OREGON BOARD OF MEDICAL EXAMINERS

Final Report

AUDIT OF THE HEALTH PROFESSIONALS PROGRAM

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KENT NEFF, MD
Portland, Oregon

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Introduction

The Oregon Board of Medical Examiners (BME or "Board"[1]) contracted for an independent audit to "evaluate the effectiveness and efficiency of the Board of Medical Examiners Health Professions Program" (HPP)." The auditor was to "make any recommendations necessary to insure that a) licensees are being appropriately monitored and b) the public is adequately protected from impaired licensees." The Board hoped that information gleaned from an audit might offer recommendations to improve a program which was already felt to be performing generally well. However, Board members did not feel that they had sufficient information to be certain that they were providing adequate oversight of HPP.

This first audit of the Health Professionals Program is timely and long overdue. Like any first audit of a new enterprise, especially one that has been in existence for 16 years, many areas for attention are likely to be uncovered. That was certainly the case with this audit. The auditor has also tried to present a tentative "road map" that can be used for addressing areas that have not been previously reviewed or brought up to date, or which need to be examined as a part of the developmental process for HPP. These recommendations should not imply that not having addressed issues previously constitutes an error on someone's part. Some issues may be simply the next step in evolution of HPP; others, secondary to the slow evolution of the governance and oversight of the program, as discussed below.

During an audit it is necessary to draw conclusions and make inferences based on incomplete information. There are advantages and disadvantages to an outside perspective. The conclusions and recommendations in this report are those of the auditor, and should be closely scrutinized before any actions are taken. HPP staff, the HPP Supervisory Council (SC), and the Board are all closer to the situation, and should not hesitate to question the recommendations and conclusions if their experience and judgment suggest otherwise.

Addressing the identified issues will take considerable time, as is to be expected. Priorities should be set collaboratively, and the most important areas identified for initial focus. Not all can be done at once. The reader should keep in mind that, despite these difficulties, the diversion program has been responsibly and professionally managed by HPP staff for many years. Staff has been diligent in their performance of the monitoring and recovery management functions of HPP. They have great passion and a strong commitment to promoting good recovery while discharging their responsibility to protect the public. Many Oregon practitioners have graduated from HPP with solid, self-sustaining recovery programs, safer practices, and better lives because of their efforts.

Method

The audit was started in late January 2006 and completed in June 2006. The auditor was given full access to all HPP files and records, staff, consultants, contractors, and group leaders. HPP staff was extremely helpful and fully collaborative in responding to all inquiries of the auditor. In fact, staff often offered additional information, frequently adding to the thoroughness of the review. Staff frequently asked questions of the auditor as to how the HPP programs might be improved. Some current problem cases were reviewed with the auditor for

[1] *"BME" or "Board" are generally assumed to refer to both BME members and the Executive Director, unless referenced otherwise.*

feedback. The Medical Director was consistently open to new perspectives and ways of improving the HPP.

Numerous interviews and telephone conferences were held with a variety of people: the Board Executive Director, Board members, Board staff, SC members, HPP staff, medical consultants, group leaders, contractors, and some participants. Considerable time was spent at the HPP office reviewing charts and other data. This gave ample opportunity to observe the staff at work, and to meet a number of group leaders, consultants, and participants. The auditor, at the encouragement of the Medical Director and with the permission of the participants, sat in on several quarterly and annual reviews. A variety of ongoing issues, clinical and programmatic, were also discussed as they occurred during the audit.

Tragically, one of the HPP staff had a personal family tragedy early in the audit. During the weeks after this difficult loss, staff pulled together and worked diligently to make sure that the key program elements continued without interruption. This did lengthen the time frame of the audit to some extent.

This assessment is based upon information available to the auditor at the time, and assumes that the accounts given are reliable. Subsequent disclosure of additional information could require reformulation, including findings and/or recommendations.

Historical Perspective

The concept of a Health Professionals Program evolved from an informal relationship between the Board and the Oregon Medical Association's (OMA) Physicians Committee, which had been actively identifying, intervening, referring, and monitoring Oregon physicians with alcoholism and drug addiction for several years in the very late 1970s and early 1980s. In 1982, the OMA Monitored Treatment Program (MTP) was established, and the Board referred 25 physicians being monitored by the Board to the MTP. MTP staff was charged with managing the recovery programs for these physicians, as well as monitoring them to insure that they were abstinent, in compliance, and were not impaired in their ability to practice because of their addictive illness. The process worked well and grew rapidly. However, it was a financial burden on the OMA, and was disbanded.

The OMA and the BME then collaborated to design the Diversion Program for Health Professionals, now known as the Health Professionals Program or HPP. The program was modeled after the previous informal programs. It was to be funded by dedicated licensee fees and was to be at arms length from the BME. Its mission was to "emphasize the maintenance of the health of licensees of the Board," and in so doing protect the public health.

A Supervisory Council was formed to oversee the program. The Board chose the SC from nominations submitted to the Board. The SC elected a Chair and selected the Medical Director, subject to the approval of the Board. The Medical Director was in charge of HPP and the employees. HPP employees were also employees of the Board. This created a dual reporting relationship. The Board, of course, had ultimate responsibility for HPP. The arm's-length relationship between the Board and the SC was purposefully established because it was felt that the public would benefit from this relationship. The SC was connected to the Board by a dotted line on the BME organizational chart.

It was reported that members of the SC were very involved with the Medical Director and HPP and reportedly provided close, albeit informal, oversight. But the SC governance structure was never formalized. HPP, under the current Medical Director, grew more sophisticated and effective, but remained informal in its organizational structure. Over the years, the OMA became increasingly less active in HPP affairs. To some extent, HPP may also have been a victim of its own success, since those referring practitioners to HPP were quite pleased with the results, and felt things were going well. Oversight was not seen to be particular problem.

Descriptions of the early years of the program suggest that HPP began in a very informal fashion, with few formal procedures. In fact, reportedly there were initially no individual participant records. In many ways, it appears to have operated as an extension of 12-step process of Alcoholics Anonymous, which was fairly typical of such programs in that era. Over the years HPP staff continued to develop HPP programs and improved the organization processes and management structure. But, considerable informality in the organizational structure remains at all levels. Contributing factors include persistence of the original culture of informality, the lack of more formal and broader oversight, and the fact that HPP has a very small staff who have worked together for a long time. The inconsistency of SC governance, as well as the lack of a formalized oversight structure, presented problems for the Board.

Despite the "growing pains" experienced over the years, HPP staff appear to have provided a very good level of service to the practitioners in the program and to the BME, while protecting the public in the process. HPP staff are dedicated and passionate about their work. HPP has had a solid record of safety during the sixteen years of its existence, supporting the conclusion of the auditor that the Health Professionals Program is a good program. The number of issues needing attention is not unexpectedly large, given the fact that there has been no audit or meaningful review since HPP started over 16 years ago. Many issues that would have been addressed one by one are now presented all together.

Oversight and Governance

There are some obvious structural problems and ambiguities in how HPP was organized under ORS 677.615. Oregon is one of only four programs in the country organized in this manner, *i.e.* as a diversion program under the medical licensing board. The statute would appear to provide sufficient flexibility that the issues described below should be able to be addressed without any immediate change in the enabling statute.

Issues related to governance and oversight frequently arose during the audit, necessitating close examination of the governance structure and how oversight of HPP is conducted. In reviewing HPP history and evolution, one can see some of the reasons for these current problems. From the beginning the SC was given little direction or guidance regarding the level of governance expected. SC members were generally busy physicians selected for their expertise and interest in chemical dependency. Previous experience and/or expertise in management issues were not selection criteria. No formal training or coaching was provided.

The SC did not develop its own formal oversight guidelines that allowed it to manage by exception. The fact that HPP employees are Board employees created further ambiguities regarding oversight. And the landscape regarding public scrutiny has changed significantly for both licensing boards and diversion programs, increasing the focus on oversight and accountability in these programs.

The Board looks to the SC to provide this oversight, and to keep the Board informed. But no formal criteria for regular reporting to the Board have been developed by either the SC or the Board, nor have these issues been clearly delineated. As a result, the evolution of the governance and oversight structure for HPP has lagged far behind the evolution of HPP. This has left a number of important governance tasks unclear or unaddressed.

The SC appears to have provided good oversight of the clinical aspects of HPP participants in terms of reviewing cases, providing consultation to the Medical Director, and reporting practitioners to the Board, for example. The SC has not provided comparable oversight over other aspects of HPP, such as insuring that the Policies and Procedures manual is written and kept updated. The SC remains in the "founding stage[2]" of governance, providing a level of oversight which is not up to the level needed at this stage of HPP's evolution.

As a result of these multiple factors, the Board has not received the information it needs to insure that the SC is adequately overseeing the HPP program and the Medical Director, creating concern on the part of the Board. Neither has there been a forum for ongoing dialogue between the Board and the SC that would facilitate open resolution of these issues, further compounding the problem.

Both the Board and the SC need to work out explicitly which organization (BME or SC or both) sets what policies, and which organization is responsible for which operational activities. Normally, the parent organization (BME) would set policies (or approve policies), and the governing body of the subordinate organization (SC) would carry out operational oversight with consultation with the parent organization. It is not at all clear to the auditor who is responsible for oversight of what. The Board is making a distinction between oversight of clinical activities and oversight of other HPP activities, but that is not necessarily how SC members would make those distinctions. These lines of authority and roles need to be openly discussed and clarified. Care should be taken that resolution preserves the arms-length relationship. Ongoing dialogue between the SC and the Board is essential. Better clarity will improve accountability, reduce conflict, and increase efficiency. Both the BME and the SC will benefit from resolution of these dilemmas.

Oversight of the Medical Director by the SC appears to have been too informal and inconsistent. The statutory structure has created a dual reporting relationship for the Medical Director. According to the Executive Director of the Board, the Medical Director reports directly to the SC for clinical issues and policy and procedure drafts, which are then forwarded to the Board. For the administrative functions such as fiscal, personnel, and governmental relations, the Medical Director reports to the Board's Executive Director. To jointly supervise the Medical Director position, the SC and Executive Director meet on a quarterly basis to discuss performance and review communication. But considerable ambiguity remains, in the opinion of the auditor. When reporting dilemmas arise, the SC and the Board need to be explicit in identifying and resolving them so the Medical Director has a single, clear set of expectations from both the SC and the Board. This will take the Medical Director out of the position of being in the middle, and should result in improved accountability and oversight.

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[2] *In the initial stage of governance, the "founding stage," board (e.g. SC) members share in the work, assist the director, roles are informal and overlapping, and oversight is informal and collegial. In the second, or "transition stage," roles become more formalized and specific, standing committees are formed, there is more oversight of the director, and criteria for oversight are developed. Management by exception, i.e. identifying specific situations or conditions which need to be reported and explained, begins to develop. In the third, or "governing stage," governance becomes even more formalized and most of the work is done in committees. True oversight and governance are achieved.*

Over the years both the Board and the SC have evolved and changed. It is not clear that both organizations still share the same vision for HPP. This is a dynamic issue. It would be an appropriate time to discuss this issue openly, and insure that there is a shared vision.

It should be kept in mind that the current situation evolved over many years. It was not due to the actions of any one person or group. Assuming a greater degree of oversight may not be an easy task for members of the Supervisory Council, who likely signed on to the job with a different idea of what was required. But improvement of governance at the SC level is essential if HPP is to maintain its organizational integrity and function optimally. Ongoing coaching and facilitation for the SC, by someone skilled in the development of oversight bodies, would be helpful and is strongly recommended if there is to be improved governance by the SC.

Oversight of Individual Cases

Oversight activities of the SC have focused on clinical review of cases, providing consultation to the Medical Director, reviewing relapses and related issues, and deciding when a given participant should be reported to the BME. The Medical Director presents cases to SC members at SC meetings and consults with them in between meetings as needed. SC members take this responsibility very seriously and are earnest in their deliberations. However, it was difficult to audit SC activities regarding the population of practitioners presented to them because the records of these deliberations and criteria upon which these decisions are based are not complete. It is recommended that the SC keep a list of all cases presented that are referred for possible reporting to the Board. This would facilitate periodic internal audits and more transparency in this aspect of the SC's oversight. Discussion of the process of review, and the criteria used in making these reporting decisions with the BME would help resolve a major concern of the BME about their oversight responsibilities.

The SC may want to consider establishing a "Clinical Committee" to assist in consultation with HPP staff on clinical cases that arise which do not require the authority of the Supervisory Council. This would enable a wider range of clinical expertise to be represented than is represented on the Council. This committee might reduce the work load on the SC, allowing members to have more time to address other governance issues described in this report.

Supervisory Council (SC) meetings

The SC currently meets only quarterly, which presents a significant problem in oversight. Formal case review is needed more frequently than quarterly, and reports to the BME need to be done promptly when they are indicated. Many other important issues need attention on a more frequent basis if the SC is to achieve an appropriate level of oversight. More frequent meetings are recommended. Meetings could be significantly shorter than the current SC meetings if they are held more frequently.

SC meetings come under the open-meetings requirements. HPP is defined as a treatment program, subject to Federal confidentiality laws regarding addiction programs. While confidential deliberations involving clinical issues therefore do not come under the open meetings regulations, this is still a problem for the SC and HPP. Clinical issues cannot always be easily separated from other SC deliberations. SC members should have frequent telephone conferences to discuss matters that come up, clinical and non-clinical. Having to give public notice of such a conference is cumbersome, and introduces an obstacle to setting up such conferences promptly and frequently as needed. It would be appropriate to revisit this in a legal

sense to see if a way can be found for the SC to gain an exemption from the open meeting requirement for its meetings.

SC meetings are currently divided into a non-confidential component, in which there is a Board representative, and a confidential clinical component, conducted without Board representation. The Supervisory Council should consider restructuring its meetings, dividing its business into a section involving SC issues only (conducted alone and including the confidential clinical portion), and a section involving issues which are of mutual concern to the Board (conducted with a Board representative present). This would facilitate improved governance and SC development.

Conclusions

The Supervisory Council's governance has not evolved to the extent that the HPP programs have evolved in complexity and sophistication. Oversight continues to be too informal and not sufficiently comprehensive. The SC remains in the "founding phase" of governance development and needs to evolve toward a much more formal and sophisticated level of governance. There is a need for more formal and consistent liaison with the Board, with ongoing dialogue regarding issues of oversight and mutual concern that affect HPP and the BME.

The ambiguity and lack of resolution about governance and oversight are at the root of a number of problems identified in this audit. Clarifying and Resolving these governance issues is the most important and pressing issue for the Board and the SC, in the opinion of the auditor.

Recommendations

- **The SC should develop a long-term plan for developing its governance and oversight processes, including getting outside assistance and education to make the transition to an oversight body that exercises consistent, formal oversight over the Medical Director and HPP programs.**
- **The SC should develop a set of oversight criteria that are regularly reported to it by the Medical Director** *(see Appendix)*.
- **The SC needs to meet more frequently for the foreseeable future, preferably a minimum of eight (8) times per year. Meetings by telephone conference should continue to be held in between regular meetings, as needed.**
- **The SC should restructure its meetings to allow for more time to deliberate SC issues by itself, as outlined above.**
- **The SC should appoint specific SC committees, starting with a Board Liaison Committee** *(see below)*. **The appointment of a Clinical Committee is strongly recommended.**
- **The current Council size of five (5) members is too small to manage the many oversight functions. The expertise of current SC members is fairly homogeneous. Other skills, particularly administrative skills and outreach/ marketing/ networking skills, are needed. Consideration should be given to expanding the number of SC members from five (5) to seven (7) or nine (9), and increasing the**

diversity of the Council, both in terms of skills and representation. No more than two (2) additional SC members should be added in a single year.

BME and Supervisory Council (SC) Communication and Liaison

The complex work of identifying, facilitating rehabilitation, and monitoring practitioners with chemical dependency requires good ongoing dialogue and communication among the various groups involved in the process, particularly between the SC and the Board. A successful program requires active participation by all- it cannot be accomplished by the Board or the SC alone. Unresolved issues between the BME and the SC greatly affect HPP staff and program. Frequent consultations are often necessary for the work of HPP to proceed effectively. Informal, ongoing dialogue works much better in these situations than formal, infrequent presentations or interviews. Such contact also is more likely to facilitate the development of the level of trust necessary to work collaboratively on the complex situations which the HPP practitioners present.

The auditor agrees that the Board needs to receive more information regarding HPP's status and activities from the SC, on a regular basis, so Board members can be reasonably assured that the SC is adequately overseeing the Medical Director and HPP activities. As there are no clear, agreed-upon oversight criteria regarding information that the Board should receive from the SC at Board meetings, these should be developed jointly. Keeping the Board better informed and increasing the transparency between the SC and the Board should reduce some of the natural tension that is inherent at the interfaces between a licensing board and a rehabilitation program such as HPP.

HPP staff currently has regular contact with the BME Executive Director and BME staff. Contact with Board members is generally limited to quarterly presentations to the BME, followed by a luncheon. The meeting is held in the Board hearing room – a very formal, and generally intimidating, setting that does not provide the opportunity for informal dialogue and the bilateral exchange of ideas necessary to resolve some of the thorny issues which arise.

Also, it is important for individual BME members to come into more frequent direct contact with the HPP Medical Director and SC members, and vice versa, as a prerequisite for increasing trust and communication.

There are certainly other issues of mutual concern which could be addressed in a Liaison Committee. One issue raised by current and past SC members was their perception of a "drift" of HPP towards the BME in recent years. They felt that this might jeopardize HPP's effectiveness as well as the essential arms-length relationship with the Board. This is an area for further joint dialogue.

Over the years, in the absence of a formal liaison structure, the locus of liaison between the Board and HPP has shifted from the Council-Board level to the staff level, through the Executive Director and the Medical Director. The locus of liaison between the Board and the Health Professionals Program should be at the Board committee – SC interface, *i.e.* through the Council, not through the Medical Director. Liaison would be the role of the Joint Liaison Committee.

Recommendations

- **The SC and BME should each appoint their own Liaison Committees, which would then form a Joint Liaison Committee to work collaboratively on matters of mutual concern. These two committees should meet jointly on a regular basis, preferably quarterly, and when critical matters arise.**
- **The Joint Liaison Committee should review and develop formal criteria initially for:**
  - **Quarterly SC reports to the BME.**
  - **Definition of relapses and relapse prodromal behavior.**
  - **Criteria for reporting relapses and non-compliance to the Board for both Board-mandated HPP participants and voluntary participants;**
  - **Definition of sexual violations;**
  - **Criteria and expectations for reporting sexual violations to the BME.**

  The establishment of formal criteria for reporting does not mean that the SC cannot continue to exercise discretion in its reporting process.
- **The Joint Liaison Committee would be an excellent forum for discussing this audit report, and for collaborative planning to prioritize and address the conclusions and recommendations in the report.**

HPP Personnel

Employees

HPP currently has three employees: Medical Director (1.0 FTE[3]), Program Coordinator, (1.0 FTE) and Administrative Assistant (0.8 FTE).

Medical Director

The Medical Director has a Master of Public Health (MPH) degree in addition to her medical degree, and has had considerable relevant work experience. She is a certified Medical Review Officer (MRO) and is very sophisticated and knowledgeable regarding chemical monitoring and urine drug testing. She is well qualified for her position. During her time in HPP, she has greatly increased the sophistication of the program. She has been very active in the Federation of State Physician Health Programs (FSPHP or "Federation"), and recently served as president of the Federation. She was instrumental in developing Federation standards for a variety of situations. Her expertise and experience in developing more objective, appropriate standards for the field have been very valuable to the HPP and to other state physician health programs (PHPs).

The Medical Director demonstrated an excellent understanding of the functions of HPP and the duty to report practitioners who present a danger to the public. She takes her responsibility to report to the Board very seriously. She was described by a SC member as "quite willing to say that a practitioner should not be practicing." The Medical Director was described as regularly and frequently bringing difficult cases to the attention of the SC, and asking good questions about the cases.

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[3] *Full-time equivalent.*

The Medical Director has been under extraordinary stress throughout the audit. Also, the ambiguity regarding oversight affects this position the most, because of the dual reporting relationship. It would be impossible and inappropriate for the auditor to evaluate her performance on the basis of observations made under these conditions.

Program Coordinator

The Program Coordinator has been an invaluable asset to HPP. She brought with her the perspective of having worked with the BME and became an effective advocate for HPP. She helped get the program started and kept it running during the early years during several transitions to new medical directors. Despite the fact that she is not clinically trained in a formal sense, she has developed significant skills on her own, allowing her to manage some clinical functions. While her performing certain clinical functions has definitely provided useful assistance to the Medical Director and HPP, the requirements for the Program Coordinator position have evolved beyond her qualifications. Her replacement must have the appropriate formal clinical training and qualifications to assist with these various clinical functions in very high-performing practitioners. He or she must also have good administrative and management skills.

There appears to be considerable overlap in the roles of the Medical Director and the Program Coordinator. While everyone in a small office "pitches in" to get the job done, it would be useful to examine the position descriptions of HPP staff very carefully to eliminate any unnecessary overlap in basic functions, particularly between the Medical Director and the Program Coordinator. Better delineation and separation of functions will be needed in this next phase of HPP organizational development. It will also facilitate hiring the most suitable person to replace the current Program Coordinator.

Administrative Assistant

The current Administrative Assistant has been with HPP for four (4) years, and is a 0.8 FTE employee. She performs a variety of office functions and oversees HPP's part of the urine testing system. She will be retiring next year. Her replacement will need excellent computer skills, including the ability to manage a relational database.

HPP staffing levels

The current staffing level of 2.8 FTE is barely enough to keep pace with the management of the current HPP enrollees. Addressing the issues identified in this audit, particularly increasing the number of referrals to HPP and managing a higher census, will require increased efficiency, more systemization, clearer delineation and separation of roles, improved computerization of office processes, as well as additional manpower. All the above measures will help, but it will mean considerable extra work to reach the point that the increased efficiencies will be realized. Planning for these future needs should begin now. No new programs, such as the addition of mental health to HPP, should be undertaken until the staff can handle these new duties. It is recommended that the administrative assistant position be increased to 1.0 FTE as soon as possible.

Conclusions and Recommendations

- **The HPP staff currently does not have much margin in terms of capacity. The coming months will be demanding ones. No new non-essential projects, for example, a significant expansion of the outreach program, or the implementation**

of a mental health program, should be implemented until the office organization has been improved, a new Program Coordinator hired and oriented, and staffing levels are adequate for new ventures. There needs to be a parallel improvement in the oversight process before any major new programs are undertaken.

Consultants

HPP Group Facilitators

HPP group meetings are held weekly in various locations around the state, facilitated by contracted group facilitators. Both the experience of the auditor and the comments of several participants and group facilitators suggest that these groups are one of the most significant, and most therapeutic, HPP activities. They offer an opportunity for participants to share concerns, get peer support and confrontation, and learn how to manage problems of living and early recovery.

Several highly experienced group leaders were interviewed at length. Their comments were quite consistent. They all felt that the therapy groups were very helpful and generally well received by the participants. All appeared to be very invested in their work with HPP and seemed to be very familiar with the individuals in their groups. They maintain close contact with HPP staff. All had highly favorable comments about the support and assistance they receive from HPP staff. They rated the skills and involvement of the Medical Director very highly. They felt that HPP staff was quite open to their suggestions and input. The group leaders interviewed seemed to be well qualified in terms of training and experience in chemical dependency. It was not possible to evaluate their group therapy skills.

The group leaders had concerns about HPP's strong emphasis on monitoring, and there was a general opinion that this emphasis needed to be balanced by a strong emphasis on rehabilitation, as well. Too much emphasis on the monitoring function may interfere with the recovery process. Group leaders reported that there is a very high level of fear among many participants about information getting reported to the Board, which makes it difficult for some participants to use the groups effectively. They all reported they make significant efforts to increase the level of trust of the participants in the group process, in order to encourage them to bring issues that might interfere with their recovery to the groups. One suggested that clearer boundaries are needed about how much and what kinds of information are transmitted to and from the groups. There were also suggestions about improvement of the reporting forms.

While preliminary, there is some evidence that the balance between emphasis on monitoring and emphasis on rehabilitation/ recovery seems to have shifted more towards the monitoring, in ways that could make it difficult for some participants to use the groups effectively. From the auditor's experience, the value of getting more participants, both voluntary and mandated, to report the difficulties they are having to their group cannot be overstated. Groups can be a "safe" forum where the practitioner can get assistance and feedback from peers- if he or she is willing to bring his or her dilemmas to the group. Increasing the degree of trust in these groups and relieving the group facilitators from some of their monitoring expectations when the public is not endangered might also encourage more voluntary admissions to HPP. Since the monitoring functions are well covered in other aspects of HPP, it is unlikely that such a change would negatively affect the monitoring process, while it could have a positive impact in improving recovery and preventing relapses.

Medical Consultants

This group of professionals includes physicians, psychologists, therapists, and addiction counselors who meet quarterly with HPP participants to review their status and progress. The Medical Director indicated that this provides an additional level of clinical oversight, particularly for participants who are in the later stages of their five (5)-year contracts. There was some confusion regarding the role of these consultants. It would be appropriate to include assessment of this program component in the HPP participant survey that is recommended below. It should also be clarified whether the quarterly consultant meetings are primarily for monitoring or for recovery management, or both, in a process similar to the one described in the section on HPP groups above.

Workplace Monitoring

There are three (3) ways that HPP participants are monitored: Observations of behavior (looking for prodromal relapse behavior); chemical monitoring, and monitoring in the workplace. Chemical monitoring usually gets the most attention in diversion programs, but the other two are at least as important. HPP staff and consultants appear to do a very good job in observing for prodromal relapse behavior, and the chemical monitoring program is well-designed and sound, although there are significant difficulties with the collection process.

The workplace monitoring program is weak, and needs to be strengthened. Workplace monitors were inconsistently identified on the records. There is no consistent communication with workplace monitors. Voluntary HPP participants may not have a specific workplace monitor identified. There may have been some hesitancy to require workplace monitors in voluntary participants over the years

Workplace monitoring is part of the standard HPP contract, and is one of the obligations incurred by all participants to enjoy the benefits of the program. It can be done in a confidential manner which protects the interests of the participant. Identifying a workplace monitor and including good workplace monitoring as part of HPP actually protects the participant, since if anyone raises a question about whether the participant is safe to practice, the record of ongoing monitoring can be used to support the participant's fitness for practice. And penetrating the silence which frequently surrounds addiction in professionals also helps to reinforce recovery. Experience shows that an active workplace monitor system can be employed in a respectful, confidential manner.

Workplace monitors may need to be educated and trained. This is consistent with the kind of education which is also needed in the hospital setting. Such education also has a leverage effect in helping more physicians and others learn about addictive illness and how it can be managed to allow practitioners to continue to practice safely. HPP has a small staff that cannot be expected to do everything. This is an area in which other groups in the medical community might provide assistance to HPP.

Conclusions and Recommendations

- **Workplace monitors are inconsistently used in HPP. The workplace monitoring system needs to be improved and expanded.**
- **A specific workplace monitor needs to be identified for each participant, voluntary or mandated, when he or she enrolls in HPP, unless there are some extenuating circumstances which preclude such an arrangement. Communication between**

HPP staff and the monitor needs to be established promptly. Regular reports should be received from the monitor and put in the participant's chart.

- **The process for workplace monitoring needs to be formalized, and a written policy and procedure developed and put in the P and P manual.**
- **Educational programs for workplace monitors should be considered in the future.**

Customer Satisfaction and Participant Survey

A Customer Satisfaction and Participant survey was a separate component in the BME Request for Proposal for which the auditor did not apply. The auditor did have direct contact and telephone contact with a number of participants in the course of the audit. Periodic contacts between HPP staff and participants were observed in the office, including several annual and quarterly review sessions that were observed. Many of these observed encounters were very positive, warm, respectful exchanges in both directions- just what one would like to see in a diversion program. Several participants who had glowing reports of their HPP experience and who could not say enough good things about HPP staff were interviewed in the office. The auditor observed numerous examples of very positive relationships between participants and HPP staff.

One of the office encounters involved an annual review of a participant and spouse who were both critical of HPP and the staff. The Medical Director, not at all defensive, offered the couple an opportunity to talk to the auditor after the meeting, which they accepted. They aired some grievances. In addition, several participants, having heard about the audit, contacted the auditor in his office. These participants were interviewed over the telephone.

It is fair to say that most of the participants who contacted the auditor were quite critical of HPP and/or staff. Several did not think they belonged in HPP, including at least one who was in the diagnostic monitoring program. So this group was skewed toward the critical perspective, and the sample, four or five, was too small to be statistically meaningful. But their concerns were given a full hearing. By and large, their concerns were earnest and had been carefully thought out. All had some positive, as well as critical comments. Several categories of concerns were common and represent areas for further inquiry: some felt they should not be in the program at all, but felt that they had no recourse for appeal; several did not feel that they had been always treated in a respectful manner by HPP staff; several did not feel that they had always been "listened to" by staff. There were concerns about the boundaries of information transmission between HPP staff and group leaders or consultants.

The participants' concerns expressed above are common and typical in diversion programs; Physicians, for example, are a critical lot, and don't hesitate to express their dissatisfactions. But these concerns suggest that more information is needed to understand fully what the participants experience with HPP has been, and to determine whether changes need to be made.

In order to understand better how participants perceive HPP, the staff, the groups, as well as gain other information about their experiences with HPP, the formal participant survey mentioned in the Board Request for Proposal should be done. This should be much more than a customer satisfaction survey, and should delve into a wide variety of HPP activities. It should be given to a large number of both current and past HPP participants, under the sponsorship of the Supervisory Council, not the Board. It should be confidential and sent out from, and returned to,

a person or entity not affiliated with the Board or HPP. The tabulated results would then be reported to the SC and the Board.

Recommendations

- **Participants should be surveyed about their experience in depth, with particular emphasis on the role of the groups, confidentiality, the degree of trust of the participants, the willingness to report personal difficulties, how the monitoring functions of the group impact trust and self reporting, the role of the medical consultants, conduct of HPP staff, etc. This survey should evaluate more than just customer satisfaction and be reframed as such.**
- **Afterward, the SC should reassess the role of the groups and the desired balance between monitoring and recovery functions. Written guidelines for sharing of information between HPP staff and group leaders should be developed. These guidelines should be shared with HPP participants to create greater transparency and develop trust. Any anticipated changes in current policies or procedures regarding these issues should be discussed with the Board.**

HPP Office Operation, Policies, and Procedures

Policies and Procedures

HPP staff follow a number of policies and carry out a number of procedures in the normal course of their work. Normally, a written Policies and Procedures ("P and P") manual is used as a guide for evaluating these. The P and P manual was examined and found to be incomplete and in the very early stages of development. It did contain a number of documents related to various activities of HPP staff and programs. But it did not contain written descriptions of the formal internal policies of HPP, nor did it contain written descriptions of the procedures staff should follow to do their work.

Upon further inquiry, it did appear that there are several completed policies and procedures, but these were not in the manual. Many more need to be completed. This deficiency made it hard to understand and evaluate certain aspects of staff performance. It would also make it very difficult for the SC to provide adequate oversight of some aspects of HPP staff performance.

The current staff has worked together many years. The Program Coordinator has been in her position since the inception of the program in 1990; the Medical Director, since 1995. They and the Administrative Assistant work together well and communicate effectively. However, in the absence of a written policies and procedures manual, it would be very hard for someone else to come in and take over their functions. In particular, the Program Coordinator has considerable knowledge and wisdom regarding HPP and its history that no one else has. She will be retiring in a few months. It is essential that developing a complete, written Policies and Procedures Manual be given the highest priority. It should be completed well in advance of her retirement date.

Conclusions and Recommendations

- **The Policies and Procedures ("P and P") manual needs to be written and completed several months before the retirement of the Program Coordinator. It should be presented to the SC, in consultation with the Board, for review and final approval well before her departure.**
- **A beginning draft list of recommended policies and procedures is included in the Appendix. (Note that this list is just intended to serve as a starting point for a complete list.)**

Telephone Calls and Inquiries

HPP staff receive numerous calls, from a variety of sources, about many different aspects related to the program. In many ways, the telephone is the lifeblood of the referral system. Discussions with staff and the personal experience of the auditor indicated that calls and inquiries are handled in a professional manner. Calls made by the auditor were answered and/ or returned promptly. There was positive feedback from group leaders and some participants that calls are returned promptly, and that staff were responsive to their needs.

There is currently no consistent log kept to track incoming referral calls, nor was there a formalized, standardized protocol for collecting information regarding these calls. So there was no way to audit the number of these calls, their origin, or what actions were taken. Data from incoming calls is particularly important as HPP seeks to increase the number of referrals from a variety of sources. Having a log of these calls and beginning to collect objective data for analysis and review would be very useful to HPP.

The current after-hours telephone message was recorded by the Program Coordinator. It appears to be the same message that is used during the daytime when someone cannot answer the phone. Given the status and importance of the physician Medical Director, it would be better if these recordings were made by her.

The caller ID of the HPP phone is "SOO-BOARD OF MEDICINE". This might be intimidating for a prospective caller or self-referring physician or family member, and might even be perceived as a violation of confidentiality in some situations. (The first time the auditor received a call from HPP, he mistakenly called the BME, thinking the call had originated there.) And there is no mention of the fact that the message is confidential. This might discourage a prospective participant or a referent from leaving a message.

The HPP office phone system does not have incoming caller ID, which might be quite useful in terms of identifying missed calls, etc.

Conclusions and Recommendations

Calls and inquiries appear to be handled in a professional and timely manner. Referral contacts are not recorded in a central place so they can be tracked and audited. A formal, paper or computer-based tracking and ongoing audit system for referral contacts is needed. The caller identification and voice messages need to be updated and modified.

- **Keep a log book for all incoming referral and inquiry calls. Each inquiry or call should be separated as to type of call, *e.g.*: referral, requests for education, request for consultation, etc. Calls should be tabulated and reviewed periodically**

and then reported to the SC. Consideration should be given to computerization of this function.

- **Develop and implement a Referral Information Sheet which would contain a brief summary of all pertinent information related to referral calls, for instance: date, name of referent, name of caller, location, call back number, source, reason for call, action taken, etc. As a computer system is developed, this sheet could become a part of that process, and could become computer based.**
- **HPP voice messages for when no one is available to answer the phone should be recorded by the Medical Director. All messages should clearly state that the calls are confidential.**
- **It is recommended that call identification be blocked for outgoing calls to protect confidentiality for HPP participants.**
- **Caller ID for incoming calls is recommended.**

Intake Process

The intake process varies according to the particular circumstances of each referral. Sometimes new referrals are seen face-to-face before they go to treatment; at other times, after treatment. Of course, when an intervention is done and the physician goes immediately to treatment, the intake process and interview are done after discharge from treatment. There is no written policy or procedure for the intake process.

It is assumed that most treatment centers, especially local ones, will refer discharged physicians to HPP. While it does appear that the great majority of practitioners are referred to HPP, there is no objective data to confirm that this always happens. In the auditor's opinion, the earlier a practitioner is formally enrolled in HPP, the better. HPP staff can be of assistance to the practitioner and her family prior to entering treatment, as well as during treatment, and earlier enrollment assures that the practitioner will actually be enrolled in HPP when treatment is completed.

Conclusions and Recommendations

- **Develop a formal, written Intake Policy and an Intake Procedure. It is recommended that an intake interview and HPP enrollment take place before referral to treatment whenever possible. At the very least, a face-to-face meeting is recommended. A formal monitoring contract with specific requirements could always be written and signed after residential treatment is completed for those practitioners who are known to HPP prior to entering treatment.**
- **Data should be collected at intake in a standard format that begins the database for the individual participant and which allows for data collection for the program.**

Participant Medical Records

Numerous charts were reviewed throughout the audit. In general, the charts were quite complete and up to date. The charts were well organized, generally by categories of information, *i.e.* progress notes, assessment and treatment summaries, BME information, urine collection and testing, group meetings, annual and quarterly reports, etc.

Information was arranged in each category chronologically. This made it easy to find information within each category. But it was very difficult to follow the course of a participant over time, since one must jump back and forth among sections in the chart to get a chronological picture of the course of recovery and compliance.

There is no one place that ties all the chart entries together, as the progress notes do not consistently contain references to activities tracked by HPP: for example, a consultation, residential treatment, or an abnormality in urine testing. The key information was generally found in the chart, however.

The Progress Notes varied in quality and completeness. Many entries were detailed and legible (a fair number were typed). But some notes lacked signatures, and it was not always possible to tell who authored the note. Progress notes were not always systematically recorded when a key event happened. Improvement is needed in this part of the record. Expanding the function of the progress notes and placing them in the most prominent part of the chart would help in this endeavor. All key events should be recorded or at least noted in this part of the record.

Currently a paper chart system is used. With an average HPP census of 100 or so, the current paper system makes it difficult to follow and track the participants. HPP staff manages numerous contacts and items for each client, from auditing urine collections to scheduling periodic reviews. An electronic system would provide considerable advantages, and potentially offer increased efficiencies.

An effective contact management program is needed, with future scheduling capabilities and an alert system. Electronic copies of group leaders' monthly reports, urine testing reports, communication from participants, consultations, etc. could be integrated into a contact management database. Many of these reports could be transmitted electronically and easily added to an electronic record, reducing clerical work in the office. Participants could also submit their meeting attendance information, etc. electronically via e-mail when the security issues are worked out.

Many records lacked an entry about whom to contact in an emergency. This is important information to have available, in the unlikely event that an emergency occurs and it is necessary to contact spouse or family.

HPP is involved in many aspects of treatment, and has been designated as a treatment program, for purposes of federal confidentiality statutes. So it makes sense to the auditor that HPP charts should meet at least the basic standards of medical charting. The auditor is not qualified to make the determination of whether current charts meet basic standards of medical records. It would be appropriate at some point to consult with a medical records specialist to insure that the charts meet those standards, and to get suggestions for modification and improvement.

Conclusions and Recommendations

- **The organization of the HPP charts should be reviewed, and a method devised so that the progress of the participant can be tracked easily. All major events, from admission to discharge, should be noted in a central place such as the Progress Notes. Whenever there is an important event, a notation should be place on the**

chart, plus a brief summary of the event when indicated. More detailed information can be retained in specific sections of the chart, as is currently done.

Examples of the types of events which need to be noted on the Progress Notes (in addition to communications and interventions by HPP staff) include, but are not limited to:

- **Initial contacts**
- **Admission Intake Summary**
- **Addiction treatment events, summaries**
- **Consultations and brief summary of results**
- **Documentation of quarterly and annual reviews with notable findings**
- **Concerns/ problems with urine collections and testing**
- **Concerns about return to drug use or suspected relapse**
- **Prodromal relapse behavior and Relapses**
- **Referrals to SC and summaries**
- **Referrals to Board**

- **Consideration should be given to using a contact management program such as ACT! or Goldmine to record contacts with participants, to create a "tickle" file, record database information, etc.**
- **Converting the charting system to a paperless one could make tracking and organization much easier. For example, electronic copies of consultant reports, discharge summaries, etc. could be requested and put in an electronic database, reducing clerical time.**
- **HPP should have a certified medical records professional evaluate the current charting system and make recommendations necessary to insure that HPP records meet current standards for medical records.**

HPP Monthly Monitoring Report

This document is the primary written record of the ongoing progress and status of HPP participants. It is sent monthly by the group facilitators to the HPP office. The form has considerable useful information on it. But again, it is difficult to track the month-to-month progress of the participant.

There is currently considerable subjective information on the Monthly Monitoring Report. Specific contract requirements such as the number of 12-step meetings actually attended each week, the number of sponsor contacts, therapy sessions, time spent exercising, and the number of hours worked each week are difficult to locate and track serially over many months. These parameters should form the basis for compliance, and need to be recorded in a flow sheet or other format that facilitates evaluating any changes in these parameters over time. This is particularly important, since reduction in recovery activities or increased non-compliance often precede a return to drug use. Evaluation of this report is currently being done by HPP staff and group leaders.

Recommendations and Conclusions

- **The Monthly Monitoring Report for Group Facilitators should be revised. It is recommended that the new report be named Monthly Progress Report. Consideration should be given to asking the participants themselves to fill out the recovery activities section and sign the form, taking more ownership in the reporting process. The form could be shorter and much simpler. A flow sheet format, for recording the actual weekly number of 12-step meetings attended, sponsor contacts, a rating for group participation, compliance, etc. would work well, plus a space for a brief progress note. The form should be computerized when resources permit.**

Confidentiality and Security

HPP participants were identified by their BME license numbers, as well as their names. There was no way to refer to a chart without identifying the individual participant. License numbers are too easily identified to function in this capacity, and it creates an illusion of directly connecting participants to the BME, which is not the case. Currently these numbers are used to identify participants on urine testing laboratory forms, which could put the participants at risk for security breaches. And there is no way to tell quickly when a participant entered HPP.

It is very important to have a system based on numbers/ characters that provide complete confidentiality for individual clients. This would facilitate confidentiality in communication with group leaders, consultants, RSS, the SC, etc. It would also facilitate confidentiality in data collection and research. A sequential number system would work well. Variations might include beginning each number with the last 2 digits of the year, *e.g.* 0623, for the 23rd admission in 2006. It is recommended that such a system be implemented to reduce the chance of a lapse in security. Any system should have sufficient characters to allow for expansion.

While confidentiality issues are discussed in the release of information forms, there is no formal written policy or procedure regarding confidentiality and security of records. There are some guidelines regarding what information may be shared between HPP and group leaders, but these are somewhat confusing and too vague. These policies and related procedures need to be developed and written. The form authorizing release of information between HPP staff and group leaders needs to be clarified and revised.

Current practices for the urine testing program need to be reviewed for how well confidentiality is protected in the process of collection, testing, and reporting. Collectors, especially in remote sites, should be periodically reminded of the need to use only the numbers and no names on the collection documents. The identification numbers used for the testing program need to be changed promptly.

HPP does have one laptop computer which is outdated and needs to be replaced. It is recommended that confidential medical information not be put on the laptop. A policy regarding confidentiality of records and use of the laptop off site is needed.

While HPP cannot control all potential areas in which confidentiality and security might be compromised, HPP staff should have a proactive program to insure that the likelihood of breaches is reduced as much as possible. It is an area that will need ongoing attention.

Participant Database and Computerized Information System

Developing a standard computerized information system for state physician health programs (PHP) around the country has been an elusive goal. This is a daunting task. It has been considered over the years by the Medical Director and Program Coordinator, but other priorities intervened, and resources for addressing this were limited.

As a result, there is currently no computerized information system for HPP, and the paper-based office systems are inefficient. Some office computers need to be updated or replaced. The laptop computer performed very poorly.

Developing computer-based office systems and a good tracking system for participants, clinical functions, and monitoring functions is a very high priority. The Board has initiated the development of a new computer system, which offers an excellent opportunity to upgrade and expand HPP's electronic capabilities.

There is no standardized participant database that is developed for each new referral to HPP. Neither is there a way to collect data from the population of participants to track the group of participants. While considerable data on each participant is collected, the data collected varies from person to person. Data is located in various places in the participant's chart, and is not always easy to locate. Assembling a complete data set for a single participant or gathering data for a survey of all participants, is very slow and cumbersome. This made the audit process very difficult.

There is no way to tell at a glance, for example, how many participants are in each phase of the program, the source of referrals, etc. If there were a standardized participant database on each individual enrolled in HPP, and this information were collected in a central database, this information could easily be extracted. If the data were entered into a relational database such as Microsoft Access, and kept updated, even greater flexibility and utility would be achieved. This would allow generation of outcome information, better tracking of progress, and other information which would be helpful to the SC, HPP staff, and BME in both understanding and defending the program. A good database questionnaire may also be useful to the participants, who must answer questions, some of which focus on key issues in their addictive illness and recovery.

This database need not be perfect. What is important is to set it up in a relational database format that can be modified or added to as needs require. Given the intellectual abilities of HPP participants, the database should be self-administered up front. Again, the Board computer development project will be very helpful.

Recommendations

- **A high priority should be given to developing a standardized Practitioner Database which is completed when each practitioner enters HPP, and periodically updated. It should include a wide range of demographic, personal, and clinical information that will have utility in individual case management; collecting statistics regarding all HPP participants; confidential information sharing with group leaders, medical/ other consultants; and internal research regarding HPP programs.**

- **Development of a computerized tracking system for the participants is also a high priority. The number of participants is now sufficiently high that keeping track of all the transactions necessary to insure that the individual clients are progressing well and in compliance with their contracts is very difficult without a computerized system. A computerized system will also improve accuracy and, likely, create greater efficiency in the office.**
- **In the interim, data could be collected by paper questionnaire (self-administered and then reviewed). It should be developed and implemented in a form that makes it readily transferable to a computerized, relational database such as Microsoft Access when resources permit.**
- **The Practitioner Database could be self-administered by participants on an HPP computer, with the data being downloaded electronically into the HPP Client Database. This information could then be shared confidentially, with appropriate written permission of the patient, to group therapists, medical consultants, evaluators, and therapists. Group data from all HPP participants could be used for reporting to SC and BME, program evaluation, program management, and research purposes.**

Body Fluid (Urine) Monitoring

Body fluid (urine) monitoring is a critical aspect of HPP, as it is in all diversion programs. Most of the relapses in HPP are identified by this method. And it is a constant reminder of the need for strict abstinence. Despite this, it is important to keep in mind that relapses and return to drug use can be identified in other ways, and one should not rely too much on drug testing alone.

Self reports of alcohol and drug use can also be an important in determining who is at risk. Experience has shown that self reporting and spouse reporting rates will increase as participants develop trust in the staff, the rehabilitative focus of the program, and the boundaries of confidentiality. This requires maintaining a balance between the rehabilitation and monitoring functions of the program, which is discussed elsewhere in this report.

The body fluid monitoring program was carefully reviewed. Numerous conferences were held with the HPP staff and many individual cases were also reviewed. All positive urine tests from 2005 were reviewed and discussed in detail with the Medical Director (see below). A lengthy conference was held with the owner of RSS, the collection service under contract with HPP. The Administrative Assistant, who receives, reviews, alerts the Medical Director to positive results, and files these reports, gave considerable input into the audit.

During the first two years in the program, participants are supposed to be tested an average of 25 to 30 times annually, at a cost of $178 per month, which includes both collection and testing. Specimen collection rates for the third year are 19 to 25 annually; the fourth year, 15 to 18 annually; and the fifth year, 11 to 14. The monthly cost is reduced accordingly.

Collections are made only on weekdays. Each participant has a stated telephone number at which they may be contacted by RSS staff the morning a collection is scheduled. Collection days are determined on a random basis, although the method of randomization remains unclear. A specimen is supposed to be produced within four hours of the call. This norm is often very difficult to meet- for many reasons, some of which are very difficult to control.

Collections are supposed to be directly observed by the collector, but this standard is often not met, again, for numerous reasons. *(More discussion to follow.)*

The required frequency of urine testing in various state diversion programs[4] is highly variable. For the first year, Oregon HPP's testing frequency ranks below the national median, but exceeds the median in the second year and beyond. HPP appropriately maintains reasonable testing frequency over more years than most other programs. The qualitative aspects of Oregon's testing panel selection appear to be very strong. Ethyl glucuronide (EtG) testing has added an important dimension in terms of detecting alcohol use. This is frequently included in testing panels, adding to the strength of HPP's panels.

HPP uses four different drug screen panels which vary in cost from $20 per panel to $65 per panel, plus administrative costs of $20 per panel and collection costs of $20 per panel. Getting the full panel plus EtG for all specimens collected would be prohibitively expensive.

Specimens are sent by RSS to Salt Lake City, Utah for testing, usually within a day. Turnaround times from collection to initial lab report are usually several days when specimens test negative; up to a week, when positive.

Confirmations are performed on all positive tests, and the main lab holds positive specimens for "batching," to increase efficiency. HPP is called immediately by RSS when a positive test is obtained, and a fax of the test report is also sent to the HPP office. Specimens which may have been diluted are identified by low creatinine levels and low specific gravity. Repeat collections are made and HPP is notified. Participants are cautioned regarding not drinking excessive fluids when a test is requested.

All testing results sent to the HPP office are double checked by the Administrative Assistant. RSS staff promptly report any missed collections or concerns about participants or collections missed to the HPP office.

The current testing program is of sound design. Frequencies of collections appear to be adequate and reasonable. The testing panels are comprehensive, more so than most other states, and are able to pick up a wide variety of medications and drugs used by medical practitioners. Criteria for dilute specimens are very strict. The cutoff levels for EtG, at the 100 mcg level, are the lowest among state PHP programs. HPP has what appears to be a very reliable system for promptly reviewing all laboratory reports for positive tests for drugs of abuse.

A review of all urine screens performed during 2005 indicated that HPP staff carefully reviewed these in a timely basis and are doing an excellent job of overseeing this part of the program. There was one instance in which a participant taking Naltrexone tested negative (indicating that he apparently had missed a dose). However, reviewing such "expected positives" is a routine part of the screening process and these are usually picked up promptly.

HPP staff report that they have had no problems with chain of custody issues with RSS. When there is any question about a specimen, HPP staff calls RSS to document that the chain of custody has been followed. The documentation is always produced promptly.

In the interview with the owner of RSS, he appeared to be quite accommodating in terms of trying to meet the demands of HPP participants, perhaps more than is necessary in some

[4] *See table in Appendix.*

cases. In general, he indicated the participants were "pretty compliant". He stated "We do everything we can to facilitate compliance", describing instances in which he or his assistant went out of their way to insure they would make contact with a participant to get the specimen the day required. He did indicate that some participants could be intimidating in their behavior. HPP staff confirmed that a very few participants complain about the process, but that this is not a significant problem.

Actual versus Target Urine Collections

Monitored urine collection is a complicated and difficult part of monitoring programs generally. It has been problematic in HPP as well. In 2004 the collection rate was unacceptably low, as indicated by the following chart furnished by the Medical Director after her audit of the RSS urine collection rate in 2004:

Audit of 2004 HPP Urine Collections

- 88% of target collected
  - 1544 collections in computed target
  - 1365 collections completed
- 27% of participants below 80% of target
  - 33% of these were "low frequency" collections
    - One "miss" = a large percentage
    - One "miss" = can be serious
  - 75% of these participants were outside Portland collection area

HPP staff made diligent efforts to correct the problem in 2005, and they succeeded.

Audit of all 2005 HPP Urine Collections

% OF TARGET COLLECTIONS	NUMBER
101 – 120	27
100	47
90 – 95	9
80 – 89	3
70 – 79	1
50 – 59	1

The collection rate was again audited by HPP for the first quarter of 2006. Only 84% of the target number of specimens were collected- again, an unacceptably low rate.

HPP Urine Collections – First Quarter of 2006

DESCRIPTION	NUMBER	PERCENTAGE (%)
Total target collections	427	–
Actual collections	360	–
Percentage: Actual / target	–	86

Distribution of actual collections by days of the week

In addition, collections were reviewed by date of the week. This is particularly important since weekend collections are not done, primarily because of availability of collectors. This leaves only five days for collections.

Of the total 360 collections performed in the first quarter, participants were likely to have a collection less than one-half as frequently on a Monday or a Friday, compared with a Tuesday, Wednesday or Thursday. *(See chart below.)* The chance that a participant will have a weekly urine specimen collection during the four-day period from Friday through Monday is less one (1) in four (4). This leaves a big gap in the urine monitoring system during that critical time of the week.

DAY	NO. OF COLLECTIONS	PERCENTAGE (%)
Monday	40	11
Tuesday	95	26
Wednesday	100	30
Thursday	80	22
Friday	45	12

Again, for 2006, actual collections again do not come close enough to target collections. These are serious problems that must be corrected promptly.

Randomization of collections

Collections are currently scheduled on a "random" basis. The randomization system is managed by RSS. It is not clear exactly what kind of system they use to develop a "random" schedule. However, the great variation in the number of specimens collected at the beginning and end of the week, versus the middle, suggests that the system is not random at all.

The collection system needs to be rebalanced so that at least as many specimens are collected on Mondays and Fridays as are collected on other days of the week.

Considerable emphasis is often placed on insuring that the collection system is random. But as the Medical Director stated, what is needed is an unpredictable schedule for collections that cannot be second guessed by the participants. Also, HPP does use "targeted" scheduling when someone is considered at high risk. Examples would be obtaining a specimen the day after a vacation from someone whose recovery was perceived as slipping. This might be used more frequently, especially until the urine collection system is more in balance and the weekend gap is closed. More transparency is needed regarding the collection scheduling system, so the SC and the Board are kept current on the status of the urine collection program.

Reliability of urine specimens collected

The standard for the collection of urine specimens in HPP is that micturition should be directly monitored by a reliable collector. In some situations, particularly in more remote areas and with females, this is not an achievable standard. However, unless one can be certain that the specimen came from the correct practitioner, and it has not been adulterated, the quality of the whole testing program is called into question.

HPP should continue to strive for as high a percentage of directly-observed specimens as possible, and arrange the best possible alternatives for those situations in which direct observation is not possible. There needs to be transparency regarding this part of the testing program, so the SC and Board are kept fully informed of the degree of reliability of collections.

While the observational status of the individual collections are recorded on the collection sheets, these are not regularly audited as a population. It is important that HPP staff get baseline information so they can assess the current status regarding observation of specimens. Once that information is available, problems, if any, can be addressed. Information available to the auditor does strongly suggest that this part of the urine monitoring program is lacking and likely needs significant improvement.

Another aspect of specimen reliability is the length of time between a request for a specimen and the actual time the specimen is collected. The HPP standard is four (4) hours or less. Given the nature of some types of medical work, e.g. surgery, and geographic considerations, full waiting rooms, etc., this standard cannot always be met. Again, the time of the call to the physician and the actual collection times are recorded individually, but are neither tracked regularly, nor audited as a population.

It is not currently known what the median or average length of times between request and collection are. Also, it is left to RSS to decide if there is a problem. This leaves HPP vulnerable, especially since RSS has repeatedly demonstrated a lack of good organizational skills.

More information and more oversight are needed. It is recommended that HPP staff have RSS compile this data for the next several months. Any needed changes can be instituted after analysis of the data is completed.

Fees for chemical monitoring

The current fee schedule for the monitoring component of HPP is as follows:

Collection fee per specimen	$20
Administration fee per specimen	$20
Laboratory testing cost per specimen	$20 - $65

HPP participants with the highest frequency of urine testing currently pay $178 per month, with reduced monthly rates as fewer tests are required. The flat fee provides some consistency and predictability for the participants. But the incentives for the contractor, while not intended, reward the contractor for collecting fewer specimens per month. The contractor is paid the additional costs for any additional specimens requested by HPP.

It is not clear the extent these issues are problematic. A review of this fee system is needed at some point in the future, and certainly before making any significant changes in the administration of the testing program.

Summary

HPP has a very well-designed urine testing program, but the contractor (RSS) has not delivered in the collection process. Diligent efforts on the part of the staff have not been successful in producing a sustained correction by RSS.

RSS staff have been very accommodating and quite flexible, but RSS has seemingly lacked the organizational framework and skill to provide consistent results in the collection of specimens. Many specimen collections are not directly observed. Information about the lag time between request call and actual collection are not known.

More involvement and oversight by HPP may be necessary, not only in insuring that adequate collections are made, but that collections are directly observed by a reliable person, and that specimens are collected as much as possible within the four-hour window. Some significant changes must be made in the near future. The integrity, validity, and reliability of the HPP chemical monitoring program must be dependable in order to protect the public, the practitioners, and the program.

In considering options, it should be kept in mind that insuring the quality of chemical monitoring is a difficult component of any diversion program. In the experience of the auditor, there is often a false sense of security in body fluid monitoring programs. No program is perfect, and many are not nearly as good as people often think. However, they do not need to be perfect in order to provide adequate safety for the public, or to serve as a significant deterrent to alcohol or drug use. Being in HPP by itself makes a difference, and HPP has backup behavioral monitoring components, as well.

HPP staff should evaluate the current collection scheduling system and consider taking a much more active role in overseeing the design and implementation of the collection scheduling system. They are in the process of considering options. The SC also needs to take a proactive role in resolving these problems. A shorter time frame for overseeing RSS should be considered, for example, monthly or bi-weekly reviews, instead of every two or three months. The collection process of the contractor needs to be much more transparent to HPP and to the Board. The contractor must meet their standards at both programmatic and individual levels.

HPP has several options:

1. Find a new contractor to do urine collections and testing.
2. Bring the urine testing program into HPP and manage it.
3. Change the relationship with RSS so that HPP would more tightly control the activities of RSS employees and monitor compliance with its standards, for example for "randomization" of testing.
4. Take over management of the collection schedule and other selected aspects of the program (e.g. finding and training U/A monitors in more remote locations) and contract out the actual collections, or some other similar combined arrangement.

Finally, while there are significant problems with the current collection system, and changes should be instituted as soon as possible, there are some real advantages to having a local system with people who are responsive and try hard to meet the requests of HPP staff.

Given all the other issues facing HPP, the current system should be shored up first, while careful consideration is given to other options.

In addition, significant modifications in the urine testing program might require additional staff, hired or contracted, up front. A major change in the urine collection system is a big event, which would further tax the functional capacity of HPP staff. Some short-term recommendations, as well as longer term ones, follow.

Conclusions and Recommendations

- **The frequency of urine specimens actually collected needs to be brought to the level of the target number immediately, regardless of what longer-term solutions might be entertained for the testing program. It is recommended that actual vs. targeted collections be audited on a monthly basis for the foreseeable future.**

- **Collections are strongly weighted toward the middle of the week, and there are too few collections on Mondays and Fridays.**

- **HPP staff should provide more scheduling oversight to insure that Monday and Friday collections are promptly brought to a frequency at least as great as the frequency of Tuesday to Thursday collections, and perhaps even more frequently, for a time.**

- **Obtaining some weekend collections on selected participants should be considered more frequently, especially in participants who have demonstrated evidence they might not be in compliance or might be slipping out of recovery.**

- **The reported frequency of directly observation of specimen collections appears to be too low. An improved system for insuring direct observation of specimen collections is needed. The level of observation for each specimen collected needs to be consistently recorded on the collection document. A system for collecting data from all collections should be devised so this can be audited in an ongoing manner by HPP. Training and education of collectors in remote sites may be needed. HPP may need to get more directly involved in these processes.**

- **The time span between the initial call to the participant and the actual collection time for each specimen needs to be audited, to find out what participant experience in this area is. Depending upon the results, improvements may be needed. If serious problems are found, HPP may need to take a more active role in this process.**

- **The flat monthly fee system creates potential negative incentives for the contractor to collect sufficient specimens to reach the target number. The fee schedule needs to be reviewed to insure that the incentives are correctly aligned to achieve HPP's goals of actual collections meeting or exceeding targets, and that the charges reflect a fair price for participants, *i.e.* they are only paying for what they receive.**

- **Some other recommendations for consideration which might facilitate short-term improvement are as follows:**

- **Review the collection schedule for the next month with RSS in advance, to insure that the number scheduled meets the target number (which should include "make up" collections for those missed during the first quarter of 2006).**
- **The collection schedule should be reviewed by days of the week, and adjustments made to insure collections are made at least as frequently on Mondays and Fridays as are made other days of the week.**
- **The randomization schedule could be changed so that target levels of collections are met over a shorter period, *e.g.* one (1) to two (2) months initially, rather than annually.**
- **Ask RSS to report actual collections vs. targeted collections on a weekly basis. This could be simply to have RSS report on which collections on the target schedule were actually collected.**
- **Insist that any collections missed in the previous week be made up the following week.**
- **Consider instituting penalties if RSS does not perform satisfactorily.**

Management of Relapse Prodromal Behavior and Relapses

Identification and management of relapse prodromes and relapses is a very important aspect of HPP. The goal is to create an environment in which participants or their associates bring problems which could either lead to relapse, or which suggest relapse prodromes or frank relapse, to the group. Urine testing is one aspect of this early warning system, but there are others. Here the arms-length relationship between HPP and the Board is essential to create an optimal system.

All relapses in the cohort of HPP participants enrolled in the program at the end of 2005 and known to HPP were reviewed by the auditor. These cases were then reviewed in detail with the Medical Director. She was very well informed about all cases presented to her. Her criteria for identifying physicians in a relapse prodrome or actual relapse were very broad, and the auditor did not identify any such cases that had been missed. Actually, the Medical Director identified a number of physicians as having relapses in HPP who actually had not. She counted relapses that led to a referral to HPP as relapses in the program, which artificially inflated the number of relapses which HPP participants had experienced while in the program.

All urine tests during the 2005 calendar year were also reviewed. (This was the year in which actual collections by RSS were equal to the target collections expected.) Numerous extra specimens had been ordered on participants if there was a question of relapse. No positive urine tests had been missed by HPP staff; all were accounted for. Positive EtG tests, even at very low levels, were noted and investigated. There was one instance in which a test for Naltrexone in a participant taking the medication was negative. The testing review system was very tight and exemplary.

The organization of the medical records and the difficulty in easily following a participant's course over time in the record is relevant here. It might be useful to have a specific

relapse prodrome/relapse management tracking form that is initiated when a participant is suspected of being at risk (repeated low-level EtG determinations; relapse prodromal behavior; positive urine; etc.). This would facilitate easier follow up and would also facilitate ongoing review of these cases by HPP staff.

Conclusions and Recommendations

HPP staff appear to be doing an excellent job of identifying and managing relapse prodromes and relapses.

- **Consideration should be given to developing a tracking form for those participants who are felt to be at increased risk for relapse.**

Referrals and HPP Census

A review of all participants enrolled in HPP as of December 31, 2005, based on information provided by HPP, revealed that self-referrals, with or without encouragement or pressure from others, are the most frequent type of referrals resulting in admission to HPP. Nearly two-thirds of the referrals (63%) come from physicians, and only one-fourth of referrals come from the BME.

Most of the Board referrals are from licensees or license applicants making a positive response to an addiction question on the renewal or application questionnaires. Very few HPP referrals come from the Board as a result of a complaint to the Board, suggesting that most practitioners identified as potentially having addictive illness go directly to HPP, a good indication that HPP is working well. The high percentage of self-referred and colleague-referred physicians is also a positive sign of HPP's acceptance.

Sources of Referral of HPP Participants
(Census figures as of December 31, 2005)

SOURCE OF REFERRAL	PERCENTAGE (%) OF CENSUS
Self-referrals	33
BME	26
Other physicians	17
Hospitals, employers, "well-being" committees	13

The geographic distribution of the current HPP participants is shown in the table on the following page: "Comparison of HPP Census by Region with Practitioners Census by Region." The results showed that HPP coverage of the state is remarkably balanced. It would have not been surprising if the more rural areas were underrepresented, but HPP staff has done well in this regard.

Notably, HPP enrollment in the three-county Portland metropolitan area (Multnomah, Washington and Clackamas counties) had the lowest percentage representation in HPP relative to total population of practitioners in the area. The majority of the under-representation was in Multnomah County, were actual participants were 7% lower than would be expected based on

population of physicians. This is consistent with the Medical Director's expectations and with several Metro hospital reports that they have few physicians to report to HPP. The Metro area may represent "low-hanging fruit" in terms of increasing referrals to HPP.

A review of referrals, discussions with several Oregon hospital medical staff services professionals, and the auditor's recent experience with hospitals in the state revealed a low rate of referrals from some hospitals and hospital medical staffs. HPP staff also report considerable inconsistency in the frequency and likelihood of referrals from various hospitals in the state. It is possible that some referrals from hospitals enter HPP in the self-referred and colleague-referred categories. If true, that also supports the auditor's experience that some hospitals tend not to stay involved in the process once a referral is made to HPP. It is much better for everyone for hospitals and medical groups to stay involved, and participate in the support and monitoring processes, as that is likely to improve the prognosis for recovery significantly. More education and outreach to hospital medical staffs and medical groups is needed, and this should be a high priority in the future.

Expanding referrals to HPP

At the end of 2005, 89 participants were enrolled in HPP. Approximately 20 new licensees enter HPP annually. Oregon currently has approximately 10,500 active physician licensees practicing in the state. There are approximately 12,000 BME licensees eligible for participation in HPP. Between 10% and 15% of physicians will develop problems with alcohol or drugs at some time during their careers. Using the most conservative figure, 10%, that means that there are at least 1,000 practicing at-risk physicians in Oregon. Obviously, only a small percentage of at-risk physicians are currently enrolled in HPP.

Experience shows that enrollment in a monitoring program greatly increases the prognosis for sobriety, thus protecting the public. The segment of the practitioner population most at risk for causing harm due to impairment from addictive illness are the large group of practitioners with significant addictive illness who are still using drugs and alcohol but are unknown to the system.

So it is logical to conclude that increasing the number of referrals to HPP is the most effective way to protect the public from these problems. Currently much of the focus, both within and outside HPP, is managing those practitioners already in the program. Consideration should be given to allocating more of HPP resources towards increasing the number of participants in HPP. HPP staff will need the help of these other groups mentioned above to increase the number of referrals.

Over time, there is a need for the Medical Director to spend more time in the community actively promoting HPP. Activities would include giving more presentations; broadening her existing network of contacts with hospital medical staffs, medical groups; and the like. These activities have been shared with the Program Coordinator in the past. But the Medical Director should have a higher profile in this network, since the presence and clout of a physician is very important and may be more effective in motivating physicians to refer colleagues to HPP.

The OMA could also be very helpful by taking a more active advocacy role for HPP. This area needs more attention. It is not clear that the SC has defined this as a priority in the past. It would be appropriate for the Council to define their future expectations for outreach activities and the priority such activities should have, taking into account staff resources and other issues.

The reader should keep in mind that the number of annual referrals to HPP has been reasonably stable over the years, but has not grown. The 20 new practitioners enrolled in HPP in 2005, was the highest number achieved except for 2001. A major problem is the lack of well-functioning hospital committees (PHC) to address these problems at the hospital level, including, and perhaps especially, in the Portland metropolitan area.

Prior to the formation of HPP, and in its early years, there was a much more active network of hospital medical leaders who generated referrals to HPP on a regular basis. This network was developed initially by a joint effort between the Board and hospital medical leaders who put on several statewide seminars to educate medical leaders how to approach the problem. This effort should be repeated. The Board's leadership is critical to this endeavor; a joint effort with the OMA would be particularly effective.

Conclusions and Recommendations

- **There is significant potential for increasing the number of referrals to HPP of eligible practitioners who need HPP services;**
- **Increasing the number of referrals to HPP is the most effective and efficient way to utilize HPP services to protect the public, as well as to rehabilitate practitioners;**
- **A medical community effort, with strong support from the BME and, perhaps, the OMA, will be necessary to assist HPP staff in this endeavor;**
- **Referrals by hospitals, in particular, are underrepresented in HPP. Particular emphasis should be placed on outreach and education to hospitals. Hospitals should be encouraged to stay actively involved when they refer a practitioner to HPP;**
- **More of HPP's resources, particularly those of the Medical Director, should be directed towards outreach and education;**
- **The SC should develop implement a proactive plan for "marketing" HPP services and increasing referrals to HPP, particularly among hospitals.**

Other Issues

Chemical Dependency Evaluations by the Medical Director

HPP receives numerous referrals, primarily from the BME, to evaluate practitioners who may be chemically dependent. Frequently these practitioners are in the process of applying for licensure in Oregon. The Medical Director does an intake interview to determine whether or not, in her opinion, there is a diagnosis of chemical dependency. If she makes a diagnosis, and the practitioner is in agreement, and accepts the diagnosis, a rehabilitation plan is developed and implemented. This usually includes a period of residential treatment, which is appropriate.

If the diagnosis is not clear, or if there is significant resistance on the part of the practitioner to a diagnosis of addiction, the practitioner may be referred to a consultant for a second opinion or referred to a treatment center for admission for diagnostic evaluation. In most

cases this system, overseen thoughtfully by the Medical Director, works quite well, and appear to be a significant service to the BME.

BME Referrals and the Role of the Board

Categories of Participants

Related to the mandated vs. voluntary issue is the role the Board assumes when the Board staff refer practitioners to HPP. Currently, if a licensed practitioner is referred to the Board, and it looks like addiction is the problem, the practitioner is referred directly to HPP. There do not appear to be clear standards for feedback back to the Board regarding the outcome of the encounter with HPP staff.

It is assumed (and likely quite correct) that all participants referred are dealt with promptly, professionally, evaluated when indicated, and enrolled in HPP when appropriate. But there is uneasiness among some BME staff that they do not always hear back about the disposition. There is no data available to determine whether BME staff's perceptions are accurate, but this is an important issue, regardless.

This is a potential problem from the BME's and HPP's perspectives. Neither group wants anyone to "slip through the cracks," and it could happen on either side. The BME has the investigators, but not the information; HPP has the information, but no investigators and no leverage except to inform the Board if the practitioner does not collaborate. It is important that these issues be discussed jointly, a clearer feedback system developed, and any potential loopholes filled.

There are two categories for HPP practitioners in terms of their relationship to the BME: "mandated" and "voluntary." The difference is whether or not there is a formal BME contract or stipulation with the practitioner. Mandated practitioners have such a relationship; voluntary ones do not. There are slightly different reporting arrangements with each category, as mandated practitioners are more quickly reported to the Board, and all positive urine tests for these participants are reported to the Board. More discretion is permitted with voluntary participants as long as they remain safe to practice. This makes sense, as it creates incentives for practitioners to sign up voluntarily and avoid being mandated by the BME whenever possible. The exact number of mandated participants in HPP was not readily available. HPP staff estimate that it is about 10% of HPP enrollees. This percentage seems consistent with at least one other well-established diversion program.

There may be situations in which a given practitioner should enter HPP as a mandated, rather than voluntary, participant, or situations in which the status of a participant should be changed. Dialogue between the Board, Board staff, SC, and HPP staff would be useful to all.

Also, HPP staff may need a different kind of Board action in cases involving, for example, a participant who is referred back to the Board after a relapse or significant noncompliance. The formal processes of investigation, etc. used by the Board may not meet the needs of HPP staff. For example, HPP staff report that they often receive such a practitioner back from the Board for further follow up and monitoring, and then experience the same difficulties as before. This is an area for more dialogue in the Joint Liaison Committee.

Diagnostic Monitoring

This category is used for practitioners referred to HPP who present in a manner suggestive of addictive disease, but who, when evaluated, are not found to have a clear-cut diagnosis. These practitioners enter HPP, sign a contract, and fully participate in HPP for a shorter period of time, for example, two years. Body fluid monitoring is also done. Modifications of the basic program are made, but very infrequently. In addition to providing a safety net in case the diagnosis has been missed, an occasional participant will eventually make her own diagnosis and enter active recovery.

However, this can be an area of great conflict. Several of these participants currently have been highly vocal, negative, and highly critical of HPP staff, by their reports. Some are also quite disruptive to their weekly groups. Their behavior is problematic for HPP staff, although they appear to work very diligently to assist these practitioners. In the opinion of the auditor, these participants create excessive work for the staff and also create a significant "hassle factor" that can only wear down an already-taxed staff.

It would be advisable to examine this category of participant, make sure that it is still appropriate, and look for ways to make it more workable at less cost to staff. One recommendation is to shorten the time frame a practitioner spends in that category.[5] Another area to assess is what the nature of their participation in HPP activities should be. Perhaps the requirements should be changed, with more individual sessions for some participants. The Medical Director and HPP staff, working with the SC, are in the best positions to make these judgments. This is not of the highest priority, but it should be kept in mind. Perhaps one way to start is to consider more individualization of programs for practitioners currently in HPP, if there is agreement that some modifications are in order.

HPP Mission Statement

"The mission of HPP is to protect the public health through maintenance of the health of licensees of the Board. This mission is accomplished through the facilitation of a) confidential assessment for potential substance abuse disorder, and b) providing effective intervention, treatment referral, and monitoring of licensees with the disorder."

HPP staff do much more than what is mentioned in the Mission Statement. They provide consultations to participants and assist them with their recovery programs, provide counseling and support to clients and spouses when emergencies arise, provide education and consultation to physicians, hospital personnel, professional organizations, and others.

Mission statements are dynamic documents which need periodic review and revision to insure that they continue to be consistent with current realities and accurately reflect what is being done. Involvement of both the SC and the Board in this endeavor would present an opportunity to develop and/ or reaffirm a consensus regarding HPP's mission and how it accomplishes same.

Conclusions and Recommendations

The HPP Mission Statement seems too narrow in scope and does not appear to accurately reflect the full range of HPP functions. The Mission Statement should be

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[5] *The Washington Physicians Health Program keeps a practitioner in this category for six months.*

reviewed and revised by the SC in consultation with the BME. A set of Goals and Objectives that outline how the mission of HPP is to be accomplished should also be developed. These will be useful as guides for future planning and growth of HPP.

Summary

Despite the structural ambiguity and oversight problems noted above, the Health Professionals Program is a good program, offering good service to addicted practitioners in Oregon. HPP staff are very dedicated and committed to the dual goals of facilitating health/ recovery and protecting the public, and Oregon has a good diversion program. But changes need to be made at both the governance and program levels for HPP to continue its record of success.

The major issues facing HPP now and in the future are ones of governance, oversight, liaison, and accountability. The current confusion about these issues prevents the establishment of the level of accountability and transparency needed for all. It is time to clarify the various roles and responsibilities of the Board, the SC, and HPP staff, and the accompanying reporting relationships, so HPP can move forward. Beginning to clarify these relationships up front will make it easier for the SC and HPP staff to address the issues identified in this audit and make needed changes.

The audit identified several major areas of concern regarding HPP operation and programs: the urine monitoring system; the lack of formal, written policies and procedures; the lack of a more comprehensive patient database; the need for improved workplace monitoring; and a need to be more proactive in outreach and increasing referrals.

The Health Professionals Program evolved from an environment of considerable collaboration around physician health/ wellness and reducing impairment in practice among physicians who were ill with addictions. In the beginning, the BME, OMA, hospitals, county medical societies, and professional societies were involved, many to a significant degree. That degree of involvement from the medical community has been lost, and HPP staff have been left without the level of support they have historically had.

It is time to rekindle that broad involvement from the broader medical community. HPP needs that level of support to provide the best level of service to practitioners and the community. The Supervisory Council and HPP staff cannot do this by themselves. Just as it takes an entire village to raise a child, it takes a similar effort to support the difficult work of the Health Professionals Program.

Kent E. Neff, MD
Portland, Oregon
June 30, 2006

APPENDICES

Oregon Health Professionals Program
Supervisory Council
Guidelines for Oversight on a Monthly Basis

Program Statistics

- Number of current participants, by program phase
- Admissions (current month and year to date)
- Discharges or resignations
- Reports to Board
- Referral Calls
    - Nature of inquiries
    - Source (hospitals, self, BME, etc.)
- Cases in development: new and old
- Participants in treatment; update on same
- Interventions done, pending, outcomes
- Participants with relapse prodromal behavior, relapses

Program Status

- General tenor of program (how things are going, client behavior, etc.)
- Major compliance problems
- Cases involving potential liability (legal or otherwise)
- Urine monitoring program status report
- Other program issues of concern to the Council
- Review of program components
    - Groups & group leaders
    - Consultants
    - Issues related to treatment centers
- Client concerns and issues

HPP Office, staff

- Staff morale, level of distress
- Workload, adequacy of available resources
- Personnel issues update
- Other issues

BME/ HPP Liaison

- Issues for the Liaison Committee
- Recent experiences with BME staff
- Positive actions taken to maintain a positive, collaborative relationship

Outreach and Marketing Activities

- Presentations given
- Contacts with hospitals, medical groups, professional associations, etc.
- Other outreach/ marketing activities

Oregon Health Professionals Program
Proposed Policies, Procedures, & Protocols

Note: These are beginning ideas. HPP staff will have their own ideas how to organize the manual, and what fits best with the current policies and procedures followed informally by the staff.

- Intake, Admission
- Participant Contracting
- Urine Monitoring
  - Client Policy, procedures re: urine monitoring
  - Toxicology Testing (completed)[1]
- Relapse Management
- Referral calls
- Reporting to BME
  - Relapses
  - Non-compliance
  - Regular reports for Board-mandated participants
- Addiction Treatment Policy & Procedure
- Maintenance of Records
- Voluntary & Mandatory Status
- Group Meetings
- HPP Consultants & Group Leaders
- Confidentiality of Records & information
- Diagnostic Monitoring
- 12-step Meetings
- Release of Information
- Participant Medical Records
- Liaison with BME
- Telephone policies and procedures
- Office opening & closing
- Interventions
- Quarterly Monitoring Meetings
- Monthly Group Progress Reports
- Medical Records
- Medication Management Policy (done)

[1] Note: other policies and procedures may be completed that are not listed here.

HPP PARTICIPANTS AS OF 12/31/2005

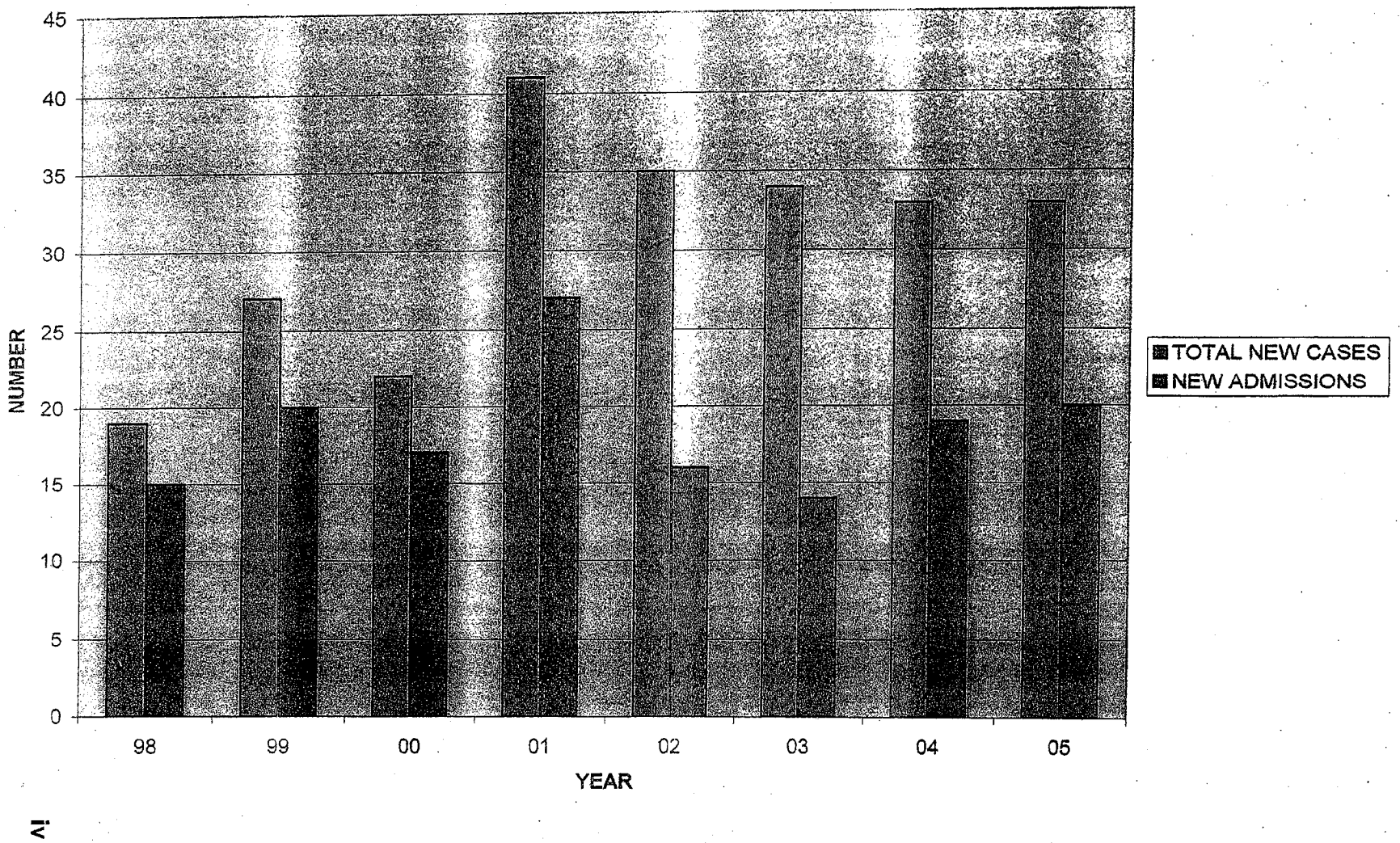
Demographic Summary

		Number	Percent
Total Participants		89	
	Stage I	34	38%
	Stage II	43	48%
	Stage III	8	9%
	Stage IV	3	3%
Sex	Female	13	15%
	Male	76	85%
Age	Mean		
	Median		
	Mode		
Marital Status			
	Married	60	67%
	Divorced	10	11%
	Single	8	9%
	LSO	6	7%
	Unknown	3	3%
Specialty			
Board Certification		64	74%

County	Number	Percent		Number	Percent
Benton	4		Metro	42	47%
Clackamas	5		Eugene	3	3%
Columbia	2		Medford	11	12%
Coos	2		Bend	5	6%
Deschutes	4		Salem	5	6%
Douglas	4		Corvallis	4	4%
Jackson	5		N. Coast	3	3%
Jefferson	1		S. Coast	2	2%
Josephine	2		K. Falls	2	2%
Klamath	2		E. Oregon	1	1%
Lane	3				

Specialty			
AC	1		
AD	7		
ADM	2	A	
AN	8		
C	1	M	31
CHP	1		
EM	10		
FP	16		
GER	1	M	
GS	3	S	16
I	10		
N	1	M	
NS	3	S	
OBG	4	S	
OPH	1	S	
OR	1	S	
OTO	1	S	
P	6		
PATH	3		
PD	2	M	
PH	1		
PL	1	S	
PM	2		
R	5		
U	2	S	
POD	2		
PA	1		
	96		

HPP NEW CASES & NEW ADMISSIONS, 1998 TO 2005

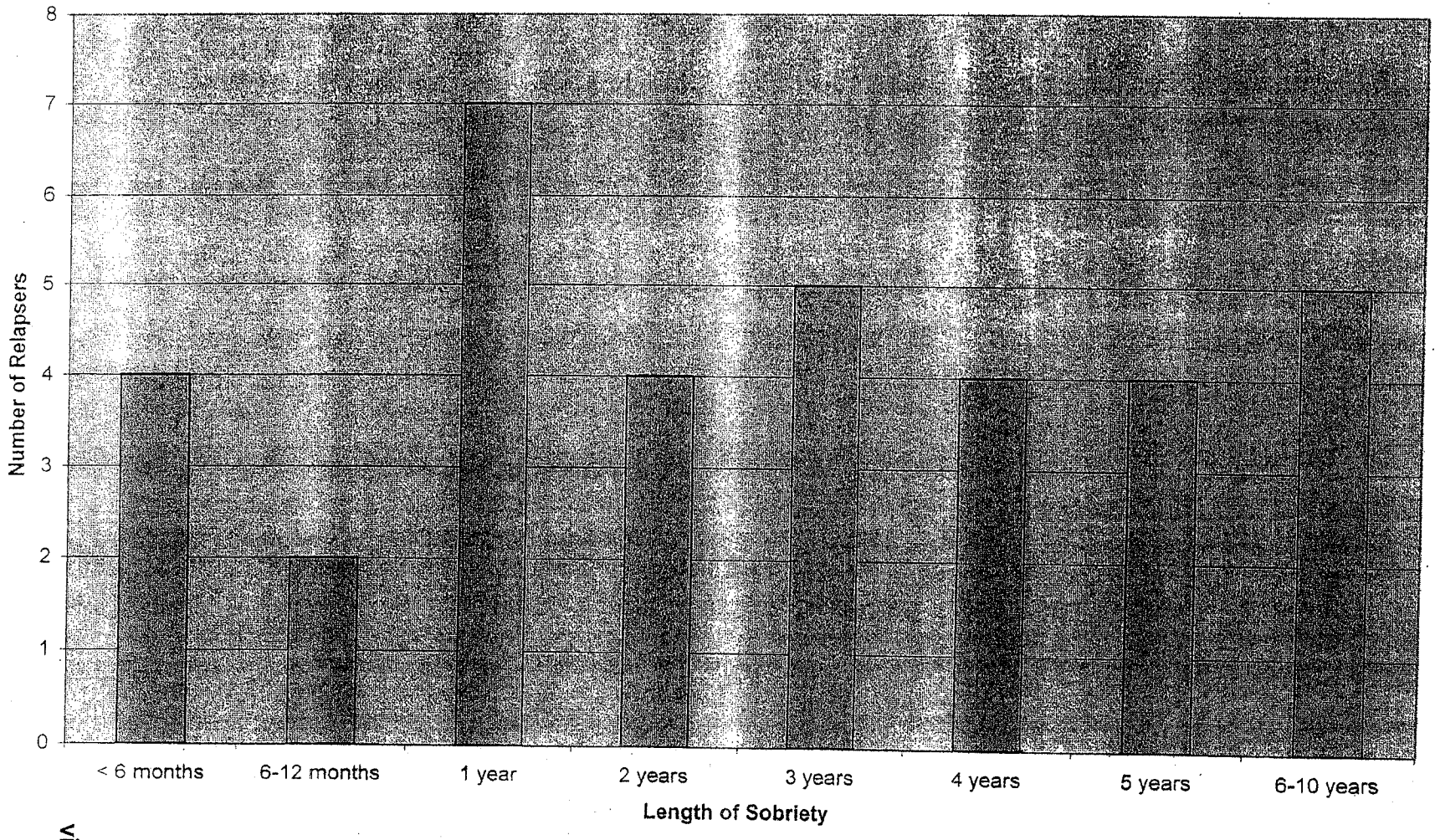


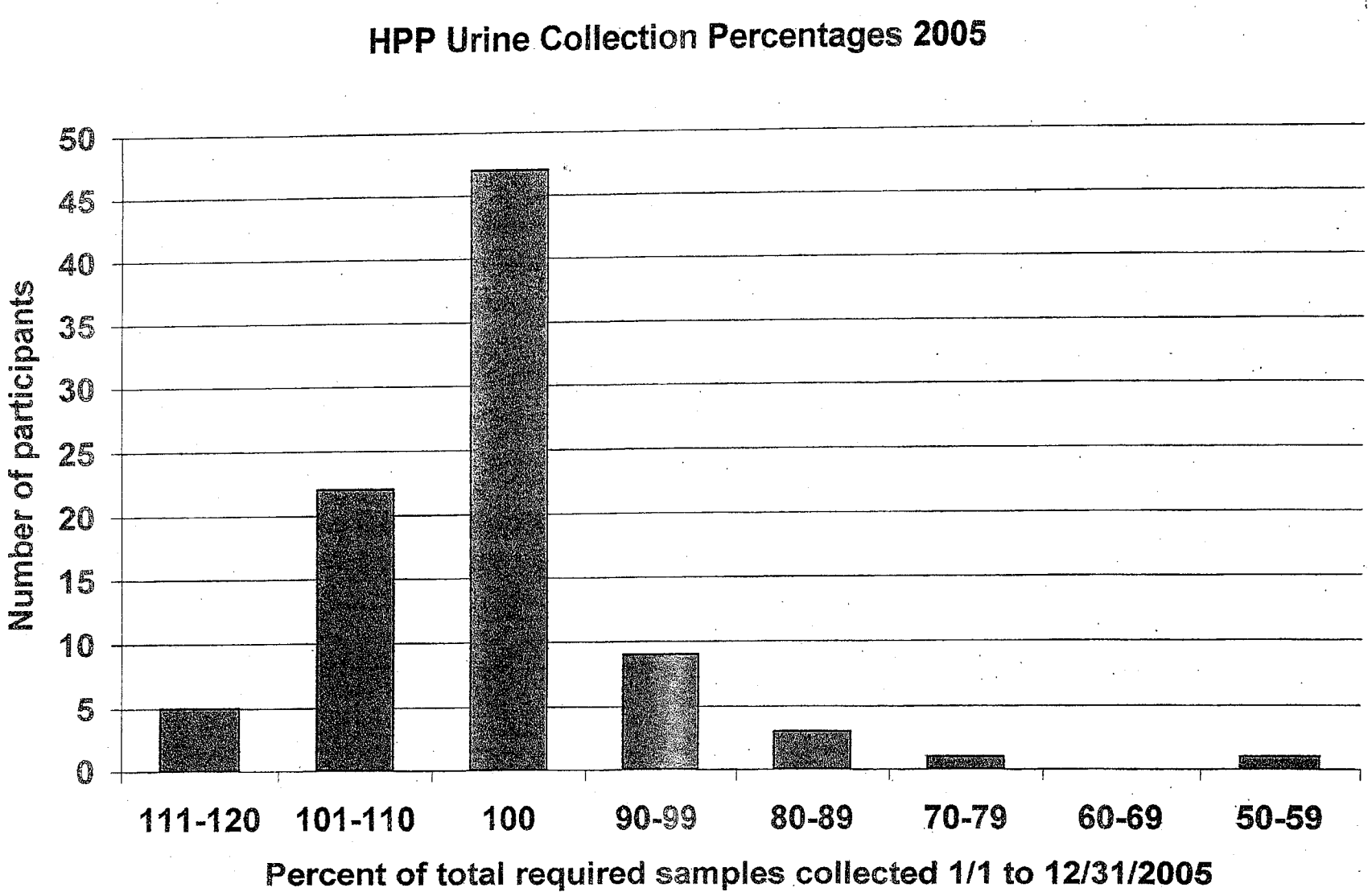
Comparison of HPP Census by Region with Licensed Practitioners' Census by Region

Region	Total Licensed Practitioners[1]	% of Licensed Practitioners	Practitioners in HPP	% of HPP Practitioners	% Difference: % HPP - % State
Tri-County	6,618	55%	42	47%	-8%
Multnomah	4,622	38%	28	31%	-7%
Washington	1,167	10%	9	10%	0%
Clackamas	829	7%	5	5%	-2%
Southwest	1,999	17%	16	18%	+1%
Lane	862	7%	3	4%	-3%
Jackson	582	5%	5	6%	+1%
Douglas	215	2%	4	4%	+2%
Josephine	162	1%	2	2%	+1%
Coos	145	1%	2	2%	+1%
Curry	33				
Midwest	1,362	11%	11	12%	+1%
Marion	679	6%	5	6%	0%
Benton	249	2%	4	4%	+2%
Yamhill	155	1%	1	1%	0%
Lincoln	83	1%	1	1%	0%
Linn	140				
Polk	56				
Central	517	4%	5	6%	+2%
Deschutes	476	4%	4	4%	0%
Jefferson	20	>1%	1	1%	+1%
Crook	21				
Northwest	133	1%	3	3%	+2%
Columbia	28	>1%	2	2%	+2%
Tillamook	33	>1%	1	1%	+1%
Clatsop	72				
Southeast	100	1%	2	2%	+1%
Malheur	84	1%	2	2%	+1%
Grant	9				
Harney	7				
South Central	160	1%	2	2%	+1%
Klamath	153	1%	2	2%	+1%
Lake	7				
Northeast	217	1%	1	1%	0%
Umatilla	119	1%	1	1%	0%
Union, Baker, Wall, Morr	98	0%	0	1%	-1%
North Central	147	1%	0	0%	-1%
Hood River	80	1%	0	0%	-1%

[1] "Licensed Practitioners" refers to all 12,105 active practitioners with MD, DO, PA, DPM, LAc Licenses

Current Duration of Sobriety Among Relapsers




HPP Urine Collection Percentages 2005
Number of participants
50
45
40
35
30
25
20
15
10
5
0
111-120
101-110
100
90-99
80-89
70-79
60-69
50-59
Percent of total required samples collected 1/1 to 12/31/2005