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Before the House Committee on Health Care
House Bill 2130—Impaired Health Professional Program

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Please accept this testimony on behalf of Northwest Permanente, P. C., Physicians and Surgeons, a multi-specialty group practice comprised of over 1,100 physicians and allied clinicians responsible for the medical care of Kaiser Permanente enrollees in Oregon and Southwest Washington.

House Bill 2130 proposes a number of changes to current law concerning the Oregon Health Authority's impaired health professional program. This program monitors licensees' conduct, but does not provide treatment for "impaired" licensees. The program is statutorily required to enroll all health profession licensees who have been diagnosed with alcohol or substance abuse or a mental health disorder, whether they are "impaired" or not under the term's statutory definition.

In section 1, the bill amends ORS 676.185 to add a statutory definition of the term "substantial noncompliance" and modifies the types of conduct that qualify. For example, current law declares as substantial noncompliance " . . . conduct that caused injury, death or harm to the public, including engaging in sexual impropriety with a patient." HB 2130 would add injury, death or harm to a patient; and would delete sexual impropriety with a patient. The bill would also add "the lack of capacity to stand trial" based on "mental disease or defect" as indication of substantial noncompliance.

In section 2, the bill amends ORS 676.190 to remove the requirements that the impaired health professional program "assess and evaluate compliance with diversion agreements by enrolled licensees" and that it oversee employers' ability to supervise and train supervisors of employees enrolled in the program. We support these proposed modifications of the program's responsibilities.

In section 2, the bill amends ORS 676.190 (5)(c), diversion agreements are allowed to require licensees to ". . . abstain from mind-altering or intoxicating substances or potentially addictive drugs, unless the drug is both properly "prescribed for a documented medical condition" and "approved by the program if the licensee's board has granted the program that authority." We are concerned that this provision puts a state administrative

monitoring agency or contractor in the position of reviewing treating clinicians' decisions for their patients when a health regulatory agency so allows.

In section 2, the bill amends ORS 676.190 (5)(g) to modify diversion agreements to mandate that licensees submit to random drug or alcohol testing " . . . unless the licensee is diagnosed with only a mental health disorder and the licensee's board does not otherwise require the licensee to submit to random drug or alcohol testing." We are concerned that this puts regulatory boards into the position of having to determine whether random testing of an individual licensee is warranted. That decision, we would submit, should only be justified following an investigation by the board of the licensee.

In section 2, the bill amends ORS 676.190 (6)(a) to allow regulatory boards to decide whether its licensees could self-refer to the program. It is not clear to us why individual regulatory boards should have this responsibility.

In section 2, the bill amends ORS 676.190 (6)(d) to specify that licensees who self-refer to the program not be reported to the licensee's board as an enrollee or when the program is successfully completed. This means that self-referred licensees who drop out of or fail to complete the program will be reported to their boards.

In section 3, amending ORS 676.200(1)(a), the word "contact" in line 11 should be "contract".

In section 3, amending ORS 676.200(1)(b), the proposed amendment can be construed to mean that individual regulatory boards may establish their own impaired health professional programs, but may not do so for the purpose of monitoring its licensees who are referred to the program. It's not clear what services a monitoring program would be expected to perform if it couldn't "monitor." Does this mean that regulatory boards could establish treatment programs for licensees that self-refer? Additional clarity concerning the organization of these programs should be provided in the legislation.

In section 3, amending ORS 676.200(4), subsection (c) seems circular. It provides that licensees can't be disciplined solely because they used prescription drugs but did not practice while impaired. To be impaired, however, a licensee must be ". . . unable to practice with professional skill and safety by reason of habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability or by reason of a mental health disorder." ORS 676.185(2). This provision should be clarified.

The effective date provisions of section 4 differentiate between licensees subject to diversion agreements and self-referred licensees. Does this suggest that self-referred licensees are not required to sign diversion agreements? If so, that interpretation seems inconsistent with ORS 676.190(1)(c), which requires diversion agreements for all "enrolled licensees".

Based on these questions, we recommend your continued consideration of the issues raised by HB 2130.

In addition, we urge the committee to consider other changes to the statutes governing the impaired health professional program, whether in this bill or in similar legislation also under consideration today here and in the State Senate.

We believe that one of the major deterrents to health licensees' seeking treatment for physical or mental impairment is contained in ORS 676.190 (1) (b)—page 1, lines 11-13 of HB 21224—where a licensee must:

> . . . sign a written consent prior to enrollment in the program allowing disclosure and exchange of information between the program, the licensee's board, the licensee's employer, evaluators and treatment entities in compliance with ORS 179.505 and 42 C.F.R. part 2.

Even if this requirement is warranted in the case of an impaired licensee referred to the program by his or her licensing board lieu of disciplinary sanctions, including loss of the practitioner's license, it is a significant obstacle to licensees' voluntarily seeking treatment, because not only their licensing board will be able to receive information about the licensee's treatment, but because his or her employer will too. It is not clear what an employer or agency is expected to do with this information, but in both cases, it seems likely that they would need to initiate their own investigations of the employee's condition, including possible personnel or license disciplinary sanctions.

Northwest Permanente offers its clinicians and employees confidential counseling and treatment services to encourage early and voluntary participation. But few would participate if they knew that both their employer and their licensing board would be furnished information periodically about their involvement.

We would urge the committee to consider whether licensees should be required to allow their employers and licensing boards to be notified of their participation in the OHA's impaired health professional program. In addition, we believe that a more thorough legislative examination of all the requirements imposed on the program may be warranted to assure that they successfully address the needs of patients and of health professionals.

Thank you for your consideration.