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Board of Pharmacy
Pharmacist Recovery Program

July 28, 2022

Virginia (Ginny) Matthews, RN, BSN, MBA
Program Director

Anita (Anne) Mireles, RN,
Clinical Case Manager

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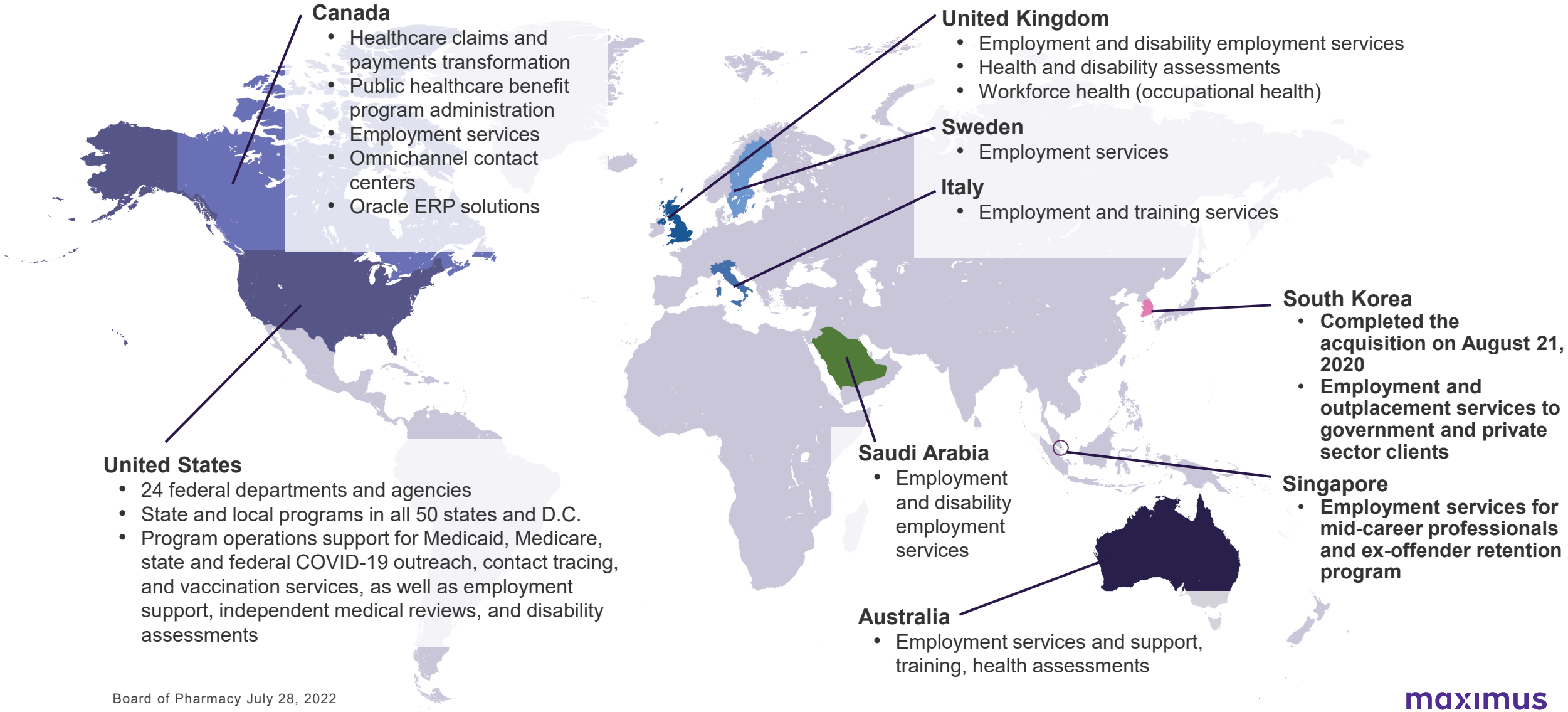
Corporate Overview Update

Updated: May 2022

28 July, 2022

Experience that spans borders and cultures



Canada
- Healthcare claims and payments transformation
- Public healthcare benefit program administration
- Employment services
- Omnichannel contact centers
- Oracle ERP solutions

United States
- 24 federal departments and agencies
- State and local programs in all 50 states and D.C.
- Program operations support for Medicaid, Medicare, state and federal COVID-19 outreach, contact tracing, and vaccination services, as well as employment support, independent medical reviews, and disability assessments

United Kingdom
- Employment and disability employment services
- Health and disability assessments
- Workforce health (occupational health)

Sweden
- Employment services

Italy
- Employment and training services

Saudi Arabia
- Employment and disability employment services

South Korea
- **Completed the acquisition on August 21, 2020**
- **Employment and outplacement services to government and private sector clients**

Singapore
- **Employment services for mid-career professionals and ex-offender retention program**

Australia
- Employment services and support, training, health assessments

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Maximus Across the Globe

9
Countries

24
U.S. Federal Agencies

50
U.S. States

The largest provider of conflict-free services

Supporting state & local health services programs

20	Medicaid Enrollment Broker	CA, CO, DC, IA, IL, IN, LA, MA, MD, MI, NC, NH, NY, PA, SC, TX, VA, VT, WI, WV
21	Assessments for Clinical Services	CT, DE, IA, IL, IN (2), LA, ME (2), MI (2), MS, ND (2), NH, NY, OH, OR, PA, TN, VA
13	Medicaid Eligibility Support (Including CHIP)	AR, CA, FL, GA, IL, IN, MA, MI, MO, NY, TX, VA, VT
12	Health Member Call Centers	CA, DC, IA, MA, MD, MI, NH, NY, OK, TX, VT, WY
11	Provider Services	DC, IA, MA, MI, NE, NJ, NY, OH, OK, TN, TX
7	State-Based Marketplaces	DC, IA, MA, MD, NJ, NY, VT
7	Other Health-Related Projects	AZ, CA, CO, ME, MI, NJ, WV

Valid as of 5.10.22

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Maximus Serves 8 Licensing Boards

Under contract with the CA Department of Consumer Affairs

- Board of Registered Nursing
- California State Board of Pharmacy
- Physical Therapy Board of California
- Osteopathic Medical Board
- Veterinary Medical Board
- Physician Assistant Board
- Dental Board of California
- Dental Hygiene Board of California

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Substance Use Disorder (SUD)

28 July, 2022

ASAM Definition of Addiction

Addiction is:

a treatable,

chronic medical disease

involving complex interactions among brain circuits,

genetics,

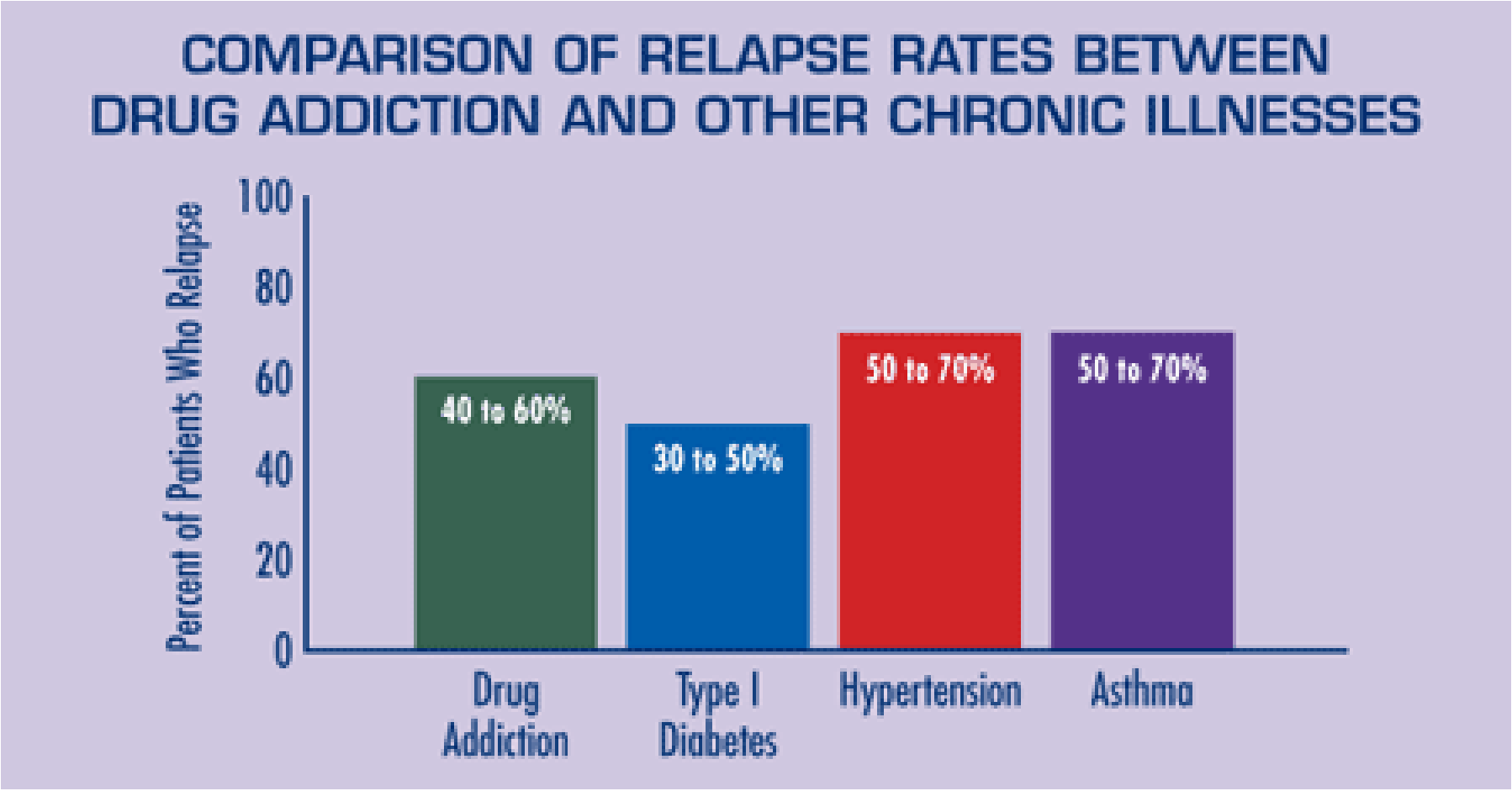
the environment,

and an individual's life experiences.

People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Relapse Rates NIDA 2014



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ASAM Definition of Addiction

- Addiction is characterized by:
  - Inability to consistently abstain
  - Impairment in behavioral control
  - Craving
  - Diminished recognition of significant problems with one's behaviors and interpersonal relationships
  - A dysfunctional emotional response.
- Like other chronic diseases, addiction often involves cycles of relapse and remission.
- Without treatment or engagement in recovery activities, addiction is progressive and can result in disability and/or premature death.

https://www.asam.org/resources/definition-of-addiction

RISK FOR HEALTHCARE PROFESSIONALS

Case study:

Relapse Events

State: California

Rate of relapse: In a retrospective study of relapse events, Maximus identified that 75% of relapses occurred during first year of participation in the program, and 80% of those were during the first six months.

10-14%
General population diagnosed with SUD

10-15%
Healthcare Professionals diagnosed with SUD*

40-60%
General population relapse within first year of recovery**

12%
MAXIMUS Recovery Program participants relapse during first four years of recovery

*Prevalence of substance abuse by physicians is between 10% and 15%. [Elliot 2010; O'Connor 1997; McCall 2001; Oreskovitch 2012; Berge 2009; Brooks 2012; Baldisseri 2007]
**Annu Rev Clin Psychol. 2007; 3 ():257-84.

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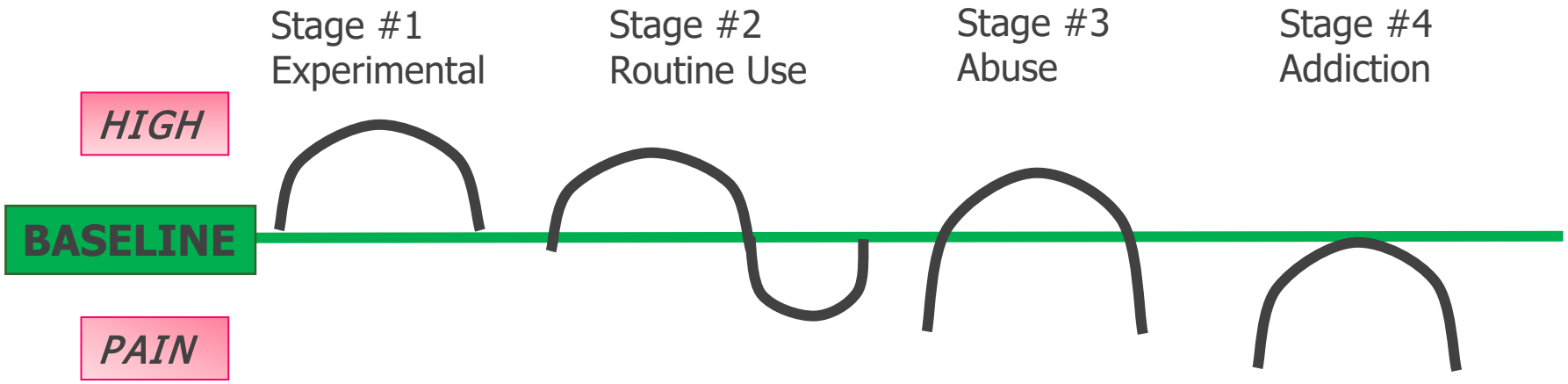
Spectrum of Addiction

The *progression of the relationship* between the person and the substance is the real issue.

The Feeling Chart



LEARNS:
- Drugs Work
- How to Control Degree of Mood Swing
- Intoxication or perceived "freedom from stress" is Added to the Person's Priorities

PRIORITIES:
- Family
- Friends
- School or Job
- Sports
- School Activities or Hobbies
- Using a Substance

LEARNS:
- Negative Consequences
- Increased Tolerance
- May get first DUI

PRIORITIES:
- Family
- Friends (old **& new**)
- School or Job
- Sports
- Getting the Substance

SEES:
- Loss of Control
- Values Change
- Self-Rules Broken
- Defenses
- Feels Bad About Self
- Preoccupation
- Lifestyle Changes

PRIORITIES:
- Getting the Substance
- Family
- Friends
- Other priorities lost

FEELS:
- Using to Survive
- Using to reach "Normal"
- No Self-Esteem
- Conflict with Values
- High Suicide Risk
- Accidental Overdose
- Feels others are intruding, feels defensive

PRIORITIES:
- Getting the Substance
- Getting more

CROSS-ADDICTION

Cross-addiction, also known as substitute addiction or addiction hopping, is when a person presenting with one form of addiction proceeds to substitute it with another addictive behavior (Burleigh et al., 2019; Sinclair et al., 2021a, b). There are a few reasons why people engage in cross-addiction including (a) forced abstinence, where a person cannot access their original addiction and seeks an immediate alternative (e.g. alcohol/drugs being substituted with smoking in detoxification/rehabilitation programs)

There has also been extensive evidence of alcohol being used as a substitute for drug addictions involving heroin, opioids, cannabis, and cocaine (Buga et al., 2017; Kim et al., 2021; Sinclair et al., 2021b)

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Driving Under the Influence in California (DUI)

28 July, 2022

In California, a motorist can get a DUI for driving while "under the influence" of (impaired by) drugs (including marijuana) or alcohol or with a blood alcohol concentration (BAC) of .08% or more. A person is considered "under the influence" if substantially impaired by drugs, alcohol, or a combination of substances.

A DUI does not necessary reflect the scope and pattern of use

First Offense is **not** the first time

50 to 75 percent of convicted drunk drivers continue to drive on a suspended license.

About one-third of all drivers arrested or convicted of drunk driving are repeat offenders.

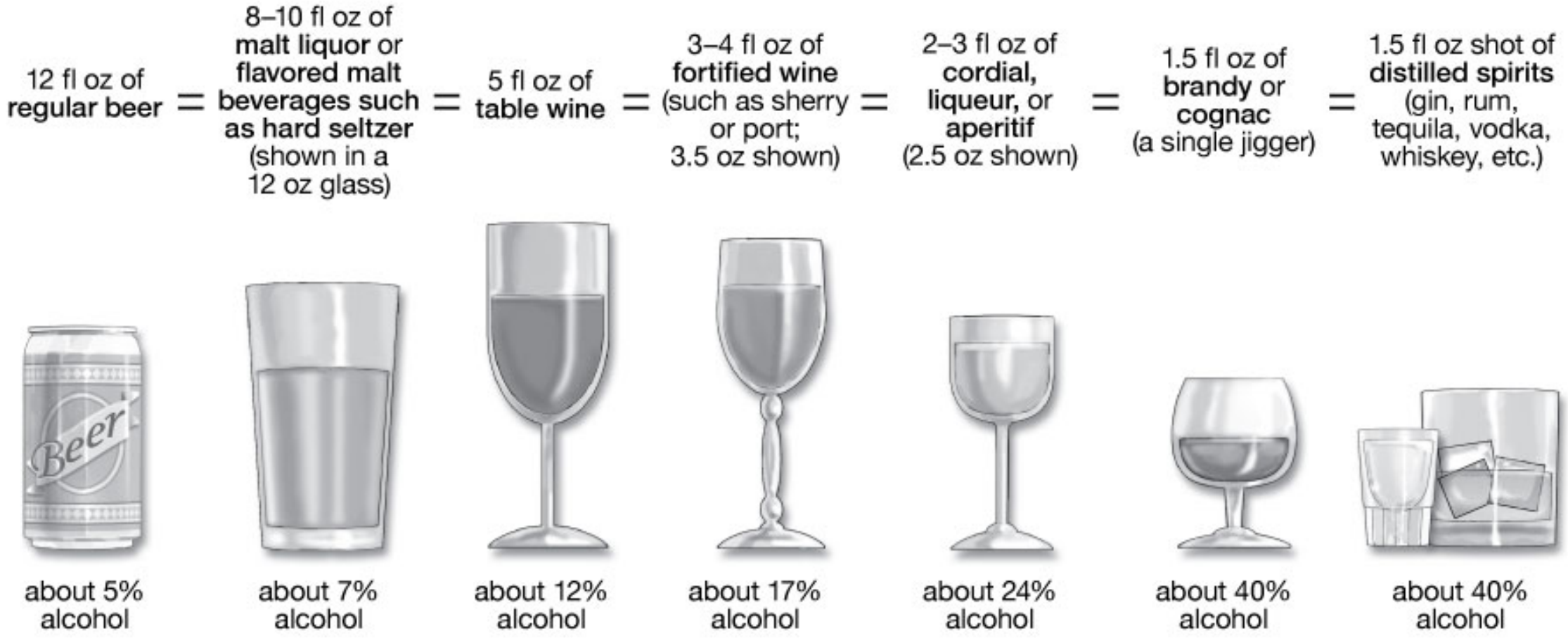
An average drunk driver has driven drunk over 80 times before first arrest.

https://www.madd.org/statistics. Accessed 07/14/22

According to MADD (Mothers Against Drunk Driving), every day there are more than 300,000 people on the roads who drive while drunk.

Yet, just over one percent of these people are arrested.

What is a Standard Drink?



Each drink shown above represents one U.S. standard drink and has an equivalent amount (0.6 fluid ounces) of "pure" ethanol.

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www.tabc.state.tx.us 1-888-THE-TABC

WOMEN

KNOW YOUR LIMIT

Approximate Blood Alcohol Content (BAC) In One Hour

Source: National Highway Traffic Safety Administration

Drinks	Body Weight In Pounds								Influenced
	100	120	140	160	180	200	220	240	
1	.05	.04	.03	.03	.03	.02	.02	.02	Possibly
2	.09	.08	.07	.06	.05	.05	.04	.04	
3	.14	.11	.11	.09	.08	.07	.06	.06	Impaired
4	.18	.15	.13	.11	.10	.09	.08	.08	
5	.23	.19	.16	.14	.13	.11	.10	.09	Legally Intoxicated
6	.27	.23	.19	.17	.15	.14	.12	.11	
7	.32	.27	.23	.20	.18	.16	.14	.13	
8	.36	.30	.26	.23	.20	.18	.17	.15	
9	.41	.34	.29	.26	.23	.20	.19	.17	
10	.45	.38	.32	.28	.25	.23	.21	.19	

www.tabc.state.tx.us 1-888-THE-TABC

MEN

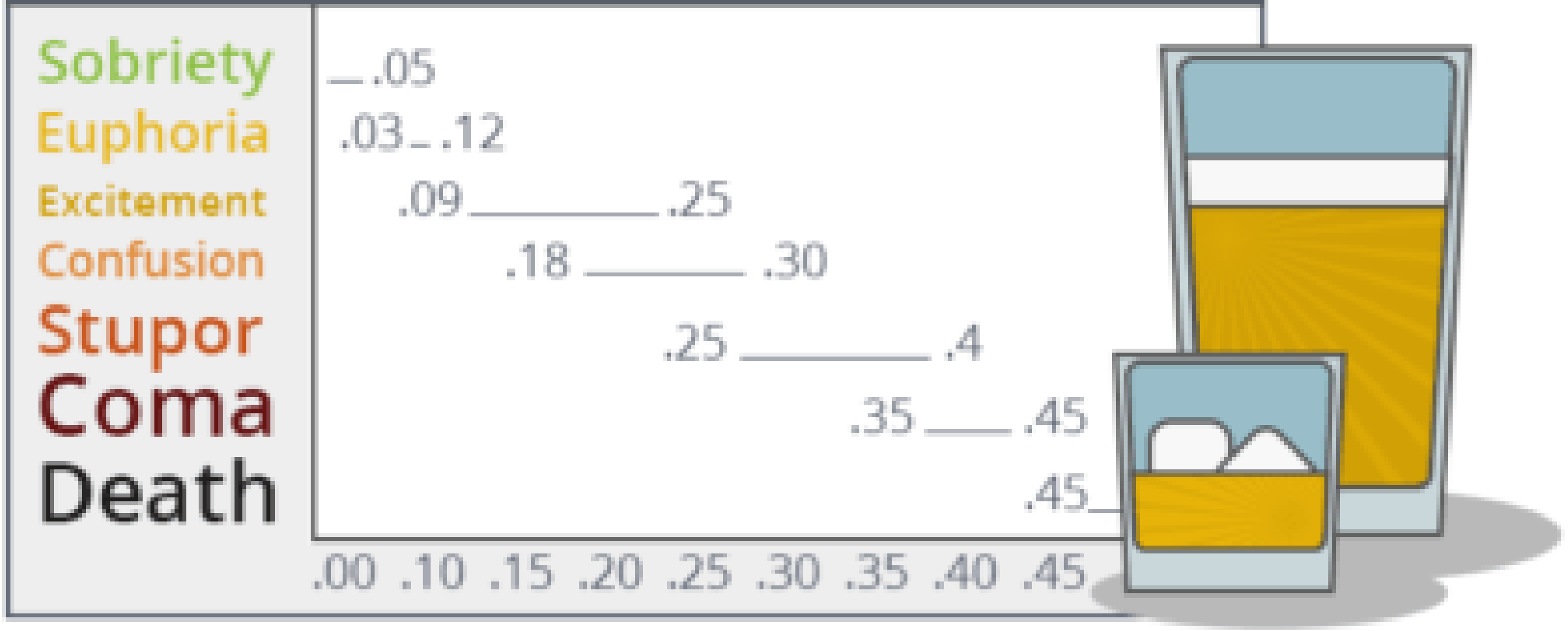
KNOW YOUR LIMIT

Approximate Blood Alcohol Content (BAC) In One Hour

Source: National Highway Traffic Safety Administration

Drinks	Body Weight In Pounds								Influenced
	100	120	140	160	180	200	220	240	
1	.04	.03	.03	.02	.02	.02	.02	.02	Possibly
2	.08	.06	.05	.05	.04	.04	.03	.03	
3	.11	.09	.08	.07	.06	.06	.05	.05	Impaired
4	.15	.12	.11	.09	.08	.08	.07	.06	
5	.19	.16	.13	.12	.11	.09	.09	.08	Legally Intoxicated
6	.23	.19	.16	.14	.13	.11	.10	.09	
7	.26	.22	.19	.16	.15	.13	.12	.11	
8	.30	.25	.21	.19	.17	.15	.14	.13	
9	.34	.28	.24	.21	.19	.17	.15	.14	
10	.38	.31	.27	.23	.21	.19	.17	.16	

The Stages of Alcohol Intoxication (BAC)
Based on Blood Alcohol Content



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What is Kombucha

Simply put, kombucha is a fermented drink made with bacteria and yeast mixed with black tea and sugar.

Kombucha is made using a SCOBY aka a “symbiotic colony of bacteria and yeast,” which is typically a dense, round, rubbery and opaque looking ingredient that often has a mild, vinegar-like smell.

Some people think that a SCOBY looks similar to a mushroom. A SCOBY is comprised mostly of cellulose and it hosts a variety of yeast and bacteria that aid the fermentation process by breaking down the tea’s sugars and converting them to alcohol, carbon dioxide and acids.

How Much Alcohol is in Kombucha?

Commercial kombuchas do have varying amounts of alcohol. This alcohol is naturally occurring and not added. A small amount of alcohol is produced as a byproduct of the natural fermentation process.

Homemade kombucha is likely to have a higher alcohol content and is difficult to estimate or predict.

Commercially produced kombucha must contain less than 0.5% alcohol in order to be sold as a non-alcoholic beverage.

Traditional Kombucha is typically 1 to 2% alcohol but could get up to 3%. Kombucha traditionally comes out to roughly 1.5% alcohol if fermented in the normal manner.

Hard / High Alcohol Kombucha will be above 3%, made using a double fermentation process.

Common Products Containing Alcohol

Participants are provided with a list of common products containing alcohol

Foods may contain varying amounts of alcohol.

- Desserts
- Foods cooked with or containing alcoholic beverages such as vodka, sherry, wine, etc.
- Foods containing significant amounts of vanilla extract (especially if added to drinks)
- Wine vinegar
- Soy sauces and other condiments with alcohol
- Fermented foods like Kefir, Kimchi, Saurkraut

Hygiene or household products may contain ethyl alcohol.

- Mouthwash
- Aftershave, cologne
- Hand sanitizer
- Hair products
- Insect repellant
- Antibacterial wipes
- Cleaning products

California's Implied Consent Laws

California's "implied consent" laws specify that all motorists agree to take a blood or breath test if lawfully arrested for driving under the influence. Motorists who refuse testing generally face license suspension of one to three years, depending on their record.

CALIFORNIA JAIL TIME AND FINES FOR DUI

The minimum and maximum jail time and fines for a DUI conviction in California largely depend on how many prior convictions you have. Here are the possible jail sentences and fines for a first, second, and third DUI conviction.

1st offense	96 hours to 1 year	$390-$1000
2nd offense	120 days to 1 year	$390-$1000
3rd offense	6 months maximum	$1800-max

In California, a DUI conviction will stay on your record and count as a prior conviction for ten years.

DUI LICENSE SUSPENSION

All California drivers who are convicted of a DUI face license suspension. The possible suspension periods for a first, second, and third DUI are as follows.

First offense	Second offense	Third offense
6 months	2 years	3 years

Reducing a California DUI Charge

If you're charged with driving under the influence in California, it's possible to "plea bargain" for a lesser charge. "Wet reckless" refers to a plea deal where a DUI is reduced to reckless driving charge.

In California, a motorist who's convicted of a wet reckless—alcohol-related reckless driving charge—faces up to 90 days in jail and/or $145 to $1,000 in fines. Generally, the convicted motorist will also have to complete an alcohol and drug awareness program.

Required Sessions PC-1000

Education Class: A combinations of lecture and films (six classes, two hours each).

Group Session: meet once a week (nine sessions, two hours each)

Individual Interviews: held at beginning, midpoint, and end of program (three meetings, 15 minutes each)

12-step meetings

No treatment

Minimal testing, usually point of care (dipstick)

Felony DUI Charges in California

In California, DUI offenses that involve certain aggravating factors can be charged as a felony. The two most common of these is having three prior DUI convictions within the last ten years or causing serious injuries to, or the death of, another person while driving under the influence.

LET'S ADD CANNABIS---
THIS IS CALIFORNIA, AFTER ALL

Cannabis effects include alterations in reaction time, perception, short-term memory, attention, motor skills, tracking, and skilled activities.

Detrimental effects of cannabis vary in a dose-related fashion, (NOTE: current strengths available in cannabis concentrates range up to 90%+ THC) and are more pronounced with highly automatic driving functions than with more complex tasks that require conscious control, whereas alcohol produces an opposite pattern of impairment.

Combining marijuana with alcohol eliminates the ability to use compensatory strategies effectively, however, and results in impairment even at doses which would be insignificant were they of either drug alone.

“Actual Physical Control”

“Actual physical control of a vehicle” is a vague phrase, but has been held by courts to mean that an accused “must be physically in or on the vehicle and have the capability to operate the vehicle, regardless of whether he/she is actually operating the vehicle at the time.“ According to California Vehicle Code 305 VC, “a ‘driver’ is a person who drives or is in actual physical control of a vehicle”.

The term “actual physical control” defines situations where you can be charged with a DUI despite not driving your car. This term is defined by the ability to move the car.

This analysis, and the difference between an acquittal or a DUI conviction, can often come down to where in the car the you were or where your keys were. If you’re in the driver’s seat and your keys are in physical reach, even if they’re not in the ignition, that will likely be a more than sufficient basis for a DUI conviction.

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Pharmacist Recovery Program (PRC)

28 July, 2022

Goals of the Recovery Program

To protect the public

To return healthcare professionals to safe clinical practice, through intervention and rehabilitation

Participant Review Committee "PRC"

- **Meets monthly**
- **Attended by BOP and Maximus representatives**
- **Formally reviews and accepts applicants into the Program**
- **Formulates a participant's ongoing recovery plan**
- **Reviews and approves requests to change recovery plan**
- **Approves program completion**

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RETURN TO WORK

Participant must apply to return to work

PRC evaluates readiness by considering:

- Compliance with program requirements
- Drug test results
- Recommendation of support group facilitator
- Participant self-report of progress (Essay)
- Relapse Prevention Plan

Return to work

Once approved by PRC, participant may return to practice

Position and Worksite must be approved by PRC

When a job is offered, must identify a worksite monitor

PRC determines % of direct supervision

Gradual release of worksite monitor supervision over time

May not serve as Pharmacist In Charge (PIC)

Participant must submit release of information

Agreement signed by worksite monitor (WSM)

Provide contact information for WSM and employer

Return to Work

Return to work

Training	Org Chart	Job Description	Affidavit
• MAXIMUS Case Manager or Compliance Specialist must provide training to WSM regarding signs of impairment, relapse, and how to contact program	• Submit Org Chart to demonstrate that the Worksite Monitor is at least one step above the participant on the Org Chart	• Submit Job Description for review for compliance with restrictions on practice	• Submit Affidavit that WSM meets criteria, has been trained, and agrees to expectations of position

“SB1441” Uniform Standards

- SB 1441 Ridley-Thomas 2008-2009 Leg Session
- Required the formation of the Substance Abuse Coordination Committee – Executive Officers of Health Professional Licensing Boards
- The bill required the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board would be required to use in dealing with substance-abusing licensees
- 16 Uniform Standards
- Clinical Assessment / Diagnostic Evaluation
- Removal from Practice / return to work/and monitoring
- Drug Testing
- Support Groups
- Treatment requirements
- Positive tests and noncompliance
- Program Statistics
- Program audit

Drug Frequencies

Level	Segments of Probation/Diversion	Minimum Range of Number of Random Tests
I	Year 1	52-104 per year
II*	Year 2+	36-104 per year

ADDITIONAL DRUG TESTING REQUIREMENTS

Drug testing may be required on any day, including weekends and holidays.

Nothing precludes a board from increasing the number of random tests for any reason.

Prior to vacation or absence, any alternative to the licensee's drug testing requirements (including frequency) must be approved by the board. Participants returning from travel abroad may be tested by hair and Peth tests. (2019)

The scheduling of drug tests shall be done on a random basis…so that a licensee can make no reasonable assumption of when he/she will be tested again.

Licensees shall be required to make daily contact to determine if drug testing is required.

Licensees shall be drug tested on the date of notification as directed by the board.

Collection of specimens shall be observed.

EXCEPTIONS

NOT EMPLOYED IN HEALTH CARE FIELD

A board may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the licensee's board. Prior to returning to any health care employment, the licensee shall be subject to level I testing frequency for at least 60 days. At such time the person returns to employment (in a health care field), if the licensee has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

TOLLING

If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

SUBSTANCE USE DISORDER NOT DIAGNOSED

In cases where no current substance use disorder diagnosis is made, a lesser period of monitoring and toxicology screening may be adopted by the board, but not to be less than 24 times per year.

PREVIOUS TESTING/SOBRIETY

In cases where a board has evidence that a licensee has participated in a treatment or monitoring program requiring random testing, prior to being subject to testing by the board, the board may give consideration to that testing in altering the testing frequency schedule so that it is equivalent to this standard.

Lab-based vs Rapid Drug Testing

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Screening and Confirmation

Screening: The first step

- Sensitive but not specific
- Less expensive
- Most specimens are negative
- The proportion of truly positive results, as measured by the gold standard, that are identified as positive by the test under study

Confirmation: The second step

- Specific
- More expensive
- Most specimens that go from screening to confirmation are positive
- Specificity: The proportion of truly negative results, as measured by the gold standard, that are identified as negative by the test under study
- Specific metabolites

Cutoffs

Cutoffs are quantitative levels. If alcohol or drug is present at or above cutoff, the specimen is positive, if not the specimen is negative.

Our program has some of the lowest (most sensitive) cutoffs in the industry.

Limit of Detection (LOD): The lowest concentration at which it can be measured and can be identified, but (for quantitative assays) the concentration cannot be accurately calculated.

What Are the Concerns About Testing?

- Efficacy of technology
- Integrity of process
- Specimen Collector Training
- Device Use Training
- Quality control / quality assurance
- Confirmatory tests
- MRO review
- Participant Integrity
- Lab error / mix-up
- Delays in shipping or processing
- Environmental interference (hot/cold temperatures)

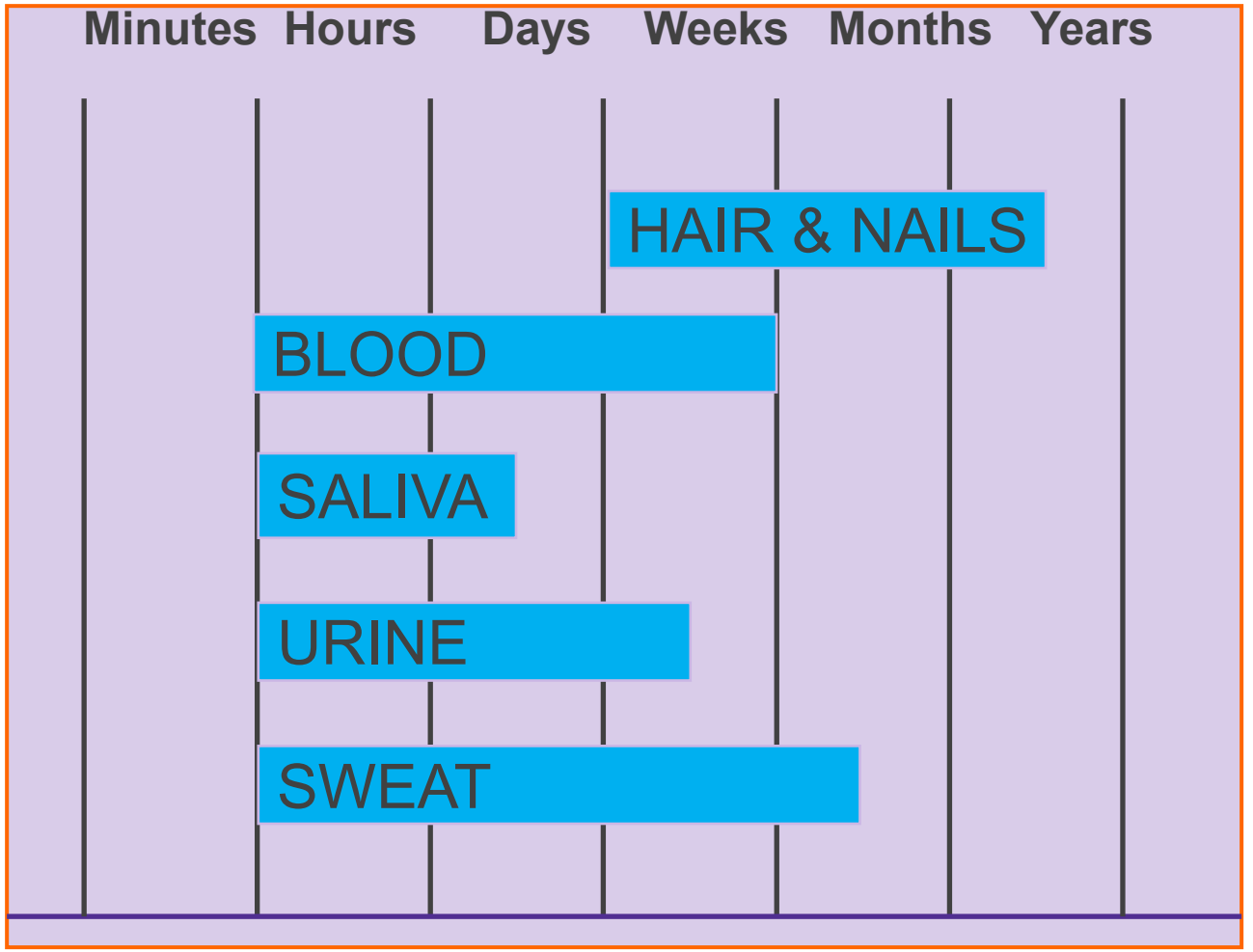
What We Do With The Result Is More Important Than The Result Itself

- The more significant the action to be taken, the more forensic defensibility a result should have.
- A single drug test result does not make a diagnosis, but…
- When used as a piece of the whole picture, it may be enough to justify a decisive action.
- Each drug test result stands on its own:
  - -A second result does not invalidate the first result
  - -An alternative specimen result does not invalidate a urine result
  - -In either case the second result may support the first
  - -**BUT: A split specimen result can invalidate the original**
- *Always have a plan for what we are going to do with the result*

Limits of testing laboratories

- A negative result does not guarantee the absence of alcohol or drug
- Positive alcohol or drug levels do not differentiate acceptable use from abuse even if elevated
- Positive alcohol or drug levels do not indicate impairment (except BAC)
- There is no dose/result relationship because there is no way to tell if level is rising or falling

Window of Detection for Different Specimens



Validity Testing (SVT)

Validity testing is the evaluation of a specimen to determine if it is consistent with normal human urine and if the observed properties allow detection of drugs of abuse

HHS mandated since 11/1/2004 on all federal urine specimens

SVT should be done on all urine specimens

Appropriate SVT should be developed and done for all forensic alternative specimens

Validity Testing includes

Measures of urine concentration/dilution

- Creatinine on all specimens
- *NOT CREATINE*
- Specific gravity if creatinine <20 mg/dL

pH

General screen for oxidants

Additional issues:

- Immunoassay interference
- Inability to confirm

Two Measures Of Dilution Required

Values selected for analysis should be expected to parallel each other as specimen concentration increases or decreases

Creatinine and Specific Gravity

Dilute

- Creatinine < 20 mg/dL but ≥ 2 AND Specific Gravity > 1.0010 and < 1.0030

Out of Range (OOR)

- Creatinine < 20 mg/dL and Specific Gravity within normal range (>1.003)

Substituted

- Creatinine < 2.0 mg/dL AND Specific Gravity ≤ 1.0010 OR ≥ 1.0200

What happens if Creatinine and Specific Gravity do not parallel?

If Creatinine and Specific Gravity do not parallel each other, the specimen is invalid:

- Creatinine < 2.0 and S.G. acceptable (>1.0010 AND < 1.0200)
- Creatinine ≥ 2.0 and S.G. ≤ 1.0010
  - An observed recollection is strongly recommended
  - If collection was observed the observation was not done properly

Result Interpretation

Dilute and OOR Specimens:

- Studies have shown from 7%-12% increase in positive results when either creatinine or specific gravity are mathematically normalized-basic algebraic equation
- Creatinine concentration varies by age and sex
- Donor specific creatinine may be a better indicator (we look at average creatinine over time)
- Testing at Level Of Detection also possible
- Negative specimens discarded within 5-7 days

Hair Testing for Drugs of Abuse

Advantages

- Longer window for drug detection (3 + mos)
- Easy to collect, handle, store
- Second collection capability
- Noninvasive
- “Beating” a hair test may be more difficult than with urine
- Participants show up fully shaved

Disadvantages

- May not detect recent or infrequent use
- Environmental contamination is a concern
- Controversial issues unresolved (e.g., color bias)
- Mechanism(s) of drug deposition not understood
- Dose/time relationships not established
- New science with few controlled studies

EARLY RELEASE

Early release from Pharmacist Recovery Program due to completion of probation is risky

In our experience, participants tend to let their guard down, think they are “in the clear”

Alternatively, rather than program closure, consider one year of Transition in PRP which allows less monitoring, more self-management

Transition Year Demonstrating Successful Completion Criteria

Demonstrate a manner of living that supports ongoing recovery

Have proof of negative random drug tests, and negative hair and alcohol tests prior to program completion

Transition Period--One Year Before Completion

Participant is placed on reduced monitoring for a period of time before granting successful completion

The objective of Transition is to allow the participant to take full responsibility for their own recovery process while still in the Program.

Participant must “petition for Transition” wherein they write an essay examining their life’s journey into recovery, develop a relapse prevention plan, and obtain letters of reference from sponsor, family members and support group facilitator.

Transition Period Requirements

Participant must maintain worksite monitor, but may have reduced frequency of contact

Participant must continue to submit monthly self-reports and call to case manager monthly.

Participant is not required to attend 12-Step meetings, or health support group. No longer required to request travel, but must inform Maximus of planned travel and location of test collection sites.

Transition/Successful Completion Criteria

Have no other evidence of relapse within 24 months of completion date

Have completed at least 24 months of satisfactory participation and compliance

Recovery Works!

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