BEFORE THE BOARD OF MEDICAL EXAMINERS
DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the adoption of New Rule I qualification criteria for evaluation and treatment providers	)))	NOTICE OF ADOPTION

TO: All Concerned Persons

1. On June 24, 2010, the Board of Medical Examiners (board) published MAR notice no. 24-156-74 regarding the public hearing on the proposed adoption of the above-stated rule, at page 1467 of the 2010 Montana Administrative Register, issue no. 12.

2. On July 20, 2010, a public hearing was held on the proposed adoption of the above-stated rule in Helena. Several comments were received by the July 28, 2010 deadline.

3. The board has thoroughly considered the comments received. A summary of the comments received and the board's responses are as follows:

COMMENT 1: One commenter offered overall support for the new rule.

RESPONSE 1: The board appreciates all comments made during the rulemaking process.

COMMENT 2: One commenter asserted that the bill sponsor had not been contacted. The commenter generally supported treatment programs, but opposed New Rule I because it is only a partial adoption of the Federation of State Physician Health Programs (FSPHP) guidelines, and the commenter desires a verbatim adoption. The commenter also stated that Mike Ramirez of the Montana Professional Assistance Program (MPAP) was aware of the guidelines, as he was a member of the committee that drafted them.

RESPONSE 2: The board notes that the date and time of the public hearing on New Rule I appeared in paragraph one of the rulemaking notice. Further, paragraph seven of the notice confirms that the primary bill sponsor was contacted by regular mail on May 6, 2009. Board staff also left a message on the sponsor's cell phone number. Further, the bill sponsor was aware of the notice and the comment period, as the sponsor submitted a timely comment.

The board notes that the FSPHP guidelines include not only the guidelines for treatment programs in Appendix II of the guidelines, but also sections on general guidelines, substance use disorders, management of other psychiatric disorders, and evaluations. Section 1(A) of the general guidelines states, "The following guidelines are applicable to state physician health programs serving physicians, and are applicable specifically to physicians. Many programs monitor other health

professionals with health conditions, which may compromise their ability to practice with reasonable skill and safety. All or part of these guidelines may be used for these populations, if determined appropriate." Partial use of the guidelines is clearly contemplated and encouraged. The board considered the guidelines and the expertise of the FSPHP when drafting New Rule I.

COMMENT 3: The primary sponsor of SB 401, the bill implemented through New Rule I, stated that the rule requires so much subjectivity and interpretation, it is questionable whether any Montana treatment provider or evaluator could ever treat or evaluate an impaired Montana physician. The sponsor also opined that the new rule is inconsistent with legislative intent and urged the board to rework the rule to be consistent with what the Legislature envisioned.

RESPONSE 3: In creating New Rule I, the board relied on the Federation of State Physician Health Programs (FSPHP) guidelines that were compiled over the course of several years, with input from physician health programs throughout the United States. The guidelines that the board relied upon were presented to all voting members of the FSPHP for review and were approved by 79 percent of the voting members. Appendix II, Treatment Programs, was approved by 66 percent of FSPHP voting members. As the cautionary statement of the guidelines states, "(t)hese guidelines reflect the consensus of existing physician health programs." Over 42 states' programs belong to the FSPHP. Thus, New Rule I reflects standards that are used throughout the United States, in more than 42 programs. In December 2009, the New England Journal of Medicine Career Center highlighted the FSPHP as the resource for state physician health programs.

Senate Bill 401 was codified at 37-3-203(2), MCA, and provides that a licensee "must be allowed to enroll in a qualified program within this state and may not require a licensee to enroll in a qualified program outside the state unless the board finds that there is no qualified program in this state." New Rule I implements this provision and sets out qualification requirements and treatment modalities that meet national criteria. The board notes that any state program meeting the broad, general criteria in New Rule I will be a qualified program. The board was cognizant of the bill's legislative intent when it relied on these nationally approved standards as the benchmark for Montana programs. In addition, MPAP audit statistics support the use of these guidelines for treatment and evaluation.

It is the board's responsibility to ensure that the public is protected against the unsafe practice of medicine. The board concluded that following the high standards of the FSPHP is essential to ensure the public's safety. FSPHP standards are objective, fair, and reasonable, and the board looks forward to having more programs in Montana that meet these standards. The board believes that the criteria in New Rule I furthers the legislative intent behind SB 401 while promoting the safe practice of medicine in Montana.

COMMENT 4: One commenter criticized several terms used in New Rule I, stating that the rule is contradictory to other laws and overlooks the patient's needs altogether. The commenter asked why the new rule did not follow the requirements that govern other state-approved addiction treatment programs, and suggested the

Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) standards for addiction treatment.

RESPONSE 4: The board relied on guidelines that are approved by a majority of state boards for treatment programs for physicians and health care providers. For the purposes of a physician health program, CARF would be relevant only for accrediting behavioral and opioid addiction programs. Joint Commission accreditation for organizations or behavioral health care programs does not focus on the impaired health care provider, but has a broad umbrella over outdoor programs, youth programs, animal therapy, eating disorder programs, and addiction programs within a larger health care institutional setting, etc. Neither entity is the nationally recognized organization for physician health programs. The board appropriately relied on FSPHP's nationally recognized and adopted guidelines in crafting the qualification criteria.

COMMENT 5: One commenter claimed that section (3)(d) limits qualification to facilities that specialize in treating physicians and whose patient are exclusively physicians. The commenter recommended the board adopt the standards of CARF and the Joint Commission, and complained about the lack of definitions for words of common understanding. The commenter questioned the requirement for a "strong family program," asked what distinguishes a strong program from a weak one, and claimed that there is no definitive recommendation for staff-to-patient ratios for addiction treatment.

RESPONSE 5: Nothing in New Rule I states that only physicians can participate in a qualified program and multidisciplinary programs are acceptable under the rule. However, programs that treat medical professionals have different qualities than programs that treat others, because physicians particularly have defensive coping mechanisms to circumvent treatment and evaluation. Multidisciplinary programs that do not treat medical professionals have favorable outcomes in approximately 20 to 25 percent of cases, while programs that treat medical professionals and adhere to the FSPHP's guidelines have 80 to 90 percent favorable outcomes.

Accreditation by CARF and the Joint Commission does not address itself to the patient population or concerns that physician health programs address. Contrary to the commenter's statement about definitive recommendations for staff-to-patient ratios, FSPHP Appendix II (1)(f) merely recommends that a staff-to-patient ratio be conducive to each patient, as does New Rule I (3)(f).

The requirement in (3)(h) to include "a strong family program" reflects a common understanding that family involvement, support, and understanding of an impaired health care provider is integral to recovery. Further, (4)(c) offers clarification of the term as used in the treatment programs.

COMMENT 6: One commenter viewed Senate Bill 401 as an opportunity for the board to recognize qualified evaluation and treatment facilities in Montana and asserted that New Rule I circumvented the need to include Montana-based evaluation and treatment facilities. The commenter noted the financial burden

placed on individuals in crisis and the concerns of facilities in Montana that have not historically been viewed as qualified.

RESPONSE 6: The board notes that any state program meeting the criteria in New Rule I would be considered a qualified program. Section 37-3-203(2), MCA (the code section being implemented by New Rule I), states that a licensee "must be allowed to enroll in a qualified program within this state and may not require a licensee to enroll in a qualified program outside the state unless the board finds that there is no qualified program in this state." New Rule I sets out qualification requirements and treatment modalities that meet national criteria. Any program in Montana that meets these broad, general criteria will be deemed qualified. The board was cognizant of the bill's legislative intent when it relied on nationally approved standards as the benchmark for programs in Montana.

The board appreciates the financial stress that evaluation and treatment causes licensees, and relied on the FSPHP's broad qualifying criteria to facilitate Montana-based programs becoming qualified. For physicians with financial hardships, MPAP can and has offered scholarships on a case-by-case basis. While the board recognizes that treatment and evaluation is expensive, it is far costlier to lose a physician to addiction, suicide, or the end of a career caused by harm to a patient.

4. The board has adopted NEW RULE I (24.156.429) exactly as proposed.

BOARD OF MEDICAL EXAMINERS
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CHAIRPERSON

/s/ DARCEE L. MOE
Darcee L. Moe
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State November 15, 2010