing meets or exceeds the contractual requirement of a maximum of 130 participants per Clinical Case Manager/Compliance Monitor Team.
2. MAXIMUS is sensitive to the program costs, and concurs that the frequency of Random Drug Testing that is required by the Uniform Standards has increased the costs participants must bear. We encourage participants to work together to identify collection sites with lower fees, and the CCMs and Boards/DECs evaluate testing frequencies often in order to reduce them if possible. Due to the extensive nature of the test panel, the per-test fee is the lowest MAXIMUS was able to negotiate among possible vendors. MAXIMUS will continue to work to identify ways to manage or reduce participant costs.
3. The Board of Registered Nursing has called together a subcommittee of Intervention Program Committee Chairs who have volunteered to review the guidelines currently in use to manage Mental Health Participants. MAXIMUS will be involved in this process and will actively participate in developing the improved guidelines.
4. Although not contractually required, MAXIMUS has provided multiple sessions of training in conjunction with the Laboratory Subcontractor which have been made available to all DPMs. In the past, training has been provided at no charge to the DPMs in a variety of formats, including all-day workshops, via interactive

web conference, and in one-hour webinars. The Diversion Project Manager makes relevant articles and publications available to the DPMs as they become available. The MAXIMUS Project Manager has also provided small group or one-on-one training as requested.

**RECOMMENDATION #6:**

Maximus should consider and evaluate all of the stated Treatment Provider obstacles/ challenges, then prioritize and implement the recommendations accordingly.

**MAXIMUS RESPONSE:**

MAXIMUS appreciates the opportunity to review the challenges faced by the Clinical Assessors, Support Group Facilitators, and Worksite Monitors, and commits to reviewing the suggestions for improvements. It is noted that Clinical Assessor recommendations # 4 and 5 are at the discretion of the Boards if the enabling statutes permit, and if not, would require legislative changes to implement. In response to a recurring request to provide online reporting access, MAXIMUS is developing an enhanced version of the online case management system, which will allow for online transmission of forms and an update to the clinical assessment tool by July, 2016.

**RECOMMENDATION #7:**

As evidenced by the success of the auditor's online survey, Maximus should periodically reach out to Treatment Providers and other stakeholders to identify ongoing issues and opportunities for continuous improvement.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. MAXIMUS values the input from stakeholders. It appears that direct email invitations are very effective in generating a response to surveys, and this method will be considered in the future.

**RECOMMENDATION #8:**

Maximus and the Boards should ensure each credential review is completed in compliance with the Uniform Standards, including evidence of: a license, experience and insurance; do not accept licensees with whom they have had a personal, financial and business relationship within the last year; and Board approval.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. MAXIMUS will implement the credentialing changes that have been suggested.

**RECOMMENDATION #9:**

Per healthcare standards, perform and document an OIG clearance for each Treatment Provider at <https://exclusion.oig.hhs.gov>

**MAXIMUS RESPONSE:**

Thank you for the recommendation. Although not contractually required, MAXIMUS will consider implementing an OIG clearance for Support Group Facilitators and Clinical Assessors.

**RECOMMENDATION #10:**

Per healthcare standards, require all Treatment Providers with access to records to sign HIPPA confidentiality statements.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. MAXIMUS will implement the use of a confidentiality statement for the treatment providers who access the participant records.

**RECOMMENDATION #11:**

Maximus should consider hiring a part-time CCM to cover vacations, illness and time away at DEC meetings, etc. This will improve the management of multiple calls.

**MAXIMUS RESPONSE:**

Thank you for this recommendation. MAXIMUS is currently in the process of filling a part-time Clinical Case Manager position to assist with coverage of Case Manager duties.

**RECOMMENDATION #12:**

Maximus program staff should continue to document reasons for delay.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. The Audit Team reports that “There was only one delay that was not explained in the case logs or participant’s profile.” MAXIMUS agrees that it is good practice to document the reasons for the delays, and the Diversion staff will be reminded to do so.

**RECOMMENDATION #13:**

All program staff should take advantage of the improved spelling and grammar check feature in the upgraded Max-CMS.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. As noted in the audit report, the upgraded version in 2016 will make spell check available to all employees and treatment providers and should correct much of this problem.

**RECOMMENDATION #14:**

The Project Manager should review and revise closing notes as necessary.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. The Project Manager currently reviews the majority of closure notes written by the Clinical Case Managers, and will continue to do so.

**RECOMMENDATION #15:**

Use the participant’s first or last name rather than pronouns only to prevent misunderstandings with case log entries.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. MAXIMUS will review options for improving clarity of documentation.

**RECOMMENDATION #16:**

Maximus should develop and implement a written policy for making deletions and retractions to case logs. The American Health Information Management Association website (<http://www.ahima.org>) has examples and sample policies Maximus could use.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. Permission to delete and edit case log notes is limited to the Project Manager, the Operations Manager, and the Information Systems Administrator. This access will continue to be restricted, and a written policy will be developed to manage this process.

**RECOMMENDATION #17:**

Maximus program staff should track and trend the reasons for program withdrawal to determine the number of participants who withdrew for financial and other reasons.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. MAXIMUS will begin tracking this data, beginning January 1, 2016.

**RECOMMENDATION #18:**

Maximus program staff should improve or modify the Program Handbook in a variety of ways.

1. Explain in the Handbook how to properly dispose of drugs according to the US Food and Drug Administration web site, and emphasize that participants may not give the drugs they are discarding to other persons for their use.
2. Attach a letter to the applicant's packet to encourage reading/re-reading the Handbook until they are familiar with the rules and expectations (participants are required to sign, date and return the Handbook Acknowledgment Signature Sheet), and consider giving applicants a pre-DEC test to validate their understanding.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. These recommendations will be taken into consideration and will be discussed with the Diversion Program Managers. The information on how to properly and safely dispose of medications will be added to the Handbook.

**RECOMMENDATION #19:**

Maximus program staff should improve or modify the Program Handbook in a variety of ways

- Add an index so applicants/participants can easily find needed information.
- Modify the drug testing information to include stronger language about the consequences of missing a call into the lab and missing a random drug test.
- Use bold letters or highlight the essential compliance information.
- Insert the Maximus Diversion Program Random Body Fluid letter into the Handbook and include additional information regarding caffeine and protein. For example: "Please be aware that any confirmed positive, dilute or out of range random body fluid testing (RBFT) may result in immediate suspension of work privileges.
- Tips to ensure test results fall within acceptable ranges include:
  - Do not use any mind-altering substances.
  - Test before 10:00 AM.
  - Avoid the use of caffeine before testing, including coffee and caffeinated drinks like energy drinks and sodas.
  - Limit fluid intake before the test.
  - Consume some protein in the morning before the test, such as an egg or protein bar, plain yogurt with fruit and nuts, breakfast burrito with black beans and cheese, whole wheat bread with 2 tablespoons of peanut butter, etc.
- Avoid exercise before testing."
- Include information about how participants can prove they followed the protocol at the collection site, such as taking a photo of the specimen, and/or post test data.

- Many participants with an upper respiratory infection unknowingly took over-the-counter (OTC) medications without thinking of the consequences of taking a banned substance. CCM's suggest Mucinex without DM for coughs. Participants might also consider using home remedies such as hot tea and honey, saline gargles, humidifiers and 'Nedi' pots with saline water for nasal cleansing rather than other OTC drugs than contain prohibited ingredients.
- Include information on ways to remember to call the lab, such as setting alarms and/or always calling at the same time every day.
- Suggest possible call reminder tools, including but not limited to: paper calendars, check lists, Google calendar or similar smart phone applications.

**MAXIMUS RESPONSE:**

Thank you for the multiple recommendations for improvement of the Program Handbook. These suggestions will be reviewed and implemented as appropriate.

**RECOMMENDATION #20:**

Maximus program staff should improve or modify the Program Handbook in a variety of ways.

- Remind participants that multiple minor violations hinder progress in the program and that 100% compliance is expected before being allowed to move to the transition phase.
- Revise the MSR information on page 8 to indicate the first page of the MSR must be submitted with the rest of the report and include a notation regarding the same on the first page.
- Revise the WSM information on page 9 to advise participants to check with their WSM by the first of the month to ensure their report is submitted timely.
- Revise the Treatment Provider Progress Report information on page 7 to advise participants to check with their treatment provider by the first of each month to ensure their reports are submitted timely.
- Revise the Support Group Facilitator information on pages 7-8 to advise participants to check with their group leader by the first of each month to ensure their reports are submitted timely.
- Include reminder tools such as, but not limited to: paper calendars, check lists, Google calendar or similar smart phone applications.
- Suggest participants call or email the Maximus CM or CCM monthly to verify that all reports have been received in a timely manner.

**MAXIMUS RESPONSE:**

Thank you for the multiple recommendations for improvement of the Program Handbook. These suggestions will be reviewed and implemented as appropriate.

**RECOMMENDATION #21:**

Maximus should include medicine disposal information from the USFDA website in the Program Handbook.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. This recommendation appears to be a duplicate of #18, and is addressed above.

**RECOMMENDATION #22:**

Maximus should consider advising participants to seek out Mental Health Services from their local county government Adult System of Care, when appropriate.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. The MAXIMUS Clinical Case Mangers offer a variety of referrals to treatment, and this resource will be made available to participants.

**RECOMMENDATION #23:**

Maximus should contact the California Chapter of the American Organization of Nurse Executives and California Hospital Association to speak at a regional or state-wide meeting regarding the prevention and detection of nurses diverting drugs.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. The MAXIMUS Project Manager and a representative of the BRN provided a presentation to the Southern California chapter of the California Hospital Association and more recently to the Kern County Chapter of the California Association of Nurse Leaders. MAXIMUS and the BRN are scheduled to present to the San Diego chapter of the California Association of Nurse Leaders in March, 2016. MAXIMUS will continue to reach out to these organizations to expand awareness of the Diversion Programs.

**RECOMMENDATION #24:**

The Board's should collectively consider identifying an acceptable, but less frequent, random testing schedule that would accomplish the goal and reduce participant cost and loss, then modify Uniform Standard 4 accordingly.

**MAXIMUS RESPONSE:**

MAXIMUS is not required to respond to this recommendation.

**RECOMMENDATION #25:**

The non-DEC Board's should consider evaluating the effectiveness of the participants' non-attendance at Board review meetings, and consider ways to improve interpersonal interaction by Skype, Face Time or other forms of communication.

**MAXIMUS RESPONSE:**

MAXIMUS is not required to respond to this recommendation.

**RECOMMENDATION #26:**

The Maximus Quality Analyst should periodically audit the FirstLab website files to ensure all program participants being drug tested are included in the database.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. The Laboratory Vendor has recently implemented a process to notify MAXIMUS when a new applicant establishes an account with the Lab. This will ensure that any delays are identified. In addition, the MAXIMUS QA Coordinator will implement a periodic comparison of MAXIMUS and FirstLab participant enrollment information.

**RECOMMENDATION #27:**

Maximus should revise the intake report accordingly to eliminate the confusion between monthly and year-to-date reporting.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. MAXIMUS will review the report for accuracy and clarity.

**RECOMMENDATION #28:**

Maximus should consider tracking and trending major violations and actions taken, and report this information in the annual report.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. This data will be tracked beginning January 1, 2016.

**RECOMMENDATION #29:**

Maximus should consider tracking and trending successful returns to work on a monthly and annual basis, and report this information in the annual report.

**MAXIMUS RESPONSE:**

Thank you for the recommendation. This data will be tracked beginning January 1, 2016.

**RECOMMENDATION #30:**

Participating Boards should attempt to monitor long range participant outcomes after program completion.

**MAXIMUS RESPONSE:**

MAXIMUS is not required to respond to this recommendation.



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February 10, 2016

CPS HR Consulting  
241 Lathrop Way  
Sacramento, CA 95815

Dear Auditor,

Enclosed is the Board of Registered Nursing's (BRN) response to the CPS HR Consulting draft report, "Department of Consumer Affairs — Contract and Performance Audit of the DCA Diversion Program provided by Maximus Health Services" dated January 28, 2016.

Thank you for the opportunity to respond to the draft audit report. Please contact Don Henry Walker, Intervention Program Manager, at (916) 574-7619 if you have any questions.

A handwritten signature in black ink, appearing to read 'Stacie'.

Stacie Berumen  
Assistant Executive Officer  
Board of Registered Nursing

**Board of Registered Nursing (BRN) Response to CPS HR Consulting's Draft Report:  
"Department of Consumer Affairs — Contract and Performance Audit of the DCA  
Diversion Program provided by Maximus Health Services"  
January 28, 2016**

**Recommendations**

- 1) If applicable and warranted, other DCA healing arts Boards should consider participating in the Diversion Program, and in particular, the Medical Board of Vocational Nursing and Psychiatric Technicians.**

The BRN agrees with this recommendation.  
No action plan needed.

- 2) The BRN should consider making probationers attend the Intervention Program as a condition of probation.**

The BRN will consider this recommendation.

Action Plan: The BRN will review the probation program to determine if opportunities exist to require probationers with substance use disorder to attend the Intervention Program as a condition of certain probation orders.

Contact Person: Elizabeth Elias, Probation Program Manager

- 4) Program participants should assume personal responsibility to contact and research coverage options and costs with the health insurance companies listed on the covered California website.**

The BRN agrees with this recommendation.

Action Plan: The BRN will add language to the BRN website FAQ section that refers individuals without health insurance coverage questions to the Covered California website.

Contact Person: Don Henry Walker, Intervention Program Manager

- 8) MAXIMUS and the Boards should ensure each credential review is completed in compliance with the Uniform Standards, including evidence of a license, experience and insurance; do not accept licensees with whom they have had a personal, financial and business relationship within the last year, and Board approval.**

The BRN agrees with this recommendation.

**Board of Registered Nursing (BRN) Response to CPS HR Consulting's Draft Report:  
"Department of Consumer Affairs — Contract and Performance Audit of the DCA  
Diversion Program provided by Maximus Health Services"  
January 28, 2016**

Action Plan: The BRN is in compliance with this recommendation. The BRN has a policy document NSG P-10 that addresses this recommendation.

Contact Person: Don Henry Walker, Intervention Program Manager

**24) The Boards should collectively consider identifying an acceptable, but less frequent, random testing schedule that would accomplish the goal and reduce participant cost and loss, then modify Uniform Standard 4 accordingly.**

The BRN agrees with this recommendation.

Action Plan: This would require the Department of Consumer Affairs to reconvene the Substance Abuse Coordination Committee who created the document, "Uniform Standards Regarding Substance-Abuse Healing Arts Licensees" that specifies the testing requirements in Uniform Standard 4.

The BRN is willing to participate in the process to develop acceptable random testing requirements.

Contact Person: Don Henry Walker, Intervention Program Manager

**30) Participating Boards should attempt to monitor long range participant outcomes after program completion.**

The BRN will consider this recommendation. The BRN requests clarification of the definition of "long range."

Action Plan: Business and Professions Code (B&PC) section 2770.12(b) states in pertinent part that all board and committee records pertaining to participation in the Intervention Program shall be kept confidential and not subject to discovery or subpoena, except as specified. B&PC section 2770.12(a) states in pertinent part that all records for a registered nurse who has successfully completed the intervention program shall be purged. B&PC section 156.1 specifies that a board shall retain all records for treatment and rehabilitation services for three years from the date of the last treatment or service rendered or until reviewed for audit by the department. After that time period the documents may be purged.

Based on the current laws stated above the information requested may only be available for three years yet participation in the program is deemed confidential. The BRN would need to seek guidance from DCA legal counsel as to what information is available to monitor outcomes.

Contact Person: Don Henry Walker, Intervention Program Manager



7  
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February 10, 2016

CPS HR Consulting  
241 Lathrop Way  
Sacramento, CA 95815

Attention: Jeff Mikles

Dear Mr. Mikles:

I have reviewed the draft report "Contract and Performance Audit of the DCA Diversion Program provided by Maximus Health Services", dated January 28, 2016. The report is comprehensive and well written. I do have a few comments.

On page 13 in the last paragraph you refer to entry into the Diversion program via "in lieu of discipline" and go on to reference the Board of Pharmacy (BOP) and the Dental Board (DBC). I recommend that last sentence be revised to reference the dental law as well as the pharmacy law....."if there has been no significant violation of pharmacy or dental laws, respectively".

Also, on page 16 in the last paragraph that starts "In 2011, Senate Bill 1441..." The second sentence implies that the DCA Substance Abuse Coordination Committee still exists. It does not. Therefore the sentence should indicate that the committee was comprised of 20 Executive Officers.....

Your recommendations for all boards have been noted. Once the report is final, I will take these recommendations to the Board for consideration.

Please feel free to contact me if you have any questions. I can be reached at [Karen.fischer@dca.ca.gov](mailto:Karen.fischer@dca.ca.gov) or (916) 263-2188.

Sincerely,

A handwritten signature in cursive script that reads "Karen M. Fischer".

Karen M. Fischer, MPA  
Executive Officer

## PHYSICIAN ASSISTANT BOARD

### RESPONSE TO THE JANUARY 2016 CONTRACT AND PERFORMANCE AUDIT OF THE DCA DIVERSION PROGRAM PROVIDED BY MAXIMUS HEALTH SERVICES

Recommendation	PAB Response
1	Agree. The PAB believes that the Diversion Program provides an additional level of consumer protection with regard to licensees who have drug and alcohol issues. Other Boards could benefit from such a program. Board staff and probation monitors do not possess the knowledge to appropriately manage these types of licensees and probationers. Maximus does. At the PAB the probation monitors and Maximus staff work cooperatively to ensure that probationers are in compliance with all terms of their probation, including abstinence from drugs and alcohol.
4	Generally agree. While we agree that participants should assume responsibility to contact and research coverage options, they are often not in a condition to do so. The PAB believes that Maximus should have the ability to assist or direct participants to appropriate resources.
8	Agree. Maximus should take the lead on this due to their knowledge and experience in this area.
24	Disagree. While the PAB is sympathetic to drug testing costs incurred by participants, as a consumer protection agency we are more concerned with ensuring consumer protection. The PAB needs the flexibility to test as often as appropriate. Additionally, the PAB must comply with the Uniform Standards. Drug testing is the most effective tool to ensure that participants/probationers are not using drugs and/or alcohol. The PAB utilizes alternative tests such as blood and hair. DCA boards review the test panels to ensure that they are up-to-date and at the lowest cost as available.
25	Agree. Alternative methods of communication would be beneficial to participants. The PAB also encourages the CCM to meet with PAB participants when attending DEC meetings for other boards.
30	Disagree. While these statistics would be valuable, we might have difficulty in following up with prior participants due to the fact that these are medical issues and would be confidential. To the best of my knowledge, the PAB does not have legal authority to randomly inquiry as to a prior participant's health issues with regard to drug and alcohol concerns once the probation is completed. The PAB has the authority react to new complaints or criminal convictions and those involving prior discipline history would be taken into consideration when investigating the new compliant.

## Veterinary Medical Board Audit Response

**From:** Mathes, Ethan@DCA  
**Sent:** Friday, February 12, 2016 12:23 PM  
**To:** Wallace, Annecia@DCA  
**Cc:** DelMugnaio, Annemarie@DCA  
**Subject:** RE: Maximus audit responses

Greetings Annecia,

Here are my comments, some are duplicative/similar to CPS's comments:

- Maximus should consider new DPM training, but at the minimum yearly refresher training covering all facets of the program, contract, recovery, etc. (and including an orientation manual?)
- Maximus should audit its program costs and costs paid by participants generally and provide suggestions on reducing costs to participants
- Maximus should audit the effectiveness of the program, including the effectiveness of a 3-year minimum mandatory participation
- Maximus should study/evaluate in cooperation with boards how to increase program participation, especially in light of diminishing participation in the last 3 years
- Maximus should study different means for participants to subsidize their recovery via insurance, and pass that information along during intake

One note on the audit for accuracy, the Board's participant co-pay in Table 7 is incorrectly identified and yearly; it is a one-time fee.

That's about it!

Regards,

Ethan Mathes  
Operations Manager  
Veterinary Medical Board  
1747 N. Market Blvd., Suite 230  
Sacramento, California 95834-2934  
Phone: (916) 515-5227  
Fax: (916) 928-6849

February 16, 2016

To: Annecia Wallace

From: Board of Pharmacy

Comments on Draft Audit as Conducted and Prepared by CPS

In general the board is concerned with the “semantic allness” used in portions of this report. We have provided some instances below in the specific comments, but feel compelled to note that portions of the report appear to indicate that it was the consensus of all DPMS when making some statements. This is not true. Further, the board is not clear how some of the conclusions were reached and as such question some of the conclusions as applicable to the Board of Pharmacy program. In the hopes it is helpful the Board of Pharmacy has referenced specific page numbers as well as the Board of Pharmacy’s comment.

#### Board of Pharmacy Specific Comments

Page 6      Drug Test File Audit Results  
The Board of Pharmacy understands the four drug test files that are identified in the audit were applicants that declined to join. Therefore, these participants would not have signed up with First Lab.

Page 8      Second sentence  
The year needs to be fixed to 2016 not 2106.

Page 12     Board of Pharmacy section codes needs a dash between 4360-4373.

Page 13     The definition provided in the audit of referral types is inaccurate. For instance the In Lieu of Referral specifies in the audit this definition pertains to BOP and DBC, which is inaccurate. The definition for In Lieu of Referral in the contract only pertains to BOP and the definition itself in the contract is different than what is defined in the audit.

The definitions provided below is the exact language provided in contract. The statistical information that is provided within the definitions in the audit report may need to be revisited to ensure the data is based on the accurate definition. This could present a problem in the future if the data does not match the statistical information reported by Maximus vs. the audit. The appropriate definitions included in the contract are provided below.

#### Definitions of Referral Types per Contract

##### **Board Referrals**

**1) Investigative/Informal Referral** (BOP, DBC, and DHCC) A licensee who may have a Board investigation pending, and upon recommendation of a Board inspector/investigator, may seek admission into the Diversion Program. The participant signs a release authorizing the Contractor to discuss his or her progress with the Board’s DPM.

**2) Non-Disciplinary Referral (BRN)** A licensee referred to the Diversion Program by the Board, based on information or complaint received by the Board, indicating that the licensee may be impaired due to substance abuse disorder or mental illness.

**3) Probation/Disciplinary Referral** A licensee referred to the Diversion Program by the Board as a condition of a Board-imposed disciplinary action.

**4) In Lieu of (BOP)** A licensee who the Board investigated and referred into the program to be assessed in order to determine if the licensee has a substance use disorder.

**Self-Referral**

**1)** A licensee who voluntarily seeks admission into the Diversion Program.

Page 14

Top paragraph after bullets

The language should reflect recovery plan not rehabilitation plan in the second sentence.

The statement in the last sentence of the first paragraph is inaccurate.

“However, if a participant does not successfully complete the program, the original complaint, would be sent to enforcement.” This statement is inaccurate for the Board of Pharmacy Program because the board never diverts a licensee from the investigation process. Although it may be true for some board programs, there is no qualifier applied to the sentence if that is the case.

Under Program Intake and Clinical Assessment

The last sentence in the first paragraph should reflect recovery plan not treatment plan.

Page 19

Under the heading Worksite monitors.

Should read - WSM observe participants up to a maximum of 100% and not just one day a week as appears in the audit. The worksite monitoring percentage can be reduced to zero percent in the transition phase. The worksite monitor percentage that is established for the participant depends on what stage the participant is at in his/her recovery.

Page 24

The last sentence in the paragraph.- One closure type that is conspicuously absent is financial hardship.

This is not a closure type.

Page 40

Under As a result of the DPM meeting, CPS learned the following:

The bullet that pertains to speaking on behalf of “All DPMs” leads the reader to believe this statement is agreed upon by all DPMs. The Board of Pharmacy did make such a claim regarding formal training.

The bullet that pertains to DPMs stating “some DEC’s have gotten away with poor practices”, the Board of Pharmacy is concerned this leads a reader to believe all DPMs agree with this statement. The Board of Pharmacy does not have DEC’s and is not in a position to make such a statement.

As a result, the DPMs suggested the following Diversion Program improvements.

The bullets in this section lead the reader to believe this is agreed upon by all DPMs.

Page 42 Under Clinical Assessors recommend - Institute DEC's for all professions  
The Board of Pharmacy is concerned with this overall statement and questions if all the clinical assessors truly recommend this.

Page 43 Under HSG Facilitators claim the following obstacles/challenges in bullet number 2 - Maximus does not give enough consideration to HSG facilitator feedback.  
The Board of Pharmacy takes exception to this comment. The Board of Pharmacy routinely requests feedback from the HSG facilitators and considers such feedback as part of the overall clinical picture of the participant. The Board of Pharmacy questions if all health support group facilitators made this statement and applied it to all board programs.

Under HSG Facilitators recommend in bullet number 2 - Provide HSG facilitators with access to intake summary, evaluations, and treatment reports.  
The clinical assessors are required to independently assess the licensee.

Page 44 Under Worksite Monitor Responses in the section WSMs recommend in bullet number 3 - Provide improved access to Board Diversion Program Managers.  
The Board of Pharmacy suggests that clarification should be sought in regards to this statement as the WSMs communicate directly with the clinical case managers. Further, worksite monitors are interviewed by the Board of Pharmacy staff, generally on a quarterly basis to gain understanding of how a participant is performing at work. This is in addition to the worksite monitor reports provided.

Page 50 Under Recommendations  
In the bullet pertaining to the handbook the bold section – remove the term **“suspension”** and replace with **“removed from practice.”** The Board of Pharmacy does not delegate the authority to the vendor to suspend a license, rather the board does this.

Page 54 The first paragraph at the top of the page  
In the sentence, “As a result, the DPMs claim self-referrals into the program have almost stopped and participant levels have dropped”, the use of the word “claims” attributes this statement to all DPMs. The Board of Pharmacy does not believe this is an accurate statement.

#### Board Review and DEC Meetings

In the second paragraph, last sentence, in stating “through reading meeting minutes”, what type of meeting minutes contain statements by participants? The DEC and Review Meetings have summary notes from the meetings that contain changes to a participants recovery plan. For example: participant is approved to reduce attending five 12-step meetings to four 12-step meetings per week.

With respect to the first bullet, the Board of Pharmacy is curious to know if the auditors surveyed board participants. If not, we are unclear how the statement can be made. The Board of Pharmacy is concerned with the overall

representation of non-DEC boards. Furthermore, the Board of Pharmacy is not aware of any board meeting minutes that would reflect comments made by participants and is unaware of any discussion at a board meeting or review meeting when a board participant has made these assumptions.

**Second Bullet – DECs**

The Board of Pharmacy is not aware of any board meeting minutes that would reflect comments made by participants and recommends that additional information be sought to clarify if minutes from DEC meetings are maintained that include specific quotes from participants.

Page 55      Recommendation to use SKYPE for non-Dec boards to improve interpersonal interaction.

The Board of Pharmacy takes exception to this comment as all probation referred participants meet with Board of Pharmacy inspectors on a quarterly basis to ensure compliance not only with his/her probation but with the Pharmacist Recovery Program. In addition, the Board of Pharmacy inspectors also meet with the worksite monitors in person.

**Audit Grid**

**Recommendation Respondents**

1. The Board of Pharmacy does not have a position on whether other boards participate in the Diversion Program.
  
4. The contracted vendor is there to assist participants with locating services. However, the Board of Pharmacy also thinks it is the responsibility of the participant.
  
8. As part of the scope of work, the credential review is included in the contract.
  
24. The drug testing was established by the Uniform Standards Committee as implementation of SB 1441.
  
25. As stated above, the Board of Pharmacy has concerns with this recommendation. Refer to the board's comment from page 55 of the report.
  
30. The Board of Pharmacy has in the contract in its Board Specifics section 7.F.1 to conduct an annual longitudinal study of former BOP participants who have successfully completed the Pharmacist Recovery Program within the past three years. This recommendation appears to apply to all programs. The board requests clarification on the specific recommendation, i.e. should it be done every three years, standard questions to assess, etc.

## Physical Therapy Board Audit Response

**From:** Kaiser, Jason@DCA  
**Sent:** Tuesday, February 16, 2016 4:29 PM  
**To:** Wallace, Annecia@DCA  
**Subject:** RE: Any more Board responses?

Hi Annecia,

After looking at the Matrix of responses you provided, I assuming we fit under the categories of "All Boards" and Non-DEC Boards".

Here is PTBC's take on the audit report.

For findings for "All-Boards",

- 1) The PTBC concurs with recommendation 1.
- 4) The PTBC concurs with recommendation 4.
- 8) The PTBC concurs with recommendation 8
- 24) The PTBC concurs with recommendation 24.

30) The PTBC does not concur with recommendation 30. Once a probationer has completed the Maximus program, they typically have 1 more year of probation compliance. Subsequent to that, should the Board have to have to monitor the licensee outside of the Disciplinary Order, we would be doing so without authority or ability to collect costs, which would be an additional draw on the Boards resources that could not be absorbed.

For findings for "Non-DEC Boards",

- 25) The PTBC concurs with recommendation 25.

Let me know if you need anything else for the response.

Thanks.

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