STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF REGISTERED NURSING
BOARD MEETING MINUTES

DRAFT

Date: June 21, 2024

9:00 a.m. **Start Time:** 9:00 a.m.

Location: **The Board of Registered Nursing (Board) held a public meeting, accessible both in-person and via a teleconference platform, in accordance with Government Code section 11123.2.**

Department of Consumer Affairs
1625 North Market Blvd. Main Hearing Room (Suite S-102)
Sacramento, CA 95834

Friday, June 21, 2024 – 9:00 a.m. Board Meeting

9:00 a.m. **1.0** **Call to Order/Roll Call/Establishment of a Quorum**

Dolores Trujillo, RN, President, called the meeting to order at: 9:00 a.m. All members present. Quorum was established at 9:02 a.m.

Board Members:
Dolores Trujillo, RN – President
Jovita Dominguez, BSN, RN
Patricia “Tricia” Wynne, Esq.
Roi David Lollar
Vicki Granowitz
Alison Cormack
Nilu Patel

BRN Staff:
Loretta (Lori) Melby, RN, MSN – Executive Officer
Reza Pejuhesh – DCA Legal Attorney

9:02 a.m. **2.0** **General instructions for the format of a teleconference call**

9:04 a.m. **3.0** **Public Comment for Items Not on the Agenda; Items for Future Agendas**

Public Comment for Agenda Item 3.0: Jessica: Said she’s here on behalf of a family member in the Intervention Program. Expressed dissatisfaction with BRN’s Intervention Program and shared information regarding her family member being extended in the program, poor communication, and

asks for a deeper look and the participants affected by the recent requirements be immediately graduated.

Callie: Thanks the Board for holding this meeting and appreciates the efforts to evaluate the changes that have been recently made. Shared information on the quarterly medication review form, the approval of treating physicians and that participants' medical conditions and restrictions and their recommendations seem to not be considered.

Chris Else: Stated the he is the nurse support group facilitator and that he's been hearing that participants are having difficulty with testing and the testing provider. Nurses may have to drive 2-3 hours on the weekends to find an in-network drug testing place.

Janet: Thanked the Board for holding this meeting today. Expressed dissatisfaction with the BRN's Intervention Program and shared that participants need safe, clear, transparent, and consistent place to heal from mental health disorders or substance use disorders. They are yet to receive any communication about a recovery plan and ask that those who are on track for completion but extended, please successfully complete them immediately.

Sam: Expressed dissatisfaction with the BRN's Intervention Program, sharing that the lack of documentation in non-compliance letters, infrequent communication, skipping IEC meetings, requiring nurses to spend over $10,000 on testing fees per year and the new changes where nurses being removed from work for 30 days for missing a check in or giving a dilute sample.

Alec: Expressed dissatisfaction with the BRN's Probation process. Shared that certain policies are unnecessary: nurse are assessed a fine, not allowed to obtain work from a registry or through a travel nursing, can only work 40 hours per week with no overtime, is subjected to further expensive drug testing at approximately $600 per week, are required to have a mental and physical health exam prior to entering the program and the BRN has a small list of physicians that they authorize to conduct these exams and none of the approved physicians accept insurance and exams cost somewhere around $3,000 per patient.

LH: Expressed dissatisfaction with the BRN's Intervention Program and request the evaluation of the cost of the ATD *(Alternative to Discipline)* program be added to a future agenda. It seems every other week a new out of pocket expense is added on for them. She recently read an article published by the online Journal of Issues in Nursing in January 2023 about the accessibility and financial barriers

for nurses with substance use disorder in alternative to discipline programs. The report listed the average cost of ATD programs across several states. And sadly, it also quoted a 2021 study that stated financial despair caused by burden of treatment for SUD while unemployed is associated with nurse suicide. Furthermore, the lack of communication and a concise care plan does not support a recovery or sobriety.

B: Expressed dissatisfaction with the BRN's Intervention Program and shared concerns about only being allowed to return to work on a part time basis versus full time basis and that this does not allow for any insurance coverage when therapy, psychiatry, and after care are all mandatory, not to mention spending approximately $500 a month in drug testing that is not covered by insurance This creates unlivable and unrealistic financial circumstances for our participant.

Mark J: Thanked the Board members for their interest and concerns this morning and expressed dissatisfaction with the BRN's Intervention Program and request an investigation to be conducted. He shared that in probation they have a judiciary contract that gives them very strict and very well-defined participation limits and that this is lacking in intervention. They need to have requirements that as they are met, are like milestones for them and then they advance to the next phase of the program. They need a clear definition of completion requirements and any changes made to the program need to be rooted in evidence.

Anthony: Expressed dissatisfaction with the BRN's Intervention Program and shared information on the medication review form dated 1/5/04. Some IECs are requesting doctors to provide a plan for weaning off of medication. Also, discussed uncertainty around work requirements.

Loretta Melby gave a reminder to the public participants that the narcotic passing requirement and the provider review are specific agenda items that will be discussed. To allow that to occur, please hold those comments back for those agenda items. This is a comment period for items that are not on the agenda. We have heard a few. One was bringing up that you guys would like a deeper investigation, another one was drug testing issues with the transition from vault to FS solutions Another one was evaluating the cost of the ADT program, et cetera, and then of course now this new form that is being discussed or the update to this current form. So I just want to make sure that we are managing this time well. During this public comment period, we cannot have a conversation with you guys. We cannot engage in any discussion with you guys because this is for

items not on the agenda. She asked to please continue on with public comment for items that are not on the agenda.

Sara S: Expressed dissatisfaction with BRN’s Intervention Program and shared that they are now required to be evaluated to return to bedside care by a psychiatrist that is the program's choice, and they must pay out of pocket and that their IEC meetings are rescheduled without notification.

Sarah: Expressed dissatisfaction with the BRN’s Intervention Program. She shared that with less than six months to completion, she was informed her program was being extended by two years. The reason because she holds an advance practice license. She shared that participants may be punished for courageously speaking up for themselves. Extending the intervention program and enacting additional requirements does not promote public safety.

Daniel: Expressed dissatisfaction with the BRN’s Intervention Program. Discussed the new requirement that he must work for six months at the minimum. He shared that there is no fairness, there is racism, there's favoritism, and there's retaliation.

JB: Expressed dissatisfaction with the BRN’s Probation process. He shared that his child has been on probation for three years and it was recently extended to eight years due to an investigation that finalized while his child was on probation for a complaint that occurred before his child was on probation. I strongly implore the board to look into the way the probation department is performing and acting and implementing laws.

Neil: Shared dissatisfaction with the BRN’s Intervention Program and shared that he is the domestic partner of a participant in the program. Shared that she was arbitrarily extended by two years. The reason given; she has an advanced license. He urges the board to rescind these unjustified extensions and graduate the participants that have completed their requirements prior to these extensions.

Steven Fisher: Shared dissatisfaction with the BRN’s Intervention Program and stated that he is a representative of the public and an advocate for the professionals who have been impacted by the new requirements. They have been raising these issues with this board since January and still nurses are being extended indefinitely and without any transparency regarding next steps. This is a grave injustice, and they are asking for you to release those nurses eligible for completion immediately.

Danielle: Expressed dissatisfaction with the BRN’s Probation process and shared that she is on probation for something that occurred over three years ago. She received the accusation from the BRN, and since then she has spent over $15,000 on legal fees, testing, and so-called cost recovery which she has found can range between $1,200 and $20,000 per registered nurse. The financial burden of testing, cost recovery, and mandatory nurse support group meetings is crippling.

Clifford D: Expressed dissatisfaction with the BRN’s Intervention Program. Stated that he would like somebody to look into the program because there are a lot of nurses, and they know how to take care of themselves and what works for them. So, to look at each individual situation and provide them with the support they need.

Anonymous 25: Expressed dissatisfaction with the BRN’s Intervention Program. Stated that the participation levels have gone from over 600 participants, to less than 250. I believe that these changes coincide with the board's decision to make these extensions for everyone in this program, and it's really a disservice to everyone that's participating because, word is getting out, people are talking about these changes that are being made, the public is being made aware, and people are hesitant to participate in this program. People are really struggling with this, and these changes are just not good at all.

Amanda H.: Expressed dissatisfaction with the BRN’s Intervention Program. Shares that it is extremely hard time finding testing locations after hours, she would like to see more availability for testing on weekends in Sonoma County. There's nowhere for them to test on weekends or after hours. She must drive very far in order to find somewhere to test that falls within the network of compliance and it's very stressful. It causes her anxiety to think every morning when she checks in that if she’s at work or it's a weekend, that she has nowhere to go to be compliant.

Eileen: Expressed dissatisfaction with the BRN’s Intervention Program. Sharing that the biggest concerns are the excessive costs. She knows of two nurses living out of their cars because they can't afford to live. They're not allowed to work. Some of the nurses in the programs are not allowed to get jobs, then they're told that they have to switch jobs. There’s a lack of testing places for the nurses on the weekends, especially females, after hours. The testing sites that are open on the weekends are open for very short periods of time.

Susan – Expressed dissatisfaction with the BRN’s Intervention Program and thanks to the board members for establishing this

meeting today. She appreciates that the intervention goals on the BRN website read that you are here to encourage, support, and guide us and the program was created and made to give help and hope for nurse participants. She had been a participant for three years, in December, the changes were made, and she would like to know what she needs to do to successfully complete this program. Things are continually being added and as the prior participant said, they find out through friends from nurse support group, not their case managers. She has had five case managers in three years.

Stacey: To the members of the board, thank you for holding this meeting. They see that your eyes are on the issues surrounding the intervention program and thank you for that. She then expressed dissatisfaction with BRN's Intervention Program. Sharing concerns about narcotics access and clinical assessment, both of which I respectfully ask for you to rescind. She understands the intention with all these changes may be trying to prevent relapse, but no, you can never prevent relapse as an outside force. It is up to the person in recovery to prevent it for themselves. While the intent of the changes may be relapse prevention, the impact is creating nothing but trauma. Please stop the changes as of today, review all the new changes and grant the participants who were denied completion due to all the changes successful completion.

Loretta Melby said she would like to try to manage public comment a bit. They've been meeting for an hour, and they have not been able to get to the agenda items to be able to do any actual work. She wants to make sure that if these comments are about the agenda items coming, she would love for the commenters to be able to save the comments for that time. If a commenter has commented the same as a person ahead of them it may be of benefit to note that and expand on any item that needs to be expanded upon. She stated that she is not trying to discourage anyone from making a public comment at all but they have to do the board work in public as well. That's why they must agendize and notice these meetings to do the work that the public is requesting of them. If the commenters can be mindful of that and save their comments for the agenda items so the board can have discussions that include the public that would be the benefit.

Matthew A. - Stated that he couldn't have asked for more perfect timing from Ms. Melby. What I wanted to say really quickly is you've heard by my account about 25 people speaking this morning. Did that seem, you know, monotonous to you? Were you ready to move on? How do you think the participants feel in this program being extended for months and months and months and months and sometimes years? So that's the only point he wanted to make here is he knows

the board wants to move on and it seems like it's rehashing the same thing, but this is a tiny taste of what participants have been going through.

John: Expressed dissatisfaction with the BRN's Intervention Program. Sharing that his sister is a participant in this program, and, he would like to say first that he's proud of her. He's seen her work really hard to rectify her mistakes. She has endured everything this program is required of her and never complained. She understood that she made a mistake and she needed to get her life together. She has used this as an opportunity to do so. Does BRN enforcement have checks and balances? If so, where are they? Do you all not think what you're doing is ethical or in protection of the public? Our medical professionals will never come to boards for help. If this is what they are all met with, how is this safe for the public? He believes the board has a real opportunity to correct these mistakes you have made by completing all the nurses that have met these requirements.

Florence – (typed comment): It does not seem like the BRN or the nurses in intervention are clear about what the Maximus role is. The five member IEC committee decides on the nurse's restrictions and then the BRN representatives, approve the changes recommended. The BRN representative has the right to override or influence the committee decision. Maximus's role is to apply the agreement guidelines as approved and to help the nurse stay in their recovery using the evidence-based practice standards and their knowledge.

Financially Abused by the BRN: Expressed dissatisfaction with the BRN's Probation process. Sharing that she is on probation because of an issue that happened three years before becoming a nurse. She feels like it has been double jeopardy. She was already punished by the state of California. She shared that she's never been suicidal in her life until being on this program. It is stressful, it's overreaching. She doesn't feel like the board has the best interest for nurses to be successful. She cannot afford to live this way. She doesn't feel supported by the board at all.

10:13 a.m. **4.0** **Report of Enforcement/Investigation/Intervention Committee (EIIC)**

4.1 Discussion and possible action: Appointment of Intervention Evaluation Committee (IEC) member

Name	Member Type	IEC	Appointment Type	Term Expiration
Barbara Neefs	Nurse	9	New Appointment	6/30/2028

Board Discussion: No public comments requested in the Sacramento location or on the WebEx platform.

Motion: **Alison Cormack** **Motion to Approve appointment of Intervention Evaluation Committee member as presented**
Moves approval of Barbara Neefs to IEC number 9.

Second: **Nilu Patel**

Public Comment for Agenda Item: No public comments requested in the Sacramento location or on the WebEx platform.

Vote:

Vote:	DT	JD	PW	VG	DL	AC	NP
	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB						

Motion Passed

After Vote: Patricia Wynne asked how many IEC vacancies there are statewide. Shannon Johnson said there are two.
Board took Break: 10:17-10:35 a.m.
Board reconvened and re-established quorum at 10:37 a.m.

10:37 a.m. **4.2** **Discussion and possible action:** Regarding needing full clinical diagnostic evaluation(s) and reassessment(s) with a focus on the participants' ability to safely return to work in a capacity as a registered nurse during the Intervention Program

Board Discussion: Patricia Wynne asked how long the Uniform Standards have been in place.

Shannon Johnson stated they had been in place since 2011 and said they were modified later but only uniform standard number four involving drug testing.

Reza Pejuhesh confirmed the standards were adopted in 2011.

Patricia Wynne said this has been a requirement for a long time and wanted to know more about how participants did not know about this requirement.

Shannon Johnson said several participants were allowed to return to practice when they were deemed not safe to practice. She said they looked back at records for the past three years and found many were working and were documented as not safe to practice which is why

many participants were stopped from completing the program. She said that if the last assessment said they aren't safe they need to have an assessment stating they're safe to return to practice with an unencumbered license.

Dolores Trujillo said her understanding from the last meeting and public comment is the biggest change was the passing of narcotics that extended time in the program.

Shannon Johnson said they identified nurses being completed and never worked as a registered nurse during the program and that's one of the criteria they have to prove they're safe to practice. She has a slide on recidivism currently as it sits 10% of nurses in the program for at least a second time. Some of those nurses never worked as a RN the first time but when they left, they went right back into narcotic access positions. The IEC discussions and rationale is that if they're going to send them back with an unencumbered license and their problem is diverting, they want to make sure the problem is not a stressor for them and that they can actually function around narcotics without diverting again. That has been a lot of the rationale and discussion for the IEC members.

Jovita Dominguez gave a scenario about a participant in the program who is a case manager or manager could give narcotics but she's a case manager who doesn't have Omnicell or Pyxis access. She asked if there is a way that person doesn't need to pass narcotics? She believed there was a scenario like that last month from a participant.

Shannon Johnson said they stated that they didn't understand why they would have to have narcotic access. She said she has some upcoming slides with statistical information showing participants hadn't been seen in 2024 by their IEC. The majority of them are diverting. There was not one single DUI case that they reviewed. They were either a DUI in conjunction with multiple DUIs with possession or a DUI in conjunction with admitted diverting in the workplace. What happens is the IEC reviews all that information and makes a determination whether or not they need to see them working and have them monitored while working around narcotics to ensure they're safe to practice.

Loretta Melby said she could probably answer that a little bit as well. As a case manager, you don't typically have access to Omnicell or Pyxis. It would not be the norm that the reason that they would be in the intervention program for diversion at work because they wouldn't have the narcotic access. The nurses that were working as a case

manager that are in our intervention program, potentially could have been using these substances, but not directly acquiring them from work. Those participants would be assessed and may not be required to work with access. As Shannon was pointing out, if there is no diverting specifically related to their employment and when it's a substance use disorder that does not encompass diverting, then they are managed differently. Because it is done on a case-by-case basis.

Alison Cormack said she had a process question. Narcotics is 4.3 and we're on 4.2. She told Shannon Johnson she's confused if the slides are complete or if there are more. She asked if they are discussing uniform standards now?

Shannon Johnson said this is 4.2 and 4.3 has all the statistical information. This item was only to discuss the diagnostic evaluation.

Alison Cormack asked if it is only the diagnostic evaluation or is it also the reassessment? These are the two things she thinks people are getting confused, it says reassessment also. She thinks she heard Shannon say, which is concerning, there were participants in this program who their last assessment said they were unsafe to work, and they were released from the program and now they're working with unencumbered licenses.

Shannon Johnson said, possibly yes. The ones she was stating were the ones that are still currently in the program, and they were returned to work before they had another evaluation.

Alison Cormack said she understood they were returned to work but with restrictions.

Shannon Johnson said some did not have restrictions and were returned to work in the "transition" phase. Shannon said they were returned to work on whatever shifts and whatever type of job they would like to work in. However, when reviewing their cases they found the assessments said they were not safe to practice.

Alison Cormack said it sounds like collectively this program made some errors.

Shannon agreed.

Alison Cormack said staff cannot unknow what they know, and it sounds like either staff or Maximus has gone through and looked at every single current participant in the intervention program to

establish if their current assessment says unsafe to work, asked them to stop working if they're working. She asked if this has happened yet.

Shannon said no. They had the participants go before the IEC, but first they asked the participants to have another assessment done and Maximus made contact to have another assessment done. Once the assessment was done they were put before the IEC to make a new recommendation based on the new assessment. If they're safe to practice, what capacity would be appropriate. If they're unsafe to practice and they're working, the IEC needed to make a recommendation to remove them or make restrictions on their employment.

Alison Cormack asked how this is communicated to the participants. She said the board heard a few things that would not be best practices.

Shannon Johnson said it would be the Maximus clinical case manager.

Alison Cormack said that person would have called them or sent them an email.

Shannon Johnson said that was correct. She said after the IEC meeting, once they vote, they review all the notes to make sure everything's accurate on the recommendations made by the IEC, they approve it, and it goes back to Maximus to create the new contract for the participant, and then that contract is communicated through the Maximus CCM to the participant.

Alison Cormack asked if staff are confident that when they were asked to come before the IEC, they knew that there had been something identified, and they would probably need to be reassessed?

Shannon Johnson said she would like to think so but from what the Board is hearing from quite a few participants they are unclear where they stand in the program.

Alison Cormack said that's a big concern and she doesn't know if this agenda item enables the board, but she'll defer to the committee chair and legal to figure that if there's anything they can do because at the end of the day, the communication is incredibly important and clearly has not been sufficient. She said it sounds like there's a second category of communication. Is it possible that when people began the

program it did not state they would have to be reassessed before they can return to work if the initial assessment says they're unsafe?

Shannon Johnson stated that it is possible.

Alison Cormack said it could certainly feel to someone in the program as if you're changing the goal posts. She asked if this is fixed as of today for someone who enters the Maximus program? Does the contract say, number 172, she hasn't seen a contract so she doesn't know how long it is.

Shannon Johnson said a contract is seven to eight pages long. It will state work restrictions but it won't say future restrictions. So for instance, it won't say in two years that you're going to have to work with narcotic access.

Alison Cormack said we can set that one aside because she's focused on the reassessment. She wants to be sure that when people enter the program, if they are deemed unsafe to work, they understand they will have to be assessed by a board approved person at the end. She said it seems like a line that could be added to the contract. She asked if board staff or Maximus write up the contracts.

Shannon Johnson said Maximus.

Alison Cormack asked what the limits are to communicating with Maximus, meaning staff, not Board members. Is staff able to direct them to add that to the contract?

Shannon Johnson answered in the affirmative.

Alison Cormack doesn't know if there needs to be a motion or if staff's agreement to do it is sufficient.

Patricia Wynne would like someone from Maximus to come up to speak about this requirement.

Alison Cormack would like to get to the part they heard about the Board approved specialists for evaluations. She said she heard something different from Shannon, that as long as someone has the qualifications staff will approve them.

Shannon Johnson stated that was correct, they ensure they meet the criteria.

Alison Cormack said they heard in public comment that none of the current board approved specialists take insurance for the evaluations. She said it's probably a hard question to answer since there are so many different types of insurance.

Shannon Johnson said there's a difference between intervention and probation. For probation they have to seek out their own mental health and physical examiner. It could be the same person or it could be two different people. It's a condition of probation that once they identify the physician, they send the CV, staff reviews it to let them know they meet the criteria. It's up to the probationer to decide or find a physician that takes their insurance or whatever the case may be. They don't oversee the financial side of it on probation. With Maximus, they identify or have pre-identified the initial assessors already. She doesn't believe they're under contract and Maximus is here so they could probably speak to that better than she, but they already have assessors in place.

Alison Cormack said she would ask Maximus when they are brought forward if they can answer the question.

Loretta Melby said she had a point of clarification that it was mentioned about an unencumbered license or a restricted license. She needs the board and public to know that there is no restricted license. There is a license or no license. Restrictions on practice is put into place either through probation or intervention, but the public license, is viewed as a license. When a person is on probation there is a section on the license lookup that says more details. The public can get copies of the public records around why that person is on probation and what the probation requirements are. When a person is in intervention the license does not reflect anything because it's confidential. As far as the public is aware, it is a full license without any restrictions and they can practice in any location. Through the intervention program, that is where the restrictions are placed on the practice of that individual while they are in the program, but the public is not aware of that.

Nilu Patel said Shannon Johnson mentioned there was a change in the uniform standards in 2011 with the drug testing being modified. She asked if Shannon could help her understand what kinds of changes were made about the range of testing in uniform standard number four.

Shannon Johnson said the standard states for the first year in the program, for both probation and intervention, they must be tested at a range of 52-104 times a year. They have flexibility in that and then for

the second year and thereafter, it would be 36-104 times per year. There are some caveats as well as exceptions. If they are not working in any health care related job, staff can take it down to no less than 12 times per year. They can also raise it if there are any positive drug screens, relapses, any dilutes if they're coming up dilute a lot. There is flexibility in that, but not outside of the range for the first and second year.

Nilu Patel asked how these changes came about or is it included in the next presentation regarding statistics?

Shannon Johnson said there was a forum with all of the healing arts boards to discuss this standard and where they felt the testing should be, flexibility, and how the language should read. She said the changes were in 2016, eight years ago.

Nilu Patel clarified that the uniform standards apply to many boards and not just BRN. She said based on public comment they heard that advance practice nurses have been extended and that goal post has been moved. She asked Shannon to speak to that.

Shannon Johnson said when there is an advance practice nurse with a furnishing license and able to furnish narcotics, especially if you're a nurse anesthetist, they may want you to have a little bit more than just that three-year mark in the program. It depends on a lot of different factors, were they diverting, were they furnishing their own prescriptions, were they writing scripts for other people, did it occur at work? There are a lot of factors that go into those discussions with the IECs and what they determine would be the recommendation to ensure safe practice.

Nilu Patel said its not all advance practice nurses who undergo an extension. She said committees are being cancelled on the participants and does the board have any control over how to minimize it? Shannon said they already have and she'll discuss more later.

David Lollar wanted to follow up on Board Member Cormack's questions about assessors and costs. If a nurse is required to get a clinical diagnostic evaluation, does that cost?

Shannon Johnson said the contract currently reads with Maximus that the first initial assessment is at the cost of Maximus. Any additional assessments within a year, would be at the cost of the participant.

David Lollar asked if they are tested two times a week.

Shannon Johnson answered in the affirmative.

David Lollar asked at that point or is it later that they are no longer allowed to work? He was trying to follow the slides but they went too fast and he didn't have a copy of them.

Shannon Johnson said when the participant contacts Maximus to go into the program, they agree to stop working and undergo the clinical diagnostic evaluation as well as an intake interview with their Maximus clinical case manager.

David Lollar asked if health insurance pays for the two times a week drug testing.

Shannon Johnson said she didn't think so and it costs about $100 per test. She has another slide with about three years of data on drug testing costs coming up.

David Lollar said he didn't want to get into the narcotic business until the next agenda item. He's curious about money because we tell them they can't work but they're going to pay out of pocket yourself for evaluations, reassessments, and tests.

Shannon Johnson answered in the affirmative.

Reza Pejuhesh said he wanted to clarify the issue of costs because it's being discussed. The BRN, board staff, board itself does not receive any portion of income received by Maximus. There are no kickbacks to the extent that anyone does it would probably be criminal. So those who are making that accusation hopefully have something more than their own speculation behind it. There is no financial incentive for the board to send folks for further reassessments or any of that. He wanted to be clear the air as far as folks who think that's what might be going on. That the board is trying to make people jump through hoops to drive up revenues. That's not the case.

Shannon Johnson said the board pays the administrative costs for the program for each participant. The BRN is the only board that does that for the participants. It doesn't cover a large portion of their cost, obviously there is a lot there, but it does pay the administrative fee for them for the program.

Loretta Melby had two points of clarification. One is to follow up on what Reza Pejuhesh said about revenue. The board's revenue comes

only from application and renewal fees collected from nurses and continuing education providers. That is the only revenue stream the board receives. The BRN does not receive any state fund either. It is application and renewal fee based. The other clarification she wanted to make about the uniform standards and the discussion between board members about how the standards had changed. She needs to make sure people understand the uniform standards are law that was implemented by legislation SB 1443 in 2007, put in place in 2011, and affected Business and Professions Code section 315 and some following sections. The amendments or changes discussed earlier were legislative amendments through Senate Bill 796 in 2017 which was implemented on January 1, 2018. These were not changes done by the boards or bureaus or DCA specific. They were done through the legislative process and signed into law.

Vicki Granowitz is having difficulty formulating her questions and comments because this is an emotional discussion and listening to the public comments it seems like there's a disconnect between the fact that something happened six months ago and doesn't seem like it was a problem prior to that. Staff started enforcing the ordinance that or the legislation that was enacted in 2007, all of a sudden is that what happened? Did anyone go back and figure that out?

Shannon Johnson said they started attending meetings just to identify the gaps and to ensure that the laws were being followed and we found that they were not in all the cases and so we monitored, reviewed, took notes, and tried to put together a plan. She knows it was said that we don't really have a plan, but behind the scenes, we do, and we did, and we were trying to implement these slowly, but unfortunately there were so many areas that they had to address because it was about public safety. So they had to move quickly and we had to ensure that some of those things were put into place and some of those items were possibly removing someone from a meeting that would be completed when an assessment said they were not safe to practice.

Vicki Granowitz asked, because not everybody chooses to go through Maximus, people choose to go through their own private recovery programs. How are those people being evaluated compared to the ones that go through Maximus? Am I confusing?

Shannon Johnson said they don't monitor anyone who doesn't go through the BRN program. She doesn't have any statistical information about other programs.

Vicki Granowitz asked if everybody has to go through Maximus.

Shannon Johnson said no, Maximus is a voluntary program. Most nurses come into the program because they have a complaint filed against them for one reason or another involving substance or mental health. That's the reason they come in for the program because it's confidential and they would like to go that route as opposed to probation. Every single complaint received in the complaint intake unit receives an email notifying them of the intervention program and offering them to call and enter the program. If they choose to come in, they start the program, if not, they go down the disciplinary route and possibly ending up on probation or revocation or surrender of their license. Normally when it is a substance or mental health issue, very rarely, as the board probably knows by reviewing those documents, they don't result in public reprovals. It is usually the more severe disciplinary action against the license. The California BRN does not have a requirement under their regulatory authority that requires an employer to let the board know that an error or something occurred at work. When the board receives complaints from a person compelled enough to reach out to the board to make the complaint that could be from a family member, a patient, a coworker, an employer, it's not mandated by law. When the complaint comes in they are required to notice the person that a complaint was received. When the complaint comes in, they reach out and let a person know that the intervention program is available to them. When they're going through the process and the complaint gets put into the system and reach out to the person the complaint was filed against, they have an option at that point to go into the intervention program confidentially or go into probation which requires public notification and it be attached to their license and sent to the Nursys data bank nationally and the national provider data bank as well. That stays attached to the license. So when the complaint is received, the person evaluates whether or not they want to do the intervention program or whether they want to go to the probation program. They don't typically see a random individual that's not involved in a complaint received by the board that reaches out to the board that says they want to join the intervention program. That is what was said in public comment. When a person is struggling with substance use disorder or has a mental health issue, they seek their own care, and they join their own program. When that occurs, they don't have any idea that is occurring. The license remains in a current and active status and is not managed by the board because the board is not aware that is occurring. There's no mandate that says a licensee must report they are undergoing treatment. That you are seeking this assistance and identically to the employers, they don't have to report that either. The employer could ask their employee to seek assistance and that employee can seek assistance based on the employer's recommendation it's some kind of a performance

improvement plan or something like that. Even with that going on, because California is not a mandated reporting state, the employer does not have to let the board know this is occurring and the board has no idea that is happening.

Vicki Granowitz said if she was thinking about herself, given what she's hearing, she would never enter Maximus because it seems punitive compared to if you do something on their own. She understands the requirement to protect the public but if they do something on their own, staff wouldn't know, you wouldn't be doing the evaluation. She knows staff can't unknow what they know but this is still a disconnection for her on the whole situation that she can't wrap her head around. She's concerned there will be some suicides because of people's stress and not knowing or understanding what's going on.

Loretta Melby said that's an accurate statement. There's been recent studies that public members shared about the risk of suicide tied to these probation and substance use disorder and is another clear reason why they're bringing this in front of the board. They're starting these discussions, actively looking into this so changes can be made to get this addressed as quickly as possible. That is not something they want to occur and hear you on that. She thinks the one thing that we need to be very clear on, she believes the disconnect here is when a complaint is received by our board, we are mandated by law to act. That means a complaint has been received when we reach out to the person that the complaint is against that is the only time they enter either probation or intervention. It's based on something that has occurred that has been brought to the attention of the board. If we have people that are out there that are practicing, and complaints are not done and errors are not occurring and harm is not happening and they seek their treatment, then that does not need to be monitored through our board because there is not a patient safety issue. What has been brought to our board through this complaint process is that there potentially was a public safety issue. That's why the complaint came to us and now that becomes the board's responsibility to act, and we either have to have them in our probation or in our intervention. We do not have the option to say, go do this on your own because now a complaint has been received.

Vicki Granowitz said once there's a complaint it seems like the intervention program is more punitive than probation and all you get is you don't get it encumbered on your license. If you're in the intervention program that's the main value of the program at this point.

Loretta Melby said the main value of the program is twofold that it doesn't show on your license and that we are actively participating with them for recovery. When they're in Probation, there is not a mandate that they go into recovery. Probation can, depending on the orders, put them into a recovery process, but that does not happen every single time. You may have a person with a substance used disorder or a mental health issue, that could be in the probation area and they would not be mandated to go into a recovery process because maybe there was not sufficient evidence that diversion was occurring, but that they were actually put into probation because of documentation issues. When a judge sees that they may not identify that that is from potentially a substance use disorder and that they were truly diverting because there wasn't evidence that could put in through the court of law to say that there was without a reasonable doubt that that was diversion. You could have a person go through probation without ever getting assistance on their underlying addiction. That's the benefit of intervention is you are receiving treatment specifically to your addiction and your mental health. The benefit of intervention is that it is anonymous, whether it's more punitive or equally punitive. She thinks the next discussion item has a comparison and she thinks that will very clearly spell out the differences. She can tell you the intention is not for intervention to be punitive in any way, and in fact, throughout the nation, it's referred to as an alternative to discipline program. It's not even referenced as intervention. It carries a different name. That is our goal is to make sure that as we're keeping this open as we're looking at it, that it truly is an alternative to discipline and that this does not take a punitive role.

Vicki Granowitz is interested in the next item to hear the statistics on percentages of where the program was. There have been speakers say there used to be 400 people enrolled in the program and now there's 200. What percentage of people are in this.

Shannon Johnson said she wants to be clear that the comparison slide with probation and intervention is in the committee presentation later today, it is not in the board presentation. She ran the reports from the last board meeting to get some of the statistics the board asked for and there are 241, which also includes applicants waiting to go before an IEC for acceptance into the program. When we talk about 600-700 participants in the program, that would be eight or nine years ago. The numbers have gone down for all boards. There are just under 300 participants total and that's for eight boards. The BRN carries the largest number of participants as far as out intervention program compared to the other boards and some don't have any.

Loretta Melby said one clarification is the BRN has the largest number of participants but not the largest percentage. The reason the BRN has the largest number of participants is because we have a very high licensee population so we're not trying to say there's more nurses by percentage in this program.

Reza Pejuhesh said the use of the word punitive; he understands what the intent was actually being said, but punitive is the wrong word to use. Intervention does not approach from a punitive stance, any requirements, whether they're viewed as excessive or unnecessary or not done with the aim of being punitive. Punitive means punishment. That's not what any of this is about. It's about rehabilitation and public safety. He thinks maybe you could replace the word punitive by saying intervention is maybe more cautious in different ways or it's just different for the reasons that Loretta Melby mentioned. The differences between public awareness, as happens with probation, versus not happening with intervention. Another distinction that about the intervention program is not the equivalent of a private treatment center where one would seek rehabilitation outside of this context because in addition to the rehabilitation of the licensee, the board has the obligation of public safety. In addition to rehabilitation and monitoring programs there is this unavoidable element of monitoring, which brings in assessments and testing and things that are understandably expensive and there's policy decisions for sure to be made about how much is appropriate and under what circumstances, all of that. He wants to make the point that there are some important distinctions between this and it's not an apples to apples comparison with private rehabilitation, someone would seek outside of this, and then again the point about punitive.

Vicki Granowitz appreciated the clarification; however, she knew exactly why she was using the word that the public speakers were using to reflect how it felt to them and they need to hear that the board is hearing that. She's sure all of the information is abundantly correct, but they will have to agree that both can be right for different reasons.

David Lollar said he wants to stick to the agenda item and what Reza Pejuhesh said, he doesn't think intervention is anything but productive. He thinks the program has positive intention. So let me be clear about the understanding that you need a diagnostic evaluation, an assessment, drug testing, and he won't use the use the word punitive. Going back to what you said earlier about who's making money off this, he knows the BRN is not profiting from it, but considering the system, as explained to them this morning is set up to make unemployed financially unstable people pay thousands of

dollars out of pocket for something the board is requiring them to do, in his opinion, is at least illogical, at most a terrible business plan that he wouldn't take part in it if he didn't have to. His question is, is there any way to require at the very least since the board’s not paying for it and the state's not paying for it, the assessors or the drug testing places that the board decides they have to go to at least take health insurance.

Shannon Johnson said that would be out their purview as far as making a requirement on a clinician and how they bill or their billing practices.

Loretta Melby said for clarification, a person in probation chooses the evaluator and submits that to staff for review and approval. Intervention, as Shannon said earlier, that person is chosen by Maximus. That is not someone chosen by the board. Maximus would be the one that would have to look at the clinician that would do the evaluation and maybe provide a listing to the public of what insurances they accept.

Shannon Johnson said in the majority of cases, the participant has their own physician, psychiatrist, psychologist that they’ve been seeing and if they meet the qualifications and criteria to be able to deem them safe to practice, the board would accept that. Many times participants have their own clinicians that they see for their rehabilitation purposes.

Loretta Melby asked if Maximus would accept that, because as Shannon said earlier, Maximus is the one that has the list of clinicians for intervention. Shannon said, yes, the initial diagnostic evaluation is done by a clinician that is obtained by Maximus.

David Lollar said that initial diagnostic is no cost to the participant.

Shannon said that is correct.

Loretta Melby asked if the return diagnostic is sought out by the intervention participant.

Shannon Johnson said the participants can either be assessed by the clinician from Maximus or they’ve had them say, they have their own, and asked if it would be acceptable and submit the documentation, CV, and resume. They make sure they meet the criteria to be a clinician assessing based on the uniform standards and then they can have it done with their own. They can seek out individuals that will take their insurance if they have it. But oftentimes, these people when

they go out of work have to go on disability and the subsidized income is not enough but there is Medi-Cal and Medicaid assistance which may not cover the totality of the costs that these programs cost.

Loretta Melby asked if this is clear in the communication, based on public comments.

Shannon Johnson said it’s in the contract that is signed with Maximus.

Patricia Wynne invited Virginia Matthews to the table to address comments and questions. She said this is supposed to be a treatment program and it doesn’t seem like there’s good communication, clear expectations, it feels like the goal posts get moved, and feels unfair. She said she’s seen Ms. Matthews at these meetings for the past few months and has heard the public comments which are not easy to listen to. She would like Ms. Matthews to comment on some of what was heard by all and then they will open up to public comment.

Virginia Matthews introduced herself as the program director for Maximus. She asked where the board would like to start and what are their questions.

Patricia Wynne asked about the clinical diagnosis evaluation and why it seems like a surprise, why people think they’re done with the program and find out they’re not done with the program.

Virginia Matthews said the clinical assessment is covered by Maximus, as Shannon said. The initial clinical diagnostic evaluation or what they refer to as the clinical assessment. The prime contract with the Department of Consumer Affairs, allows one reassessment per participant up to 50 per year. Maximus reached the limit early this year because they realized there were many that needed to be done. As a result, they needed to put the expense on the participants for anything that exceeded the initial 50.

Dolores Trujillo and if additional clarification was needed. Dolores Trujillo said she wonders how the assessment limit was reached early this year.

Virginia Matthews said they realized they had a number of reassessments to do this year because the process changed and participants were permitted to return to work because they were assessed by the IEC committees in previous years. The assessment said they were not safe to practice but the committees were making those determinations in the past and the process was changed. As

board staff looked at the processes and determined that wasn't the proper way to handle it and that's why the board is hearing the process changed. They realized they needed to get an independent evaluation of the assessor to make the determination and that's when the process changed and the assessors are making those re-evaluations. The participants can use their own assessors, psychiatrist or psychologist, and in some cases an MFT or LCSW, if they have the required level of experience, which is typically because of a substance use disorder, then they have to have three years' experience in the field. They have the participants submit their resume, look at experience, and provide a form in a standard format that is used for the reassessment, if their practitioner meets all the criteria. In those cases, insurance covers. To answer the insurance question, it's not that Maximus won't allow them to accept insurance, or the providers aren't accepting insurance, or the labs either, it's the insurance companies won't pay for those services. They don't meet the criteria for insurance to pay. She said in the case of the lab, it's because there isn't a physician order for the laboratory testing, and she thinks that's one of the requirements for insurance to pay in most cases and that's why they won't. She's not an insurance expert, so she's not sure but she thinks the reason for the evaluation is probably the same thing. Maybe there's somebody that knows more about that and can clarify it for us but in those cases that they can't submit those to their insurance for reimbursement because they won't pay for them. She asked if that answered the questions and it helped.

Dolores Trujillo asked if there's a physician on staff.

Virginia Matthews said they have a consulting physician.

Dolores asked if Maximus could mitigate this issue by having the physician put the order in for the labs so it would be covered by the participants' insurance.

Virginia Matthews said she doesn't know the answer to that, it isn't anything they've done and she doesn't know if other programs do it that way either and could look into it because she doesn't know the answer.

Dolores Trujillo said it seems like this program is cost prohibitive.

Patricia Wynne asked if Virginia Matthews could speak to the lack of predictability. She knows there are a lot of variables but when someone comes into the program and get a contract is there an expectation that if you do everything right, you go to all your assessments, you cross every T, dot every I, never had a relapse,

that a person can get through the program in a certain amount of time.

Virginia Matthews said they say it's a three-to-five-year program. It's pretty clear, and in their handbook, and in the information that is given to participants.

Patricia Wynne asked if most people get through in three to five years.

Virginia Matthews said yes and typically the average length of time is 3.5-4 years.

Nilu Patel asked for clarification about the 50 participants covered based on BRN regulations or contract. Is that for nurses or every healing arts board has 50 participants that can get covered.

Virginia Matthews said she didn't understand the question.

Shannon Johnson reiterated and asked if it's 50 for all boards.

Reza Pejuhesh said the initial assessments are covered by Maximus and 50 reassessments per year for all boards but most of the participants are the BRNs.

Nilu Patel appreciated the clarification. She said there isn't a process of who gets covered, first come gets covered. She said there's a financial need for some and asked if there's a way to implement that over the course of time where they can apply. Is there a way to try to be considerate of those.

Virginia Matthews said this has never come up as an issue until this year. This is the first time they've ever reached the limit. There are no criteria up to this point. She said going forward they could implement something and is something to think about.

Alison Cormack said the board is, as one of the public commenters said about six months into this, and she thinks in what she just heard, they finally understand the source of the initial problem, which is that the IECs were determining return to work safety and is that consistent with the uniform standards or not?

Virginia Matthews answered no.

Alison Cormack said she’s going to take a little bit of issue with the fact that the process changed. She thinks the team implementing it was not doing it correctly. She asked if this is an accurate statement?

Virginia Matthews said yes.

Alison Cormack stated that she not interested in assigning blame. She’s interested in understanding how to fix the process. She thinks two things, one is sort of retroactive to the extent that the BRN staff learned that there were significant problems, she thinks those should have been surfaced proactively to the board, to the members of the program, and worked through with Maximus. She understands, she’s worked in different levels of government for a long time. It's hard when you find something that's gone wrong, and it takes a lot to come forward and say we've made some mistakes and now we're going to fix them, and this is going to be hard on everybody. She wishes that had happened, because she thinks that's why we're here today. She can't imagine how frustrating it must be for the participants. It is ridiculously inefficient for a nursing support facilitator group to wait three months, come and tell the board there's a problem, have the board tell the EO, have the EO tell intervention, have intervention tell Maximus. She wants to get that out because this is not the first or last time any organization will find a problem, but it does not help to not surface it. That's one thing that she wants to say. Her other thought about this is that the board has to figure out some way and she doesn't know if it is in this item or in the committee or if this will be a staff led process that comes forward to them next time or some other idea, she can't think of right now to apologize. She thinks there are some apologies in order, for how this is affecting people's lives today. She thinks there's also an important point to be made and EO Melby has made it that people are in this program because there was a problem. A problem occurred and the job of everyone sitting up at the dais is to protect public safety. That is why the board is here. The board has to balance these things. It can be difficult, and she thinks there's some more social emotional work that the board could do. She shares board member Granowitz's concerns and they were evidenced by people who were willing to step forward. She also at the same time knows that their job is to make sure that the nurses who work in this state are safe. Those are the two balances. It is not inconsistent with protecting public safety to say that the board made a mistake and they're sorry, they're sorry that they let people return to work when they weren't safe. They're sorry that it feels like they're changing the rules. They're sorry because they weren't implementing them correctly. She wanted to say that, because as you know, it's been hard for everyone to participate in this and feel like they're not really getting to the basis of it. She can see why someone would say the

process changed. She thinks the more accurate statement is they were not doing it correctly and now they are, and they're doing it for all the right reasons. She’s sure it feels horrible for some people. That's what she wanted to say on this topic.

Jovita Dominguez said Virginia Matthews mentioned 50 reassessments per year are through Maximus. Is that correct?

Virginia Matthews said all initial assessments and 50 reassessments.

Jovita Dominguez asked on average how many reassessments does on person go through in a year?

Virginia Matthews said typically not more than one.

Jovita Dominguez asked Virginia Matthews if she mentioned that the majority of the participants already have 50 and it is June, is that correct?

Virginia Matthews said it would be unusual to do one for everyone.

Shannon Johnson said she could explain why and can show it in an upcoming slide. When looking at all the cases where their last assessment said they were not safe to practice, there were upwards of 37 plus and staff requested they be reassessed. Right off the bat, at the beginning of this year they were asked to have another reassessment.

Loretta Melby said that isn’t 37 for one person but 37 individual people. She said it sounded like Jovita Dominguez was saying one person had 50 reassessments. Loretta Melby clarified that eight healing arts boards have 50 reassessments available each year.

Jovita Dominguez said she misunderstood and thought one person had 50 reassessments per year. She was thinking about insurance coverage.

After Public Comment:
Patricia Wynne said they’ve heard the commenters and they’re listening. This is the third meeting they’ve had where they’ve allowed public comment. There’s a lot of note taking going on and they’re all committed to making improvements to this program. She’s asking both staff and Maximus staff who’s listened to this to try to improve this program. There’s some longer-term improvements that could be made but she’s glad they’ve done this even though it’s not easy and it’s heartbreaking. She asked for any other board comments. She

doesn’t think this item needs a motion and encourages staff to keep working on this and the board will be discussing this at a committee meeting when the board meeting is over and at the next board and committee meetings.

Alison Cormack said with respect to the reassessments they were speaking about earlier this morning. She brought up the opportunity for the board to make a motion to direct staff to direct Maximus that if someone joins the program tomorrow there will be a line that says something to the effect of, if at some point you are assessed as unsafe to work or it sounds like there’s a modification of that or safe to work only with restrictions, you may or shall, be required to undergo a reassessment at your own cost. All of that needs to be in there to address this one item. She would like to know if this is something they need to vote on and have a specific motion on.

Patricia Wynne said is this something that might be addressed through the request for proposal (RFP)?

Alison Cormack stated that she doesn’t want to wait for the RFP.

Shannon Johnson said that could be done now.

Alison Cormack asked if staff requires direction from the board to do so?

Virginia Matthews said they could make the changes immediately by Monday.

Alison Cormack said it sounds like in the long term there’s a whole new question about who does the reassessments and what information they have available. That was a new concern that she heard in the most recent public comments but doesn’t think that can be addressed directly today. She thanked staff and Maximus for taking this on and it’s her expectation that will be fixed immediately.

Patricia Wynne said another thing she heard pretty consistently throughout is how difficult it is to get drug tested on weekends and evenings in rural areas. If a participant checks in and they live in a place that doesn’t have a testing site and they work that day. It feels like they’re setting people up. She doesn’t know if there’s an easy fix for that.

Virginia Matthews said it is especially difficult in rural areas. Even in San Francisco they’ve had problems on the weekends finding collection sites. She doesn’t know San Francisco has been so difficult

but it has been. They've recently started making oral fluid testing available. They allow the participants to purchase five kits for $35, so it isn't too expensive, but purchase oral fluid kits and they help them arrange that through the vendor. If they're testing on the weekend and they can't find a site, they contact the vendor and they'll do a video collection so they're on camera the whole time they do an oral swab, put it in the collection kit on camera and it gets sent off. It's very close to the same test panel that is used for the urine test. It's not exactly the same but it's close. That allows them to have a substitute when they can't go out. They've made it available for anybody in remote locations that can't get to testing.

11:47 a.m. Public Comment(s) for Agenda Item:

Chris Else: Stated that he's the nurse support group facilitator for San Luis Obispo and the surrounding area . He wants to make the board aware that the California Medical Board is now trying to get rid of the uniform standards. He doesn't know if everyone on the board is aware of what the Medical Board is doing. In 2000, they took part in a national study by the National Council of State Boards of Nursing, which is establishing best practices and encourages the boards to follow them. It sounds like some of what is happening with uniform standards is that they are being misinterpreted as well. Some of the numbers Shannon put out here from National Institutes of Health, which covered 56 state boards says the national average is 48 to 90% of the nurses do recover in the in the recovery program. If ours in California is 10%, we're well within standards. 10% recidivism for addicts and alcoholics in general is very, very low. If we're seeing 10%, of course that's not acceptable. He thinks they need to go back to the National Council of State Boards of Nursing instead of these Uniform Standards.

Amanda: Expressed dissatisfaction with the BRN's Intervention Program. She's shared concerns about being extended in the program and required to pass narcotics in direct patient care. The case managers don't have any answers when questions are asked of what the new expectations to graduate are and the IEC members will not answer questions during the meeting. They only state they will deliberate and make a decision at a later time. Unfortunately, for her, she has a medical condition as to why she is unable to perform the duties of a floor nurse and have had numerous surgeries over the last few years. Not only did she get multiple doctors notes indicating these physical limitations that prevent her from working on the floor, she also uploaded disability paperwork, MRIs, surgeons' progress notes, and medical records to no avail. The IEC still refused to exempt her

from these new requirements and denied her completion. Now she is being mandated to do a job that she cannot physically do without serious medical ramifications or sustaining further injuries. She urges you to please remove these new requirements, as many people before them have graduated, returned to work safely, and have maintained sobriety without them.

Daniel: Expressed dissatisfaction with the BRN’s Intervention Program and the return to work eval., the requirement to work six months with narcotics and shared difficulty communication with the case managers.

May: Expressed dissatisfaction with the BRN’s Intervention Program. She wanted to give an example regarding the discussion earlier, her last IEC meeting was May 10. She didn't have any issues. She was given high praise et cetera and was told that a decision would be made regarding her completion in 10-15 days and she found that on June 4, that not only is she not completed, but was added back into the nursing support group without explanation and she would have been non-compliant if she wasn't looking it up herself. Also, regarding getting into the program, it was verbalized to her that if she didn't get into this program, she would lose her license and be prosecuted, so that's the kind of voluntary program that this is. Since April 2020, she’s paid almost $20,000. Don't even apologize, she wants this nightmare to be over.

Danielle: Expressed dissatisfaction with the BRN’s Probation process. She shared she is on that she had a complete evaluation performed by a physician who was board certified in addiction medicine and had been practicing for well over the three-year minimum and it was not accepted.

Dr. Julie Armstrong: She’s an evaluator for the board and she wants to concur from her side of things that the participants that must be evaluated do experience this as punitive. Not so much because of the board's actions, and to be very direct, it's because of the experience at Maximus. The on the ground work of the case managers is not supportive, not helpful, and sometimes even perceived as threatening. Regarding insurance covering any of these costs, they will not cover the costs because it's not considered medically indicated. Medical necessity is a consideration for insurance coverage. If there was something that included, e.g., at Maximus, a standardized protocol, in addition to writing orders indicating the necessity, then those nurses might be able to get some insurance reimbursement. But as, as it stands now, these nurses are not going to be able to get their services covered because they are

administrative needs, not medical needs. Finally, she would say that it might be helpful to consider having a maximum fee for each of the different services.

Callie: Expressed dissatisfaction with the BRN’s Intervention Program. She shared that they have this clinical assessment when they enter the program then they are removed from work and they're told that if they go into this program, they’ll be prosecuted or lose their license. It's not voluntary. They understand there are things that need to be done to prove that they are safe to practice.

Anna: Expressed dissatisfaction with the BRN’s Intervention Program. Said it's a known fact that the BRN is not getting any money, but someone is getting her sister's $12,000 dollars that she's paid for testing alone in the last three years. Her sister was deemed safe to return to work after a year and then, when she was told to meet this requirement for controlled substances, she did get a job with access, and she was told that she needed another evaluation to deem her competent and safe to return to work. That was her second evaluation. This requirement of controlled substances is not going to decrease the number of repeats. It will prevent people from self-reporting, which is the safest for the public. People want these nurses to report themselves because there are so many nurses out there that have substance abuse problems that do not report themselves because of what's happening.

Mark J.: Expressed dissatisfaction with the BRN’s Intervention Program and shared that the program is most definitely punitive. Board member Cormack hit the nail on the head. They were not accurately represented the requirements of the uniform standards upon entry, and then three to four or five years down the line, they were getting these “new processes” imposed even though the uniform standards have been in place for years. They were not done in practice or described or detailed to them upon entry or placed in their contract. They're watching this unfold in real time in front of their eyes. Miss Johnson and EO Melby seem to be gravely misinformed yet again about the scope of the narcotic passing requirement. It is not done on a case-by-case basis. He can tell you for a fact, this is misrepresented. This is why he calls for an investigation of each case under Maximus because there are participants who are being imposed this requirement.

RAN: Expressed dissatisfaction with the BRN’s Intervention Program. and stated that you guys don't know anything about recovery. It’s so obvious, that's it.

Tara O’Flaherity: Said she’s the director of nursing at Lifelong Medical. She has a number of nurses that are in this program in both diversion and probation. she was a bit shocked to hear that there are only 50 reassessments that have been done this year, yet at their relatively small organization that has 56 nurses. She has four nurses in this situation, so that doesn't seem to make sense to her. The math there, she lost a nurse last week at a small clinic that only had one nurse. Previously she had been suspended for 30 days or her license had been suspended for 30 days because she was forced to get another job and was working seven days a week trying to meet this requirement of passing or having access to narcotics. She has yet to receive any guidance about how to accommodate these employees, which she would like to do because their clinics depend on them. In that month that she was out, she had a significant incident report that happened because they didn't have nursing coverage and they were trying to scramble to find coverage last minute with literally no notice, and a patient’s care was jeopardized because of that. This program is causing far more harm than it is good. She would agree that it is punitive. The things that she has seen while hiring nurses that are in these situations have been shocking. She has been searching for peer reviewed articles around addiction to see where it is a therapeutic recommendation that you force someone to have access to narcotics. There's access to narcotics all throughout the life. So just having access to it in the job, making that a requirement to her is nonsensical. Somebody if they really wanted to use, would use. It would be like forcing somebody who is dealing with alcoholism to go and get a job in a bar. To her it's completely nonsensical and she would think that the BRN needs to take accountability, not just the apology, she heard the apology which she appreciated, but she was concerned that while they have not been implementing this correctly and we apologize for that, we will now implement it correctly. It should not be put in place at all. She’s been overseeing these nurses since 2020. This is the first time she’s heard of it, in January is when it came up. She still has yet to see anything in writing.

Anonymous 25: I wanted to thank the board for holding a robust discussion on this topic which has caused so much strife and trauma for participants in the Maximus program. I'm a member of the public, I am not a nurse and expressed dissatisfaction with the BRN’s Intervention Program. Sharing that they would never recommend a nurse enter this program. They would tell them to seek outside treatment. Isn't that sad that a program designed to help nurses with substance use disorder is being described as punitive and inflicting trauma on its participants. We just heard a participant mention they have never felt suicidal in their life until now. That actually breaks my heart. That is so sad. Shouldn't the board strive to operate a program

where nurses feel safe and heard at the most vulnerable time in their lives? Your nurses are scared, traumatized, and in fear. Is this a program you want to operate? If the answer is no, then do something.

Oscar: Expressed dissatisfaction with the BRN's Intervention Program. Hearing these stories kind of breaks his heart because he'll tell you a little bit of his story and his opinion shortly. He has been in contact with the board of nursing over the years to try to get the statement of issues of his nursing license off the website. Just about five, six months ago he interviewed at a facility, and he was asked by the HR director, "hey, do you need to be in recovery?" His last DUI was in 1985. The statement of issues in his "history of disciplinary action", if you go to the Board of Nursing is still there, not even felonies that get a prison sentence must endure this thing for 30 plus years. It is punitive and he thinks that it even goes to punitive and cruel and unusual punishment for somebody that has had a stellar career to 35 years later because it was in the Board of Nursing website that said that you had a punitive action taken against you, and then they can go in there and read that you had a DUI and how you were arrested and all those kinds of things three or four decades later.

Aaron: Expressed dissatisfaction with the BRN's Intervention Program and requests a major deep dive into this.

Judy Corless: She's really saddened to hear a lot of what's going on here. She chaired the disciplinary committee. Four years from 2009 through 2012, and we hired Virginia Mathews from Maximus to manage the program, and all their people that were in it. We never had these types of statements going on from the participants, and in fact we saw every month all of the people that had these issues and got them released, got them back to work, listened to their cases in person on the disciplinary day, which was very important for student nurses to see how this works because she think it helps them see that they never want to get involved in these types of things. She would think at this point, you would look back at what they did that worked and compare it to now with Ms. Mathews and see what is different because they never had all of these problems or the discriminated nurses. They came, they participated, they did their work and sure there were some that were in a long time, but much of that was due to their own inability to work through it. She would like to see the board do a comparison and try to get this straightened out and she thinks being back in person would really help the students. She's involved with students every day, and when they get to see the hearings, they're so appreciative of it.

Reza Pejuhesh said he didn’t know if something was different back then or there’s some confusion, but he thinks the board may have sat in on discipline hearings which are different than intervention evaluation committee meetings to review.

Judy continued saying she understands that. It's just that they were able to see how the board allowed them to get through the program and they can make it and can get back to work. It really made a big difference in our students and that wasn't the IEC. It was the actual discipline hearings to get them back to work or released or that type of thing.

Board break for lunch from 12:32 p.m. – 1:05 p.m.
Board reconvened and re-established quorum at 1:05 p.m.

Matthew A.: Expressed dissatisfaction with the BRN’s Intervention Program. Said before the break, board member Cormack, he appreciates your words and offer to apologize to the participants, and felt that was heartfelt, but apologies don't help the participants get out of the program after years of successful compliance. The IECs say, you have to get your information from Maximus and the case managers, participants ask the case managers, what's going on? Why are they being extended? Why are these new requirements? Case manager says they have no idea, ask your IEC. Now the participant waits three months, goes into the IEC, the IEC members don't allow them to ask any questions. They essentially give a barrage of questions and then say, thank you, you'll get a decision in seven to ten days. Again, decision comes out later, case manager relays the decision, and participant asks why these decisions are being added? The CCM has no idea, ask your IEC. So it goes around and around. The board's interpretation and application of the uniform standards. are what's causing the issues. He believes Ms. Granowitz was the one who asked the right questions about that these issues not starting until about six months to a year ago. That's right because that's when enforcement or the board started interpreting these uniform standards in a certain way.

Reza Pejuhesh provided an announcement that the BRN website is having technical difficulty. In fact, all boards and, DCA websites are having issues. If anyone left the Webex during the break and tried to return to Webex from the agenda on the website will not be able to do so because it is inaccessible. If anyone is trying to join after coming back from lunch.

Loretta Melby said there are 112 participants, 107 attendees. Prior to going to break the numbers were fluctuating between 100 and 120.

She’s seen the attendees increase over the last couple minutes from 103 to 107.

Reza Pejuhesh said if there are members of the public who are hearing from other colleagues or participants or anybody that they can’t access the meeting, please let them know that’s the reason. They can alternatively access it through the phone number it’s listed on the website. As Lori said, it looks like there are still roughly the same number as there were before.

Loretta Melby said it just increased to 108 to another person was able to join while we were speaking.

Reza Pejuhesh apologized for the interruption and said we can go back to the public commenters.

LH: Expressed dissatisfaction with the BRN’s Intervention Program. Said shared concerns regarding the reassessment part of 4.2, stating that this is not a case-by-case individualized decision. So according to Ms. Johnson, they are all out here working as nurses and every single one of them had been previously deemed unsafe to practice. She has a hard time believing that unless she's equating unsafe as equal to not having had a follow up clinical evaluation. The committees make the decisions to return them to work based on the monthly and quarterly reports and evaluations completed by their case managers, treatment providers, nurse support group facilitators, and themselves regarding their progress in the program, personal life, sobriety, mental health issues, work performance et cetera. It's not done absent mindedly. At an initial evaluation when she started the program, she was told this was to determine her appropriateness for the program. At her six-month IEC after completing IOP and starting after care, her IEC determined she was safe to return to work with some limitations. Just because she did not have another clinical evaluation right before returning to work does not equate that she was unsafe to return to work. The board is basically covering their rear ends at the expense of the participants. Regarding Ms. Melby’s statement about complaint letters with invitations to voluntarily join the program, that was not the case for her. Her complaint letter had no mention of this program. She was voluntold to enter this program by the DCA rep if she wanted to protect her license because there was a chance that she wouldn't get to do probation, her license would get revoked.

Bobby: Expressed dissatisfaction with the BRN’s Intervention Program and shared her experience after receiving a DUI.

Cheri Giles: She’s a nurse group facilitator with Molly Shirk in Oakland, California. She thinks one of the things she’s really looking forward to is seeing some of the data. She'd like to know the correlation between what happened pre-pandemic in 2020 versus what's been happening the last several years. She completed the intervention program in 2019 after spending three and a half years in the program she met with her IEC in person every three to six months. It was consistent, people that saw her growth and called her out on some things when that needed to happen, it was so valuable for that kind of consistency. It seems to be all over the place for evaluations. It seems like if this evaluation through a therapist is what's going to get forward, it should be the same therapist or provider throughout the whole process.

Sophia: Expressed dissatisfaction with the BRN’s Intervention Program. She shared concerns about the clinical reassessment, delays with her IEC, fees, testing requirements, work reports, and work restrictions.

Anon 2024: Expressed dissatisfaction with the BRN’s Intervention Program. He wanted to convey the information presented from Shannon has been misleading and misrepresentative of the true costs. There is no advocate that he’s heard represent the nurses. There's no advocacy group, there's no advocacy component within the board of nursing and when he sees the reactions on people's faces in the meeting from the board members, they're shocked and amazed at things that are going on underneath their care.

David: First, he’d like to say he is grateful for the program of recovery, and he thinks without it nurses would be left in dismay. Additionally, he expressed dissatisfaction with the BRN’s Intervention Program. He shared that the medical doctors are instituting their own recovery program and when reviewing the uniform standards, they found them to be very punitive and they rejected those uniform standards. He also shared concerns with testing requirements, missed calls and being taken out of work for 30 days.

APRN: She said thank you for taking the time to have this discussion, it is so difficult, and thank you board members. She then expressed dissatisfaction with the BRN’s Intervention Program and shared that it feels like this is a giant cover up and this is the government agency.

Participant K: Let her start off by saying that the diversion program saved her life. She trusted that by entering this program and staying compliant, she would retain her nursing license. She will have been clean and sober for four years next month. In August she will have

been in this program for four years and expressed dissatisfaction with the BRN’s Intervention Program sharing that she was scheduled to complete the program and less than two months before she was scheduled to complete the program, she was told that her meeting was canceled because the BRN is adding new requirements. Her case manager told her that before she could meet up with the committee again, she would have to find a job where she would have to work with narcotics at least six months. She has no desire to pass narcotics again. She doesn't know what to do anymore. It has been a year and a half since her last committee meeting, and she still doesn't have another meeting scheduled even though she asks every month that she be placed on the docket.

Hey M: Expressed dissatisfaction in the BRN’s Intervention Program. She was encouraged by her committee to not do patient care, not because she diverted drugs, but because of her mental health and the stress that she was under in her personal life. At the end of December, early part of January she was informed that she would have to get a job passing narcotics when she had been at her job for over two and a half years and then she was told that she would have to have this clinical assessment done and pay the $225 after she had already been in this program for three and a half years, that she did so she could have her next IEC meeting next month, she has done everything that she’s been asked to do, told to do, and everything that's in her contract. She completed and wants to be done. Please listen and please do something.

Participant: Expressed dissatisfaction with the BRN’s Intervention Program and shared that about a week to a week and a half before her IEC meeting she was told that she would not be meeting with IEC. She wants to be reevaluated by the IEC. She has health problems that she was hospitalized and she’s afraid to continue treatment because of all the documentation that they're having to do. She was supposed to be done. She feels like a prisoner in this program.

Anthony: First, he wanted to say thank you to Ms. Cormack and Ms. Granowitz. He expressed dissatisfaction with the BRN’s Intervention Program. Something needs to be investigated. You need to follow the money because there's a huge issue.

Reza Pejuhesh apologized for the interruption but said the website is back up, so if any of the members of the public knows of anybody who had difficulty getting back into the meeting, they should be able to access the agenda. This was DCA wide, not just BRN. He checked with the moderator to see how many more commenters remain and the moderator confirmed that there were four.

Mary Hagerty: Shared dissatisfaction with the BRN’s Intervention Program and shared that in 2022, Shannon Johnson, an enforcement and probation expert was placed in charge of the diversion or the intervention program. Since she has been appointed, she has arbitrarily made decisions without any conferencing with the clinical experts of the program. Not only must they now have another clinical evaluation but the intervention program, she has canceled the transition phase of the program. She has participants no longer being seen by their committees. She has mandated single handedly that nurses who miss one call in, will have to be taken off work for 30 days. None of these implementations that she has mandated single handedly went through the board process.

Florence: Expressed dissatisfaction with the BRN’s Intervention Program. Sharing that Maximus has run a successful program for decades and it wasn't until the BRN promoted staff from the enforcement division to lead what is supposed to be an evidence-based program, not discipline, that these concerns arose. The current BRN leadership is turning intervention into a branch of enforcement and probation and adopting the same rules for both. Maximus is the vendor and Maximus follows the directions of the BRN and the intervention committee. Clearly, there has been a major alteration in the interpretation of programming with an enforcement lens as opposed to a treatment lens. The BRN needs to monitor the direction their staff are going to the contractor to truly understand where the issues are coming from.

Millie: Expressed dissatisfaction with the BRN’s Intervention Program. Stating, the core of the IP used to be the IEC, clinical case managers, and nurse support groups. Since Shannon became chief, the clinical component of the program has been replaced with complying with the uniform standards. The IEC's role has been greatly diminished and the CCM's have become over educated note takers. Shannon comes from discipline and probation. It's obvious her understanding of recovery is limited at best. How can you oversee a program you don't believe in? Requiring nurses to work in patient care with access does not guarantee a relapse will not occur. She implores the board to reject this item. One of the main reasons the doctor's program no longer existed was because a board tried to run it using board staff instead of contracting out to an agency that has the background and expertise. You can't run a recovery program without the clinical.

Alec: Expressed dissatisfaction with the BRN’s Intervention Progra. He’s not a nurse, but he wants to speak again on their behalf as a concerned citizen. He hopes the board recognizes that the steep

financial impositions of the program in addition to it seemingly at times arbitrary nature and lack of transparency are in no uncertain terms as many have noted unnecessarily punitive and dare he say immoral. He hopes the testimony of nurses today leads to much needed reform. Needless to say, any state sponsored program that has the potential to make participants suicidal is inherently unjust and in dire need of reform. There is absolutely no excuse for inaction in maintaining the status quo. He implores you all to make this right.

Terry: Expressed dissatisfaction with the BRN's Intervention Program. She wanted to tell the board she was a case manager for Maximus for almost 15 years. She resigned last year in May. One of the main reasons that she resigned from her job is because it totally changed. She agrees with a lot of what the participants are saying. There were a lot of inconsistencies from the board. The interpretation of the guidelines changed, the guidelines have not changed. In the 14 years that she worked there, the committee made all the decisions. This was a committee of educated nurses, psychologists, a doctor, and a public member, who looked at the case, they looked at the case individually. Decisions were made based upon if the person was compliant, if they were doing well in their recovery, they had treatment provider reports, nurse support group reports, recovery reports to go by and how they were doing. Now the committee could make a recommendation and then the BRN made the final decision. Tell me where on earth a non-clinical person should be making decisions about RNs or any healthcare providers careers.

Kevin: Expressed dissatisfaction with the BRN's Intervention Program. He is a grateful recovering alcoholic and also a nurse, and he wants to thank the board for having this forum. In particular, thank you, to those that seem to be listening with the intent to understand and not just defend. Then to the rest of the 100 or so nurses that are on here he wants to thank them for being courageous and tell them that there is a place for them and a place where they have an opioid epidemic. They have a place in nursing and in recovery, to do a lot of good and look to your other fellow nurses because they have your back and support. Finally, please reach out to your local elected representatives because they want to hear from you.

Eric" He's a retired 37-year law enforcement detective and specialized in fraud investigations. As an outsider looking in on how Maximus operates, he would have loved to investigate this organization. He said this appears to be a systemic problem where the almighty dollar seems to rule at the end of the day and not the well-being of the participants. If this business was designed to help

guide the participant toward a healthy reintegration back into the workforce, they have failed tremendously.

Susan: She wants to say thank you to board members, Alison Cormack and Vicky Granowitz for your acknowledgement of the situation, your concern, and empathy that you are listening to them. She then expressed dissatisfaction in the BRN's Intervention Program. One of the reasons she enrolled in the program three years ago is because of the success rate of the program, 98% success, and her sponsor went through this program. She's got seven years sobriety close to eight and she gave her the expectations of what was expected of her, and that she was capable of doing this program. She was reading her contract. Her agreement reads, "I understand as a participant in the program, if I am non-compliant, I may be terminated from the program." She feels like she's losing hope in this program.

Break from 2:25-2:35 p.m.
Board reconvened. Quorum reestablished at 2:36 p.m.

2:36 p.m. **4.3** **Discussion and possible action:** Regarding working as a registered nurse in a position requiring patient care, with or without narcotic access, prior to successful completion of Intervention Program (including review of supplemental information requested by the Board during the May 23-24, 2024, Board Meeting)

Board Discussion: David Lollar said he had two questions about testing. He said the slides were great with the average cost for testing based on the amount of money some of the participants say they pay out of pocket. He asked if there are other costs besides testing included in this program?

Shannon Johnson said that information would be in the presentation scheduled during the committee meeting later today. She doesn't think they'll have time but there are other costs for the mental health exam, physical exam. The comparison is for both probation and intervention that shows where the costs lie. They also have costs for nurse support group, therapy, treatment. She was going to do a slide showing costs for all of that, but it depends whether they have insurance and what type of treatment they start with. For instance, if they start with residential treatment, that will be higher versus starting with an intensive outpatient program with aftercare. All those costs are different depending on many variables she didn't include it here, it would be a lot. She can do more research if you would like.

David Lollar asked the testing company's name. Shannon said the company's name is Vault. It used to be First Source and First Lab. It's Vault, who was purchased by another company.

Virginia Matthews said they were recently purchased by Sterling and then by First Advantage.

David Lollar asked if the one of the issues is finding a testing center or a time they're available to test.

Shannon Johnson said they are under contract for use in probation, the field investigators for random testing and Maximus for intervention.

David Lollar asked if we could contract with others to increase testing locations. Shannon said they could go out for bid if they needed to.

Virginia Matthews said they are a third-party administrator so that there is some manner of control over how they do the testing, what's being tested, where it's being done, and what labs they're using.

David Lollar said he understands that but there are other testing companies in the state that do the same things.

Shannon Johnson said about 15-16 years ago the BRN had a different testing company and then moved to Vault. She also said some of the other boards use a different testing company so it's a possibility.

Reza Pejuhesh asked for clarification about whether Vault is a subcontractor with Maximus or directly in contract with BRN.

Shannon Johnson said both.

Reza Pejuhesh said direct contract for the probation side and subcontract with intervention and Maximus. Reza Pejuhesh continued to ask when Vault collects testing fee or whatever fee they collect, if it gets remitted in full or part to Maximus.

Virginia Matthews said no fees or money goes through Maximus.

Alison Cormack said this is a good start. She said she used her phone to take photos of the slides since they aren't posted to the web. She said this is something to discuss with staff because it can be difficult to catch things as they go by and if someone later wants to review the materials they would have to watch the entire thing. She

said other places she served would post the slides in advance or concurrently so people can see them. She asked about transition because Shannon used it in the past tense so is transition no longer a stage in this program.

Shannon Johnson said she wants to get rid of or away from it as an underground regulation of a one applies to all kind of method because it should be based on a single person and previously was a point in time and automatic.

Alison asked if it was automatic after two years. She asked if transition still exists.

Shannon Johnsonsaid it does, but it isn't being called transition. They're having the IEC look at them as an individual and not say they're in transition for one year and then automatically completed.

Alison Cormack asked if there is a step down where some of the restrictions are lifted and is standard for everyone in the process.

Shannon Johnson agreed.

Alison Cormack stated that she is glad to hear there will be an additional day added to the IEC to get people caught up. She asked if this would catch up the reassessments or people who are in limbo.

Shannon Johnson said there is a redistribution of cases because one IEC has 42 and one has 18. The redistribution, IEC additional days for the next couple months, and backlog will be cleared up in the next two months.

Alison Cormack said that because there seem to be communication issues with this program, she expects that if someone is transitioned from the IEC with 42 to the IEC with 18 that there it will be done in a thoughtful manner with handoffs, etc.

Shannon Johnson answered in the affirmative.

Alison Cormack said she can imagine that would be concerning for people who worked with their IEC and then to be sent to another group who isn't used to them.

Shannon Johnson said another backlog created is because there used to be an evaluation consultant from the IEC who would make a decision on their own on every case that would be similar to the board members reviewing disciplinary cases and you are the sole person

making a decision. Those decisions weren't being made by the whole IEC and being voted on and that position was eliminated because that was outside the law to have that position make those decisions. Because of this a lot more decisions had to go to the IECs as opposed to having that decision made quickly over the phone by a single person. That created a backlog because it was eliminated about a year ago.

Alison Cormack said she had more questions for Maximus and clinical care managers but she's cognizant of the fact they're supposed to be discussing requiring patient care and narcotic access, which were not directly addressed in the slides.

Patricia Wynne said they are going to segway into that so Alison can ask her questions and she will follow up with hers.

Alison Cormack she would like to understand the turnover rates for the CCMs and their tenure would be helpful. She would also like to know what the process is if a participant cannot get in touch with their CCM for an extended period of time. She would like to get that on the public record.

Virginia Matthews said she doesn't know off the top of her head the turnover rate, but they are filling a vacancy for a part time case manager who is leaving at the end of next week. They already hired a replacement and she'll be starting in the middle of July. It takes time to onboard, but the replacement has been hired as a full-time position rather than part time. They had a part time case manager and hired per diems to fill the rest of the time. She said this may have been the case for one of the public commenters. Hiring the full-time position should resolve this.

Alison Cormack asked if there is a phone number or email for participants to use.

Virginia Matthews said they have the case manager and compliance monitor who work as a team on each caseload. They also have some part time staff that help to fill in to make sure they're getting their phone calls returned and someone is on call 24/7 to handle emergencies or after-hours calls.

Alison Cormack asked if it was a requirement up through 2023 that someone in the intervention program had to work with narcotic access before they could complete the program.

Shannon Johnson said no.

Alison asked if some people were required to be in a position that had access to narcotics before they could end the program.

Shannon Johnson said she believed so.

Alison Cormack said then it was done on an individual basis, it wasn't a blanket requirement.

Shannon Johnson said no.

Alison Cormack asked if it is currently a blanket requirement to exit the intervention program to work in a position that has access to narcotics and provide them to patients.

Shannon Johnson said no.

Alison Cormack asked for help to understand the concerns of what seems like new information, new requirements.

Shannon Johnson said she's not sure because if a participant has not gone before an IEC, the body that is making the determination on what is needed to complete, because it isn't herself or Jaspreet Pabla, the program manager, it's not Maximus, it's not the case manager. It's the IEC. She said what's different now is they're looking at every aspect of the cases instead of making decisions without all the evidence in front of them. Evidence meaning all the exams, all the reports, all the violation information, that wasn't being reviewed as to why they were in the program or what brought them to the program initially. There was a lot of missing puzzle pieces and now they're asking them to review all aspects of a participant individually and make the determination.

Alison Cormack asked Shannon to unpack this because it's a big topic they've been hearing about for months, and this is the first time they've had a chance to ask questions about it. She continued and asked if someone is in the program for narcotic use would that be the kind of person asked to be in a job with access to narcotics?

Shannon Johnson said it is typically people who have diverted or been impaired at work or something along those lines that the IEC has determined they should be monitored for a while before being released from the program. She hasn't seen single DUIs requested by the IECs to work with narcotic access. They completed someone recently who worked without direct patient care.

Alison Cormack said she would like to come back to that. she continued by saying she knows the probation and intervention program serve different purposes. Nevertheless, we probably won't do it today because she doubts, they will get to the committee meeting today, but you will be presenting them with some information to compare and contrast. In your experience, if someone has had a history of diversion and is in the probation program, are they expected to go into work that includes access to narcotics before their probation ends?

Shannon Johnson answered in the affirmative. She said that's reviewed on a case-by-case basis and they take the recommendation of the mental health and physical exam because they write their recommendations on employment, in what capacity, and if restrictions should be made and that's for probation. They also have an enforcement nurse on staff, and she reviews all cases and reviews employment and has conversations with the employer to ensure that they have them in the appropriate monitoring position prior to completing.

Alison Cormack said they see people in probation move from maximum, to moderate, to minimum supervision with that. She will be interested to hear more from the public and her colleagues on this topic of whether it is appropriate or indicated and to the extent that it's being done because they're hearing it's being done on a blanket basis from the public or from people who are participating in the program. As to the patient care, you know, they've had some people say they feel based on what stage they're at in their recovery, they like the case manager work that they're doing, that they don't want to go back to bedside, that they don't want to have access to narcotics, and they feel stuck. They're recognizing what they would like to do if they were not in this program, there would be no requirement for them to do something they don't want to do before returning to what they must do. How can we think about solving this problem?

Shannon Johnson said she's not sure, and that's why the question of the recidivism came up because they have nurses that are in the program for the second or third time and they were not required to work as a registered nurse or work in patient care, but when they successfully completed, that's the position that they went to because that's what they came from and that's what they know. In fact, they recently had a case that was reviewed that successfully completed and when the IEC asked what capacity they were working previously because this person wanted to be completed without working in direct patient care or with access and this individual stated that they were not required to work as a registered nurse in any capacity, but when

asked what they did when they left and this individual stated they went back into the emergency room ICU, and the IEC looks at that and say they didn't monitor before, so should we monitor now in this capacity. It's all case by case. If this board wants to vote or, she doesn't want to say dictate, but decide whether to remove certain restrictions or ask the IEC not to put in place certain restrictions on licenses or requirements to complete successfully that's up to this board to decide.

Alison Cormack said the scenario Shannon is painting is one they struggle with all the time whenever they're trying to make decisions that apply to everyone. What the potential harm of letting one person out who perhaps should have had more restrictions versus the cost imposed on the other nine. She’s using these numbers hypothetically; she’s making these numbers up. This is a balance they have to strike all the time. How strict should the rules be to prevent one person from causing harm, and what is the impact that has on all of the other people who have to abide by rules? This is one of those instances. This is how it feels to her based on her experience. Balancing the costs they are imposing, or the requirements being imposed on this many people that there might be a problem and she doesn't know that she has the answer to that today. It is a little bit hard to reconcile what they're hearing from the participants with the information you're providing, which is that it is not a blanket requirement. She thinks this will be the task for them to figure out today.

Patricia Wynne said Alison raised a number of issues that she had. The one thing she wanted to follow up with Virginia Matthews on is the case management. They've heard repeatedly throughout all the public comment how integral case managers are who work with Maximus to get people through the program. Yet they hear that there's a high turnover and a lot of people said they call and call and can't get a call back and that certainly doesn't go toward recovery. That leads to total frustration and unhappiness. She’s hoping Virginia Matthews will take that message back. Maybe it's more training, maybe it's more staff. She doesn't know what it is, it's your business, but she hopes that Virginia Matthews has taken that to heart because certainly that is so important in a program like this.

Patricia Wynne said on the furnishing issue, there's so much finger pointing, the participants are being told it's a board decision staff is saying the IEC's makes some of these decisions, Maximus is in there somewhere and she hopes we continue down this road of program improvement we try to get away from all the finger pointing and come up with a policy that works. She likes the case by case very much. She thinks that's really where we ought to be and certainly the

participants feel, totally blindsided by it. That would be a priority for her to try to figure out how to do that well. She knows it's not easy. It's going to be hard to come up with a policy and she appreciates the case-by-case approach. And you know, to just follow up with you again, board member Cormack, you know, that's the difference between probation and diversion. In probation, it's totally transparent. Everything is public, everything gets published, we get to see everything we get to see the step down probation, we get to see when someone has the relapse or has a problem and it comes back to the board and they're extended but in this diversion program, which is confidential, which she appreciates, that's the choice that people make, but it really makes it harder for the board to observe how decisions get made, which also results in public frustration because she heard different stories from different people and there's no way for them to verify. They're all doing their best. So, that's an observation it's not a question.

Nilu Patel said to please correct her if she isn't understanding this correctly. It seems to be a black and white approach that if there's a diversion that the person must go back into a job where they are supposed to give narcotics safely. There are numerous studies that have been done to indicate that being placed in an environment really heightens a person's recidivism rate, or even tempts that person into going back to the problem that they had in the beginning. We're not going to solve this problem today, but if we can come up with some ideas, she has a potential suggestion to consider a tiered program. Look at what they did before, but before you get to that point of getting back into that job, let's try you out for a certain amount of time in this particular area without narcotics and then move on after, is that an option at this point?

Shannon Johnson said that's what the IECs have been doing. They slowly want to transition them back into the workforce. Based on uniform standards, the only criteria is part time/full time, because you have to meet certain criteria to become full time employment. Most of the time the IEC will allow them to go back to work in non-direct patient care for at least 24 hours part time hours up to 32 hours. Then have them come back in six months. The participant can come back and then ask or the committee can say they think now they're ready for direct patient care, but maybe no access. Then they also look at if they are putting them back into patient care with narcotic access if they want to increase testing for a little while to ensure that they're covering their bases as far as random drug testing if they're going back into this environment, do they want to increase supervision levels? And do they want to look at getting more worksite monitor reports to make sure they're doing well before they come back. Those

are the discussions that she’s been privy to and the rationale behind their thought process. She thinks they are trying to do that step down approach.

Nilu Patel said that's very reassuring because based on the public comment, it seems as though they're just being mandated to do this one thing, otherwise they can't go back into the job. There's some confusion, so she appreciates the clarification on that point.

Shannon Johnson said she thinks some may have been told by their case manager that they have to go back or they're going to have to go back into patient care but they hadn't been seen by their IEC to make that determination would be inappropriate.

Nilu Patel said she sees, and for the advanced practice nurses, you'd mentioned that with furnishing being an issue with the nurse anesthetist being around narcotics often. Is there a different approach that the IEC takes with advanced practice nurses? Because that is part of the job.

Shannon Johnson said that is correct. She thinks that the discussions that she’s been in when there's an advanced practice nurse, say a nurse practitioner who has a furnishing certificate, they've kind of looked at that a little differently, they need to make sure that this is watched, and it depends on why they came into the program. Were they writing their own prescriptions? Were they writing false prescriptions for somebody else? Was it an issue of maybe a nurse anesthetist that was diverting from the patient in the surgical suite or whatever the case maybe, but they look at each individual case. They don’t say because you're a nurse practitioner, you get XYZ. It's a case-by-case situation and all of the factors are taken into consideration when they're having their discussion.

Nilu Patel requested advanced practice providers be looked at a little bit closely in terms of how they can be successful after this program because advanced practice nurses oftentimes there's independent CRNAs that function without any managers. If they're having to go through a process where they need to be supervised by someone, that's not an option in a lot of instances. She thinks the board has to look at that from a different lens and think about a different concept for the advanced practitioners that are functioning independently.

Shannon Johnson said the supervision is different than had been mentioned the maximum, moderate, minimum is for probation. For those of you that aren't aware, minimum is that they have to have a worksite monitor contact at least once per shift, moderate is half of

their shift they have to be in contact with that worksite monitor, and maximum is the entire shift. It's a one to one. In intervention, they only have to make contact once per week. There's a different supervision level. They also look to see if it is an advanced practice, it may be more appropriate for physician to be the oversight as far as the worksite monitor. They take all of that into consideration in probation and the IEC when looking at intervention.

Virginia Matthews said the AANA has guidelines for a CRNA that recommends a year before they return to work and five years of monitoring just because of the risks.

David Lollar said he needs to clarify what he believes Shannon Johnson was talking to Board Member Cormack about. Did you say that the requirement to work with patients and have narcotic access for six months is not a requirement for someone who only had a DUI? None of the participants who had a DUI are being asked to do that. He asked if that is true?

Shannon Johnson said the IEC may have said they have to work for six months. That is not a blanket requirement. It is, however, in probation, and it's written into the decision and order under the employment condition, they must work for a minimum of six months for 24 hours per week for six consecutive months. That is stipulated in that order. That is followed by probation, but intervention is different. The determination on the length of time that needs to be monitored is made by the IEC.

David Lollar asked it’s six months with access to narcotics, right?

Shannon Johnson sought clarification asked if Lollar meant probation or with intervention? With probation, it depends again the other factors, why are they in on probation? What was their violation? It may be, but that's reviewed. They have them get an exam done prior to, and you might have seen some of the orders where there's a suspension. If they think that we don't want to release this person back to work and we need that order first to make sure they're safe to practice. They put the suspension on the front end of that order and say that the suspension will be in place until they have the mental and physical evals done. Then they get those and in the evaluation is a recommendation for employment, treatment, therapy etc.

David Lallar wondered what the benefit to a participant who had a DUI misdemeanor to have access to narcotics? What does that prove or how does that help them? But he also has the same wonderment about a participant with a diagnosed narcotic abuse problem. He

wonders what the benefit is to them to work for six months with access to narcotics other than now they just got access to narcotics. He doesn't see the benefit to either one. He doesn't understand why this requirement even exists. He said without being able to solve the problem or change the statute, it's another example of something that's illogical in a program that's obviously broken, and the participants complaints from 50 out of 226, he hopes they're listening to them and this is not just a one off, that the case manager's standard answer to their questions, if they can get a hold of them, is they don't know. He hopes there is training. That they are aware of what to say and informed of what to say to their participants who ask these questions. As of right now, and he knows he’s basing this on public comment, but if he didn't hear from almost half of your entire program, he wouldn't take it as seriously as he is. But because they've heard from such a significant percentage, he can't deny the reality of the truth or veracity in it. Somewhere along the line, an audit, a redevelopment, some form of professional development has got to be done to get them to know to say something to a participant who, as you hear are in dire stress, something other than, I don't know.

Vicki Granowitz said she loves what David just said. She had the same feeling about that. Two things, people have gone back and forth saying that the rules in the Nursing Act that you're following are interpreted differently and she would like for someone to speak to that point in a way that is clear, because it's clear as mud to her. The other thing that she wanted to say is, Shannon (Johnson), it sounds to me like what she’s hearing is you're not the ultimate decision maker on what happens to an individual person in Maximus that that's handled by the IEC, because there was a lot of testimony that you're arbitrarily making those decisions. Did she hear that correctly?

Shannon Johnson answered in the affirmative. She said they've never single handedly made a decision on an intervention participant's care plan or determination on employment.

Vicki Granowitz asked if she is part of the team that makes the decision?

Shannon Johnson said no, it’s the IECs. When they say that it's approved by the board, basically what we're doing is we're just looking at the notes that are sent to us from the meeting, the rationale, and making sure that all the points of their care plan were notated so that when the contract's written, we make sure that we have it correct as the IEC voted on. That's been the only input that they've had. We normally try to stay out of all their discussion in IEC meetings. We do not interject our opinion. We state the facts of the

case and allow them to have their discussion and make their determination.

Vicki Granowitz said it's similar to what happens in closed session.

Shannon Johnson said absolutely, it's almost exactly the same.

Vicki Granowitz said she can attest to the fact that all you do is go over from a legal standpoint, the points of the case, the board is left to decide it and Shannon does not influence them on those decisions. She thinks it's important that they can't restate that enough because there seems like there is a whole lot of misinformation about your role in this that they need to make sure they consistently clarify that it isn't Shannon or your staff making those decisions.

After Public Comment:
Patricia Wynne said thank you to the public because they spent half the day listening to the public because it’s necessary to make changes. There is so much confusion about this issue and who is telling participants information and why do they think this is a blanket issue. She wanted staff to try and find out why the public thinks this is a blanket issue if it is a case-by-case thing. She has a question about the 30 day work stoppage for a missed test and whether it happens consistently.

Shannon Johnson said it is part of the uniform standards and is considered a major violation and the consequence is to cease practice.

Patricia Wynne wanted more information about the cost of testing and the new product on the market which seems less expensive and wonders if they could try to expand that.

Shannon Johnson agreed.

Patricia Wynne said they need more accountability because nothing ever gets written down and the requirements change and she wants to move towards that approach, she would be in favor of that. She said the EIIC meeting will be rescheduled for July 16, 2024, and the agenda and meeting materials will be posted to the website next week.

David Lollar said the good news is every single person had a very consistent and similar complaint so there aren’t 100 things to fix there are a handful because everyone said the same thing which puts a light on the major issues, most of which they’ve covered. He wasn’t

going to bring up the 30-day work stoppage but the fact that a standing rule says that’s a major violation takes him back to his question about the testing centers and whether the only one they have contracted is only open until 4 p.m. then that’s our issue with a lack of common sense.

Shannon Johnson said that isn’t a blanket and that is taken into consideration by Maximus who tries to work with the participants where there are certain situations that are out of their control. They don’t state they’re automatically removed from work for 30 days, and with probation they’re only being removed from work on a positive. That’s where the cease practice comes in or if the mental or physical exam comes back that they should not be working and the same with intervention if they’re found not safe to work then you don’t want to put them back into the workplace.

David Lollar said the only other comment was about the IEC committees because once again, this time around, they did repeat the ideas of some of the decisions those committees had made or the lack of meetings that they were able to attend because they were being canceled and like with many of the other issues he was addressing when Maximus was here, that it appears to be for some reason whether it's because we have to follow standing rules or whether it's because they've been given a mandate that there appears to be, at times, a lack of common sense being used in the process or an understanding that these are people. When their guest well when their public commenter who was in the room, was discussing her experience with them, it reminded him of the mindless, thoughtless decision almost made for him personally when he moved from Illinois to California to go from the university to high school, and they said he needed to take a class for his credential that he had already taught at the University of Illinois. He said he’s not taking their class. So he went to another school and got his credential. That was a mindless, thoughtless person who was looking at a piece of paper that needed a box checked. He’s not a piece of paper. When he leaves today, he doesn't have to decide which box, which slot that's going to go in. You shouldn't be treating people like that at an IEC, so maybe whoever is involved in running IECs could tell their people to add some common sense to some of these decisions instead of just looking at pieces of paper, that might help. That's his only other comment today. He looks forward to the committee meeting on July 16, 2024. Reza said that’s an advisory committee meeting so as far as promising action that’s an advisory committee meeting.

Dolores Trujillo asked if there are staff from Maximus that are available 24 hours.

Shannon Johnson said Maximus has a 24-hour line.

Dolores Trujillo asked if someone who gets off of work and can't find a center to do a drug test, can they call Maximus and ask where the nearest testing center or let them know that they're not able to do this. 30 days missing work is a huge financial impact on a family and not only that but the individual having to stay home and mentally get through that being off for 30 days because they feel like they missed something they were supposed to do but it was out of their control. She asked if there is somebody available 24 hours seven days a week.

Patricia Wynne said they were told a receptionist answers the line and then somebody gets back to them. She said that may need to be looked at a little bit more.

Dolores Trujillo said she's talking about an actual person, not a receptionist.

Alison Cormack said she feels like she has so many more questions now even than when they began. She has one specific one and then a general thought. She said one of the public commenters mentioned he had successfully completed an intervention program in another state but has to quote start over in California. She asked what the BRN's current philosophy or policy on that is.

Shannon Johnson said they don't have a policy on that it's up to the IEC to determine whether they want to accept documentation from the previous program that was attended. They have nothing in their NS. As far as probation, they don't have anything within their laws that state we can allow them to conduct their probationary term in another state or accept the probationary terms from another state.

Alison Cormack said they have this problem every week where someone has got an infraction in another state and completed their remediation as instructed and it's up to the board to decide whether that is sufficient and that's done every week right?

Shannon Johnson said the board gets complaints every week from Nursys for out of state discipline that the board can take action on the single disciplinary action by another state, but they don't necessarily use that other state's conditions that were ordered within the disciplinary order.

Alison Cormack said it's used as mitigation sometimes.

Shannon Johnson agreed. If a nurse has taken courses, then that is considered but intervention doesn't have courses they have treatment.

Alison Cormack said given the number of travel nurses and multi state nurses then there should be a task force to look at creating general guidelines for this. She would like to know how long it would take to get every participant seen by an IEC and have a 30-minute conversation with a case manager because some have said they can't speak to anyone, and have an updated contract/profile because they're going to hear this at every single meeting until a handle is gotten on this. These are the three issues she sees needs to be addressed and she knows everyone is frustrated as she is as well. She took a look at the EIIC agenda and said the only thing that's missing is any information about Maximus, data for turnover, what does a profile look like, what does a contract look like. What is the expectation for working with a case manager, how long does it take to get a profile/contract updated.

Loretta Melby recommended adding that item as an informational item. She said there were two agenda items today and it went all day. The EIIC agenda has two items, and this new agenda item could be informational with materials and no presentation.

Alison Cormack said she'll defer to the chair but would like a presentation from Maximus on the information requested.

Patricia Wynne said Maximus needs to be intimately involved in this conversation and agrees three agenda items is probably too many items if we do want to take public input, which they do because it's important.

Nilu Patel asked if there is a way to request information from the other healing arts boards if they're experiencing the same problems with Maximus.

Loretta Melby said DCA conducts an audit as part of the uniform standards on a routine basis. The last audit was completed in 2024.

Vicki Granowitz said a review of the uniform standards makes sense to her or they're never going to get out of this mess. She realizes its legislation but there has to be something done to fix these things because the 30 day rule makes no sense at all and they routinely re-disciplinary things where people have missed check ins and they aren't being put into that kind of nightmare scenario. They need to try

to influence people to try to change the uniform standards and to suggest ways in which they get changed, whether that's through subcommittees but to her that needs to happen.

Shannon Johnson wanted to remind the board that at a previous board meeting, she had requested permission to start a regulation package for intervention because they need to identify some areas that need new language and they're trying to work on putting that together to present to the board as well.

Vicki Granowitz doesn't want to wait another three months. She thinks this needs to be done in a more timely fashion because peoples lives are really in danger. She's willing to sit through more meetings to try to do something to fix this because it's untenable and unacceptable and she can't sleep at night.

Dolores Trujillo agrees and is working on an ask right now. She asked Loretta Melby if it's possible for her and Reza Pejuhesh to review the changes that have taken place since November to look at the participants that were affected and give the board a report in closed session.

Loretta Melby asked if the report is for specific participants. Dolores Trujillo said yes to the participants and the changes that have happened in the program. She thinks there are issues that need investigating and doesn't want to wait until the next board meeting.

Loretta Melby said for clarification, you are requesting she pull a participant list, do a review of the actions and changes, how frequent their IEC meetings have been, what are their conditions, etc.

Dolores Trujillo said yes.

Loretta Melby said then report that out to the board in closed session because of the confidentiality of the participants.

Reza Pejuhesh said that would be something he would have to look a bit more into because the statute specifically speaks to authority for the IEC to meet in closed session and he's not sure there's anything else that specifically speaks to the board talking about IEC participants in closed sessions, so unfortunately it's not obvious.

Loretta Melby said what could be done is she could pull the data and look at it. She could meet with legal counsel and see what is legally able to be presented in open and or closed session. She said if

changes need to be made then that could be done as soon as that review is done.

Reza Pejuhesh wanted to clarify what the ask is. Is it to look at all the participants and review the changes that have occurred since November?

Dolores Trujillo said yes.

Loretta Melby said she would do what she could and that what can be shared publicly will be added to the upcoming board agenda. She'll get a game plan put together and share during the Admin Committee meeting.

Alison Cormack thanked Dolores Trujillo for the request. She said today is June 21, 2024, and said if during this assignment Loretta finds that a nurse has already passed narcotics to a patient without trouble and can fulfill the requirement, what would be the next steps. She wants to ensure the public understands what the expectations are for trying to resolve issues, that it won't be done in the next two months.

Loretta Melby said she will look first at those 78 in year three, where they are, what they've done, what needs to be done to be completed. If there was a change that was asked of them that that we had questioned on that does not look like everything lines up, she would let the program know and they would have that discussion with IEC, Maximus et cetera, and then she would ask for a time frame of when that person could get back in front of IEC, if that needs to be changed and if we needed to add days or whatever, that's something that she would work with them on to look at. If it is discovered that everything is okay, which she's not thinking that it will be discovered that actually everything is okay. She would then report that out, but she would continue to work with board's legal counsel and board president during this time to make sure that we get everything lined up. That way action can be immediately taken.

Loretta Melby thanked Shannon for all that she's done. She said a public commenter asked for her immediate dismissal which will not happen. The board members have the ability to do immediate dismissal of her and she is the one that has the ability to work with personnel matters of board staff and Shannon is considered board staff. As you guys have all asked for reconsideration that you guys have asked for leniency and grace and to be considered to be human, she's asking you guys to do the same thing for her staff. Shannon is an amazing employee and anything that she has done, she is very

confident that she has done it with the best intentions. They will review this process and if anything does come up as an opportunity for improvement, she is always the first person to recognize that and immediately take action on it.

3:28 p.m. **Public Comment for Agenda Item:**

Sacramento:
Lisa: Expressed dissatisfaction with the BRN's Intervention Program. She shared that she should have completed the program this month after over three years of continuous sobriety and compliance with all programs during her recovery. Her husband was placed in hospice with a terminal illness. She was his primary caretaker for 51 weeks until he passed. She had access to and administered narcotics in her home under supervision of Maximus. She didn't have even the slightest temptation to use these medications which included oxycodone, morphine, and fentanyl, given around the clock. In June of 2023 she requested transition. Her IEC meetings were repeatedly canceled extending her time in diversion. A meeting was finally scheduled in October of 23, which she attended, even though it was only 3 hours after her husband of 28 years had passed away. She was accepted into transition. Two months later she asked her case manager about the new requirement that wasn't in her contract nor was she ever told about it until she brought it up. This requirement means she would have to give up her current patient care job, which she finds rewarding and highly supportive of her recovery. To comply, she's submitted 40 plus applications since January. Not being able to find a job it seemed reasonable to ask the IEC to consider her administering narcotics to her husband for almost a year as meeting these criteria. She was told she must still get a narcotic access job. This basically forces her to be in diversion for an unknown period of time given my inability to find a job in six months despite constant and diligent effort. Adding a new major requirement to the diversion program for those who have been fully compliant and almost to completion is not only inequitable, but contradictory to the goal of rehabilitating nurses so they can return to safe practice.

Webex:
Matthew A.: Expressed dissatisfaction with the BRN's Intervention Program. Sharing specific concerns about transition, being required to go to in person narcotics anonymous or AA meetings, working for six months before we give you narcotic access and after those six months now you go into narcotic access, and you're extended by another six months until you meet that.

Chris Else: He is the nurse support group facilitator for the central coast. He had a question because he brought up about testing in rural areas and Virginia Matthews Matthews talked about the at home

testing that they're offering, but that's not the probation side. He was wondering if they can get any answer on the probation nurses doing the same thing because they consist of a larger percentage than even the Maximus nurses. The next thing, a quick discrepancy that he noticed when board member Cormack was talking to Ms. Johnson. She was asking, is there a time when all restrictions are lifted? He believes that she said yes, but he doesn't believe that's true. That used to be the transition part. That's the point of transition. They went through all this stuff and then transition was most of their stuff was lifted and they were just kind of cruising along, doing everything right for the last year.

Anthony: Expressed dissatisfaction with the BRN's Intervention Program. This doesn't seem like it's being done on a case-to-case basis. It still seems like it's blanketed..

Sally: Thank you for listening to us. Some of them haven't been listened to in this way by anyone with authority for years. Thank you for asking Maximus to deliver an apology because it shows me that you understand the emotional damage that has been and continues to be done to them. She then shares her story. She has no desire to return to bedside. She knows she has made some serious mistakes in her past, but she feels like the decision to not return to bedside nursing should be honored and should be hers to make. She urges the board to abolish this change requiring nurses to return to narcotic access. But if the change is approved, let it be approved immediately and in writing. It has been seven months now of uncertainty and confusion and they are eager to make informed decisions about their futures.

Daniel: Expressed dissatisfaction with the BRN's Intervention Program. He would like to get a little bit more clarification on the health problems and disabilities because he has been sending letters to Maximus, three letters from his neurologist for a neck injury that he has. He exacerbated his injury by working and the type of job that he's forced to do because they told him two weeks before he was finished that he had to do six months. He doesn't feel like he can do it anymore. He would really like more clarification on that because they are putting them at risk of injury, not only the patients, but themselves.

Participant: Expressed dissatisfaction with the BRN Intervention Program and shared their story. I wanted to tell you guys I got into this program, it helped me with my sobriety. I've learned so much. I only ask that you guys please review these new terms and conditions.

Anonymous 25: Thank you, board members, for holding this meeting today and then expressed dissatisfaction with the BRN’s Intervention Program. He would just like to say that he was successfully participating in an intervention program for over two years with another state board of nursing with the same requirements as California's. He was notified by the board two years into my recovery and the other board of nursing program that he would either have to move to California and start over intervention program with California, or face revocation of his California license and pay over $40,000 in cost recovery. He was forced to move to California when he was in stable recovery for over two years with his home state board of nursing, even though the other state board of nursing was willing to send monthly correspondence as to his recovery efforts. He was given no credit for his time in the other state's program. The board's website states they allow transfers into the programs from other states. Why did they not allow participants to participate in other state board of nursing programs without threatening moving and entering intervention or license revocation? How does he pose a risk to the California public if he is safely practicing and being monitored by another state board of nursing’s program?

Sophia: Expressed dissatisfaction with the BRN’s Intervention Program and disagreed with statements shared around work requirements. Another point she would like to make is not all participants are automatically completed after transition. They have to have 12 months of 100% compliance. If that is not the case, they do not finish.

David: Thanks for hosting this meeting. This has been very fruitful for many, he believes. He expressed dissatisfaction with the BRN’s Intervention Program and shared information related to the elimination of transition.

Millie: Expressed dissatisfaction with the BRN’s Intervention Program. She shared that the program is being so diminished. No one's talking recovery. These nurses have worked hard to get to the point to request transition. It was an important part of the program. They had to write a paper telling where they were when they initially came in and how they progressed, what tools they have and everything. And for them to suddenly be told, there's no transition and by the way, you're not going to complete. Please board, these people that are waiting, that did everything they were supposed to do. Had the clean tests, everything was compliant in all aspects of their program should not still be in the program dangling around because now someone decided if they do patient care with access, they will never relapse. You can't guarantee that a nurse will not relapse just because they do

patient care with access while in the program. She believes in the nurses. She strongly believed in this program that had been successful and a star for the whole country.

Mark J.: Expressed dissatisfaction with the BRN’s Intervention Program. The IEC slowly transitioned candidates for years, so the assertion of this kind of step-up thing was already being done well before any board direction from any board staff. An individualized program which you were assessed by your IEC. They hear time and time again that there's only one RN license and that the uniform standards require that they demonstrate safe practice. Someone at the board staff decided that safe to practice means able to pass narcotics for a period of no less than six months without diverting. All he wants to know is, where is the data that suggests that this is either something that is effective or that is ethical? Forcing nurses who have diverted narcotics or who have a documented substance abuse problem either past or present to now work with them in many cases against their will or intention, is cruel. Without strongly validated clinical evidence that's correlated, and peer reviewed that say nurses who have these problems, who then work under supervision in an IEC or in a program for a period of six or more months have a significantly lower relapse rate, then I will digress. But without that evidence, this should be rescinded effective immediately and any participant who was unjustly extended to accommodate this requirement, a swift and immediate review of their case.

Callie: Expressed dissatisfaction with the BRN’s Intervention Program. She’s never felt so hopeless than how she feels right now. When she feels like they're all drowning and reaching out for help, and nobody is pulling them up. Nobody's helping. She was supposed to have her last IEC in February of 2024 and then she was told no. She’s been working for over three years, no issues. She works in case management where she wants to be. She has a year left. She has no intention on going back to the bedside either, nor does she want to. She had a severe back injury. She’s had three back surgeries, a spinal fusion, she’s sitting here right now with horrible sciatica. But she’s looking for a job to fulfill this requirement because she wants out of this program. She just wants out, so she’s willing to put herself at risk to get out of this program. So that would mean that now she’s working six to seven days a week while still trying to attend meetings, be a mother, be a wife. Where does this end? This needs to be rectified immediately.

Danielle: Expressed dissatisfaction with the BRN’s Probation process. She would like to see more transparency on the data presented and

its sources. She should be granted early termination of probation. The only thing that will prevent her from being released early is money.

LH: She expressed dissatisfaction with the BRN’s Intervention Program and would like to address the recidivism slide that Ms. Johnson presented. 248 RNs recidivated back into the program after graduating between 2003 and 2024. Out of how many nurses, that's 21 years, how many total nurses graduated? What is the percentage and what is your threshold percentage as the board that you are going to accept? If you're hoping for zero recidivism, it's never going to happen. And it doesn't matter if you require a nurse to give narcotics for six months or ten years there will always be some who relapse and recidivate. An RN that she knows was recently in her IEC and was told she had to meet this new requirement. They also told her she didn't have to quit her job to conform she could just work overtime and as little as 8 hours a week. This is another example of how out of touch with reality the program is. There are no 8 hour a week shifts. That doesn't exist unless you work per diem, which they are not allowed to do. Part time is 24 hours a week. So you're saying they don't have to quit their full time jobs that they are perfectly happy and provide work life balance and insurance benefits. They can work an extra 24 hours at another job that they don't want or have any interest in. She cannot lose her insurance or full time pay, and she can't work 64 hours a week. She doesn't ever want to return to patient care. What do you think the impact is going to be on employers? What's going to happen when they find out they're hiring them into a position that are only going to be temporary because they're going to have to quit those jobs. What about the employers of these patient care positions that they are being forced to get? You don't think they're going to notice that these nurses are quitting in a matter of months as soon as they can because they don't want to be in that position to start with. These employers are going to stop hiring nurses out of this program.

Participant #2: Expressed dissatisfaction with the BRN’s Intervention Program. In December, Maximus called and said everyone now needed a job with narcotics. When I informed my employer, they fired me, citing fear of liability to their own licensing and that they could no longer help me. It's my opinion that working with narcotics should be a very personal decision within our recovery path and not mandated

Amanda H.: Expressed dissatisfaction with the BRN’s Intervention Program. Yesterday, life happened, she checked in at 5 am and she doesn’t know if any of you guys have ever done this, but she fell asleep, she was exhausted. She had four days where she was working, and she woke up and forgot she had to test and it was after

5:00 p.m. She struggled everywhere in her location and can't find any after hour testing except for one place. She drove and drove for 5-6 hours trying to find anywhere, 24 hour check in. She called trying to find help, trying to find anywhere to go test. And unfortunately, at midnight she walked into her home and never found anywhere to test. She was told within a 150-mile radius of where it is, and there was no testing after 5:00 p.m. which is unacceptable when she is required to test to be compliant to finish this. She's worked so hard to get as far as she has and she's human. She needed a day of rest and she doesn't want to beat herself up about that because rest is part of her recovery, making sure that she eats and sleeps and takes care of herself so that she is well to do her job for herself and for others. She's also just a one DUI person, but she's required to pass narcotics and been told that by her case manager. She implores people to investigate further.

Participant K: Expressed dissatisfaction with the BRN's Intervention Program. She wants to bring up two points. One is, she learned up to two months before she was going to complete that she had to extend her program. She's at four years now. A second question she has is, what happens if she doesn't get the three months of direct patient care and the six months of direct patient care is two separate jobs with narcotics in five years? Does that mean that she gets kicked out of the program? Does that mean her program's extended? What's going to happen to her? She's very happy in her job. She has the ability to be promoted, but she can't because of this program. She doesn't want to work in patient care again.

PM: She was an IEC member for eight years and she accepted a position as a case manager in 2020 with Maximus. She would like to acknowledge the courage of all those who have spoken today and at previous board meetings and in public sessions of the IEC meetings. It's invaluable. Maximus makes no decisions. They are the vendor. The BRN began implementing changes in November of 2022 and despite multiple requests for changes to be reflected in writing, she was provided with nothing. The IEC committees across the state are relatively new. Every single change in this program was a directive, albeit verbal, from the BRN. She believes in recovery and second chances. This program was once amazing and so many were invested, including IEC members, nurse support group facilitators, and Maximus staff, and at one time the BRN.

Dr. CS: She wanted to make a quick comment, especially after listening to everyone. She was the manager of the program for a number of years. She retired a few years ago and her heart is broken. They never had this problem before. It is a program that was case by

case. There's been a lot of misinterpretation of things that occurred like the transition process is totally different from what she’s hearing. It was case by case, no one automatically got transitioned. What she would love to say, and I thank you, this board is amazing. She appreciates your questions; she appreciates you seeking out information. She would like to say if you need any information from her, any help, any support, she’s here. She’s on a committee right now. She’s here to support staff, the board members. Anything she can do about the history of this program, there is a deep history in why there was a transition that occurred. There was a period of time when they didn't have a transition and they realized that was doing a disservice to the nurses not having a step down. So they incorporated a transition and it wasn't done by just the board, it was all the stakeholders. The thing she sees missing is that you're no longer having what they used to have is the intervention or diversion liaison committee meetings which incorporated a board member, the legal representatives from each committee throughout the state representatives from the nurse support group, and it was open to the public and there was an agenda. There's not been one held for years, the diversion liaison committee meeting.

Susan: Expressed dissatisfaction with the BRN’s Intervention Program. Shas been looking for a second job in narcotic access since January without success. She’s never worked in the hospital in over 20 years. She’s a dialysis nurse. She doesn't want to leave the job she currently has to find a full time narcotic access job. She feels it is unethical to start a new job and then leave in six months. She feels that is unfair to everyone in this situation. She does not want a job in narcotics. She’s mentioned that in her IEC. Taking a job in narcotic access is not safe for some of our nurses. It is like asking a recovering alcoholic to become a bar tender. It does not make sense. She agrees it should be a personal decision. It would be very difficult for her to have two jobs on top of what she already has to do in this program.

Janet: Expressed dissatisfaction with the BRN’s Intervention Program. She wants to reiterate something that's been said over and over and over in these meetings. You can never prevent relapse as an outside force. It's up to the person who's in recovery to prevent it for themselves. What's worse, holding all of them accountable for the relapses of other nurses suffering with substance use disorder sets a terrifying precedent. They need to have a plan for what to do to successfully complete.

Anon 2024: Expressed dissatisfaction with the BRN’s Intervention Program. This meeting shows her failure to follow Board of Nursing

policies and procedures by making decisions and policy changes without approval. Failure of board members to act today will send a message to the nurses and the public. It will only be a matter of time before the news agencies create an expose on this issue, all of your actions and lack of actions will be up for public review and critique. Please do something today.

Anna: Expressed dissatisfaction of the BRN’s Intervention Program and shared their loved one's story. She literally had her IEC last week. She turned her notice into her advice nursing job that she loves to go meet this requirement. She's going to do it because she wants to complete this program and she's been 100% compliant. Anybody who knows anything about recovery and substance abuse knows that there's more to that than just the substance and punishing people, which is what's happening.

Public Protection?: Expressed dissatisfaction with the BRN’s Intervention Program. She understands that the intervention program is individualized, but I've also heard that everybody receives a letter inviting them to the intervention program. But it does feel like it's a lot of information gathering and as she understands it, all the information that is gathered about you over the course of your three-to-five-year experience. If you leave the program, then that information, because you've signed the paperwork, is all turned into an accusation. She also thinks that the bottom line is it feels like the best way to protect the public from the board's perspective perhaps is for us not to ever return to practice. And if we give up our licenses, we surrender them, then it's even harder to try to get them back. She thinks the board's bottom line is that they're here to protect the public.

Reza Pejuhesh interrupted to say a couple things. One, a correction on what was just said in that comment, which was that over the three to five years a participant is in the program, the board is gathering information, which the board will then use in an accusation against the participant, and that's not entirely accurate. In fact, that's generally not what happens at all. The board is required under statute to purge any records of a participant who successfully completed the program. For any participants in the program who do not successfully complete the information in the records that are obtained and produced during their participation in the intervention program are not turned over to the enforcement division unless there's a determination that the individual is a public risk. He’s trying to find the code section, it's Business and Professions Code section 2770 .7, subdivision D, he’s doing this on the fly, so he hopes he got that right. It is in the code that that information is not used against a participant after their

participation in the program in the disciplinary process unless that person is deemed to be a public risk.

Amanda: Expressed dissatisfaction with the BRN’s Intervention Program. As a participant, she can tell you with certainty that sending them to work in patient care with or without narcotics has absolutely nothing to do with whether they relapse. If she wanted to drink or do drugs, she could do that regardless of where she is working or if she’s working. Shannon had mentioned that approximately 10% came back to this program for a second or third time with the old requirements. So that means that 90% didn't and successfully completed without these new requirements. She thinks that any statistician would tell you that a 90% success rate is pretty darn good. These new requirements should only be for new participants, not existing ones that are close to completing. This needs to be changed today, enough with the delay.

Eileen: Expressed dissatisfaction with the BRN’s Intervention Program. She has a comment about the cost that Shannon had placed on the PowerPoint. On average, if you're testing four times a month, most of the average cost is a $110 per test, which then comes out to $440 a month, which is $5,280 a year. She’s not sure where these numbers Shannon is getting are from the testing people, two times a week in the first and second year, that comes out to eight tests a month at a $110 a test, which is $880 a month coming out to a cost of $10,560 a year. Plus your nurse support group at an average of $40 to $50, we'll say $50 a month is $600. Then you add on a cost recovery at least for the probation people, which is anywhere from $10,000 to $20,000. That has to be paid over three years. She’s seen the increase of mental health issues with nurses, increased depression, anxiety, and hopelessness. Addiction is an incurable disease that is progressive. If someone has a disease such as diabetes, it is a progressive disease as well, but it's manageable. So is addiction but it's not when you take away the tools that they need to manage it. If a nurse finally comes into the program and is deemed unsafe, but is allowed to work and after two or three years of working without incident and has positive accolades from administrators, coworkers, and a positive recovery program, complete compliance, how is this nurse suddenly deemed unsafe right when they're getting ready to graduate.

Kevin: Expressed dissatisfaction with the BRN’s Intervention Program. He wants to say that he appreciates this board listening and taking their time. He believes the general public really understands what these nurses are saying. He believes a lot of people in the general public know somebody that's been affected by a substance

use disorder and he fears the board and Ms. Cormack made a good example that you're constantly making the balance of protecting the public with how you have to do and he respects the job of that because that is a very difficult job. But he fears right now that instead of protecting the board or protecting the public, this board is going to lose the public trust and the job that they're doing and that to him is a very dangerous place to be, in a profession where the public may not trust the board that dictates their practice. They have 23 year old uniform standards. He would like to think today that they're on the precipice of a paradigm shift in sort of how the board manages and seeing all substance abuse issues. And said thank you for their time and the gentleman that's worried about how many more people there already comment and hope you can find yourself a more comfortable seat.

Reza said he guesses that's directed to him. He’s the board's counsel. It's 4:45 p.m. and this meeting is scheduled until 5 p.m. He’s sure they're going to be here after that and it was not for his own convenience or comfort. He takes that as kind of a nasty insult, trying to manage the time that the board has, in fact, they had a committee meeting scheduled after this to continue discussing these issues and continue to work and make progress, and yet you chose to call him out for asking how many comments were left to just manage that. It is unfortunate that your perspective has caused you to put a spin on every little thing but to clear the air, his comment about how many comments were left was not to limit public comment or say that he’s uncomfortable and that he doesn't want to be here. He thinks that this board, including himself as legal counsel, are trying in good faith to hear everybody out.

Kevin said he respects that and apologizes for that comment.

Concerned: Expressed dissatisfaction with the BRN’s Intervention Program. Thank you for taking the time to listen to all of their comments. She just wanted to shine a little light on and bring a little rigorous honesty to some of the kind of fuzzy statistics that were provided in those slides. As far as the testing fees are concerned, there is a $57 testing fee charged for every test. However, what was not included was that each testing site also collects their fee which can be $30 to $50 depending on the testing site. So that's why you're hearing a discrepancy between the participant's truths and what you are being presented with in the room. She is a participant and initially she was told that she needed to get a job doing patient care. She is not a patient care nurse. She was not a patient care nurse before she entered the program, so that was a big shift for her. And then she was told after she had acquired that job that she needed to get a job with

narcotics. She would like to point out that it is incredibly difficult to find these jobs as other participants have stated. Also, she would like to point out that there was some inaccuracy in the fact that we are able to reach our case managers. There is no way to reach their case manager. They are all funneled into a hotline that you call that's answered by a receptionist. When they say that you're able to reach somebody on call, that on call person does not always call you back or answer you.

5:01 p.m. **5.0** **Adjourn**

- Dolores Trujillo, President, adjourned the meeting at 5:01 p.m.

Submitted by:	**Accepted by:**
Loretta Melby, MSN, RN Executive Officer California Board of Registered Nursing	**Dolores Trujillo, RN** President California Board of Registered Nursing