Thursday, May 9, 2019 9:00am

9.0 Call to Order/Roll Call/Establishment of a Quorum/Approval of Minutes

9.0.1 Review and Vote on Whether to Approve Previous Meeting Minutes:
   ➢ March 14, 2019

9.1 Information Only: Complaint Intake and Investigations Update

9.2 Information Only: Discipline and Probation Program Update

9.3 Intervention Program Update

9.4 Status Report Regarding Mental Health Ad-Hoc Report

9.4.1 Vote Whether to Recommend Board Approval of Revisions to Guidelines for Mental Health Pre-IEC Assessment (DIV-P-18)

9.4.2 Vote Whether to Recommend Board Approval of Revisions to Intervention Program Guidelines for Impairment Due to Mental Illness (DIV-P-09)

9.4.3 Vote Whether to Recommend Board Approval of Revisions to Intervention Program Guidelines for Monitoring Participant Compliance: Mental Health (DIV-P-25)

9.4.4 Vote Whether to Recommend Board Approval of Proposed Intervention Program Guidelines for Considering a Participant for Clinical Reassessment (DIV-P-31)

9.4.5 Vote Whether to Recommend Board Approval of Revisions to Intervention Program Criteria for Successful Completion: Mental Health (DIV-P-13)

9.5 Public Comment for Items Not on the Agenda; Items for Future Agendas

Note: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting. (Government Code, Sections 11125 and 11125.7(a)).
9.6 Adjournment

**NOTICE:**
All times are approximate and subject to change. Items may be taken out of order to maintain a quorum, accommodate a speaker, or for convenience. The meeting may be canceled without notice. For verification of the meeting, call (916) 574-7600 or access the Board’s Web Site at [http://www.rn.ca.gov](http://www.rn.ca.gov). Action may be taken on any item listed on this agenda, including information only items. Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited.

The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or email [webmasterbrn@dca.ca.gov](mailto:webmasterbrn@dca.ca.gov), or send a written request to the Board of Registered Nursing Office at 1747 North Market Blvd., Suite 150, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone # (800) 326-2297.) Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.
DATE: March 14, 2019

SITE: Sutter Health
Big Sur/Manchester Room
2700 Gateway Oaks Drive
Sacramento, CA 95833
(916) 286-6539

MEMBERS PRESENT: Imelda Ceja-Butkiewicz – Chair
Cindy Klein
Elizabeth Woods

STAFF PRESENT: Stacie Berumen, Enforcement Chief
Shannon Silberling, Deputy Chief, Discipline, Probation & Diversion
Joseph Pacheco, Deputy Chief, Complaints and Investigations
David Chriss, Chief, Division of Investigation
Bill Jones, Deputy Chief, Division of Investigations

The Chair called the meeting to order at approximately 12:37 p.m.

9.0 Review and Approve Minutes:

Approve/Not Approve: Minutes of January 10, 2019

<table>
<thead>
<tr>
<th>Motion: Cindy Klein to approve the January 2019 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second: Elizabeth Woods</td>
</tr>
<tr>
<td>CK: Yes       EW: Yes        ICB: Yes</td>
</tr>
</tbody>
</table>

9.1 Complaint Intake and Investigations Update

COMPLAINT INTAKE UPDATE:

GENERAL UPDATE

The Complaint Intake Unit is piloting a new process for transmitting Expert case reviews electronically through the secure DCA Cloud. Transmitting electronically is more secure, eliminates shipping time, and is less costly than the current method of mailing investigation report copies. The goal is to transmit all Expert reviews electronically by July 2019.
STAFFING

The Complaint Intake Unit currently has one office technician position open. Recruitment for this position is ongoing.

FISCAL YEAR 2019 WORKLOAD STATISTICS, AS OF 02/25/2019

| Public Complaints Received | 2,782 |
| Licensee Arrest & Conviction Reports | 890 |
| Applicant Conviction & Discipline Reports | 2,055 |
| Total Complaints Received (FY 18/19) | 5,727 |

CURRENT COMPLAINT INTAKE WORKLOAD, AS OF 02/25/2019

| Complaint Intake Desk Investigations Pending (All open complaints, except Applicant and Field Investigations) | 747 |
| Desk Investigations Pending > 1 year | 90 |
| Applicant Open Cases | 342 |
| Applicant Cases Pending > 1 year | 11 |
| Cases Pending Expert Review | 74 |

INVESTIGATION PROGRAM UPDATE:

GENERAL UPDATE

In late February, the BRN Investigation Unit held its annual investigator training conference. The two-day training event included presentations from the US Drug Enforcement Agency, the DOJ Bureau of Medical and Fraud, the San Diego District Attorney, the BRN Liaison Deputy Attorneys General, an RN Expert on Wound and Ostomy Care, and Lexis Nexis Accurint.

STAFFING – BRN INVESTIGATION UNIT

The BRN Investigation Unit has a vacant Supervising Special Investigator position in our Central Unit. Recruitment to fill this position is ongoing.

SUMMARY INVESTIGATION STATISTICS

Cumulative Investigation Referrals – Fiscal Year 2019

<table>
<thead>
<tr>
<th>No. of Cases</th>
<th>Percent of all Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to DOI</td>
<td>330</td>
</tr>
<tr>
<td>Referred to BRN Investigation Unit</td>
<td>552</td>
</tr>
</tbody>
</table>

Cumulative Investigation Closures – Fiscal Year 2019
<table>
<thead>
<tr>
<th>Division of Investigation Closures</th>
<th>No. of Completed Investigation Reports</th>
<th>Average Days to Complete Investigation</th>
<th>Average Cost Per Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRN Investigation Unit Closures</td>
<td>497</td>
<td>168</td>
<td>$2,567</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As of March 1, 2019, BRN has 7 and DOI has 85 open investigation cases over one year old.

**OUTREACH ACTIVITIES:**

Sonya Wilson, Complaint Intake Manager, has volunteered to present the DCA SOLID Enforcement Academy Class on Complaint Intake.

BRN and BVNPT recently finalized a Memorandum of Understanding between our Enforcement programs which allows the sharing of investigation materials between boards. This MOU was made possible by a renewed cooperation between BRN and BVNPT Enforcement Chiefs. BRN shares approximately 14,800 mutual licensees with BVNPT, more than BRN shares with any other Board or Bureau within DCA.

**Public Comment:** None

9.2 Discipline and Probation Update

**PROBATION UNIT**

The unit has two vacant positions, which is an Associate Governmental Program Analyst (AGPA) position. This position is vacant due to the promotion of John Knowles and Tim Buntjer into the Probation Manager positions (SSMI). These positions should be filled by end of March.

Current caseloads are 91 cases per monitor. This includes all cases active and tolled.

New employment and employment modifications continue to get approved on average of 1.5-2 weeks.

Probation team continues to partner with SOLID to instruct the Probation Monitoring Module of DCA’s SOLID Enforcement Academy. The last course was held on Thursday, August 30, 2018 and the next class is scheduled for March 2019.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active In-State Probationers</td>
<td>1,095</td>
<td>1,189</td>
<td>1,196</td>
<td>1,003</td>
<td>880</td>
</tr>
<tr>
<td># of Chemical Dependency Probationers</td>
<td>707</td>
<td>785</td>
<td>787</td>
<td>580</td>
<td>492</td>
</tr>
<tr>
<td>Tolled Out of State Probationers</td>
<td>290</td>
<td>345</td>
<td>380</td>
<td>394</td>
<td>394</td>
</tr>
<tr>
<td>Total Probationers</td>
<td>1,385</td>
<td>1,534</td>
<td>1,576</td>
<td>1,397</td>
<td>1274</td>
</tr>
</tbody>
</table>

**CITE AND FINE**
We are currently fully staffed.

As of 2/25/2019, we have issued 396 citations. Of those, we have received full payment on 250 and held 158 appeal conferences and 2 Administrative Hearing Appeals.

<table>
<thead>
<tr>
<th>Citation Information</th>
<th>FY 2015/16</th>
<th>FY 2016/17</th>
<th>FY 2017/2018</th>
<th>Current FY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citations Issued</td>
<td>542</td>
<td>366</td>
<td>770</td>
<td>396</td>
</tr>
<tr>
<td>Amount Ordered</td>
<td>$299,638</td>
<td>$266,428</td>
<td>$519,133</td>
<td>$294,326.00</td>
</tr>
<tr>
<td>Amount Received</td>
<td>$253,974</td>
<td>$202,614</td>
<td>$391,233</td>
<td>$186,675.00</td>
</tr>
</tbody>
</table>

**DISCIPLINE UNIT**

Tammy Logan, Discipline Manager, retired February 28, 2019. We have promoted Tim Buntjer as the new Staff Services Manager of Discipline (SSMI).

<table>
<thead>
<tr>
<th>Cases Pending</th>
<th>As of 02/25/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cases at AG</td>
<td>991</td>
</tr>
<tr>
<td>Pending Board Vote</td>
<td>82</td>
</tr>
<tr>
<td>Final Decision Processing</td>
<td>91</td>
</tr>
<tr>
<td>Pending hearing</td>
<td>136</td>
</tr>
<tr>
<td>Over 2 yrs. at AG</td>
<td>50</td>
</tr>
<tr>
<td>1-2 yrs. at AG</td>
<td>144</td>
</tr>
<tr>
<td>Subsequent AG Cases (Probationers)</td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AG Referrals</td>
<td>1,395</td>
<td>1,198</td>
<td>1,282</td>
<td>812</td>
</tr>
<tr>
<td>Petitions to Revoke Probation</td>
<td>87</td>
<td>120</td>
<td>100</td>
<td>60</td>
</tr>
<tr>
<td>Pleading Served</td>
<td>1067</td>
<td>938</td>
<td>848</td>
<td>670</td>
</tr>
<tr>
<td>EO Signed Surrenders</td>
<td>255</td>
<td>254</td>
<td>218</td>
<td>209</td>
</tr>
<tr>
<td>Withdrawals of SOI</td>
<td>15</td>
<td>9</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Decisions Adopted</td>
<td>1,641</td>
<td>1,282</td>
<td>1,141</td>
<td>864</td>
</tr>
</tbody>
</table>

Public Comment: None
<table>
<thead>
<tr>
<th>License Type*</th>
<th>Case Outcome</th>
<th>Public Reproval</th>
<th>Revoked, Stayed, Probation</th>
<th>Revoked, Stayed, Suspension, Probation</th>
<th>Surrender</th>
<th>Revocation</th>
<th>Voluntary Surrender</th>
<th>Total FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td></td>
<td>101</td>
<td>141</td>
<td></td>
<td>4</td>
<td>167</td>
<td>222</td>
<td>42</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td></td>
<td>11</td>
<td>13</td>
<td></td>
<td></td>
<td>14</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Psych/Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
<td>7</td>
<td>10</td>
<td></td>
<td></td>
<td>14</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>NP-Furnishing #</td>
<td></td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td>11</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Nurse-Midwife</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>NM-Furnishing #</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

*Specialty certifications are a subset of the Registered Nurse license. When enforcement action is taken on an RN license, all advanced certifications a nurse holds is also included in the action. More than one enforcement action may be taken (thus counted here) against an RN during the time period.
9.3 Intervention Program Update

**Staffing**
The Intervention unit is fully staffed.

**Program Update**
In the fourth quarter of 2018, the Intervention program hosted the fourth in a series of five Mental Health Ad Hoc Committee meetings. The committee members worked effectively to review all current practices and discussed different approaches, potential changes and worked on finalizing the development of a Mental Health treatment toolbox that will serve as a resource to assist the IEC’s in addressing the needs of participants with Mental Illness. The fifth and final meeting is scheduled for March 22, 2019.

The Intervention team is currently involved in ongoing meetings with DCA contract and legal staff along with the participating boards Diversion Program managers to work on the upcoming Diversion Program Contract bid process. The current contract ends December 31, 2019.

**Intervention Evaluation Committees (IEC)**
There are currently four physician member vacancies.

San Jose (IEC 7)
Los Angeles (IEC 3)
Fresno (IEC 5)
Irvine (IEC 4)

There are two public member vacancies.

San Jose (IEC 7)
Fresno (IEC 5)

**Statistics – Intervention**
The Statistical Summary Report is attached. As of February 28, 2019, there have been 2,362 successful completions.

**Public Comment:** None
9.3.1 Discussion and Possible Action Regarding Appointment of New Intervention Evaluation Committee Member

BACKGROUND:
In accordance with B & P Code Section 2770.2, the Board of Registered Nursing is responsible for appointing persons to serve on the Intervention Evaluation Committees. Each Committee for the Intervention Program is composed of three registered nurses, a physician and a public member with expertise in substance use disorders and/or mental health.

APPOINTMENT
Below is the name of the candidate who is being recommended for appointment to the Intervention Evaluation Committee (IEC). Mr. Rashid’s application and résumé is attached. If approved, his term will expire June 30, 2022.

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>IEC</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saqib Rashid, MD</td>
<td>Physician Member</td>
<td>Fresno</td>
<td>5</td>
</tr>
</tbody>
</table>

Motion: Cindy Klein to Recommend Approval of Appointment to the Board.
Second: Imelda Ceja-Butkiewicz

CK: Yes  EW: Yes  ICB: Yes

Public Comment: None
9.4 Division of Investigation Presentation and Report

David Chriss, Chief of the Division of Investigation and Bill Jones, Deputy Chief of the Division of Investigation provided an update regarding investigation processing times, staffing, BCP positions, and answered committee members questions.

Public Comment: None

9.5 Public Comment for Items Not on the Agenda

The IDC members requested Dr. Morris, Joseph Pacheco, and David Chriss meet to review existing CPEI requirements to move priority 1 and 2 investigations back to BRN with an update at the next committee meeting.

No other public comment for items not on the agenda.

The Chair adjourned the committee meeting at approximately 1:14 p.m.

Approved: ______________________________
AGENDA ITEM: 9.1
DATE: May 9, 2019

ACTION REQUESTED: Information Only: Complaint Intake and Investigations Update

REQUESTED BY: Imelda Ceja-Butkiewicz, Chairperson

GENERAL UPDATE

SB 799 UPDATE

Senate Bill 799 and the newly created BPC section 2761.5, passed in October 2017, required the California Research Bureau (CRB) to deliver a report to the Legislature evaluating to what extent employers voluntarily report disciplined nurses to the board and offer options for consistent and reasonable reporting mechanisms. The completed CRB report is attached as an addendum.

COMPLAINT INTAKE UPDATE:

GENERAL UPDATE

Previous updates have reported that the Complaint Intake team has heavily recruited Expert Practice Consultants to review practice related investigation cases. I have also reported the addition of one staff person dedicated to the preparation, delivery and payment of Expert workload. The improvements in volume and processing time are noticeable. When comparing the first three months of 2019 (Jan-Mar) to the same period last year, Complaint Intake is processing 43% higher volume (165 vs. 115) while simultaneously reducing overall processing times by 23% (35 days vs. 46 days).

As we continue to recruit Experts and improve our internal processes, I anticipate the unit will be able to handle the increased workload of practice related complaints.

STAFFING

The Complaint Intake Unit is fully staffed with no vacancies.

WORKLOAD

In response to committee request for workload comparisons to last year, the following two tables compare 2018 and 2019 Complaint Intake workload.

FISCAL YEAR 2018 WORKLOAD, AS OF 4/16/18
Public complaints are significantly higher than last year, but the Board has seen a reduction in the number of Arrest/Conviction and Applicant Cases.

OPEN COMPLAINT INTAKE WORKLOAD, AS OF 03/19/2019

<table>
<thead>
<tr>
<th>Complaint Intake Desk Investigations Pending (All open complaints, except Applicant and Field Investigations)</th>
<th>647</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk Investigations Pending &gt; 1 year</td>
<td>72</td>
</tr>
<tr>
<td>Applicant Open Cases</td>
<td>278</td>
</tr>
<tr>
<td>Applicant Cases Pending &gt; 1 year</td>
<td>19</td>
</tr>
<tr>
<td>Cases Pending Expert Review</td>
<td>36</td>
</tr>
</tbody>
</table>

INVESTIGATION PROGRAM UPDATE:

GENERAL UPDATE

Investigation timeframes have been a major focus of mine for both the BRN Investigation Unit and Division of Investigation. Of course, not all investigations result in disciplinary action against a licensee. However, for cases where the RN is impaired, incompetent, or has caused significant harm or death to a patient, BRN’s disciplinary action cannot go forward without a complete investigation.

Investigation timeframes will be a focus going forward, and the committee will receive regular updates.

STAFFING – BRN INVESTIGATION UNIT

The BRN Investigation Unit has a vacant Supervising Special Investigator position in our Central Unit. Recruitment to fill this position is ongoing.
SUMMARY INVESTIGATION STATISTICS

Cumulative Investigation Referrals – Fiscal Year 2019

<table>
<thead>
<tr>
<th></th>
<th>No. of Cases</th>
<th>Percent of all Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to DOI</td>
<td>369</td>
<td>36%</td>
</tr>
<tr>
<td>Referred to BRN Investigation Unit</td>
<td>668</td>
<td>64%</td>
</tr>
</tbody>
</table>

Cumulative Investigation Closures – Fiscal Year 2019

<table>
<thead>
<tr>
<th></th>
<th>No. of Completed Investigation Reports</th>
<th>Average Days to Complete Investigation</th>
<th>Average Hours Per Case</th>
<th>Average Cost Per Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Investigation Closures</td>
<td>307</td>
<td>330</td>
<td>39.2</td>
<td>$7,684</td>
</tr>
<tr>
<td>BRN Investigation Unit Closures</td>
<td>566</td>
<td>199</td>
<td>28.9</td>
<td>$2,545</td>
</tr>
</tbody>
</table>

As of April 29, 2019, BRN has 6 and DOI has 104 open investigation cases over one year old.

ADDENDUM: California Research Bureau Report - SB 799

NEXT STEP: N/A

PERSON TO CONTACT: Joseph Pacheco, Deputy Chief Complaint Intake & Investigations (916) 515-5268
Employer Reporting of Nurse Practice Act Violations in California

January 2019

California Research Bureau

California State Library

www.library.ca.gov/crb
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Author

Patrick Rogers

Mandated by

California Business and Profession Code § 2761.5 (as amended by Statutes 2017, Chapter 520, Section 5)

Acknowledgements

Research assistance provided by Kellie Hogue and Benjamin Tang

The author wishes to thank the California Board of Registered Nursing, the California Hospital Association, the California Nurses Association, the Connecticut Board of Examiners for Nursing, the Florida Department of Health, and the Oregon State Board of Nursing for their invaluable assistance in preparing this report.

Recommended Citation:


ISBN Number: 1-58703-281-3


Executive Summary

Background

Chapter 520, Statutes of 2017 (SB 799, Hill) requires the California Research Bureau to prepare a report examining voluntary reporting of disciplined nurses by employers to the California Board of Registered Nursing (Nursing Board). As required by the statute, the report also must include a review of existing laws that require reporting in California and in other states, a list of laws “permitting, prohibiting, encouraging, or discouraging voluntary reporting” to the Nursing Board, a summary of employer reporting requirements in other boards within the Department of Consumer Affairs, under which the Nursing Board is housed, and options the state could consider for “consistent and reasonable reporting mechanisms.” This report contains the Research Bureau’s analysis of these issues. The report does not include a required analysis of employer reports to the Nursing Board. Though the Nursing Board maintains significant amounts of data, the relationship of the person reporting to the registered nurse who is the subject of the report is not currently collected. The Research Bureau found that this was also the case in three other states with which it collected detailed interviews.

Reporting Practices

The primary purpose of professional licensing in healthcare centers on protecting the public from fraudulent and/or substandard care. Regulatory oversight can be broadly divided into two forms, prospective regulation that actively seeks out violations (e.g. police patrols), and reactive regulation that relies on reports of violations from the larger community (e.g. fire alarms). Among nursing boards in the United States, including in California, the standard practice is to adopt a “fire alarm” approach toward the oversight of registered nurses. Aside from established requirements when renewing their license, once a registered nurse has received their license, they interact little with their state boards unless a complaint is made. Where states differ is in when, how, and who they require to submit a report of a violation.

Eighteen states (36 percent), including California, have no mandatory reporting rules for registered nurses. If someone believes a registered nurse has violated some portion of the Nurse Practice Act, that person has discretion about whether or not to report the alleged violation. Thirty-two states (64 percent) require mandatory reporting by one or more groups. This includes the nurse’s employer (19, or 38 percent), fellow nurses (27, or 54 percent) and/or other licensed medical professionals (8, or 16 percent). Taken together, the data shows no strong relationship between a state having or not having mandatory reporting rules, and the rate of complaints per licensee.

The non-mandatory approach adopted for registered nurses in California is fairly standard for other boards within the Department of Consumer Affairs, with only a few exceptions, including the Board of Chiropractic Examiners, the Respiratory Care Board and the Board of Vocational Nursing and Psychiatric Technicians.

Barriers to Reporting

To begin an investigation, nursing boards must learn about alleged violations. For this to happen, employers, nurses and others must contend with multiple barriers. In a 2018 study,
37.2 percent of nurse executives stated experiencing some form of barrier that prevented them from reporting alleged violations, including uncertainty about what is reportable and having a non-punitive facility culture. Managers also have incentives to avoid strict reporting policies, including the impact that such reporting has on employee morale and turnover. Registered nurses can be reticent to report a colleague if they feel the error was unintended, or they could have easily made it themselves. In cases where a nurse has committed a medical error, the error can also have a systemic cause outside nurses’ control—such as inadequate staffing, frequent overtime, and intershift fatigue. Decentralized and fragmented medical healthcare delivery means cause of error can be spread over multiple practitioners, or due to poor communication and coordination. In such cases a licensee can be reticent to report a colleague if the error was not solely due to individual negligence or misconduct, but due to such systemic causes.

**Options for Reporting Mechanisms**

Given these barriers to reporting, there are several options the state can consider to provide for more “consistent and reasonable reporting mechanisms.”

- **Maintain current reporting practices:** Within the healthcare profession, there exists a norm of safeguarding patient health, and reporting dangers to patient safety. Furthermore, the data does not show a strong difference in the number of reports made among the 18 states with voluntary regimes, compared to the 19 states with mandatory employer reporting or the 13 states with some other form of mandatory licensee reporting. The only data that points to potential underreporting is in Connecticut, where the drug and mental health diversion program for healthcare professionals saw a 30 percent increase the year mandatory reporting was instated.

- **Expand training and outreach efforts** (independently, or in conjunction with one of the other two options): One of the most significant barriers reported by nursing administrators was uncertainty about which behaviors constituted a reportable offense. This

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**Table 1: Count of States and Registered Nurses by Nurse Practice Act Violation Reporting Regime**

<table>
<thead>
<tr>
<th>No Mandatory Reporting (i.e. Voluntary Reporting)</th>
<th>Mandatory Reporting by Healthcare Professionals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mandatory Reporting for Employers</td>
<td>Mandatory Reporting for Registered Nurses</td>
</tr>
<tr>
<td>States</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Licensees (RNs)</td>
<td>1,855,351</td>
<td>1,933,801</td>
</tr>
</tbody>
</table>

Note: Some states have more than one mandatory reporting regime and can appear in multiple columns. Because comparable data was not available, the District of Columbia and Puerto Rico have been omitted from this review. Source: License counts are drawn from the National Nursing Database, 2017 Active RBN Licenses ([https://www.ncsbn.org/6161.htm](https://www.ncsbn.org/6161.htm)).
indicates there is an opportunity to capture more unreported violations by increasing the level of outreach provided on the California Nursing Practice Act, with a particular focus on identifying violations and how to report them.

- **Enact mandatory reporting requirements:** These can vary by who is being required to report—employers, fellow registered nurses, or all licensed medical professionals more broadly—as well as in regard to the criteria used to trigger a mandatory report. The draft language included in early versions of SB 799 included one of the least restrictive approaches—only requiring employers to report dismissals, suspensions, or “resignations in lieu of dismissal.” Other states, such as Oregon, Florida and Connecticut, use a broader standard, including requiring employers to report to their nursing boards if a nurse is “unable to practice his or her profession with reasonable skill or safety” under a variety of circumstances (Connecticut), if a “nurse's behavior or practice presents a potential for, or actual danger to, a client or to the public's health, safety and welfare” (Oregon), or “any person who the licensee knows is in violation of this chapter” (Florida). Oregon is also implementing a Complaint Evaluation Tool, first created by the State of North Carolina, to assess and provide guidance and clarity about when and how to report a potential violation to the board. Oregon hopes that having a more objective criteria for reporting will both reduce the number of reports made to the board that are later found to lack merit, while also encouraging some valid complaints that might have historically gone unreported due to uncertainty about whether they should have initially been reported.
Mandatory Employer Reporting Practices for Registered Nurses

Introduction
The California Board of Registered Nursing (Nursing Board or Board), along with the Board of Vocational Nurses and Psychiatric Technicians (Vocational Nursing Board), is tasked with protecting the health and safety of Californians by licensing and regulating the practice of nursing in the state.

As part of a 2016 review of the Nursing Board, the California State Auditor assessed the Board’s investigations and enforcement program. The audit noted a discrepancy between mandatory reporting requirements for licensed vocational nurses—regulated by the Vocational Nursing Board—and registered nurses, regulated by the Nursing Board. Employers of vocational nurses are required to report to the Vocational Nursing Board when they suspend or dismiss a licensed vocational nurse, or if one resigns in lieu of dismissal. No such requirement exists for registered nurses in the state.

The audit recommended that the Legislature update the Nursing Practice Act to include a requirement that employers of registered nurses “report to BRN [Board of Registered Nursing] the suspension, termination, or resignation of any registered nurse due to alleged violations of the Nursing [Practice] Act” (California State Auditor, 2016). Earlier versions of the bill requiring this report, Senate Bill 799 (Hill, 2017), included language implementing this recommendation, although the provisions were ultimately removed and replaced with a requirement for a report by the California Research Bureau. SB 799 required the Research Bureau to prepare a report “that evaluates to what extent employers voluntarily report disciplined nurses to the board and offers options for consistent and reasonable reporting mechanisms.” It also required the report to “include, but be limited to...:

(a) A review of existing mandatory reporting requirements that alert the board to nurses who may have violated this chapter.

(b) A review of existing laws permitting, prohibiting, encouraging, or discouraging voluntary reporting to the board.

(c) An analysis of the number of employer reports to the board, the number of those reports investigated by the board, and the final action taken by the board for each report.

(d) Employer reporting requirements of other boards within the department.


1 Referred to as Licensed Practical Nurses in every state with the exception of California and Texas.
Background

Early Licensure

Nursing as a formal occupation developed out of the professionalization of traditional patient-centered care-taking roles. While the role of a doctor is to focus on and treat the disease, the role of the nurse is to support and care for the patient, so they can recover and heal (Nightingale, 1876; Shaw, 1993). Recognizing that “unprepared or incompetent practitioners” posed a risk to public health, states began to regulate medical professions—including nursing—in the early 20th century (Russell, 2017). North Carolina passed the first Nurse Practice Act in 1903 (Wyche, 1938; Smith, 2009), which created a State Board of Examiners of Nurses and instituted an exam and licensure for nurses wishing to use the title “registered nurse.” New Jersey, New York and Virginia followed with similar statutes later the same year. California passed a similar law on March 20, 1905.

North Carolina’s nursing law included provisions allowing the board “to revoke any license issued by them for gross incompetency, dishonesty, habitual intemperance, or any other act in the judgment of the board derogatory to the morals or standing of the profession of nursing”; however, the law did not formally address how to report such violations, including specifying whether any reports would be mandatory.

Early nursing laws had other limitations as well. They did not restrict the practice of nursing under a title other than registered nurse, formally define nursing, nor describe a scope of practice. Within a few decades, the need for further regulation was recognized, and the first “modern” Nurse Practice Act with such

provisions passed in New York State in 1938 (Smith, 2009; Russell, 2017). The primary provisions of California’s current nursing law were enacted soon after, in 1939. By the 1970s, all states had this form of a Nurse Practice Act. Unlike California, most states regulate registered nurses and practical/vocational nurses through a single Board of Nursing—California, Louisiana and West Virginia are the only states to split oversight between two separate boards.

Current Reporting Practices

The primary purpose of professional licensing in healthcare is centered on protecting the public from fraudulent and/or substandard care. To achieve this, the traditional role of the nursing board is to: (1) evaluate and certify educational programs, (2) verify the skills, training and education of new licensees, and (3) to identify and discipline individuals whose professional practice is deficient (Cooke, 2006).

Regulatory oversight can be broadly divided into two forms, prospective regulation that actively seeks out violations (e.g. police patrols), and reactive regulation that relies on reports of violations from the larger community (e.g. fire alarms) (McCubbins & Schwartz, 1984). Based on the Research Bureau’s review of nursing boards across the United States, it appears that the standard practice is to adopt a proactive “police patrols” model for monitoring the quality of educational programs, but to adopt the “fire alarm” approach toward the oversight of practicing nurses. Aside from continuing education requirements, once a registered nurse has received their license, they interact little with their state boards outside of regular licensure renewal, unless a complaint is made.

2 North Carolina amended its nursing law in 1917 to remove this loophole, specifying that “no one shall represent herself or himself, or in any way assume to practice as a trained, graduate, licensed or registered nurse in North Carolina without obtaining a license through the Nurses’ Examining Board” (Wyche, 1938).
Employer Reporting Practices for Registered Nurses

Table 1: Count of States and Registered Nurses by Nurse Practice Act Violation Reporting Regime

<table>
<thead>
<tr>
<th>Reporting Regime</th>
<th>No Mandatory Reporting (i.e. Voluntary Reporting)</th>
<th>Mandatory Reporting by Healthcare Professionals</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td>19</td>
<td>1,933,801</td>
</tr>
<tr>
<td>Mandatory Reporting for Registered Nurses</td>
<td>27</td>
<td>2,133,695</td>
</tr>
<tr>
<td>Mandatory Reporting for other Health Professionals</td>
<td>8</td>
<td>728,758</td>
</tr>
</tbody>
</table>

Note: Some states have more than one mandatory reporting regime and can appear in multiple columns. Because comparable data was not available, the District of Columbia and Puerto Rico have been omitted from this review. Source: License counts are drawn from the National Nursing Database, 2017 Active RBN Licenses (https://www.ncsbn.org/6161.htm).

Where states differ is in when, how, and who they require to submit a report of a violation.

All states have mechanisms to receive and investigate reports of violations of their Nurse Practice Act (See Table 1, above). Eighteen states (36 percent), including California, have no mandatory reporting rules for registered nurses. If someone believes a registered nurse has violated some portion of the Nurse Practice Act, that person has discretion about whether or not to report the alleged violation. Thirty-two states (64 percent) require mandatory reporting by one or more groups. This includes the nurse’s employer (19, or 38 percent), fellow nurses (27, or 54 percent) and/or other licensed medical professionals (8, or 16 percent). Table A-1, in the appendix, provides a detailed list of the reporting practices for each state, along with the number of registered nurses licensed by their boards, as of December 31, 2017.

Taken together, the data shows no strong relationship between a state having or not having mandatory reporting rules, and the rate of complaints per licensee. On balance, this appears to indicate that there is not a large pool of unreported violations to capture by stricter reporting rules. However, because the data is so limited, it is not possible to discount other explanations for the patterns or to draw any causal conclusions.

California

There are no universal reporting requirements for the three groups in Table 1 (employers, registered nurses and other healthcare professionals). However, there are specific conditions under which other entities are required to report information to the Nursing Board. These broadly fall into three categories, which are also generally standard across other states and include criminal conviction, discipline by other licensing agencies, or for child and elder abuse. Other than these specific instances, there are no statutory or regulatory requirements for a person or organization to report an alleged Nursing Practice Act violation in California. Nor are employers required to report if they fire, discipline or otherwise restrict the practice privileges of a registered nurse.

Court clerks in California are required to report to the Board if a registered nurse has been found to have “committed a crime, or is liable for any death or personal injury resulting in a judgment for an amount in excess of thirty thousand dollars ($30,000) caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services” (Cal. Bus. and Prof. Code § 803, 2012). Licensees are also required to self-report in a number of specific instances. They are required
to report any conviction, as well as any disciplinary action they are subject to from another licensing entity, including those in California, other states, or at the federal level (Cal. Code Regs. tit. 16, § 1441, 2018). Licensees are also mandated reporters for child, dependent adult or elder abuse (Cal. Penal Code § 11166, 2016; Cal. Welf and Inst. Code § 15630, 2013). A registered nurse must report any abusive conduct by another licensee.

Two other circumstances may result in a report of an alleged violation to the Board of Registered Nurses.

- State law requires healthcare facilities to report specific adverse events to the California Department of Public Health within five days of the event, or within 24 hours if “an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors” (Cal. Health and Safety Code. § 1279.1, 2007). The director of the department “may” then send any evidence of nursing care violations discovered during its investigations on to the Board of Registered Nursing, for additional investigation and discipline (Cal. Health and Safety Code. § 1280.20, 2014).
- In California, hospitals are required to report the loss of any controlled substances to the Board of Pharmacy within three days (Cal. Code Regs. tit. 16, § 1715.6, 2018). The Board of Pharmacy is also required to report to the Board of Nursing when it receives a complaint about dangerous dispensing practices of certified nurse-midwives or nurse practitioners (Cal. Bus. and Prof. Code § 4175, 2017). The Board of Registered Nurses licenses both nurse-midwives and nurse practitioners. Both have the authority to prescribe medication. The statute does not, however, cover the largest pool of licensees at the Board—registered nurses—as they do not have the authority to prescribe medications.

Practices of Other Professional Licensing Boards at the Department of Consumer Affairs

This non-mandatory approach in Table 1 is common for other boards within the Department of Consumer Affairs, with some exceptions:

- The California Board of Chiropractic Examiners requires licensees to report any violations by another licensee (Cal. Code Regs. tit. 16, § 314). Furthermore, unlicensed individuals cannot own a chiropractic practice in California. This means that all chiropractors in the state are either self-employed, or employed by another licensee. As a result, chiropractors who are not self-employed are subject to mandatory employer reporting (Cal. Code Regs. tit 16, § 312.1, 2018).
- Employers of respiratory care practitioners in the state are required by statute—rather than regulation—to report if they fire or suspend a licensee (Cal. Bus. and Prof. Code § 3758).
- The Board of Vocational Nursing and Psychiatric Technicians, which has oversight of licensed vocational nurses—the other large group of professional nurses in the state—defines the failure to report a violation of the Vocational Nursing Practice Act (Cal. Bus. and Prof. Code § 2840-2895.5, 2018) by any licensee as unprofessional conduct (Cal. Bus. and Prof. Code § 2878, 2004). Licensed vocational nurses can face discipline for unprofessional conduct, including having their license revoked. Furthermore, any employer of a licensed vocational nurse is also required to report “the suspension or termination for cause, or resignation for cause” of any licensed
Employer Reporting Practices for Registered Nurses

vocational nurse they employ (Cal. Bus. and Prof. Code § 2878.1, 2012). Both reporting requirements were added to statute in 2003. However, employers are not required to report if they discipline in a more limited fashion—for example, if they restrict a licensed vocational nurse’s privileges, or if they impose additional education or training requirements on a vocational nurse.

Non-Mandatory (Voluntary) Reporting by Employers

It is not possible with the existing data to measure how often employers report violations to the Board of Nursing. While the Board does collect copious amounts of information relevant to investigating alleged violations, the precise relationship between the complainant and the target of a report is often unknown. However, there is reason to believe that—even without mandatory reporting requirements—employers of registered nurses in the state often voluntarily report dangerous or impaired actions. When the California Hospital Association surveyed its members, the association determined that most California hospitals have established processes for handling the reporting of alleged violations resulting in a firing, resignation or suspension, if at varying levels of formality (California Hospital Association, 2018). In some cases, the employers have formally documented policies and procedures. In other cases, there are established practices they follow, based on how they have handled such issues before. Hospitals also vary in who is responsible for making the decision to report. Decisions to report are typically made either by the chief nursing officer, or through the human resources staff, although reporting decisions may also go through risk management.

Reporting Practices in Three Comparison States

To provide an in-depth comparison to California’s Nursing Board, the Bureau conducted phone interviews with staff from the boards of three other states that have different reporting structures: Connecticut, Florida and Oregon.

Connecticut

Among states that have mandatory employer reporting provisions, most codify the requirement within their individual Nurse Practice Act and limit the requirement to the nurse’s employers. However, some take a broader approach, expanding the mandatory reporting requirement to cover most if not all healthcare professions licensed by the state. Connecticut is an example of this. Until 2015, Connecticut had no mandatory reporting, i.e. it was a voluntary reporting state. That year, the state changed its laws to require that any “health care professional” or “hospital” report (to the state board of nursing) if any other healthcare professional “is, or may be, unable to practice his or her profession with reasonable skill or safety” for any of the reasons quoted below:

(A) Physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process;

(B) emotional disorder or mental illness;

(C) abuse or excessive use of drugs, including alcohol, narcotics or chemicals;

(D) illegal, incompetent or negligent conduct in the practice of the profession of the health care professional;

(E) possession, use, prescription for use or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes;

(F) misrepresentation or concealment of a material fact in the obtaining or
reinstatement of a license to practice the profession of the health care professional; or

(G) violation of any provision of the chapter of the general statutes under which the health care professional is licensed or any regulation established under such chapter. (CGA § 19a-12e(3)(b), 2015)

The law went into effect on October 1, 2015, potentially offering a window into the likely impacts of transitioning from a voluntary reporting regime to a comprehensive mandatory one. Unfortunately, the Connecticut Department of Health does not track when employers are the source of violations reports, making it impossible to directly measure the impact of the law on employer reporting. From 2015 to 2016, the first year of implementation and the last year for which any data is available, the health department reported that the overall increase in reports of nursing violations was not substantial. This is not the result anticipated when the change was being debated. The department raised concerns that it might be overwhelmed by new reports, and be “unable to investigate the number of complaints generated within current resources” (Connecticut Public Health Committee, 2015).

In fact, due to separate budgetary issues, the department reduced the staff assigned to investigations of complaints against licensees between 2015 and 2016. While board complaints for healthcare professionals do not appear to have significantly increased, Connecticut’s alternative to discipline program, the Heath Assistance InterVention Education Network (HAVEN) did see an increase in program enrollment. HAVEN provides a mechanism for nurses to undergo treatment for drug or alcohol addiction or mental illness without going through the traditional board disciplinary process. Connecticut’s HAVEN program reported a 30 percent increase in enrollment between 2015 and 2016, necessitating the hiring of four additional staff. This increased enrollment in the HAVEN program is the only data to suggest that there is a pool of unreported violations that mandatory reporting rules could capture.

Florida
Florida has a broad statute with mandatory reporting for all healthcare practitioners licensed by the Florida Department of Health (Florida Statutes 456.072(1)(i), 2018):

(i) Except as provided in s. 465.016, failing to report to the department any person who the licensee knows is in violation of this chapter, the chapter regulating the alleged violator, or the rules of the department or the board. However, a person who the licensee knows is unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Unlike Connecticut, Florida’s statute does not include a requirement for facilities to report—the state only has that requirement for licensed practitioners. Just as in California and Connecticut, Florida does not record the relationship between the individual making the report and the licensee. As a result, it is not possible to estimate probable impact of this policy difference on the reporting rate of hospitals or other employers. During interviews, staff indicated that Florida does not pro-actively monitor the mandatory reporting provisions, although it does enforce the statute when a failure to report is discovered as part of another investigation. The enforcement of the reporting rules is also contingent to a degree on the
severity of the initial violation, such as the presence or absence of patient harm (Florida Department of Health, 2018).

While the state does not have formal outreach or training on reporting rules for facility administrators, it does provide outreach and training as the opportunity arises. Furthermore, Florida has specific provisions requiring licensees to take two hours of training on laws and regulations as part of its biennial continuing education requirements (Florida Department of Health, 2018).

**Oregon**

Licensees in Oregon are required to report any “licensed nurse whose nursing practice fails to meet accepted standards” as well as if they have “knowledge or concern that a nurse's behavior or practice presents a potential for, or actual danger to, a client or to the public’s health, safety and welfare” (OAR. 851-045-0090, 2018). This effectively results in managers being subject to mandatory reporting, as the vast majority of practicing nurses in Oregon are under the supervision of another licensed nurse. Licensed healthcare facilities are required to report any “suspected violations” by licensees of the board of nursing, with the exception of nursing assistants (ORS 678.135, 2009). In fact, the majority of reports of alleged violations in Oregon come from nurse managers (Oregon Board of Nursing, 2018).

Oregon has recently adopted North Carolina’s Complaint Evaluation Tool (North Carolina Board of Nursing, 2018; Oregon Board of Nursing, n.d.). The goal in adopting the tool is to provide guidance and clarity about when and how to report a potential violation to the board. The hope is that having more objective criteria for reporting will reduce the number of reports made to the board found later to lack merit, and also encourage valid complaints that have historically been under-reported due to uncertainty about whether they rise to the level of reportable violation. A copy of the Complaint Evaluation Tool is in the appendix.

Oregon’s nursing board also focuses on training and outreach, providing educational presentations on Oregon’s Nurse Practice Act including when and how to report alleged violations of the Act. Board staff regularly travel the state to provide training to nurses, nursing managers, and chief nursing officers. The board estimates this outreach has increased reports by about 20 percent (Oregon Board of Nursing, 2018).

**Barriers to Reporting Alleged Violations**

**Employer Barriers**

Facility administrators and other employers are in a position to know about the skill and competence of the licensees they employ. They are among the first to discover if a standard of care has been violated, or if a licensee suffers from an impairment—such as substance abuse or an untreated mental illness—with the potential to affect the quality of care. It is this privileged position that has led 19 states to add mandatory employer reporting as part of their regulatory toolkit. However, employers also face a number of barriers and disincentives to reporting (Hudspeth, 2008; Budden, 2011; Martin, Reneau, & Jarosz, 2018).
When researchers surveyed nurse executives on their reporting practices, a large minority—37.2 percent—stated experiencing some form of barrier that prevented them from reporting alleged violations to state nursing boards. Nurse executives reported a number of reasons preventing them from reporting (see Table 2); however, when Martin, Reneau and Jaosz (2018) conducted a combined multivariate analysis that looked at all barriers simultaneously, the two with the strongest evidence of impact were uncertainty about what is reportable and having a non-punitive facility culture. Executives at the nursing boards in California, Florida and Oregon all noted the challenge of employers understanding what is reportable, and each focused training resources on the issue. Non-punitive facility culture directly relates to job satisfaction and retention of nursing staff.

<table>
<thead>
<tr>
<th>Barriers Encountered</th>
<th>Number Reporting</th>
<th>Percent Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>277</td>
<td>62.8%</td>
</tr>
<tr>
<td>Uncertainty as to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is reportable</td>
<td>83</td>
<td>18.8%</td>
</tr>
<tr>
<td>The reporting process</td>
<td>53</td>
<td>12.0%</td>
</tr>
<tr>
<td>The legal ramifications</td>
<td>55</td>
<td>12.5%</td>
</tr>
<tr>
<td>Non-punitive facility culture</td>
<td>136</td>
<td>30.8%</td>
</tr>
<tr>
<td>Other facility policy</td>
<td>128</td>
<td>29.0%</td>
</tr>
<tr>
<td>Concern for legal exposure</td>
<td>40</td>
<td>9.7%</td>
</tr>
<tr>
<td>Concern for facility reputation</td>
<td>17</td>
<td>3.9%</td>
</tr>
</tbody>
</table>


How organizations respond to medical errors influences perception of the work environment, and ultimately turnover. A strong error-management culture focuses on pro-actively detecting, analyzing and handling and/or resolving errors. Such organizations rely on open communication around those errors and reward nurses who participate in knowledge-sharing and other assistance (Guchait, Paşamehmetoğlu, & Madera, 2016). Whereas error-elimination cultures are typically more centralized and punitive, error-management cultures are more cooperative and believed to result in increased group cohesion, as well as reduced stress and nurse burnout. As a result, organizations with such cultures experience lower rates of nurse turnover (Bakker, Demerouti, & Verbeke, 2004).³

³ Unsurprisingly, job stress and perceived work demands have a negative effect on a nurse’s reported job satisfaction (Ellenbecker & al, 2007). When nurses exiting the profession were interviewed about the reasons for their decision to change careers, they cited emotional exhaustion and problems with work design as key causes (Aiken L. H., et al., 2001). More broadly, nurses’ perception of organizational climate were also correlated with turnover (Stone P. W., et al., 2007). Zhang, Punnet, Gore, et al (2014) identified four key features that reduced turnover: getting along with supervisors, getting along with co-workers, feeling respected, and being able to make decisions during the course of their work. Nurses who reported high scores in those four areas had a 77 percent reduction in their reported intention to leave nursing. This can include the perceived level of centralization in the organizational structure (less was reported as better, on average), the ability to have flexible hours, an emphasis on professional autonomy, and the presence of strong communication between management and staff (Aiken, Smith, & Lake, 1994;
nurses can be reticent to report a colleague if they feel the error was unintended or they could have easily made it themselves (Cooper, et al., 2016). In cases where a nurse has committed a medical error, the error can also have a systemic cause outside nurses’ control—such as inadequate staffing, frequent overtime, and intershift fatigue (Famolaro, Yount, Hare, Thornton, & al, 2018). Decentralized and fragmented medical healthcare delivery means cause of error may spread over multiple practitioners, or due to poor communication and coordination. This presents another barrier to reporting—a licensee can be reticent to report a colleague is if the error was not solely due to individual negligence or misconduct, but due to systemic causes.

When a complaint has been made against a nurse, the state’s evaluates the nurse’s actions to first verify that unsafe actions occurred, and if so, to what extent the violation threatened patient safety. In general, increased severity of unsafe actions results in the board imposing an increased severity of discipline. Such an approach works well when considering nursing

Licensee Barriers (Self-Reporting or Colleague Reporting)

A report to a state board of nursing carries with it the potential for serious disciplinary consequences to the licensee. These consequences create strong disincentives against individuals self-reporting (Wolf & Hughes, 2008; Leape L. L., 1994). In addition, Buchan, 1994). A large part of the work environment is made up of the relationships nurses have with each other, with supervisors, and with other parts of the medical care team—particularly the doctor-nurse relationship. If these relationships interact to make the nurse feel supported and empowered, that will have a significant impact on improved job satisfaction (Breau & Rheumne, 2014). Recognizing the professional nature of nursing is consistently cited in the literature as reducing turnover. Moore (2001) found that a nurse’s intention to quit could be mediated by a sense of professionalism. This reduced the impact of frustration at changing work conditions, perceptions of poor management, and reduced the impact of burnout. Spence Laschinger et al identified organizations with a high level of group cohesion and autonomy as having a high level of “structural empowerment,” which was correlated with overall job satisfaction, and ultimately, lower turnover rates (Spence Laschinger, Finegan, Shamian, & Wilk, 2001; Manojlovich & Spence Laschinger, 2002). Even something as simple as a nurse’s perception that they had a shared role in decision-making was correlated with job satisfaction.

4 In California—as in most states—there are continuing concerns about maintaining a registered nurse workforce adequate to meet demand, although recent studies of the California registered nurse workforce leave some cause for optimism. Nursing school enrollments doubled between 2001 and 2010 (Waneka & Keane, 2012). Anecdotally, one explanation for this increase was that individuals who lost their jobs during the recession of 2007 chose to enter school programs instead of continuing to look for work. Additionally, the recession led practicing nurses to remain in the profession when they might have otherwise retired or changed careers (Spetz, 2017). As a result of recent trends in California, forecasters expect the state to be able to meet the demand for registered nurses through at least 2035.
as a highly professionalized practice, with a large degree of autonomy (Beardwood & French, 2004). In such cases, it is reasonable to assume that the nurse was uniquely at fault. However, nursing culture is shifting toward less individual autonomy, and a higher reliance on organizationally determined top-down rules. As this occurs, the importance placed on individual accountability can sometimes put board regulation in tension with the cooperative nature of nursing. It can also make it easy to overlook many of the systemic sources of error in healthcare. Recognizing this issue, nursing boards have begun adapting their processes to reflect the changing nature of the profession. An example of this is the Regulatory Decision Pathway, developed in 2012 by the National Council of State Boards of Nursing specifically to provide a tool for state nursing boards to use in making discipline decisions (Russell & Radtke, 2014). A key focus of the tool is determining to what extent the adverse event resulted from systemic failure vs. how individual nurse behavior contributed.

Emphasis on a systemic understanding of medical error is being driven—in part—by research into nursing and healthcare outcomes. Starting in the 1990s, research efforts have examined how treatment success is interdependent across the healthcare team, facility, and subject to influence by outside factors (IOM, 2000; IOM, 2001). Complicating the issue is the fact that there is not one single approach to measuring health outcomes (Doran, 2011). Many studies see adverse events as outcomes of interest (American Nurses Association, 2000; Aiken L. H., et al., 2001; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). While others look at more qualitative outcomes like functional status and/or mental and social well-being (Lush, 2001; Ditmeyer, Koepsell, Branum, Davis, & Lush, 1998), or a mix of both (McGillis Hall, et al., 2003).

A commonly adopted model of error in nursing literature is Reason’s model of accident causation (Boysen, 2013). The potential for mistakes—what Reasons calls “latent failures”—exist because of organizational deficits or other systemic issues. These deficits lay dormant within the system, and are typically undiscovered. The conditions under which the error occur are either poorly understood, or when they are recognized, are dismissed as unlikely (i.e. “black swan” events). These latent errors are typically embedded in the system because of decisions made when the organization and its processes were designed, which can be far removed from day-to-day activities. To a certain extent, it is impossible to avoid the potential for all latent failures entirely, and the more complex a system is the more difficult it is to identify and predict where and when failures will occur. The presence of a latent failure can give otherwise innocuous actions and behaviors a greater potential for harm. Given this, it is unsurprising that a large proportion of nursing error include a systemic cause or contributor (IOM, 2000). The need to provide accountability toward individual nurses along with the need to create a reporting environment where mistakes are widely reported and used as opportunities to learn is broadly referred to as “just culture.” More information on this topic is in Appendix III: Just Culture.

Indeed, individual error itself often has an underlying systemic contributory cause. A recent review of nursing care studies finds nurse well-being (operationalized as the level of stress, anxiety and depression, for example) and occupational burnout highly correlated with an increased risk of error and worse patient safety (Hall, Johnson, Watt, Tsipa, & O’Connor, 2016). Four important systemic sources of error are: (1) the level of nurse staffing and available time per patient, (2) the use of overtime to cover gaps, leading to burnout, (3) an organizational
culture that helps or hinders error avoidance, and (4) whether the implementation of nursing practice at a facility supports the cognitive needs of nurses.

**Staffing and Time per Patient**

One reason a nurse might decide against reporting an alleged violation by a colleague is if inadequate staffing contributed to the error. A number of studies point to concerns that nurses are often required to cover more patients than is optimal for patient health outcomes. There is evidence that the time a nurse is able to give per patient is associated with improved medical outcomes (Penoyer, 2010). Other studies find associations between nurse-to-patient ratios and/or time per patient with a number of health outcomes, such as a lower risk of central line associated bloodstream infections (CLBSI), ventilator-associated pneumonia, 30-day mortality, and bed sores (decubiti) (Stone P., et al., 2007); decubiti (bed sores) (Blegen, Goode, & Reed, 1998; Unruh, 2003); infections (Amaravadi, Dimick, Pronovost, & al, 2000; Kovner & Gergen, 2007; Sovie & Jawad, 2001; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002); other outcomes (Blegen M., 2006); and general patient survival (Aiken L. H., Clarke, M., & al, 2002; Blegen, Goode, & Reed, 1998).

Lucero, Lake and Aiken (2010) found a large proportion of surveyed nurses reported being regularly unable to meet all nursing care requirements (Table 3). However, some research has cast doubt on the robustness of these associations. Shekelle (2013) conducted a meta-analysis, and found that the bulk of the studies reporting an effect had substantial limitations. Among the studies they identified as “high-quality,” only a few could not rule out random chance as the cause of the observed data. Problems in publication bias toward positive results compound these results. In general, however, the literature links nurse ratios and health outcomes, and the larger issue is whether nurses themselves believe it to be true, and allow it to influence their decisions to report alleged violations.

**Overtime and Burnout**

Understaffing not only influences the time nurses are able to spend with individual patients, but also impacts the ability of nurses to do their job effectively, particularly when short staffs are covered through regular use of overtime. A number of recent nursing care studies find that nurse well-being generally (i.e. stress, anxiety, depression) and burnout specifically were found to be highly correlated with the increased risk of error and/or worse patient safety (Bogaert, Kowalski, Weeks, Van Heusden, & Clarke, 2013; Kirawn, Matthews, & Scott, 2013; Koy, Yunibhand, Angsuwor, & Fisher, 2015; Hall, Johnson, Watt, Tsipa, & O’Connor, 2016). As a result, nurses might be

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**Table 3: Barriers to Adequate Nursing Care Reported by Registered Nurses**

<table>
<thead>
<tr>
<th>Reported</th>
<th>Percent Reporting</th>
</tr>
</thead>
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<tr>
<td>Unable to consistently complete the development and/or updating of nursing care plans.</td>
<td>41%</td>
</tr>
<tr>
<td>Unable to provide adequate comfort and interaction with patients.</td>
<td>40%</td>
</tr>
<tr>
<td>Unable to provide needed back rubs/skin care.</td>
<td>30%</td>
</tr>
<tr>
<td>Unable to adequately teach patients and family.</td>
<td>29%</td>
</tr>
<tr>
<td>Unable to adequately document nursing care.</td>
<td>22%</td>
</tr>
<tr>
<td>Unable to provide oral hygiene for patients.</td>
<td>20%</td>
</tr>
<tr>
<td>Inadequate preparation of patients for discharge.</td>
<td>12%</td>
</tr>
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</table>
less likely to report alleged violations if overwork or fatigue are contributing causes.

Nurses on 12-hour shifts get inadequate sleep and suffer from intershift fatigue—they do not fully recover between shifts, so they start each new shift with an increasing sleep deficit (Geiger-Brown, 2011). In surveys, nurses self-report higher rates of error due to fatigue from overtime (Rogers, Hwang, Scott, & al, 2004). Observational studies associate higher rates of catheter-associated urinary tract infections with decubiti [bedsores], for example (Stone P., et al., 2007). Just working over 40 hours a week is associated with an increased rate of adverse events (Olds & Clarke, 2010).

There are caveats, however. The above studies are observational, and therefore it is difficult to draw definitive conclusions from them. For example, the same study that observed an increased risk of catheter-associated urinary tract infections and decubiti found a decreased risk of central line associated bloodstream infections (Stone P., et al., 2007). Nonetheless, the preponderance of the literature shows that a nurse’s likelihood of error or of adverse patient outcomes correlates with the number of hours they work per day and per week.

Organizational Culture

Even more generally, research shows that nurses’ perception of their workplace culture can be associated with improved patient outcomes and reduced likelihood of medical error (Braithwaite, Herkes, Ludlow, Testa, & Lamprell, 2017; Stone P., et al., 2007). Effective and error-free clinical practice is not an individual effort, it relies on “social, cultural and organizational factors” much of which are outside of the individual nurse’s control (Patel, Kannampallil, & Shortliffe, 2015).

Nurses who feel empowered, through the support and respect of fellow nurses, doctors and supervisors, also report higher perceived quality of care at their institutions (Breau & Rheume, 2014). If they report that they had opportunities to specialize and report reduced occurrences of “backfilling” duties, their perception of their work environment improves, and they report better patient safety outcomes (Breau & Rheume, 2014; Hopkins Duva & al, 2011). Awareness of the importance of organizational culture in nurse performance might also represent a mitigating factor that leads nurses to refrain from reporting alleged violations.

Much emphasis in this area of the nursing literature focuses on creating a “culture of safety” and “high-reliability organization.” Reason and Hobbes (Reason & Hobbs, Managing Maintenance Error: A Practical Guide, 2003) highlight three values embodied by high-reliability organizations: trust, reporting and improvement. When nurses trust their peers and the larger organization, they feel safe reporting mistakes without fear of unfair treatment. They also feel safe reporting unsafe conditions, without the fear of retaliation or “blaming the messenger.” Removing institutional barriers and disincentives against reporting, responding to reports quickly and widely communicating improvements establish trust. Chassin and Loeb (2013) argue that these three values create a self-reinforcing organizational culture.

These values are part of a larger shift among safety researchers away from error elimination and toward error recovery. Rather than requiring perfection, high-reliability organizations operate with the expectation that mistakes and errors will occur, and create systems to quickly recognize and recover from them before the errors result in adverse events. There is reason to believe that to do otherwise—focusing on the elimination of error, rather than identification and recovery—actually results in more error, and increases the
Employer Reporting Practices for Registered Nurses

likelihood that errors will result in negative consequences (Patel, Kannampallil, & Shortliffe, 2015). Identifying individual responsibility is still a necessary part of such strategies, but the purpose is not to “pin the blame” or purely punitive. Even where there are individual causes of error they still need to be recognized as operating within a larger systemic context.

Cognitive Processing
Organizational factors do not just influence propensity toward error through practices such as understaffing, overtime, insufficient training, or ineffective error monitoring. Safety researchers also recognize the importance of removing impediments to cognitive processing. Decades of research acknowledge the role of cognition in human and medical error (Reason, Human Error, 1992; Leape L. L., 1994).

Technology is often poorly adapted to human behaviors and processing models. The system forces humans to adapt to the technology, rather than the technology adapting to how humans think and work. This causes increased risk of error, particularly in high-stress environments (Norman, 2018). The typical response increases emphasis on training. Essential in fields where complex, but repetitive, tasks are common, training is also important where patients’ needs are changing and/or uncertain (Dekker, 2007). However, training itself can be a source of error. Highly trained clinicians are more prone to “premature closure,” a type of error where the first diagnostic hypothesis that fits is accepted rather than evaluating all possible alternatives (Patel, Kannampallil, & Shortliffe, 2015). This type of cognitive error can be difficult to identify because it so often does not result in an adverse event. Because they occur more frequently, some diagnostic hypotheses are easy to recall, meaning the use of such cognitive shortcuts results more often than not in a correct diagnosis. Premature closure resulting in an incorrect diagnosis is therefore comparatively rare. As a result, a diagnostician can commit this error many times before it results in an adverse event.

When error detection systems are put in place there is added benefit in bringing the potential for errors like premature closure to the forefront of clinical practice, reducing the likelihood of committing these errors in the first place (Patel, Kannampallil, & Shortliffe, 2015). Organizations that focus on post-hoc punishment of individual error can actually reduce the ability of practitioners to achieve that goal.

Concerns about cognitive processing are somewhat abstract and not always raised with this precise wording. These issues often appear in the literature as a concern about inadequate and/or ineffective training or as poorly designed technology.

Options for Reporting Mechanisms
Given these barriers to reporting, below are several options for “consistent and reasonable reporting mechanisms” for consideration.

Continue Current Reporting Practices
One approach to employer reporting is to maintain the current policy of voluntary reporting. Approximately a third of states have no mandatory reporting for registered nurses, including California.

Healthcare professional culture safeguards patient health by reporting dangers to patient safety. This is particularly true within the nursing profession, where the patient-centered tradition is a source of individual and collective pride. This explains why nurses report patient care violations at a comparatively higher rate compared to other medical professions (Wolf & Hughes, 2008).
In fact, there does not appear to be a strong difference in reporting between states with voluntary regimes, states with mandatory employer reporting or states with some other form of mandatory licensee reporting. The experience of Connecticut’s HAVEN program—which saw a 30 percent increase in enrollment when the state first adopted mandatory reporting rules—indicates some instances of underreporting in substance abuse or mental illness, though it is possible there are other explanations for the increase.

**Expand Training and Outreach**

Many barriers to reporting described by nursing administrators were due to uncertainty and lack of training. As enumerated in Table 3 above, managers said that uncertainty about which behaviors were potentially reportable violations to the board made them less likely to notify their state board. This offers an opportunity to capture unreported violations by expanding outreach provided on the California Nursing Practice Act, focusing on identifying violations and how best to report them. Recognizing this need, the Nursing Board has already increased outreach this past year, providing enforcement presentations to hospital staff as well as to deans and directors of nursing schools (California Board of Registered Nursing, 2018).

Beyond presentations, adopting tools similar to the Complaint Evaluation Tool used by North Carolina and Oregon could also provide clearer and objective guidelines on when and how to report potential violations. Expanding these activities into a formal outreach program extends their impact, and helps guarantee their continuance across board administrations.

**Mandatory Reporting for Alleged Violations of the Nurse Practice Act**

Mandatory reporting states vary regarding who is required to report: employers, fellow registered nurses, or, more broadly, all licensed medical professionals. States with mandatory employer reporting provisions also vary according to criteria that trigger a mandatory report. Least restrictive versions only require employers to report dismissals, suspensions, or “resignations in lieu of dismissal” resulting from alleged violations. Draft language in SB 799 adopted this less restrictive approach. Earlier versions required employer reporting in the case of “the suspension or termination for cause, or resignation for cause, of any registered nurse in its employ.” This level of mandatory reporting gives the facility leeway to provide internal discipline and training without requiring a report to the board that triggers an investigation, so long the nurse is not suspended, terminated or resigns.

States with more restrictive rules require employers to report if violations result in the imposition of restrictions on a nurse, or if other internal discipline is used, such as requiring supplemental training or placing additional oversight on the licensee. The strictest form of employer reporting requires reporting by the employer if they are aware of any practice act violations by a nurse they employ. Mandatory reporting rules that cover nurses or other licensed professionals are generally of this broader type, but sometimes limited by severity or type of reportable violation. Some states have narrower reporting requirements, only mandating a report if the nurse is fired due to an alleged violation. It is possible increased reporting requirements could be used as a retaliation or bullying tool. The literature indicates this most likely occurs in organizations with quasi-formal disciplinary processes, rather than in organizations with highly formalized mandated reporting structures. However, while mandatory reporting potentially reduces opportunity for arbitrary punishment, it also may worsen the impacts of retaliation when it does happen (See Appendix IV: Management...
Bullying and Retaliation in Nursing for more information.)

To the extent stricter reporting requirements capture alleged violations otherwise unreported, they are also more likely to capture complaints of lower severity, and concomitantly, of lower priority for the board. Unfortunately, limited resources dictate that lower-severity complaints potentially go uninvestigated because staff focuses, by necessity, on higher-severity violations.
## Appendices

### Appendix I: Detailed Table

**Table A-4: Mandatory Reporting Rules, License Counts (2017), and Complaints (2017), by State**

<table>
<thead>
<tr>
<th>State</th>
<th>Employer</th>
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<th>Other Practitioner</th>
<th>RN Licenses</th>
<th>LPN/LVN Licenses</th>
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<th>Complaints</th>
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## Employer Reporting Practices for Registered Nurses

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<th>State</th>
<th>Category</th>
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<th>Other Reporting</th>
<th>Registered Nurses</th>
<th>Licensed Practical/Vocational Nurses</th>
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<td>16,443</td>
</tr>
<tr>
<td>VA</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>104,667</td>
<td>27,745</td>
<td>132,412</td>
</tr>
<tr>
<td>WA</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>96,664</td>
<td>11,513</td>
<td>108,177</td>
</tr>
<tr>
<td>WV*</td>
<td>○</td>
<td>●</td>
<td>○</td>
<td>32,669</td>
<td>NA</td>
<td>32,669</td>
</tr>
<tr>
<td>WI</td>
<td>○</td>
<td>●</td>
<td>○</td>
<td>102,908</td>
<td>13,166</td>
<td>116,074</td>
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<tr>
<td>WY</td>
<td>○</td>
<td>●</td>
<td>○</td>
<td>15,579</td>
<td>1,465</td>
<td>17,044</td>
</tr>
</tbody>
</table>

* Board regulates Registered Nurses only.
### Appendix II: NC Complaint Evaluation Tool

**North Carolina Board of Nursing (NCBON)**

**COMPLAINT EVALUATION TOOL (CET)**

<table>
<thead>
<tr>
<th>Allegations</th>
<th>Human Error</th>
<th>At Risk Behavior</th>
<th>License Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Failure to establish criteria for a patient's care</td>
<td>1. Inadequate, improper, or unethical conduct</td>
<td>1. Failure to work with patients for an extended period of time</td>
<td>1. Failure to work with patients for an extended period of time</td>
</tr>
<tr>
<td>2. Failure to establish criteria for a patient's care</td>
<td>2. Inadequate, improper, or unethical conduct</td>
<td>2. Failure to work with patients for an extended period of time</td>
<td>2. Failure to work with patients for an extended period of time</td>
</tr>
<tr>
<td>3. Failure to establish criteria for a patient's care</td>
<td>3. Inadequate, improper, or unethical conduct</td>
<td>3. Failure to work with patients for an extended period of time</td>
<td>3. Failure to work with patients for an extended period of time</td>
</tr>
<tr>
<td>4. Failure to establish criteria for a patient's care</td>
<td>4. Inadequate, improper, or unethical conduct</td>
<td>4. Failure to work with patients for an extended period of time</td>
<td>4. Failure to work with patients for an extended period of time</td>
</tr>
<tr>
<td>5. Failure to establish criteria for a patient's care</td>
<td>5. Inadequate, improper, or unethical conduct</td>
<td>5. Failure to work with patients for an extended period of time</td>
<td>5. Failure to work with patients for an extended period of time</td>
</tr>
</tbody>
</table>

**Criteria Score**

- 1: Very poor
- 2: Poor
- 3: Fair
- 4: Good
- 5: Excellent

**Score**

- 0: No
- 1: Yes

Also available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6604742/

---

California Research Bureau | California State Library
## North Carolina Board of Nursing (NCBON)
### COMPLAINT EVALUATION TOOL (CET)

<table>
<thead>
<tr>
<th>Mitigating Factors - check all identified</th>
<th>Aggravating Factors - check all identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication breakdown (multiple handoffs, change of shift, language barriers)</td>
<td>Took advantage of leadership position</td>
</tr>
<tr>
<td>Limited or unavailable resources (inadequate supplies / equipment)</td>
<td>Especially heinous, cruel, and / or violent act</td>
</tr>
<tr>
<td>Interruptions / chaotic environment / emergencies – frequent interruptions / distractions</td>
<td>Knowingly created risk for more than one client</td>
</tr>
<tr>
<td>Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet agency needs</td>
<td>Threatening / bullying behaviors</td>
</tr>
<tr>
<td>High Work volume / staffing issues</td>
<td>Disciplinary action (practice related issues) in previous 13 – 24 months</td>
</tr>
<tr>
<td>Policies / procedures unclear</td>
<td>Vulnerable client geriatric, pediatric, mentally / physically challenged, sedated</td>
</tr>
<tr>
<td>Performance evaluations have been above average</td>
<td>Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet personal needs</td>
</tr>
<tr>
<td>Insufficient orientation / training</td>
<td>Other (identify)</td>
</tr>
<tr>
<td>Client factors (combative / agitated, cognitively impaired, threatening)</td>
<td></td>
</tr>
<tr>
<td>Non-supportive environment – interdepartmental conflicts</td>
<td></td>
</tr>
<tr>
<td>Lack of response by other departments / providers</td>
<td></td>
</tr>
<tr>
<td>Other (identify)</td>
<td></td>
</tr>
</tbody>
</table>

Total # mitigating factors identified | Total # aggravating factors identified

### Criteria Score from page 1

<table>
<thead>
<tr>
<th>No Board Contact Required</th>
<th>Board Consultation Required</th>
<th>Board Report Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact with NCBON is not required if:</td>
<td>Consult with NCBON if:</td>
<td>Mandatory report to NCBON if:</td>
</tr>
<tr>
<td>o 3 or more criteria in green OR</td>
<td>o 3 or more criteria in yellow OR</td>
<td>o 2 or more criteria in red OR</td>
</tr>
<tr>
<td>o Criteria score of 6 or less</td>
<td>o Criteria score 7 – 15</td>
<td>o Criteria score 16 or more OR</td>
</tr>
<tr>
<td>Call- 919-782-3211 ext 256 or 226</td>
<td></td>
<td>Incident involves fraud, theft, drug abuse, diversion, sexual misconduct, mental / physical impairment.</td>
</tr>
</tbody>
</table>

Go to website: [www.nchsm.com](http://www.nchsm.com) or Call 919-782-3211 ext 282 for assistance

CET Completed by: _________________________________ Facility Name: _________________________________

Contact Number & Email address: _________________________________

Date of Consultation with NCBON _________________________________ NCBON Consultant: _________________________________ Action Taken: _________________________________

2011 – Version 2.0 @ NCBON-Permission Required Before Use
Appendix III: Just Culture

In the 1970s, researchers started making greater effort to understand causal models of medical error. The primary driver behind this research was a growing concern around increasing medical malpractice lawsuit rewards (Hiatt & al., 1989). It had become clear that the current malpractice insurance system exposed insurers to significant liability and/or would require increased insurance premiums dramatically above what doctors were used to paying, or could afford. Much of what researchers now know about the sources of medical error came out of this literature. The most widely cited of such studies was the Harvard Medical Practice Study, the results of which were first published by the New England Journal of Medicine in 1991 (Brennan & al., 1991). The Harvard study drew “a weighted sample of 31,429 records of hospitalized patients from a population of 2,671,863 non-psychiatric patients discharged from [51] nonfederal acute care hospitals in New York in 1984.” The researchers then used this sample to estimate an overall rate of adverse events, and further estimated the proportion of medical injuries that were the result of negligent or otherwise substandard care. Of the original 31,429 records sampled, the researchers identified 1,278 hospitalizations with at least one adverse advent. Of those, 306 were determined to have occurred due to negligence or substandard care.

When researchers weighted and adjusted those numbers to match the broader patient population in New York State, they estimated that approximately 3.7 percent (with a 95 percent confidence interval of 3.2 percent and 4.2 percent) of hospitalizations result in an adverse event. They further estimated that 1.0 percent (95 percent confidence interval of 0.8 percent to 1.2 percent) of hospitalizations result in hospitalizations that were due to negligence or substandard care. This implies that the largest portion—73.0 percent—of adverse events occurred without evidence of negligence. An earlier—but smaller—California study found similar results (Mills, 1987).

Ten years after the Harvard Medical Practice Study, the Institute of Medicine’s (IOM), Quality of Health Care in America Committee published *To Err is Human*, produced with the goal of identifying the causes of medical error and providing effective strategies to reduce them. One key conclusion of the report was that the majority of medical errors were not the result of an individual or group’s recklessness (IOM, 2000). In other words, eliminating “bad apples” and/or maintaining more stringent standards of practice would not eliminate more preventable adverse events:

> “More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.... [M]istakes can best be prevented by designing the health system at all levels to make it safer—to make it harder for people to do something wrong and easier for them to do it right. Of course, this does not mean that individuals can be careless. People still must be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.”

To the extent that disciplinary action is primarily punitive—i.e. fear of consequences is meant to deter lax behavior—safety researchers have argued that such punishment is ineffective in cases where most (if not all) practitioners would have made the same mistake (Miller B., 2008; Miller, Griffith, & Vogelsmeier, 2010). Even in cases where readily identifiable human error...
occurred and contributed to an adverse event, it can be more valuable to identify the systems that failed to recognize and prevent the error (Whittingham, 2003; Kerfoot, 2008). Focusing on individual punishment also carried the risk of forestalling needed systemic improvements. If there are systemic contributions to the medical error, prioritizing the identification of the individual(s) to blame can lead to premature closure. This is a cognitive error where the first viable explanation is adopted, preventing the full consideration of alternative explanations. Once an individual has been blamed, and the disciplinary process is underway, additional causes can be overlooked—and therefore any systemic issues that contributed to the error will remain uncorrected (Ebright & Rapala, 2003).

These concerns are often cited by the many studies that focus on organizational changes to reduce medical error, and improve patient safety. There is a significant body of literature that has identified replacing the punitive culture with a culture of safety as the most important piece of effective patient safety policy (Wolf & Hughes, 2008; Force, Deering, Hubbe, & al, 2006; Stump, 2000; Boysen, 2013). This shift away from a pure punitive approach began about the same time that the healthcare industry began reducing individual autonomy in healthcare provision, shifting away from one that emphasized the individual professional role toward a more systematized group care model. This occurred largely because of changes to the industry outside of the patient safety-medical error purview—primarily the changes were a response to increasing medical costs and the emergence of HMOs and industry consolidation to control costs. But whatever the impetus, the result was a reduction in individual autonomy for licensed health providers, a change which effected nurses to a significant degree (Boysen, 2013). In this new environment, systemic concerns are more important than ever.

Importantly, when surveyed, most hospital leaders reported that mandatory reporting to nursing boards deters reporting patient safety incidents to internal reporting systems. They were also concerned that the non-confidential nature of such systems could also encourage lawsuits (Weissman, Annas, Epstein, & al, 2005). Patients, on the other hand, support mandatory reporting (Blendon, DesRoches, Brodie, Benson, & al, 2002).

In response to these divergent and opposing concerns, the patient safety community has coalesced around a series of policy preferences and cultural values called “just culture.” Just culture attempts to balance the need to provide accountability toward individual nurses with the need to create an environment where mistakes are widely reported and learned from (Marx, 2001; Miller B., 2008; Kerfoot, 2008). It draws heavily from the “highly reliable organizations” model, building on the key concepts that: 1) human error cannot be avoided 100 percent of the time, 2) even well-designed organizational systems can fail, and 3) risk is everywhere.

The IOM (2000) report recommended adopting mandatory reporting, but with an emphasis on adverse events resulting in serious harm or death. Recognizing that mandatory reporting systems involved both learning and accountability mechanisms, it suggested conducting “root cause” analyses of the health delivery system as a whole. Under such an approach, individual blame—and ultimately board discipline—is contingent on whether the individual error was the root cause of the practice breakdown, and whether error is due to 1) unavoidable human error, 2) at-risk behavior, or 3) reckless behavior (Boysen, 2013).

A number of state boards of nursing embrace approach. Ohio’s Board of Nursing explicitly adopted just culture principles in its “Patient Safety Initiative” (Ohio Board of Nursing).
Ohio’s goal is to improve overall reporting of error, create a statewide patient safety database, and improve opportunities for employer-sponsored remediation and alternative discipline programs. Missouri’s “Just Culture Collaborative” places focus on learning and implementing the principles of just culture (Miller, Griffith, & Vogelsmeier, 2010). The collaborative currently has 67 members, including business, government and professional associations. California took similar steps. Formed in 2007, the California Patient Safety Action Coalition introduced state healthcare leaders to just culture. Active for a number of years, they ultimately felt they met their educational goals and have since disbanded. While no organization in California is currently dedicated to advancing just culture, the California Hospital Patient Safety Organization invests resources and works in this area.
Appendix IV: Management Bullying and Retaliation in Nursing

Punishment models in an employer-employee context, historically, increase the "docility" of the workforce (Knight & Latreille, 2000). Nurses, expected to be advocates for their patients, may at times find themselves in opposition to managers and employers. Discipline that punishes nurses’ fulfilling their role as patient advocates causes the disciplinary process to work at odds with patient health outcomes. A rhetoric of correction, then, could effectively mask punishment. This is a recognized phenomenon within professional nursing (Fenley, 1998; Cooke, 2006).

The larger workplace retaliation literature offers helpful detail. The typical pattern for workplace retaliation is for punishment to take place through small repetitive acts, occurring over an extended period, often with escalating harassment (Glasø, Løkke Vie, & Hoel, 2010). Typically, retaliatory acts do not come from a single individual, but from diverse sources (Miceli, Near, & Dworkin, 2008). Coworkers, even those sympathetic, add to isolation felt by targeted individuals when they pull away from professional and personal relationships to avoid being targeted themselves (Beardshaw & Thorold, 1981, p. 37; Bjørkelø & Matthiesen, Preventing and Dealing with Retaliation Against Whistleblowers, 2011).

Retaliatory bullying creates significant additional stressors in the work environment (Wilson, 1991; Adams & Crawford, 1992; Zapf, Knorz, & Kulla, 1996), with negative consequences for physical health (Soeken & R., 1987), psychological health (Rothschild & Miethe, 1999), and triggers symptoms analogous to post-traumatic stress disorder (Bjørkelø, Ryberg, Matthiesen, & Einarsen, 2008). When workplace retaliation includes reports to a state nursing board, the potential for such stress increases. Lodging a complaint has an "immediate and devastating impact on their feelings about nursing and their confidence in their professional skills" (Beardwood & French, 2004). If the complaint results in practice restrictions, the impacts on a nurse’s career and personal well-being are profound. A recent review of Australian nursing boards shows that reports coming from one’s employer are taken more seriously and have a higher likelihood of resulting in discipline (Spittal, Studdert, Paterson, & Bismark, 2016).

One concern about instituting mandatory reporting employer reporting requirements is its potential to influence the ability of managers to punish and retaliate against nurses for workplace organizing or for reporting for quality of care violations. Existing research does not specifically address this issue. Cooke (2006), however, points out that such use of punishment for worker-management disagreement is most common where the disciplinary processes are quasi-formal. In these situations, managers apply standard of care criteria more aggressively on targeted individuals than on staff as a whole. When managers have less discretion in when and how to apply discipline, the potential to use the disciplinary process for retaliation is more limited. If accurate, research indicates mandatory reporting reduces the amount of discretion managers have, therefore reducing their ability to target specific nurses for retaliation. However, while mandatory reporting potentially reduces the opportunity for arbitrary punishment, it could also worsen impacts of retaliation when punishment happens.
**Works Cited**


California Board of Registered Nursing. (2018, 10 30).


Florida Statutes, Title XXXII, Chapter 456, Section 72(1)(i). (2018).


Employer Reporting Practices for Registered Nurses


Oregon Board of Nursing. (2018, 11 5).


AGENDA ITEM: 9.2
DATE: May 9, 2019

ACTION REQUESTED: Information Only: Discipline and Probation Program Update

REQUESTED BY: Imelda Ceja-Butkiewicz, Chairperson

PROBATION UNIT
The unit has one vacant position, for a Staff Service Analyst (SSA). This position should be filled end of this FY, June 30, 2019.

Current caseloads are 91 cases per monitor. This includes all cases active and tolled.

New employment and employment modifications continue to get approved on average in 2-3 weeks.

The Probation team continues to partner with SOLID to instruct the Probation Monitoring Module of DCA’s SOLID Enforcement Academy. This course has been taught by our probation staff since its inception in 2009.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active In-State Probationers</td>
<td>1,095</td>
<td>1,189</td>
<td>1,196</td>
<td>1,003</td>
<td>881</td>
</tr>
<tr>
<td># of Chemical Dependency</td>
<td>707</td>
<td>785</td>
<td>787</td>
<td>580</td>
<td>491</td>
</tr>
<tr>
<td>Probationers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolled Out of State</td>
<td>290</td>
<td>345</td>
<td>380</td>
<td>394</td>
<td>397</td>
</tr>
<tr>
<td>Probationers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Probationers</td>
<td>1,385</td>
<td>1,534</td>
<td>1,576</td>
<td>1,397</td>
<td>1,278</td>
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</tbody>
</table>

CITE AND FINE
The unit is currently fully staffed.

As of April 18, 2019, staff have issued 471 citations. Of those, full payment has been received on 288 and 158 appeal conferences held and 2 Administrative Hearing Appeals.

<table>
<thead>
<tr>
<th>Citation Information</th>
<th>FY 2015/16</th>
<th>FY 2016/17</th>
<th>FY 2017/2018</th>
<th>Current FY</th>
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<tbody>
<tr>
<td>Citations Issued</td>
<td>542</td>
<td>366</td>
<td>770</td>
<td>435</td>
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<tr>
<td>Amount Ordered</td>
<td>$299,638</td>
<td>$266,428</td>
<td>$519,133</td>
<td>$341,926</td>
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<td>Amount Received</td>
<td>$253,974</td>
<td>$202,614</td>
<td>$391,233</td>
<td>$245,950</td>
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</tbody>
</table>
DISCIPLINE UNIT

This unit has one (1) Office Technician vacancy. It should be filled by end of this FY, June 30, 2019.

<table>
<thead>
<tr>
<th>Cases Pending</th>
<th>As of 4/22/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cases at AG</td>
<td>924</td>
</tr>
<tr>
<td>Pending Board Vote</td>
<td>30</td>
</tr>
<tr>
<td>Final Decision Processing</td>
<td>78</td>
</tr>
<tr>
<td>Pending hearing</td>
<td>153</td>
</tr>
<tr>
<td>Over 2 yrs. at AG</td>
<td>34</td>
</tr>
<tr>
<td>1-2 yrs. at AG</td>
<td>114</td>
</tr>
<tr>
<td>Subsequent AG Cases (Probationers)</td>
<td>78</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AG Referrals</td>
<td>1,395</td>
<td>1,198</td>
<td>1,282</td>
<td>959</td>
</tr>
<tr>
<td>Petitions to Revoke Probation</td>
<td>87</td>
<td>120</td>
<td>100</td>
<td>71</td>
</tr>
<tr>
<td>Pleading Served</td>
<td>1,067</td>
<td>938</td>
<td>848</td>
<td>718</td>
</tr>
<tr>
<td>EO Signed Surrenders</td>
<td>255</td>
<td>254</td>
<td>218</td>
<td>253</td>
</tr>
<tr>
<td>Withdrawals of SOI</td>
<td>15</td>
<td>9</td>
<td>9</td>
<td>2</td>
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<tr>
<td>Decisions Adopted</td>
<td>1,641</td>
<td>1,282</td>
<td>1,141</td>
<td>1051</td>
</tr>
</tbody>
</table>

NEXT STEP: Follow directions given by committee and/or board.

FISCAL IMPACT, IF ANY: AG’s budget line item will be monitored for Discipline and Probation.

PERSON TO CONTACT: Shannon Johnson, Chief Discipline, Probation, and Intervention (916) 515-5265
<table>
<thead>
<tr>
<th>License Type</th>
<th>Public Reproval</th>
<th>Revoked, Stayed, Probation</th>
<th>Revoked, Stayed, Suspension, Probation</th>
<th>Surrender</th>
<th>Revocation</th>
<th>Voluntary Surrender</th>
<th>Total FY 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>120</td>
<td>180</td>
<td>6</td>
<td>197</td>
<td>272</td>
<td>50</td>
<td>825</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>11</td>
<td>16</td>
<td>1</td>
<td>17</td>
<td>10</td>
<td>3</td>
<td>58</td>
</tr>
<tr>
<td>Psych/Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>8</td>
<td>15</td>
<td>1</td>
<td>14</td>
<td>2</td>
<td>4</td>
<td>44</td>
</tr>
<tr>
<td>NP-Furnishing #</td>
<td>7</td>
<td>12</td>
<td>1</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>38</td>
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<tr>
<td>Nurse-Midwife</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>NM-Furnishing #</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>4</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
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<td></td>
<td></td>
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<td>11</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Specialty certifications are a subset of the Registered Nurse license. When enforcement action is taken on an RN license, all advanced certifications a nurse holds is also included in the action. More than one enforcement action may be taken (thus counted here) against an RN during the time period.
<table>
<thead>
<tr>
<th>Probation Data</th>
<th>Numbers</th>
<th>% of Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>261</td>
<td>30%</td>
</tr>
<tr>
<td>Female</td>
<td>620</td>
<td>70%</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>491</td>
<td>55.7%</td>
</tr>
<tr>
<td>Required Drug-Screening</td>
<td>414</td>
<td>47.0%</td>
</tr>
<tr>
<td>Practice</td>
<td>265</td>
<td>30.1%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>7</td>
<td>0.8%</td>
</tr>
<tr>
<td>Conviction - excluding chemical dependency/alcohol use</td>
<td>114</td>
<td>12.9%</td>
</tr>
<tr>
<td>Advanced Certificates</td>
<td>73</td>
<td>8%</td>
</tr>
<tr>
<td>Southern California</td>
<td>477</td>
<td>54%</td>
</tr>
<tr>
<td>Northern California</td>
<td>398</td>
<td>45%</td>
</tr>
<tr>
<td>Tolled Probationers</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Pending AG</td>
<td>70</td>
<td>8%</td>
</tr>
<tr>
<td>License Revoked Fiscal YTD</td>
<td>46</td>
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</tr>
<tr>
<td>License Surrendered Fiscal YTD</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Terminated Fiscal YTD</td>
<td>136</td>
<td></td>
</tr>
<tr>
<td>Successfully Completed Fiscal YTD</td>
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</tr>
<tr>
<td>Active In-State Probationers</td>
<td><strong>881</strong></td>
<td></td>
</tr>
<tr>
<td>Completed/Revoked/Terminated/Surrendered YTD</td>
<td>369</td>
<td></td>
</tr>
<tr>
<td>Tolled Probationers</td>
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<tr>
<td>Active and Tolled Probationers</td>
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AGENDA ITEM: 9.3
DATE: May 9, 2019

ACTION REQUESTED: Intervention Program Update

REQUESTED BY: Imelda Ceja-Butkiewicz, Chairperson

INTERVENTION PROGRAM UPDATE

Staffing

The Intervention unit has one vacancy for a Staff Services Manager I (SSMI).

Program Update

On April 16, 2019, the Intervention program conducted a Mental Health Ad-Hoc Committee meeting to vote on the final draft of the Mental Health Ad-Hoc Report. The committee members have approved the finalized draft report, and is being presented to the Intervention Discipline Committee (IDC) for review at the May 2019 IDC meeting.

The Intervention team is currently involved in ongoing meetings with DCA contract and legal staff along with the participating boards alternative to discipline programs to work on the upcoming Recovery Programs Request for Proposal (RFP) bid process. The current contract ends December 31, 2019.

Intervention Evaluation Committees (IEC)

There are currently four physician member vacancies.

<table>
<thead>
<tr>
<th>San Jose (IEC 7)</th>
<th>Fresno (IEC 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles (IEC 3)</td>
<td>Irvine (IEC 4)</td>
</tr>
</tbody>
</table>

There are two public member vacancies.

| San Jose (IEC 7) | Fresno (IEC 5) |
Statistics – Intervention

The Statistical Summary Report is attached. As of April 23, 2019, there have been 2,378 successful completions.

NEXT STEP:
Follow directions given by Committee and/or Board.

FISCAL IMPACT, IF ANY:
None currently.

PERSON TO CONTACT:
Shannon Johnson, Chief Discipline, Probation and Intervention
(916) 515-5265
Board of Registered Nursing

Intervention Program Statistics

For FY 2018/2019 (as of 4/1/2019)

### Complaints Referred to Intervention

<table>
<thead>
<tr>
<th>Quarter</th>
<th>FY2018/19</th>
<th>FY2017/18</th>
<th>FY2016/17</th>
</tr>
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<tbody>
<tr>
<td>Q1</td>
<td>208</td>
<td>285</td>
<td>295</td>
</tr>
<tr>
<td>Q2</td>
<td>323</td>
<td>276</td>
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<tr>
<td>Q3</td>
<td>259</td>
<td>234</td>
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<tr>
<td>Q4</td>
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### Intervention Offers Sent to RNs

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<th>FY2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
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<td>221</td>
<td>166</td>
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<tr>
<td>Q2</td>
<td>205</td>
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<td>Q4</td>
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### Intakes Completed

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### Board of Registered Nursing

### Intervention Program Statistics

For FY 2018/2019 (as of 4/1/2019)

#### Presenting Problem

(As Determined at Intake)

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<tr>
<th>Month</th>
<th>SUD</th>
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<th>Dual</th>
<th>Undetermined</th>
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<tr>
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#### Drug of Choice

(As Reported by RN at Intake)

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<tr>
<th>Month</th>
<th>Alcohol (Beer, Wine, Hard Liquor)</th>
<th>Opioids (Oxycodone, Morphine, Heroin, etc.)</th>
<th>Depressant (Xanax, Valium, Ambien, etc.)</th>
<th>Stimulant (Adderall, Cocaine, Methamphetamine, etc.)</th>
<th>Cannabinoids</th>
<th>Other (Hallucinogens, Inhalants, etc.)</th>
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<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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<tbody>
<tr>
<td>Complaints sent to Intervention</td>
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<td>58</td>
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<td>Program offer letters mailed</td>
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<td>53</td>
<td>36</td>
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<td>71</td>
<td>138</td>
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<tr>
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### Participant Population

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<th>Oct</th>
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<th>Jan</th>
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<th>Mar</th>
<th>Apr</th>
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<tbody>
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### Intake Demographics - Referrals

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<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>PTD</th>
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### Intake Demographics - Presenting Problem

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<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
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<th>Apr</th>
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<th>Jun</th>
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### Intake Demographics - Drug of Choice

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<th>Sep</th>
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<th>Apr</th>
<th>May</th>
<th>Jun</th>
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## Case Closures

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<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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AGENDA ITEM: 9.4
DATE: May 9, 2019

ACTION REQUESTED: Status Report Regarding Mental Health Ad-Hoc Report

REQUESTED BY: Intervention/ Discipline Committee

BACKGROUND: On November 5, 2015, the Board established the Mental Health Ad-Hoc Committee to develop best practice strategies to meet the unique needs of nurses with mental illness and to develop a model rehabilitation plan for use by all the Diversion Evaluation Committees.

Attached for the Board’s review is the Mental Health Ad-Hoc Committee’s report.

NEXT STEP: Vote to Recommend Approve/Not Approve policy revisions as recommended by the Mental Health Ad-Hoc Committee to the Board

PERSON TO CONTACT: Shannon Johnson, Chief Discipline, Probation and Intervention (916) 515-5265
Mental Health Ad-hoc Committee Report

Intervention Program
BOARD OF REGISTERED NURSING
1747 North Market Blvd, Suite 150
Sacramento, CA 95834
916-574-7692
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Mental Health Ad-hoc Committee

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Gina Skinner, BRN Intervention Program Analyst
Lorraine K. Clarke, BRN Intervention Program Analyst
Introduction

In 1985, BRN’s Intervention Program (formerly Diversion Program) was established as an alternative-to-discipline program. The Program’s mission is to seek ways and means to identify and rehabilitate registered nurses whose competency may be impaired due to misuse of substances or due to mental illness and return them to practice in a manner that does not endanger public health and safety.

Since the Program’s inception, about 35% of registered nurses presented with some form of mental illness or co-occurring disorders (both mental illness and substance use disorder).

In 1991, to meet the unique needs of the mentally ill nurse, the Board established the Mental Health Ad-hoc Committee (MHAC) as a subcommittee of the Board’s Diversion/Discipline Committee (now Intervention/Discipline Committee). Its charge was to develop a model rehabilitation plan for use by all Diversion Evaluation Committees (now called Intervention Evaluation Committees - or IECs).

In 1993, MHAC released its original report, which is currently used by all IECs. Many years, however, have passed since MHAC released its original report and during that time mental health services have evolved. As such, it was recognized that Intervention Program’s mental health-related system needed to be reviewed and updated accordingly.

In 2017, the Board reestablished MHAC to re-evaluate and revise the Intervention Program’s mental health-related system according to current best practice. Over the past 1 ½ years, MHAC members met to collaborate and make recommendations for the IECs to follow when evaluating mental health participants. The following information in this report summarizes the results of our findings and recommendations.

Goals and Objectives

The goal of MHAC is to ensure that BRN’s Intervention Program continues to be effective in meeting the needs of California consumers by ensuring registered nurses with mental illness are rehabilitated in an appropriate and safe manner.

To achieve this goal, MHAC aimed to:

1. Develop guidelines to ensure greater use of current evidence-based practices for mental health treatment
2. Develop acceptable criteria for those participants requesting acceptance in the Intervention Program due to mental health issues
Methodology
MHAC chose to review feedback from various stakeholders, including members from all 14 IECs, nurse support group facilitators, program participants, and Program staff. Additionally, MHAC reviewed a sample of cases that were identified as either mental health or those with co-occurring disorders (both mental illness and substance use disorder). Additionally, MHAC reviewed existing program policies, procedures, and recovery planning tools\(^1\) used by IECs to monitor clients with mental health needs and made modifications where appropriate.

Recommendation
MHAC’s recommendations primarily focus on the need to build strong resources (or “toolbox”) for reference by all IECs - each which have varying expertise and background in mental health – and use by program participants. Among other things, the toolbox covers resources for treatment, self-help community support groups, education, and recovery/wellness workbooks, which help to reinforce key components of successful mental health management and recovery. The Committee also worked to strengthen data collection tools with the aim of ensuring sufficient information is provided to IECs so that they can develop a successful treatment and recovery plan for each program participant.
MHAC’s specific recommendations for revisions to program policies, procedures and recovery planning tools are detailed in the *Addenda* section of this report.

\(^1\) Business and Professions Code §§ 2770-2770.14 and California Code of Regulations §§ 1446-1449, Guidelines for Pre-IEC Assessment: Mental Health (DIV-P-18), Impairment Due to Mental Health (DIV-P-09), Criteria for Selection of Treatment Providers (DIV-P-17), Guidelines for Monitoring Participant Compliance: Mental Health (DIV-P-25), Guidelines for Returning a Nurse to Practice (DIV-P-30), Guidelines for Work Site Monitor Reports: Mental Health (DIV-P-26), Transition Phase Minimum Monitoring Parameters (DIV-P-06), Criteria for Successful Completion: Mental Health (DIV-P-13), Criteria for Successful Completion (DIV-P-08), Other than Successful Completion: Mental Health (DIV-P-07), Intake Assessment Form, Clinical Assessment Form, Treatment Provider Report, Interim Participant Review, Assessment and Rehabilitation Plan, Nurse Support Group Facilitator Monthly Report Form
MHAC emphasizes the importance of obtaining enough history on nurses who request admission into the Intervention Program. IECs should be provided with as much clinical documentation available to validate the true mental health issues and impairment. If all information necessary to make an informed decision is not available prior to the IEC meeting, then the RN may be held in “applicant” status until all necessary information is provided. MHAC suggested there be a generous scope of acceptance in general. However, RNs who are acutely suicidal, dangerous, unable to take care of themselves or in active psychosis may not be appropriate for program acceptance.

NOTE: The Committee removed all assessment references to “five axis” as the most common diagnostic system for psychiatric disorders is in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), currently in its fifth edition, which did away with the multiaxial diagnosis system.

Referral Screening
Any referral to the Intervention Program - whether a self-referral or board-referral - must be screened to ensure the applicant meets initial admission criteria. MHAC recommends that if the applicant is a board-referral, the Board should provide information regarding the nature of the complaint along with any other pertinent information from the applicant’s Board history.

Program Entry Screening
Upon enrollment in the Intervention Program, the contractor will obtain the following information:

Intake Assessment. Upon verification that the registered nurse meets initial admission criteria, the Clinical Case Manager (CCM) shall interview the nurse through a telephonic intake assessment to determine immediate treatment needs. MHAC recommends several additions to the Intake Assessment interview questions (detailed in Addenda section of this report) in an effort to obtain more thorough information.

Prior treatment records. As part of the program entry agreement, the RN must agree to cooperate by providing required medical information and disclosure authorizations. At intake, the Contractor should request and then obtain information, authorizations and releases as may be necessary for the RN to participate in the Intervention Program. While current policy requires that the Contractor obtain reports from all mental health providers for the past 5 years, MHAC recognizes there are current difficulties in obtaining reports for this timeframe. While there should be an attempt to get as much treatment history as possible, MHAC recommends the policy be changed to require the contractor attempt to obtain records for “at least the past two (2) years.” MHAC recommends the contractor obtain the treatment provider’s discharge document.

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2 CA Code of Regulations § 1447. Criteria for Admission
3 CA Code of Regulations § 1447.1. Procedure for Review of Applicants
4 Board Intervention Program Policies: Guidelines for pre-IEC assessment (DIV-P-18)
which should provide sufficient information, likely cost less for the RN to request from the provider, and would be easier to obtain.

**Self-Assessment.** The self-assessment is important for information about the RN’s history and program goals. The participant must submit a detailed self-report (autobiography) regarding the history of their mental health concerns and issues to include challenges, relationships, substances if it applies, medication regime and goals for their participation in the program. MHAC recommends several modifications to the Self-Assessment interview questions (detailed in *Addenda* section of this report).

**Clinical Assessment.** Nurses are referred for an in-person clinical assessment with a mental health professional (i.e. marriage and family therapist, licensed clinical social worker, psychologist, psychiatrist, or psychiatric/mental health nurse). MHAC recommends several revisions to the Clinical Assessment interview questions (detailed in *Addenda* section of this report).

**Psychiatric Evaluation.** As part of the Program entry agreement, all RNs must agree to undergo any reasonable medical and/or psychiatric examination necessary for evaluation for participation in the program. For applicants who are referred primarily for mental illness or are suspected to have a co-occurring disorder (both mental health and substance use disorder), current Board policy requires them to be under the care of a psychiatrist. However, MHAC acknowledges some challenges in meeting this current requirement. One such challenge is the limited availability of psychiatrists who can examine the RN prior to the RN’s first IEC meeting (which in some cases may take place 30 days after program application). Additionally, applicants may have entered the Program while under the care of a primary care provider (e.g. psych nurse practitioner or MD with general licensure as physician) for medication management although they may have seen a psychiatrist previously. Instead MHAC recommends this requirement be individualized based on a clinical assessment of the RN’s needs. **NOTE:** The CCM shall recommend such medical/psychiatric examinations as may be necessary to determine the applicant’s eligibility for the program.

**Poly Substance Drug Screen.** Studies show that mental illness may place an individual at risk of misusing drugs or alcohol as a form of self-medication. Additionally, individuals who initially present with mental illness may have a co-occurring substance use disorder. The Program must take an approach that allows for proper identification and evaluation of the need to treat both conditions. For this reason, the contractor should obtain a poly substance drug screen(s) as part of the pre-IEC admission process.

In cases where there is no current substance use disorder diagnosis, the RN may be monitored with at a lower random drug testing frequency of 24 times per year (minimum). However, for

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5 BRN Intervention Program Policies: *Impairment due to Mental Illness (DIV-P-09)*

6 For example, geographical areas such as Inland Empire, Northern and Sierra, Orange County, and San Joaquin Valley all see per population rates of psychiatrists and psychologists at lower than the state average—a number of them will reach retirement age within the next decade. California Health Care Foundation. (2018). *Mental Health in California: For too many, care not there*

7 CA Code of Regulations § 1447.1. Procedure for Review of Applicants

those participants who are identified as having co-occurring disorders, the RN will be required to randomly drug test at the minimum allowed.  

**Determining Eligibility for Program**

To determine whether an applicant is eligible for the Intervention Program, the IEC must first review and consider all pre-IEC information, including the nature of the BRN complaint, self-assessment, intake assessment, clinical assessment; psychiatric examination, prior/current treatment records (if applicable); nurse support group facilitator’s report, and CCM’s recommendation/pre-IEC compliance report. IECs typically assess an applicant in person before deciding whether the individual is eligible for the Intervention Program. If the IEC finds that additional information regarding the applicant’s medical and mental health treatment records is necessary to determine his or her eligibility for the Program, the IEC may hold the RN in “applicant” status pending receipt of the additional required information. 

In general, the IEC must determine whether the applicant:

1) will **substantially benefit** from participation in the program, or
2) whose participation in the program **creates too great a risk** to the public.

If either of these conditions apply, then the IEC may deny the applicant admission into the Intervention Program.  

Various mental health diagnoses have been seen by the IECs over the years, including severe depression, severe anxiety, bi-polar disorder, post-traumatic stress disorder, other behavioral addictions (e.g. gambling, eating, sex/relationship), etc. Serious mental illnesses are widely accepted by the medical field as illnesses that have symptoms and well-established treatment. However, in looking at the applicant’s history, IEC may need to be determined whether certain factors are indicators of the nurse’s ability to **substantially benefit** from the program or creates too great a risk to the public:

- Suicidality
- Homicidality
- Violence history (domestic, child abuse, patient abuse, etc)
- Highly acute mental issues (i.e.as meeting Welfare & Institutions 5150 definition)  
- Other medical complications
- Risk of withdrawal
- Other behavioral addictions (e.g. sexual harassment, misconduct)  

In cases where RN’s are in mental health crisis, they will be advised them to seek treatment voluntarily or call law enforcement to take the nurse to a mental health facility if refusing. The nurse will be evaluated when no longer acutely symptomatic. This does not apply to nurses who are chronically self-destructive but not acutely suicidal, or chronically delusional/hallucinating who do not fit 5150 standards.

**Developing a Treatment & Recovery Plan**

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10 **CA Code of Regulations. § 1447.2. Causes for denial of admission**

11 Danger to self; danger to others; gravely disabled (unable to take care of own food, clothing, housing needs)
IECs may employ mental health guidelines for participants with a primary diagnosis of mental illness or applicants with co-occurring disorders (substance use disorder and serious mental illness).

While IECs should aim to identify appropriate treatment needs early, some nurses may not be understood to have a co-occurring disorder (or “dual diagnosis”) until well into the intervention program.

- If co-occurring disorders are revealed for nurses in substance only program, then appropriate mental health conditions will be added (e.g. being taken off work if appropriate, referral for mental health treatment, psychiatric examination, therapist reports, AA/NA participation, etc.).
- If co-occurring disorders are revealed for nurses in a mental health only program, then appropriate conditions will be added/increased (e.g. being taken off work if appropriate, referral for SUD treatment, more frequent testing, AA/NA participation, etc).

**Treatment**

All applicants to the Intervention Program with a primary diagnosis of mental illness or applicants with co-occurring disorders (substance use disorder and serious mental illness) may be required to be under the care of a psychiatrist. The treatment program should provide information as follows:

A) Course of treatment with diagnosis, any barriers to treatment, medication regime and compliance, changes in symptoms, ability to recognize escalation, history of any suicidal ideations/attempt or violent behaviors.

B) Participant’s willingness to participate in treatment, current ability to exercise judgment, engage in logical thought process, work effectively with others, the support system, family involvement, and any other factors which would indicate the participant’s ability to practice safely.

**Medication Management**

An initial medication management plan needs to be submitted from the applicant’s psychiatrist. Additionally, the IECs may need to be provided quarterly reports of medication adherence, adjustments, and any adverse effects.

While most prescribed psychotropics have an indication, the IEC may consider whether certain psychotropics may be not in line with the program, particularly benzodiazepines, high dose amphetamines or heavily sedating anti-psychotics.

**Self-Help/Community Support Groups**

While most Intervention Program participants are required to attend 12-step groups such as AA or NA and in some cases CODA, MHAC recommends IECs guide participants to the availability of other support groups specific to mental health and wellness. Such groups include CODA, EA, NAMI, WRAP, DV, Al-Anon, ACOA, depression, bipolar, etc.

AA meetings should not be ignored as they are an important resource for self-reflection, socialization and acceptance. Additionally, IECs may address and encourage the involvement of family or significant others be involved as main support systems.

MHAC provides further self-help/community support group information in the *Addenda* portion of this report.
**Nurse Support Groups**

The role of a nurse support group is to help its members openly share their experiences and provide strength, hope and support to each other in addressing issues related to the recovery process - with focus on challenges specific to the nursing profession. Nurse support groups benefit RNs who are struggling with shame and isolation that comes with addiction or mental illness through the support of other RNs who have similar feelings and circumstances.

MHAC recommends it be mandatory for all Program applicants to participate in nursing support group as part of the Pre-IEC process. Especially for early recovery, nurse support group is an important component.

MHAC accepts that IECs may decide a nurse should no longer need to attend nurse support group - for some cases. However, MHAC recommends, that IECs keep in mind that a nurse’s ability to recognize an escalation in behavior symptoms is one marker of successful mental health management. As such, IECs may wish to maintain feedback from nurse support group facilitators so they could provide another perspective as to the nurse’s ability to recognize and appropriately respond to their symptoms.

The facilitator may determine the nurse is not appropriate to participate in nurse support group due to:
1) The nurse’s inability to follow group discussion (cognitive or attention deficits)
2) The nurse’s inability to tolerate group discussion (triggers, anxiety or agitation)
3) The nurse’s disruptive behavior in the group
IEC’s determination should be based on careful review of feedback from the nurse support group facilitator, the CCM, and the nurse themselves, as well as their own assessment on how the RN is benefiting from participation in Nurse Support Group.

**Drug Testing (Random)**

In accordance with drug testing requirements, RNs with no current substance use disorder diagnosis may be monitored with at a minimum random drug testing frequency of 24 times per year. However, MHAC recommends that, for some cases, mental health participants may be appropriate for drug testing at a lower minimum frequency of 12 times per year. The lower minimum frequency of 12 times per year is permitted for cases where the participant is not working. In cases where there is a co-occurring substance use disorder, the RN shall be randomly drug tested at no less than the minimum frequency allowed by drug testing requirements.\(^\text{12}\)

Additionally, while IECs cannot require drug testing of mental health participants specifically for the purpose of determining appropriate therapeutic levels of medications (as this should be the responsibility of the treating psychiatrist or physician), IECs may require drug testing for the specific purpose of determining the presence of any medication that has been reported by the treating psychiatrist or physician as part of the participant’s treatment plan.

**Wellness and Recovery Literature/Workbooks**

MHAC recommends participants begin recovery and wellness workbooks early in the program. This will allow them to accept and understand their illness. Additionally, it will provide a

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\(^{12}\) Department of Consumer Affairs (2011). *Uniform Standards Regarding Substance-Abusing Healing Arts Licensees.*
foundation for development of their written plan to move into the Transition phase of their recovery plan.

In particular, MHAC, recommends the Wellness Recovery Action Plan (WRAP), a manualized group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness.\(^{13}\)

However, there are many workbooks specific for the entire variety of disorders such as childhood abuse, OCD, PTSD, depression, eating disorders, dysfunctional relationships, etc. There are many general pathways to wellness workbooks, which would benefit all mental health participants, including those with Schizophrenia.

IECs should consider available resources for participants with either mental health only or co-occurring disorders.

**Clinical Reassessments/Psychiatric Re-evaluations**

MHAC recommends the Board approve specific guidelines for IECs to follow in considering face-to-face clinical reassessments of participants. This tool should be employed by the IECs in the event there are concerns about a participant’s mental health recovery (see proposed “Guidelines for Considering a Participant for Clinical Reassessment” in the Addenda portion of this report). Additionally, IECs may – at any time - require a psychiatric or medical evaluation during the licensee’s participation in the Intervention Program.\(^{14}\)

**Returning A Nurse to Practice**

Re-entry into practice is the ultimate goal. RNs are given return to work privileges based on an Intervention Committee's (IEC's) view of their mental health and/or substance abuse problem, progress in recovery and, most importantly, safety to practice. When recommending that a nurse be allowed to return to work, IEC members should take into consideration the progress the nurse made since the date of the initial Intake (telephone assessment.)

At minimum, the following must be completed prior to returning an RN to any capacity of nursing practice:

1. Intake assessment
2. Clinical assessment
3. Treatment provider letter confirming completion or enrollment (program must meet Treatment Provider Criteria (DIV-P-17))
4. Other state board treatment contract/report (if RN is transferring from another state’s diversion program)
5. Documented input from supervisor (if job is being held).
6. RN must be compliant with the program entry agreement

For current IEC considerations below, MHAC offers some clarification:

7. Results from drug testing.


\(^{14}\) BRN Intervention Program Policies. Guidelines for Monitoring Participant Compliance: Mental Health (DIV-P-09)
This includes results of bioassays testing for medication levels from mental health providers.

8. Attendance at Nurse Support Group meetings.
   Mental health participants will be required to attend meetings appropriate to their diagnosis which address the mental health challenges and recovery guidance. Typical Nurse Support Groups that address addictive issues would not be able to adequately address only mental health issues. Participants with Co-Occurring diagnosis may be referred to a Nurse Support Group whose facilitators are educated to and sensitive to mental health diagnosis, observations and issues.

9. Self-help/community support group meeting attendance.
   Self-help/community support group meetings may not include alcohol or drug 12 step meetings if the mental health participant is not alcohol or drug addicted. The participant may be referred to other 12 step programs that address pertinent issues i.e. Adult Children of Alcoholics, CODA, Emotions anonymous etc. that may enhance the participants recovery process.

10. Input from primary care physician with knowledge of addiction
    If the mental health patient has co-occurring issues. Input from the participant's treating psychiatrist will be necessary for the mental health participant in order to provide more accurate assessments of the participants recovery process and information regarding any safety issues.

11. Results of a physical and/or psychological examination.
    MHAC also recommends that IECs consider the following information:

12. Participant must demonstrate awareness and willingness to appropriately leave the work environment when symptoms of relapse occur and until approved to return after a psychiatric assessment and documented return to work by appropriate mental health care provider.

13. Participant must demonstrate recognition of symptoms of relapse and knowledge of action necessary to intervene on symptoms progression.

**Transition Phase**

The objective of the Transition Phase is to allow participants, while within the safeguards of the Intervention Program, to demonstrate that they are able to take full responsibility for their own recovery process. MHAC provides additional guidelines for IECs to consider when determining whether a participant with mental health or co-occurring disorders can enter into the Transition Phase of the Program:

- 24 months of consistent stabilization
- 24 months of random drug testing consistent with recovery plan requirements
- Complete a wellness workbook (for participants with co-occurring disorders, this would be in addition to a relapse workbook)
- Write a symptom management/relapse plan
- Demonstrates functional stability in successful management of symptoms
- 100% program compliance
- Support letters, including those from mental health providers

**Termination of Program Participation**
**Other than Successful Completion**

If, after acceptance into the Intervention Program, the IEC determines the RN is unable to derive substantial benefit from the program due to the chronic and serious nature of the RN’s mental illness, the IEC may terminate the nurse’s participation in the program. In this event, the IEC should refer the nurse for Vocational Rehabilitation for career retraining.  

MHAC does not recommend any substantive changes to this guideline. However, as IECs have varying knowledge and experiences, MHAC provided some specific resources for vocational rehabilitation (detailed in *Addenda* section of this report).

**Successful Completion**

MHAC does not recommend any substantive changes to Successful Completion criteria. IECs must continue to determine if a mental health client is ready to successfully complete the Program:

1) Participant must have completed a minimum of two years of total compliance with all parameters of participation including:
   a) Maintaining the therapeutic regimen prescribed by the psychiatrist,
   b) Taking medications as prescribed,
   c) Submission by mental health provider(s) of letters supporting successful completion, and
   d) Having negative random body fluid reports consistent with the rehabilitation plan requirements.

2) Participant must have demonstrated stability in daily living characterized by:
   a) The ability to recognize his/her own cycle of accelerated symptoms,
   b) The ability to express, with a reasonable degree of clarity, a self-knowledge about mental health and his/her personal life style,
   c) If psychiatric symptoms were identified, sought prompt, appropriate treatment.

**Additional Recommendations**

**Mental Health Training for Nurse Support Group Facilitators**

The committee agreed that BRN should require that all group facilitators demonstrate competency in mental health. MHAC recommends that nurse support group facilitators be required to take, at minimum, two (2) mental health related courses with one course being Mental Health First Aid. This course is basic but may be necessary for some facilitators. It is a nationally-recognized certification, is provided in a classroom setting, and is consistent. Other additional courses that can be taken through Wellness Recovery Action Plan (WRAP), National Alliance on Mental Illness (NAMI) and Psychiatric Nurses Association (APNA). Further information is detailed in the *Addenda* section of this report (under “Resources List”).

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15 *CA Code of Regulations. § 1448. Causes for denial of termination from the Program*

16 *BRN Intervention Program Policies. Other than Successful Completion: Mental Health (DIV-P-07)*

17 *BRN Intervention Program Policies. Criteria for Successful Completion: Mental Health (DIV-P-13)*
INTERVENTION PROGRAM
GUIDELINES FOR PRE-IEC ASSESSMENT:
MENTAL HEALTH

The Contractor for the Intervention Program for Nurses will obtain the following data on participants referred to the Program for mental illness or dual diagnosis.

- Telephone intake information
- Self assessment packet
- Report from an individual assessment performed by a Psychiatric/Mental Health Nurse, LCSW, or Psychologist, or Psychiatrist experienced in mental health
- Reports of urine screen for poly drugs
- Reports from ALL mental health provider(s) for the past five years
- The request(s) should specifically ask for:
  - Five axis Comprehensive assessment and diagnosis,
  - Prognosis including rehabilitation potential,
  - Treatment plan and medication regimen,
  - Assessment of the effort or energy the participant committed to therapy, and
  - Recommendations about employment.

DIV-P-18
Approved 2/91, Revised 2/21/2017
INTERVENTION PROGRAM
IMPAIRMENT DUE TO MENTAL ILLNESS

The Intervention Program is available to any Registered Nurse whose practice may be impaired by drugs, alcohol or mental illness and who meets the admission criteria (CCR, Section 1447).

ASSESSMENT

If mental illness is (a) the primary reason for referral to the Intervention Program, or (b) suspected as a primary diagnosis in addition to chemical dependency/substance use disorder (co-occurring disorders/dual diagnosis), the Intervention Program contractor will refer the initial assessment to a licensed mental health practitioner.

All applicants to the Intervention Program with a primary diagnosis of mental illness will be required to be under the care of a psychiatrist. The physician shall submit a report to the Committee which contains (a) the comprehensive assessment and diagnosis (DSM-5), (b) prognosis, (c) course of treatment, and (d) an evaluation of the applicant’s current ability to (1) exercise judgement, (2) engage in logical thought processes, (3) work effectively with other people, and (4) any other factors which would indicate the applicant’s ability to provide safe nursing care.

The Intervention Program contractor will implement all pre IEC restrictions and approve monitoring parameters approved for all Program participants.

COMMITTEE REVIEW

The mental health assessment, psychiatric evaluation, history and record of pre IEC compliance will be considered by the committee in making a decision to accept or not accept a mentally ill applicant based on the criteria for admission (CCR 1447), causes for denial of admission (CCR 1447.2) and guidelines for the admission and denial of the mentally ill applicant.

REHABILITATION PLAN

The Applicant Review, Assessment and Rehabilitation Plan: Mental Health worksheet may be used by the Intervention Evaluation Committee to develop an appropriate and comprehensive rehabilitation and monitoring program for each mentally ill participant.

COST OF ASSESSMENT AND MEDICAL/PSYCHIATRIC EXAMINATIONS

The initial assessment by the licensed mental health practitioner (psychiatric/mental health nurse or licensed psychotherapist) is borne by the contractor as part of the contract.

Any other medical or psychiatric examinations conducted by a licensed physician, the cost of random body fluid tests and support group fees will be paid for by the participant.
INTERRUPTION PROGRAM
CRITERIA FOR SELECTION OF TREATMENT PROVIDERS

In making inpatient or outpatient treatment referrals for Intervention participants, the Intervention Program Contractor/Intervention Evaluation Committee shall consider:

A. Treatment program components and philosophy which:
   • Use a 12-step recovery model with 12-step group participation as a treatment expectation.
   • Advocate total abstinence from mood/mind altering drugs.
   • Offer educational components which address, at a minimum: disease concepts, relapse prevention, recovery process and recovery oriented life style changes.
   • Use a variety of therapeutic modalities to meet the treatment needs of clients, which may include: group therapy, individual counseling, lectures, and family/couples therapy.
   • Use treatment plans which reflect client specific aftercare recommendations.

B. Treatment facility staff and services which have:
   • Licensure and/or accreditation by appropriate regulatory agencies.
   • Sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification, and manage any medical emergency.
   • Professional staff who are competent and experienced members of the clinical staff of the facility.
   • Treatment planning involving a multidisciplinary approach and specific aftercare plans.
   • Means to provide treatment/progress documentation to the Program Contractor.
INTERVENTION PROGRAM
GUIDELINES FOR MONITORING PARTICIPANT
COMPLIANCE: MENTAL HEALTH

The Intervention Evaluation Committee will monitor the participant’s compliance with the Intervention Program requirements and with on-going management of the mental illness.

Compliance monitoring may include, but is not limited to:

a) periodic psychiatric evaluation with reports to the IEC. The report(s) will include:
   1) the comprehensive assessment and diagnosis (DSM, all axis)
   2) drug therapy (therapeutic level and compliance with treatment regimen)
   3) evaluation of safety to practice

b) licensed mental health practitioner therapy reports

c) random body fluid screens (including poly drug)

d) self-report

e) work site monitor report (when working in nursing) or employer work evaluation (if not working in nursing)

f) attendance and participation in support groups (e.g. NAMI, emotions anonymous, codependents anonymous, etc.) as required by IEC

The committee may require psychiatric or medical evaluation at any time during the licensee’s participation in the Intervention Program for Nurses.
INTERVENTION PROGRAM GUIDELINES FOR RETURNING A NURSE TO PRACTICE

Re-entry into practice is the ultimate goal of successful intervention and treatment of chemically dependent nurses as well as nurses with mental health illnesses. RNs are given return to work privileges based on an Intervention Evaluation Committee’s (IEC’s) view of their mental health and/or substance abuse problem, progress in recovery and most importantly, safety to practice.

When determining if a nurse may be allowed to return to work, IEC members should take into consideration the progress the nurse has made since the date of the initial Intake (telephone assessment). Return to work may be approved by an IEC chairperson prior to an RN’s first IEC meeting in some cases.

The criteria below are intended to assist Intervention Evaluation Committees in facilitating a return to work as soon as it is safe for both the RN and the public.

The following are the minimum criteria required in order to approve an RN’s request to return to work:

- Intake (telephone assessment with contractor staff) must be completed.
- A face-to-face assessment must be completed.
- A letter from the treatment provider (i.e. inpatient, intensive outpatient, psychiatrist) must be in file (unless treatment is not required). For inpatient or outpatient, this letter must include treatment program elements and patient response. (Treatment program elements should include those elements identified in Intervention Policy “Intervention Program Criteria for Selection of Treatment Providers” (Div-P-17)).
- If the RN is transferring from another state’s alternative program, documents relating to treatment and compliance with that state’s program must be in file, along with a written consent to communicate with the appropriate person from the other state’s program.
- Input from supervisor (for those nurses who have a job that is being held) must be in file.
- Applicant must be in compliance with entry agreement (when applicable).

Additional criteria that may be considered include:

- Results of drug testing
- Attendance at Nurse Support Group Meetings
- Input from Nurse Support Group Facilitator on RN’s progress
- 12-step meeting attendance
- Input from primary care physician with knowledge of addiction
- Results of a physical or psychological examination
• No relapses
• Case Manager Summary
• Input from therapist
• Compliance with Intervention Program Contract

RN’s must still submit job descriptions and obtain IEC approval prior to returning to any job that requires an RN license. In addition, any job that does not require an RN license but is in the health care field or environment must also be approved by an IEC. RN’s must also have a Work Site Monitor identified prior to return to work.
INTERVENTION PROGRAM
GUIDELINES FOR WORK SITE MONITOR REPORTS:
MENTAL HEALTH

Initially, the work site monitor will be required to submit monthly reports on an Intervention Program participant returning to work under a Mental Health Rehabilitation Plan. These reports will provide a baseline for behavioral assessment of the participant in the workplace.

After the first three months, work site monitor reports will be required each subsequent quarter. Work site monitor reports should address work-related behaviors including attendance, interpersonal relationships with patients, peers, supervisors and job performance competencies.
INTERVENTION PROGRAM
GUIDELINES FOR CONSIDERING A PARTICIPANT
FOR CLINICAL REASSESSMENT

Nine months to one year of continuous rehabilitation with reports and concerns from any or all treatment programs, the IFC should take proactive action considering the following:

1) Has the person been back in inpatient treatment during that period
2) Nurse support group facilitator reports that express concerns (e.g. evasive in groups, negative comments, withdrawn)
3) Work site monitors reports that express concerns with any unusual behaviors or improvement needed
4) Treatment provider observations
5) Collaborations with Clinical Case Manager, physician and/or therapist
6) Intervention Evaluation Committee members observations (e.g. mood, affect, memory, etc.)

DRAFT
INTERVENTION PROGRAM TRANSITION PHASE
MINIMUM MONITORING PARAMETERS

An Intervention Evaluation Committee (IEC) will place a participant on a minimum monitoring transition phase for a period of time before granting successful completion from the Intervention Program.

The objective of a Transition Phase is to allow the participant to take full responsibility for their own recovery process while still in the Intervention Program. An individual placed in a transition phase should have met all the criteria for successful completion of the Intervention Program and have submitted a "transition packet" acceptable to the Committee.

During the Transition Phase, all limitations on nursing practice and all requirements of the Intervention Program will be removed with the exception of the following:

Minimum monitoring to reasonably assure public safety:

- Random body fluid monitoring
- Work-site monitor reports
- Monthly self-reports
- Fees

Participants should have returned to nursing practice with no restrictions unless the Diversion Evaluation Committee believes that the participant has made a career change from hands on patient care.
INTERVENTION PROGRAM
CRITERIA FOR SUCCESSFUL COMPLETION:
MENTAL HEALTH

The following criteria may be followed by the Intervention Evaluation Committee in determining when a registered nurse in the Intervention Program as mental health client is ready to successfully complete the Program.

1) The participant must have completed a minimum of two years of total compliance with all parameters of participation including:
   a) Maintaining the therapeutic regimen prescribed by the psychiatrist,
   b) Taking medications as prescribed,
   c) Submission by mental health provider(s) of letters supporting successful completion, and
   d) Having negative random body fluid reports consistent with the rehabilitation plan requirements.

2) The participant must have demonstrated stability in daily living characterized by:
   a) The ability to recognize his/her own cycle of accelerated symptoms,
   b) The ability to express, with a reasonable degree of clarity, a self knowledge about mental health and his/her personal life style,
   c) No evidence of unrecognized psychiatric symptom, and
   d) If psychiatric symptoms were identified, sought prompt, appropriate treatment.
INTERVENTION PROGRAM
CRITERIA FOR SUCCESSFUL COMPLETION

The following criteria may be considered by an Intervention Evaluation Committee in determining when a registered nurse is ready to successfully complete the Intervention Program.

1. The participant must demonstrate a manner of living that supports ongoing recovery. A written plan that demonstrates that such a manner of living has been developed will be submitted by the participant. This plan will address the emotional, psychological, interpersonal, vocational, economic, spiritual and familial aspects of the participant's life and will demonstrate stability in these areas.

2. A participant must have proof of appropriate body fluid analyses for a minimum of 24 months after acceptance into the Intervention Program. Appropriate body fluid analyses are defined as test results negative for unauthorized drugs or alcohol for chemical dependency cases and maintained therapeutic levels of medication for mental illness cases.

3. There must be no other evidence of relapse for at least 24 months.

4. A participant must have completed a minimum of 24 continuous months of satisfactory participation in the Intervention Program.
INTERVENTION PROGRAM
OTHER THAN SUCCESSFUL COMPLETION:
MENTAL HEALTH

A participant may be terminated from the Intervention Program for Nurses as Other than Successful completion: Mental Health if, in the opinion of the Intervention Evaluation Committee, he/she is unable to derive benefit.

- Due to failure to comply with the requirements of the Program
  
  And / Or

- Because of the chronic and serious nature of the disease process.

When a participant is terminated as Other than Successful Completion: Mental Health, the Intervention Evaluation Committee should refer the nurse to Vocational Rehabilitation for career retraining.
Data Collection Forms

Self-Assessment Questions

1. What brings you to the Diversion Program at this time?
2. What kind of help would you like to receive from the Diversion Program?
3. What current problems do you have that might benefit from some type of assistance or treatment?
4. List what you see as your strengths (+) and weaknesses (-) that might help or hinder you in resolving problems or accomplishing goals.
5. Briefly describe your cultural, ethnic and religious background that might impact your recovery efforts.
6. Briefly describe any negative effects your substance use, trauma, or mental health disorders may have had on various aspects of your life.
7. Briefly describe any positive effects your substance use, trauma, or mental health disorders may have had on various aspects of your life.
8. List any family members (including extended family) with a history of alcohol or drug abuse problems or a history of emotional problems and suicide.
9. Briefly describe any life events (e.g. important loses, trauma, major life changes), recent or in the more distant past, that are currently having an impact on you.
10. How might family or friends support your recovery or make it more difficult? Also, briefly note those that may be most helpful (+) and harmful (-) to your recovery and how or why that might be the case.
11. What is most important for you to deal with now?
12. How has your substance use and/or substance abuse, trauma, or mental health issues impacted your career/profession?
   12a. What were there things about your childhood that influenced who you are today?
   12b. What were there things about your adult life that influenced who you are today?
   12c. How do you understand the struggles you have had in your life?
   12d. What gives you comfort and strength in your life?
   12e. What interventions or treatments have been most helpful in the past with your problems? Have you been involved in support groups or 12 Step programs? What are your thoughts about why they were helpful. What are your thoughts about why they might not have been as helpful as you hoped? Have you had any negative experiences with treatment or support groups?
   12f. Please list all treatment programs, therapy and inpatient treatments where you have had treatment, including names, dates, locations and addresses. Please describe the reasons you sought treatment with each provider.
   12g. Are you currently having symptoms or mental illness related problems, such as suicidal thinking, depression, anxiety, hallucinations or confusion? Are you currently taking any medications? Are you currently using any drugs, even if you have a prescription or recommendation?
   12h. Are you in denial of any of your difficulties currently or in the past?
   12i. Though some areas may have been covered in earlier questions, please write as detailed an autobiography as you are able. Please include information about your parents, your siblings, your education, your health, your mental health problems, your important relationships, your jobs, your substance use, your hobbies, your spiritual beliefs and your current life.
13. What additional information would you like us to know about you or your situation that you consider to be important or that has not been asked?

Intake Assessment Questions

1. Have you previously participated in another licensing board’s diversion program?
2. Have you previously participated in the CA Diversion/Intervention Program?
3. How many years of school did you complete?
4. What is your profession?
5. Do you hold a valid professional California license?
6. How were you referred to treatment? (Select only one, the major referral source)
7. What is your current employment situation?
8. How many people depend on you for financial support? (Do not count yourself)
9. Do you have enough income to pay for necessities such as food, shelter and medical expenses for your dependents?
10. Do you have health insurance for yourself?
11. Do you have a current and valid driver's license?
12. Do you own a car or have one that you can use when you like?
13. Are other forms of transportation (for example, bus, rides from family or friends) convenient and affordable so that you can get where you need to go (e.g., appointments, treatment and work)?
14. Do you need childcare or elder care assistance to be able to participate in treatment?
15. In the past 30 days, how many days did you work for pay? (Include regular and "under the table" or "off the books" work.)
16. In the past 30 days, on how many days did you receive paid time off from work? (For example, sick time, vacation time.)
17. In the past 30 days, how much money was your take home (after taxes) pay from work? (Include regular and under the table or off the books work.)
18. In the past 30 days, how many days did you have problems that affected your work? (For example, missing days, not completing tasks or difficulties with co-workers.)
19. In the past 30 days, how troubled or bothered have you been by difficulties by problems at work or problems in looking for work?
20. Are you currently pregnant?
21. How many times (if ever) in your life have you been hospitalized for physical or medical problems? (Do NOT include alcohol/drug medical complications)
22. When was the last time you were hospitalized overnight for physical or medical problems? (Do NOT include alcohol/drug treatment, psychiatric hospitalizations, or childbirth without medical complications.)
23. In the past 30 days, how many days have you stayed overnight in a hospital for physical or medical problems? (Do NOT include alcohol/drug treatment, psychiatric hospitalizations, or childbirth without medical complications.)
24. Do you have a long-standing physical problem that limits or interferes with your daily activities?
25. Do you have a long-standing problem for which you take (or should be taking) medication?
26. “Do you have or has a doctor told you that you suffer from a psychiatric disorder, such as depression, anxiety, PTSD, eating disorder or Schizophrenia?”
27. “Have you ever thought that suffered from a mental illness, substance abuse problem or victimization by others?”
28. ___ Do you have or has a doctor told you that you have a serious alcohol or drug-related medical problem (for example, cirrhosis or abscesses) that will worsen if you continue to use drugs or alcohol?
29. ___ In the past 30 days, how many days did you have any physical or medical problems (for example, illness, pain, discomfort, and disability) that were not due to alcohol or drug symptoms or withdrawal?
30. ___ In the past 30 days, how troubled or bothered have you been by these medical problems?
31. ___ How important to you now is treatment for these medical problems?
32. ___ Will any current medical problems prevent you from being able to participate in outpatient treatment?
33. ___ Are you currently receiving help for any medical problems from a professional?
34. ___ Do you have a primary health care provider?
35. ___ How old were you when you first drank and felt the effects of alcohol?
36. ___ How many years in your life did you drink alcohol (beer, wine, liquor) on a regular basis, at least 3 days a week?
37. ___ When was your last drink?
38. ___ In the past 30 days, how many days did you have at least 5 drinks a day on a regular basis, at least 3 days a week?
39. ___ In the past 30 days, how many days did you drink any alcohol? (For example, beer, wine, liquor.)
40. ___ When was your last drink?
41. ___ In the past 30 days, how many days did you have at least 5 drinks? (For example, beer, wine, liquor.)
42. ___ How old were you when you first experienced symptoms of depression?
43. ___ How old were you when you first experienced symptoms of hallucinations?
44. ___ How old were you when you first experienced symptoms of confusion?
45. ___ How old were you when you first experienced symptoms of mood swings?
46. ___ Were you ever told in school that you had a learning disorder, hyperactivity or ADHD?
47. ___ Have you ever been prescribed medication for sleep? When and what?
48. ___ How old were you when you first prescribed psychotropic medication for anxiety, depression or psychoses
49. Are you currently prescribed any psychotropic medications? What? If not now, when was the most recent time you were prescribed any psychotropic medications? When and what?

39. How old were you when you tried any illicit drugs or abused any prescription medication?

40. How many years in your life have you used any illicit drugs or abused any prescription medication at least 3 or more days a week?

41. If you have used Cannabis (Marijuana) in the past 30-day, how many days did you use this drug?

42. If you have used Barbiturates in the past 30-day, how many days did you use this drug?

43. If you have used Sedatives/ Tranquilizers in the past 30-day, how many days did you use this drug?

44. If you have used Hallucinogens in the past 30-day, how many days did you use this drug?

45. If you have used Stimulants in the past 30-day, how many days did you use this drug?

46. If you have used Heroin in the past 30-day, how many days did you use this drug?

47. If you have used Cocaine/Crack in the past 30-day, how many days did you use this drug?

48. If you have used Methadone in the past 30-day, how many days did you use this drug?

49. If you have used Other Opiates in the past 30-day, how many days did you use this drug?

50. If you have used Inhalants in the past 30-day, how many days did you use this drug?

51. During the past 30 days, how many days did you use more than one type of drug or use alcohol and drugs on the same day?

52. Overall, during the past 30 days, on how many days did you use any illegal drugs or abuse any prescribed medication?

53. How many days ago did you use any drugs?

54. What is your primary substance of abuse (i.e. substance of choice)?

55. Substances used during the last 12 months prior to intake?

56. Have you ever injected any drug?

57. Have you ever overdosed on drugs to the point where you needed help?

58. How many times have you overdosed on drugs to the point where you needed help?

59. Have you ever had serious withdrawal sickness or seizures after you cut down or stopped using alcohol or any of the drugs you are currently using?

60. Are you currently having any withdrawal sickness?

61. How many times (if ever) in your life have you entered treatment for alcohol or drug problems?

62. In the past 30 days, how many days did you attend any outpatient program or clinic for alcohol or drug treatments?

63. During the past 30 days, how many days were you in an inpatient or overnight residential treatment program for alcohol or drug problems?

64. Have you ever attended self-help groups (e.g., AA/NA/CA) for alcohol or drugs?

65. In the past 30 days, how many days did you attend self-help groups (e.g., AA/NA/CA) for alcohol or drugs?

66. How long (in months) was the last clean/abstinent period you had from alcohol and other drugs? (Enter 0 if abstinent now and have been for one month or more)

67. How many months ago did you begin using again? (Enter 0 if abstinent now and have been for one month or more)

68. Can you identify specific situations or behaviors that lead to your using drugs and/or alcohol even when you were not trying to use?

69. To what extent do you feel coerced into treatments?

70. During the past 30 days, how much money did you spend for alcohol?

71. In the past 30 days, how many days did you have problems related to your alcohol use? (For example, craving or strong urges to drink, withdrawal or sickness, arguments, or poor work performance.)

72. In the past 30 days, how troubled or bothered have you been by these alcohol problems?

73. How important to you now is treatment for these alcohol problems?

74. During the past 30 days, how much money did you spend for drugs?

75. In the past 30 days, how many days did you have problems related to your drug use? (For example, craving or strong urges to use, withdrawal or sickness, arguments, poor work performance.)

76. In the past 30 days, how troubled or bothered have you been by these drugs problems?

77. How important to you now is treatment for these drug problems?

78. Are you currently on probation or parole?

79. Are you awaiting charges, trial or sentencing?
80. How many times have you been arrested or charged with driving under the influence (DUI)?
81. In your lifetime, have you ever been arrested?
82. In the past 30 days, how much money did you make from any illegal activities?
83. In the past 30 days, how many days did you do anything illegal for profit? (For example, shoplifting, stealing, selling drugs, or prostitution.)
84. How serious do you feel your present legal problems are?
85. How important to you now is counseling or assistance for your legal problems?
86. In the past 30 days, how many days, if any, have you spent in jail or prison?
87. What is your current marital status?
88. Are you satisfied with your current marital status?
89. During the past 30 days, were there periods of time when you had serious problems getting along with your husband, wife, or romantic partner?
90. What is your current living arrangement?
91. During the past 30 days, were there periods of time when you had serious problems getting along with any of your children or stepchildren?
92. During the past 30 days, were there periods of time when you had serious problems getting along with any friends, neighbors, associates or co-workers?
93. In the past 30 days, how many days did you have serious conflicts or arguments with any family member?
94. How troubled or bothered have you been by family problems during the past 30 days?
95. How important to you now is treatment or counseling for family problems?
96. How much do you associate with people whose alcohol or drug abuse use keeps them from meeting family, school, or work obligations?
97. During the past 30 days, were there periods of time when you had serious problems getting along with any parents, siblings, or any other family members (e.g. grandparents, aunts, uncles)?
98. During the past 30 days, were there periods of time when you had serious problems getting along with any friends, neighbors, associates or co-workers?
99. How troubled or bothered have you been by family problems during the past 30 days?
100. How important to you now is treatment or counseling for family problems?
101. How much do you associate with people whose alcohol or drug abuse use keeps them from meeting family, school, or work obligations?
102. How much will your family or friends help or encourage your substance abuse and mental health recovery effort?
103. How many times (if ever) in your life have you been hospitalized for emotional psychological problems?
104. During the past 30 days, how many days have you stayed in a hospital or an overnight residential treatment program for emotional or psychological problems?
105. How many different times in your life have you entered any type of outpatient treatment for emotional or psychological problems? (Do not count hospitalizations)
106. During the past 30 days, how many outpatient sessions have you had with a therapist or counselor for emotional or psychological problems?
107. Were you are ever prescribed medication for psychological or emotional problems?
108. Have you taken prescribed medication for psychological or emotional problems during the past 30 days?
109. Has there ever been a period of time when you had serious thoughts of killing yourself?
110. In the past 30 days, has there been a period of time when you had serious thoughts of killing yourself?
111. Have you ever attempted suicide or tried to kill yourself?
112. In the past 30 days, have you attempted suicide or tried to kill yourself?
113. Has there ever been a period of time when you had trouble controlling violent behavior?
114. In the past 30 days, has there been a period of time when you had trouble controlling violent behavior?
115. Has there ever been a period of time when you heard voices other people didnt hear or saw things that were not there?
116. In the past 30 days, has there been a period of time when you heard voices that other people didnt hear or saw things that were not there?
117. In the past 30 days, has there been a period of time when you experienced serious depression?
118. In the past 30 days, has there been a period of time when you experienced serious tension or anxiety?
119. In the past 30 days, has there been a period of time when you had serious trouble understanding, concentrating or remembering?
120. On how many of the past 30 days have you experienced any serious psychological or emotional problems?
In the past 30 days, how much have you been troubled or bothered by psychological or emotional problems?

How important to you now is treatment for these psychological problems?

Do you have mandated child abuse, elder or adult dependent abuse treatment?

Are you currently receiving help from a professional for any psychological or emotional problems?

Is there a family history of substance use disorders?

Is there a history of mental health problems in your family?

Have you ever experienced physical, emotional or sexual abuse?

Have you ever felt sexually harassed in the workplace or in school?

Have you ever harassed or stalked others?

Have you ever been violent towards another adult?

Has domestic violence ever been a problem in your life?

Clinical Assessment Questions

A. Presenting complaint/reason for requesting acceptance into Diversion Program

B. Substance Use History

1. Age at first use of alcohol
2. Age at first use of illicit drugs
3. Years of alcohol use more than 3 times per week
4. Years of alcohol use more than five (for men) or three (for women) drinks per day
5. Years of illicit drug use or abuse of prescription drugs
6. Applicant’s description of current/recent use of alcohol, illicit drugs or abuse of prescription drugs:
   - Applicant’s description of other current/recent compulsive behaviors – i.e. gambling, eating, sex/pornography, internet, work, exercise
7. Does Applicant acknowledge that he/she has a problem with drugs or alcohol or that his/her substance use has adversely affected his/her life?

C. Psychiatric/Mental Health History

8. Describe history of psychiatric symptoms, (if none, proceed to next section), What is the applicant’s understanding of their mental health problems? Do they believe that they have a mental health problem and need treatment? How does applicant describe themselves as a person? Strengths and obstacles in functioning?
   - At what age did the symptoms first appear? Sexual abuse?
   - Were symptoms treated? How? Please include history of all inpatient/outpatient mental health treatment, including history of psychotropic medications?
   - What are current symptoms?
   - Is Applicant currently receiving treatment? Describe?
   - Do symptoms cause Applicant to be a danger to self or others? Please describe?
   - Do symptoms interfere with Applicant’s daily functioning? Please describe?
   - Do symptoms interfere with Applicant’s ability to work? Please describe?
   - Does Applicant Acknowledge mental health problems

D. Professional Status

- Is Professional License active?
- Is Applicant licensed in states other than California? (Please list)
- Is Applicant licensed in any other healthcare profession? (Please list)
- Is Applicant employed?
- What is status of employment?

E. Medical Status and History

- Is the Applicant currently experiencing signs/symptoms of withdrawal?
- Does the Applicant have any current, acute medical concerns?
- Does the Applicant have any long-term medical concerns, including any conditions which contribute to chronic pain?

F. Legal Status

- Has the Applicant had a DUI?
- Has the Applicant had more than one DUI?
- Is the Applicant dealing with any other current legal issues related to drugs or alcohol?
27. Is the Applicant dealing with any current legal issues not related to drugs or alcohol?

G. Family and Social
28. Marital Status
29. Children (gender and ages)
30. Lives with
31. Significant family history of Substance Use Disorders:
32. Peer/social support:

H. Mental Status Exam
33. Level of Consciousness:
34. Orientation
35. Appearance:
36. Attitude:
37. Speech and Language:
38. Mood and Affect:
39. Thought Process:
40. Attention and Short-Term Memory:
41. Comments:

I. Summary of Clinical Assessment:
42. Does applicant demonstrate symptoms of a Substance Use Disorder or Mental Illness diagnosis?
43. Is applicant appropriate for Diversion Program?
44. Is applicant appropriate for Substance Use Disorder Treatment? If yes, at what level?
45. Is applicant safe to return to work?

Treatment Provider Questions
1. DSM 5 Comprehensive Diagnosis
2. Impressions: Please indicate any areas that are contributing to the participant's current condition.
3. Progress Summary
4. Treatment/Aftercare Plan (e.g. Modality, Frequency, Duration)
5. Relevant Psychosocial Issues (Current living situation, work history, family and community support)
6. Medications
7. Additional Comments
Interim Participant Review, Assessment, and Rehabilitation Plan

(Ref: DWI 01-06-01)

Participant Name: ___________________ Meeting Date: __________ Clinical Case Manager: ___________________

IEC/DEC/Board: __________ IEC/DEC Consultant: __________ Chairperson: __________

- ✔ Monthly Self Report: Submit a monthly self report, to be submitted by the 10th of the month
- ✔ Monthly check in: Call to check in with Clinical Case Manager at least once each month (800-522-9198)
- ✔ Random Drug Testing: Must check in with Lab provider daily between 5am and 8pm; provide sample for test if selected; must maintain an active account; must enter post test data on provider website within 24 hours.

- ✔ Medications: Report all prescribed medications to Clinical Case Manager, submit prescription
- ✔ 12-Step/Community Support Group (CSG) Meeting: AA/NA/AlAnon/CoDA/OTHER ________ X per week
- ✔ Sponsor: Identify and maintain same-gender sponsor with ≥ 5 years of sobriety
- ✔ Support Group: Attend Health/Nurse Support Group ______ times per week
- ✔ Naltrexone / Antabuse / Suboxone/ OTHER medication: ______ per Physician order

- ✔ Treatment (circle): INPATIENT IOP OUTPATIENT Complete AFTERCARE ______ Hours/week for 52 weeks
- ✔ Residential Program/ Recovery Home/SLE __________________________________
- ✔ Psychiatric / Counseling / Family Therapy: ____________________________________
- ✔ May NOT Work
- ✔ May work or return to work/practice: DEC/Board must approve Job description/Worksite/WSM

- ☐ If working, all of these restrictions apply: May not work in Registries or Home Health setting. May not float to other floors or assignments. No double shifts or double back shifts. No more than 2 different shifts in a 7 day period. No Charge/Supervisory position. May not work as only RN/PT/Licensee on duty. May not change work area without Board/IEC/DEC approval. May not work night shift.

- ☐ Exceptions to the above restrictions approved by committee: ____________________

- ☐ May NOT work more than _______ hours/week
- ☐ May work ______ additional shift(s), _______ overtime hours, per ______ week or ______ pay period

- ☐ NON-PATIENT CARE: NO NARCOTIC or CONTROLLED DRUG ACCESS
  - Not to dispense or administer any mind-altering medications
  - Not to carry keys, access code, or have narcotic/controlled drug access
  - Not to count controlled drugs
  - No direct patient contact

- ☐ PATIENT CARE: NO NARCOTIC or CONTROLLED DRUG ACCESS
  - Not to dispense or administer any mind-altering medications
  - Not to carry keys, access code, or have narcotic/controlled drug access
  - Not to count controlled drugs

- ☐ PATIENT CARE: CONTROLLED SUBSTANCES ACCESS GRANTED
  - Must have primary Work Site Monitor (WSM) ______ who provides ______ hours of supervision/week
  - Must have secondary Work Site Monitor (on site at the Work Site)
  - CEU’s required: Classroom CEUs related to SUDs required before program completion (BRN=15; PT=7; VMB=7)
  - Complete Relapse Prevention Workbook as assigned:
  - Transition Application Granted, may complete Transition Request and submit to MAXIMUS at least 30 days prior to next IEC/DEC/Review meeting.
  - Approved for Transition: no practice restrictions (however, worksite must be conducive to regular, direct contact with worksite monitor, WSM required, may not change worksite or position without IEC/DEC/Board approval), support group optional, 12-Step/CSG meetings optional.
  - Individual Reassessment:
    - ✔ Next IEC/DEC or committee reassessment: 3 months 6 months 9 months ______ months
  - ☐ Other: ________________________________

This agreement is considered a Recovery Terms and Conditions Agreement and will serve as such until a formal agreement is executed. MAXIMUS will provide the formal Recovery Terms and Conditions Agreement to the participant online in the Documents section of the MAXCMS system, which must be electronically signed and submitted within 10 days of posting. Participant will be notified via system notification when the Agreement is ready for review and signature.

IEC/DEC Member: ___________________ Participant: ___________________
**Resource Lists**

The information contained within is for general information purposes only and does not constitute an endorsement. Please note that website domain names are subject to change.

**TREATMENT PROVIDERS**

Links to additional resources from external professional groups are provided as a courtesy and are not reviewed by BRN.

- Substance Abuse and Mental Health Services Administration (SAMHSA): [https://findtreatment.samhsa.gov/](https://findtreatment.samhsa.gov/)
- Health Resources & Services Administration (HRSA): [https://bphc.hrsa.gov](https://bphc.hrsa.gov) (click on “Health Center Locator”)
- California Psychiatric Association (click on option below “Find a Psychiatrist”): [https://www.calpsych.org/](https://www.calpsych.org/)
- American Psychological Association: [https://locator.apa.org/](https://locator.apa.org/)
- WebMD Physician Finder: [https://doctor.webmd.com/](https://doctor.webmd.com/)

**SELF-HELP/COMMUNITY SUPPORT GROUPS**

<table>
<thead>
<tr>
<th>TYPE</th>
<th>WEBSITE</th>
<th>FORMAT</th>
<th>TYPE</th>
<th>OTHER INFORMATION</th>
</tr>
</thead>
</table>
| 1) Depression and Bipolar Support Alliance (DBSA) | www.dbsalliance.org | 🎨 In-person 🦄 Online | DBSA | • Find a Group  
• Wellness Toolbox  
• Find mental health professionals or facilities |
| 2) Anxiety and Depression Association of America (ADAA) | www.adaa.org/supportgroups# | 🎨 In-person 🦄 Chat 🦄 Online | Obsessive-compulsive  
• Panic Assistance  
• Anxiety and Phobia  
• DBSA | • Find a Group  
• Find a Therapist |
| 3) National Alliance for the Mentally Ill (NAMI) | www.nami.org | 🎨 In-person | Mental health | • Find a Group  
• Educational Program |
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<tr>
<th>TYPE</th>
<th>WEBSITE</th>
<th>FORMAT</th>
<th>TYPE</th>
<th>OTHER INFORMATION</th>
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<tbody>
<tr>
<td>4) Emotions Anonymous (EA)</td>
<td><a href="http://www.emotionsanonymous.org">www.emotionsanonymous.org</a></td>
<td>In-person, Skype/Phone, Chat</td>
<td>Emotional Well-being</td>
<td>Find a Group, Literature, Workbooks</td>
</tr>
<tr>
<td>5) Co-Dependents Anonymous (CoDA)</td>
<td><a href="http://locator.coda.org/">http://locator.coda.org/</a></td>
<td>In-person, Phone, Online</td>
<td>Developing healthy relationships</td>
<td>Find a Group, Literature</td>
</tr>
<tr>
<td>6) Wellness and Recovery Plan (WRAP)</td>
<td><a href="https://copelandcenter.com/find-facilitator/facilitator-directory">https://copelandcenter.com/find-facilitator/facilitator-directory</a></td>
<td>In-person</td>
<td>Mental health</td>
<td>Find a Group</td>
</tr>
<tr>
<td>7) Recovery International</td>
<td><a href="http://www.recoveryinternational.org/meetings">www.recoveryinternational.org/meetings</a></td>
<td>In-person, Phone, Chat, Online</td>
<td>Mental illness</td>
<td>Find a Group (limited to Sacramento, SF, LA, SD, Palm Desert areas)</td>
</tr>
<tr>
<td>8) Psychology Today</td>
<td>Dialectical (DBT) Support Groups in California</td>
<td>In-person</td>
<td>Dialectical (DBT) Support Groups</td>
<td></td>
</tr>
<tr>
<td>9) SHARE!</td>
<td><a href="http://shareselfhelp.org/">http://shareselfhelp.org/</a></td>
<td>In-person</td>
<td>Co-occurring disorders, Neurotics Anonymous, Anger Management, Childhood Trauma</td>
<td>Find a Group (limited to LA area), Access to Self-help Group Sourcebook Online</td>
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</table>

**WELLNESS WORKBOOKS/TOOLS**

<table>
<thead>
<tr>
<th>Book / Workbook</th>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>1) Wellness Recovery Action Plan (WRAP) Updated Edition (2018)</td>
<td>Book</td>
<td>Wellness Recovery Action Plan, often called the Red Book, summarizes the principles of this evidence-based practice and is the “go-to” book for people seeking a recovery resource or starting their own personal WRAP program. It lays the foundation for the program and explains the benefits of WRAP while</td>
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|                 |      | guiding you through developing your own WRAP. The updated Red Book will help you:  
|                 |      | - Discover your own simple, safe wellness tools  
|                 |      | - Develop a daily plan to help you stay as well as possible  
|                 |      | - Identify upsetting events or circumstances and develop action plans for responding to them  
|                 |      | - Create a strategy to gain support and stay in control of your wellness during and after a crisis |
| 2) WRAP Workbook | Workbook | The new WRAP Workbook has been fully revised and updated to match the new editions of your favorite WRAP books, including Wellness Recovery Action Plan (aka, The Red Book) and WRAP for Veterans, Active Service Members, and Military in Transition.  
|                 |      | From building your Wellness Toolbox through developing all six parts of your WRAP, the WRAP Workbook contains all the forms you need to build your personal Wellness Recovery Action Plan: forms for lists and action plans, forms for the crisis and post-crisis plans, and brief descriptions of each part of WRAP for your reference |

- For bibliotherapy, I often recommend “Couldn't Keep It to Myself” by Wally Lamb and the Women of York Correctional Institution. It is an amazing hopeful inspiring book particularly focused on moving past childhood abuse, but its general theme is face your demons and self-honesty.

**TRAINING**
<table>
<thead>
<tr>
<th>Training Course/Source</th>
<th>Format</th>
<th>Description</th>
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<tbody>
<tr>
<td>Mental Health First Aid</td>
<td>In-person</td>
<td>Mental Health First Aid is an 8-hour course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.</td>
</tr>
<tr>
<td>Mental Health and Illness</td>
<td>Online</td>
<td>Mental Health and Illness is a 2-3-hour course that teaches why mental well-being is so important and how to identify mental health problems. Mental Health Studies - Suicide, Violent Behavior and Substance Use is a 3-4-hour course that teaches why mental well-being is so important and how to identify mental health problems. Offers numerous courses regarding mental illness. Each course has several modules. Courses are free with registration. Fee for completion certificate.</td>
</tr>
<tr>
<td>Brain Health – Mood, Metabolism, and Cognition</td>
<td>Online</td>
<td>Brain Health – Mood, Metabolism, and Cognition – this is a streaming video (fee $81) that provides an overview of key factors that can improve mental health, as well as to ensure cognitive health. Also offers eBooks and home study.</td>
</tr>
<tr>
<td>The Ever-Changing Brain</td>
<td>Online</td>
<td>The Ever-Changing Brain is a 6-hour home study program for Health professionals that reveals how the human brain modifies itself in response to learning, stress, depression, injury, pain, addiction, and aging. Listening to the Body is a 6-hour home study program that describes the connection between thoughts, emotions, and symptoms. In addition, this program provides effective approaches for managing stress. Mental Health and Illness is a 2-3-hour home study course teaches why mental well-being is so important and how to identify mental health problems to help reduce the stigma of mental illness today. Courses are free and each course provides a completion certificate.</td>
</tr>
<tr>
<td>Seminar I: Developing a Wellness Recovery Action Plan (WRAP)</td>
<td>In-person</td>
<td>For anyone who wants to learn about the WRAP® and begin to incorporate it into their life to improve personal wellness and achieve an improved quality of life. This workshop is designed to be highly interactive and encourage participation and sharing from all present. This workshop also lays a broad foundation for building a peer workforce. Course meets in live online sessions and requires work in-between sessions. This class fulfills the prerequisites for being trained as a WRAP Facilitator.</td>
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<tr>
<td>Course</td>
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<tr>
<td>Stress, Resilience, &amp; Happiness</td>
<td>Online</td>
<td>This 6-hour course (fee $83) teaches you how perception, thinking, emotions, and memory combine to produce cognitive appraisals and behavior. Learn the positive-psychology approach to increasing life satisfaction, and determine the elements of happiness and optimism and how to apply them to increase well-being. Courses are offered in several formats (seminars, live webinar, DVD home-study with option for CEU credit.</td>
</tr>
<tr>
<td>Brain Health: Mood, Metabolism &amp; Cognition</td>
<td>Online</td>
<td>This 6-hour webinar ($83) provides an overview of key factors that are essential for a healthy brain, both cognitive function and mental health. Courses are offered in several formats (seminars, live webinar, DVD home-study with option for CEU credit.</td>
</tr>
<tr>
<td>Understanding Depression &amp; Bipolar Disorder</td>
<td>Online</td>
<td>This 6-hour webinar ($83) explains how changes in brain chemistry and structure occur in depression and bipolar disorder and how chronic stress becomes a pathway for the development of major depressive disorder. Courses are offered in several formats (seminars, live webinar, DVD home-study with option for CEU credit.</td>
</tr>
<tr>
<td>BALANCED – Mood Disorder Support Sacramento area</td>
<td>Group</td>
<td>A free support resource for anyone affected by depression or bipolar disorder, including friends and</td>
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family members. We work together as a team to grow in knowledge, share resources, provide acceptance and understanding.

Resources include Balanced Support Group news articles and Bipolar Information and local resource links.

## OTHER RESOURCES

<table>
<thead>
<tr>
<th>Resource</th>
<th>Services Provided</th>
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| **1. Substance Abuse And Mental Health Services Administration (SAMHSA)** [https://www.samhsa.gov/](https://www.samhsa.gov/) | • Behavioral Health Treatment Services locators  
• Peer Support (Mental Health)  
• Self-help guides and wellness planning (Recovering Your Mental Health, Speaking Out for Yourself, Recovery and Wellness Lifestyle, Dealing with the effects of Trauma, Building Self-Esteem, Action Planning for Prevention and Recovery, etc.)  
• Hotlines (Suicide prevention, Veteran’s Crisis hotline)  
• Research Data/Publications |
| **2. National Alliance on Mental Illness (NAMI)** [www.Nami.org](http://www.nami.org) | • Free peer-to-peer group program  
• Family Support Group  
• Classes and Programs |
| **NOTE: Recognized in SAMHSA’s National Registry of Evidence-based Programs and Practices** | • Wellness planning  
• Peer Support  
• Facilitator Resources  
• Literature/Articles  
• E-learning  
• Alternative Therapies |
• Education on different mental health topics  
• Mental Health Screening Tools |
• Publications  
• Advocacy |
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| 6. CA Department of Health Care Services: Mental Health Services Division [https://www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx](https://www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx) | • Obtaining Mental Health Services  
• County Provider Directory  
• Prevention and Early Intervention Programs  
• Veteran's Mental Health Resources  
• Mental Health Services Act |
| 7. Anxiety and Depression Association of America. [http://www.adaa.org](http://www.adaa.org) | • Resources for Public and Professionals  
• Directory of licensed therapists  
• Free ADAA Online Support Groups  
• Support Group Lists  
• Mental Health Apps  
• Literature/Articles/Fact Sheets |
| 8. WebMD [www.webmd.com](http://www.webmd.com) | • Group Therapy Recommendations |
| 10. Southern California Recovery Center | | |
| 11. Silicon Beach Outpatient Center for Co-occurring Disorders | | |
| 12. Costa Mesa Recovery Sober Living | | |
| 13. Elevation Behavioral Health in Agoura Hills and Malibu | | |
| 14. Anchor Recovery Community | | |

**VOCATIONAL REHABILITATION**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CA Department of Rehabilitation <a href="http://www.dor.ca.gov/Home/JobSeekerConsumer">http://www.dor.ca.gov/Home/JobSeekerConsumer</a></td>
<td>The Department of Rehabilitation (DOR) assists Californians with disabilities to obtain and retain employment and maximize their equality and ability to live independently in their communities. We do this by tailoring our services to each individual to ensure a greater chance of success. A vocational rehabilitation team works closely with each job seeker to establish the best combination of services and resources necessary to prepare for, find and retain employment. DOR services may include career assessment and counseling, job search and interview skills, independent living skills, career education and training and assistive technology.</td>
</tr>
<tr>
<td>Resource</td>
<td>Services Provided</td>
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<tr>
<td>If you have a disability or serious health condition that makes it hard for you to get or keep a job and you want to work, then DOR may be the choice for you.</td>
<td></td>
</tr>
</tbody>
</table>
| 2. **Vocational Rehabilitation and Employment (VR&E)**  
US Department of Veteran Affairs  
[https://www.benefits.va.gov/vocrehab/](https://www.benefits.va.gov/vocrehab/) | You may receive Vocational Rehabilitation and Employment (VR&E) services to help with job training, employment accommodations, resume development, and job seeking skills coaching. Other services may be provided to assist Veterans in starting their own businesses or independent living services for those who are severely disabled and unable to work in traditional employment. |
| 3. **California Association of Social Rehabilitation Agencies (CASRA)**  
[https://www.casra.org/](https://www.casra.org/) | Dedicated to improving services and social conditions for people with psychiatric disabilities by promoting their wellness, recovery and civil rights. |
AGENDA ITEM:  9.4.1
DATE:  May 9, 2019

ACTION REQUESTED:  Vote Whether to Recommend Board Approval of Revisions to Guidelines for Mental Health Pre-IEC Assessment (DIV-P-18)

REQUESTED BY:  Mental Health Ad-Hoc Committee

BACKGROUND:  Mental Health Ad-Hoc Committee is recommending the attached revisions to BRN’s Intervention Program Guidelines for Pre-IEC Assessment: Mental Health.

The revisions allow for a psychiatrist to perform the individual mental health assessment and also removes reference to “five-axis” as the Diagnostic and Statistical Manual of Mental Disorders, currently in its fifth edition, did away with the multiaxial diagnosis system.

NEXT STEP:  Upon approval, seek approval from full Board at its June 13th meeting

PERSON TO CONTACT:  Shannon Johnson, Chief
Discipline, Probation and Intervention
(916) 515-5265
INTERVENTION PROGRAM
GUIDELINES FOR PRE-IEC ASSESSMENT:
MENTAL HEALTH

The Contractor for the Intervention Program for Nurses will obtain the following data on participants referred to the Program for mental illness or dual diagnosis.

- Telephone intake information
- Self assessment packet
- Report from an individual assessment performed by a Psychiatric/Mental Health Nurse, LCSW, or Psychologist, or Psychiatrist experienced in mental health
- Report from a Psychiatrist
- Reports of urine screen for poly drugs
- Reports from ALL mental health provider(s) for the past five years

The request(s) should specifically ask for:

- Five-axis Comprehensive assessment and diagnosis,
- Prognosis including rehabilitation potential,
- Treatment plan and medication regimen,
- Assessment of the effort or energy the participant committed to therapy, and
- Recommendations about employment.
AGENDA ITEM:  9.4.2
DATE:  May 9, 2019

ACTION REQUESTED:  Vote Whether to Recommend Board Approval of Revisions to Intervention Program Guidelines for Impairment Due to Mental Illness (DIV-P-09)

REQUESTED BY:  Mental Health Ad-Hoc Committee

BACKGROUND:  Mental Health Ad-Hoc Committee is recommending the Board approve the attached revisions to BRN’s Intervention Program Guidelines for Impairment Due to Mental Illness (DIV-P-09)

The revisions include updated terms and removes reference to “five-axis” as the Diagnostic and Statistical Manual of Mental Disorders, currently in its fifth edition, did away with the multiaxial diagnosis system.

NEXT STEP:  Upon approval, seek approval from full Board at its June 13th meeting

PERSON TO CONTACT:  Shannon Johnson, Chief
Discipline, Probation and Intervention
(916) 515-5265
INTERVENTION PROGRAM
IMPAIRMENT DUE TO MENTAL ILLNESS

The Intervention Program is available to any Registered Nurse whose practice may be impaired by drugs, alcohol or mental illness and who meets the admission criteria (CCR, Section 1447).

ASSESSMENT

If mental illness is (a) the primary reason for referral to the Intervention Program, or (b) suspected as a primary diagnosis in addition to chemical dependency—substance use disorder (co-occurring disorders—dual diagnosis), the Intervention Program contractor will refer the initial assessment to a licensed mental health practitioner.

All applicants to the Intervention Program with a primary diagnosis of mental illness will—may be required to be under the care of a psychiatrist. The physician shall submit a report to the Committee which contains (a) the comprehensive assessment and diagnosis (DSM five axis), (b) prognosis, (c) course of treatment, and (d) an evaluation of the applicant’s current ability to (1) exercise judgement, (2) engage in logical thought processes, (3) work effectively with other people, and (4) any other factors which would indicate the applicant’s ability to provide safe nursing care.

The Intervention Program contractor will implement all pre IEC restrictions and approve monitoring parameters approved for all Program participants.

COMMITTEE REVIEW

The mental health assessment, psychiatric evaluation, history and record of pre IEC compliance will be considered by the committee in making a decision to accept or not accept a mentally ill applicant based on the criteria for admission (CCR 1447), causes for denial of admission (CCR 1447.2) and guidelines for the admission and denial of the mentally ill applicant.

REHABILITATION PLAN

The Applicant Review, Assessment and Rehabilitation Plan: Mental Health worksheet may be used by the Intervention Evaluation Committee to develop an appropriate and comprehensive rehabilitation and monitoring program for each mentally ill participant.

COST OF ASSESSMENT AND MEDICAL/PSYCHIATRIC EXAMINATIONS

The initial assessment by the licensed mental health practitioner (psychiatric/mental health nurse or licensed psychotherapist) is borne by the contractor as part of the contract.

Any other medical or psychiatric examinations conducted by a licensed physician, the cost of random body fluid tests and support group fees will be paid for by the participant.
AGENDA ITEM: 9.4.3  
DATE: May 9, 2019

ACTION REQUESTED: Vote Whether to Recommend Board Approval of Revisions to Intervention Program Guidelines for Monitoring Participant Compliance: Mental Health (DIV-P-25)

REQUESTED BY: Mental Health Ad-Hoc Committee

BACKGROUND: Mental Health Ad-Hoc Committee is recommending the Board approve the attached revisions to BRN’s Intervention Program Guidelines for Monitoring Participant Compliance: Mental Health (DIV-P-25).

The revisions include updated terms and removes reference to “five-axis” as the Diagnostic and Statistical Manual of Mental Disorders, currently in its fifth edition, did away with the multiaxial diagnosis system.

The revisions also include examples of mental-health related peer support groups (NAMI, emotions anonymous, codependents anonymous) that may be required by the Intervention Evaluation Committees (IECs).

NEXT STEP: Upon approval, seek approval from full Board at its June 13th meeting

PERSON TO CONTACT: Shannon Johnson, Chief  
Discipline, Probation and Intervention  
(916) 515-5265
INTERVENTION PROGRAM
GUIDELINES FOR MONITORING PARTICIPANT
COMPLIANCE: MENTAL HEALTH

The Intervention Evaluation Committee will monitor the participant’s compliance with the Intervention Program requirements and with on-going management of the mental illness.

Compliance monitoring may include, but is not limited to:

a) periodic psychiatric evaluation with reports to the IEC. The report(s) will include:
   1) the comprehensive assessment and diagnosis (DSM, all axes)
   2) drug therapy (therapeutic level and compliance with treatment regimen)
   3) evaluation of safety to practice

b) licensed mental health practitioner therapy reports

c) random body fluid screens (including poly drug)

d) self-report

e) work site monitor report (when working in nursing) or employer work evaluation (if not working in nursing)

f) attendance and participation in support groups (e.g. NAMI, emotions anonymous, codependents anonymous, etc.) as required by IEC

The committee may require psychiatric or medical evaluation at any time during the licensee’s participation in the Intervention Program for Nurses.
AGENDA ITEM: 9.4.4  
DATE: May 9, 2019

ACTION REQUESTED: Vote Whether to Recommend Board Approval of Proposed Intervention Program Guidelines for Considering a Participant for Clinical Reassessment (DIV-P-31)

REQUESTED BY: Mental Health Ad-Hoc Committee (MHAC)

BACKGROUND: Mental Health Ad-Hoc Committee is recommending the Board approve the proposed Intervention Program Guidelines for Considering a Participant for Clinical Reassessment (DIV-P-31)

MHAC believes that by providing specifying guidelines for considering the need for face-to-face clinical reassessments, IECs will take a proactive action in mandating these reassessments. This tool should be employed by the IECs in the event there are concerns about a participant’s mental health recovery.

NEXT STEP: Upon approval, seek approval from full Board at its June 13th meeting

PERSON TO CONTACT: Shannon Johnson, Chief  
Discipline, Probation and Intervention  
(916) 515-5265
INTERVENTION PROGRAM
GUIDELINES FOR CONSIDERING A PARTICIPANT FOR CLINICAL REASSESSMENT

Nine months to one year of continuous rehabilitation with reports and concerns from any or all treatment programs, the IEC should take proactive action considering the following:

1) Has the person been back in inpatient treatment during that period
2) Nurse support group facilitator reports that express concerns (e.g. evasive in groups, negative comments, withdrawn)
3) Work site monitors reports that express concerns with any unusual behaviors or improvement needed
4) Treatment provider observations
5) Collaborations with Clinical Case Manager, physician and/or therapist
6) Intervention Evaluation Committee members observations (e.g. mood, affect, memory etc.)
AGENDA ITEM: 9.4.5  
DATE: May 9, 2019

ACTION REQUESTED: Vote Whether to Recommend Board Approval of Revisions to Intervention Program Criteria for Successful Completion: Mental Health (DIV-P-13)

REQUESTED BY: Mental Health Ad-Hoc Committee (MHAC)

BACKGROUND: Mental Health Ad-Hoc Committee is recommending the Board approve revisions to Intervention Program Criteria for Successful Completion: Mental Health (DIV-P-13).

MHAC recommends removing “no evidence of unrecognized psychiatric symptoms” since it seems redundant to the subsequent criteria “If psychiatric symptoms were identified, [the participant] sought prompt, appropriate treatment.”

NEXT STEP: Upon approval, seek approval from full Board at its June 13th meeting

PERSON TO CONTACT: Shannon Johnson, Chief  
Discipline, Probation and Intervention  
(916) 515-5265
INTERVENTION PROGRAM
CRITERIA FOR SUCCESSFUL COMPLETION:
MENTAL HEALTH

The following criteria may be followed by the Intervention Evaluation Committee in determining when a registered nurse in the Intervention Program as mental health client is ready to successfully complete the Program.

1) The participant must have completed a minimum of two years of total compliance with all parameters of participation including:
   a) Maintaining the therapeutic regimen prescribed by the psychiatrist,
   b) Taking medications as prescribed,
   c) Submission by mental health provider(s) of letters supporting successful completion, and
   d) Having negative random body fluid reports consistent with the rehabilitation plan requirements.

2) The participant must have demonstrated stability in daily living characterized by:
   a) The ability to recognize his/her own cycle of accelerated symptoms,
   b) The ability to express, with a reasonable degree of clarity, a self knowledge about mental health and his/her personal life style;
   c) No evidence of unrecognized psychiatric symptom, and
   d) If psychiatric symptoms were identified, sought prompt, appropriate treatment.