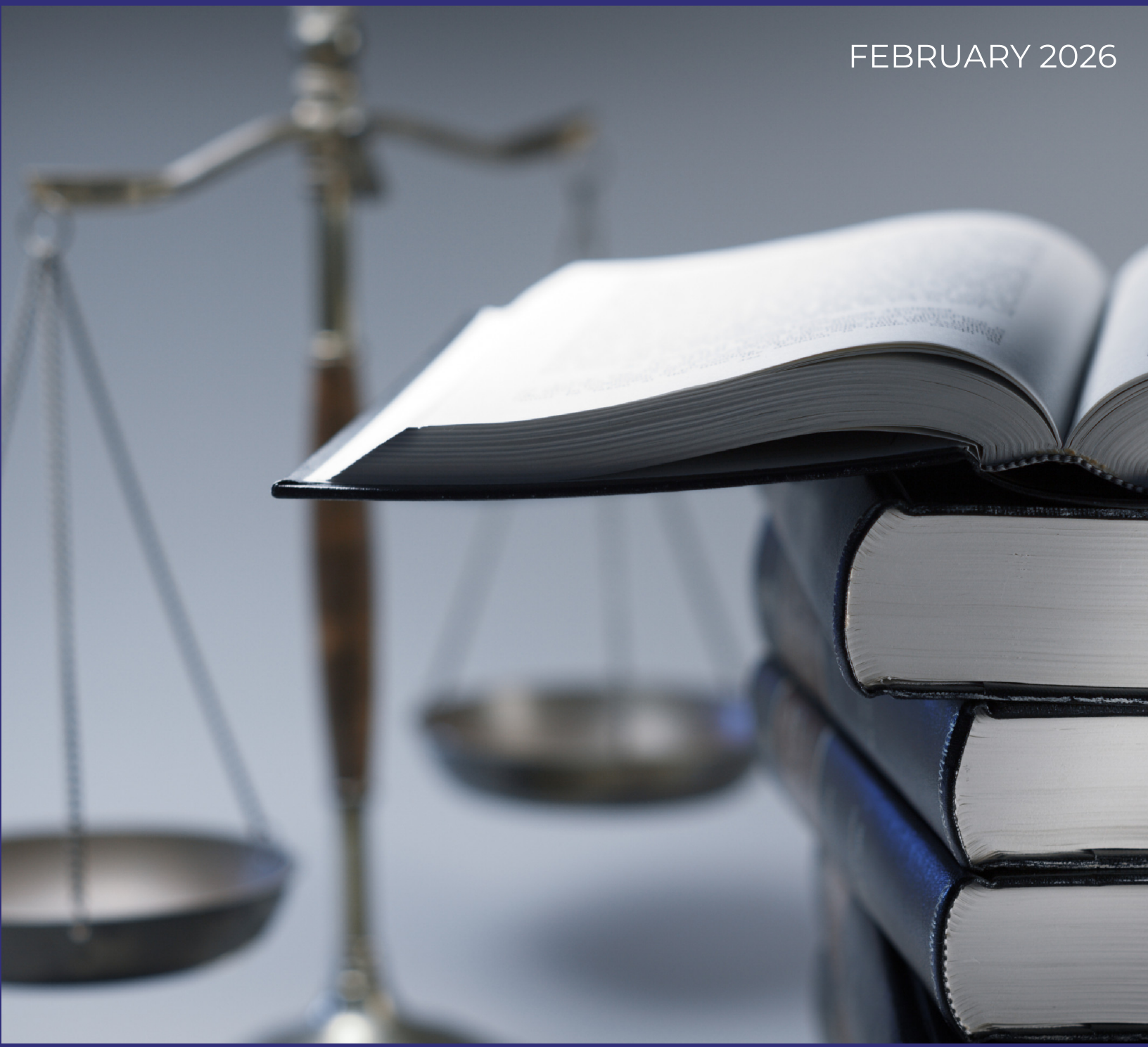
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

MODEL ADDRESSING DRUG DIVERSION IN HEALTHCARE SETTINGS ACT

FEBRUARY 2026



LAPPA
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

This project was supported by the Model Acts Program, funded by the Office of National Drug Control Policy, Executive Office of the President. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the Office of National Drug Control Policy or the United States Government. Research is Current as of February 2026.

MODEL ADDRESSING DRUG DIVERSION IN HEALTHCARE SETTINGS ACT

ACKNOWLEDGMENTS

The Legislative Analysis and Public Policy Association (LAPPA) is grateful to the Office of National Drug Control Policy for its support in funding, enabling, and contributing to this Model Act.

This Model Act could not have been developed without the valuable input of the Model Addressing Drug Diversion in Healthcare Settings Act working group. LAPPA wishes to thank its distinguished members, many of whom are listed below, for providing their expertise, guidance, and suggestions that contributed to the model's development.

Charlie Cichon
National Association of Drug Diversion Investigators

John Gadea, Jr., RPh
Department of Consumer Protection, State of Connecticut (retired)

Marc Gonzalez, PharmD
National Association of Drug Diversion Investigators

Tom Knight
HealthCareDiversion.org

Deborah Koivula, RN
Statewide Peer Assistance for Nurses (SPAN)

Timothy Lahey, MD
University of Vermont Medical Center

Alex Meredith, PharmD
Office of National Drug Control Policy

Mary Nelson, RN
HonorHealth

Maggie Ortiz, RN
Advocates for Nurses, PLLC

Aimee Posivak, PharmD
Healthcare Diversion Consultant
National Association of Drug Diversion Investigators

Kristin Waite-Labott, RN
Wisconsin Peer Alliance for Nurses

MODEL ADDRESSING DRUG DIVERSION IN HEALTHCARE SETTINGS ACT

TABLE OF CONTENTS

SECTION I. SHORT TITLE.

This Act may be referred to as the "Model Addressing Drug Diversion in Healthcare Settings Act," "the Act," or "Model Act."

SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) Legislative findings.—The [legislature][1] finds that:

(1) Nearly 48.3 million Americans aged 12 and older reported having a substance use disorder in 2024, the most recent year for which there is data;[2]

(2) The rate of substance use disorder among healthcare professionals is estimated to be 10 percent, similar to that of the general population;[3]

(3) Substance use disorder is a progressive, chronic disease, and healthcare professionals who develop this disease can, with appropriate treatment, be assisted with recovery and return to practice in their fields;[4]

(4) An average of 75 percent of healthcare professionals with a substance use disorder who were engaged in a monitoring program remained in recovery and were working in their professions at follow-up;[5] and

(5) It is the duty and obligation of state regulatory boards to promote the early identification, intervention, treatment, and rehabilitation of individuals subject to the authority of a board in this state who may be impaired by reason of the misuse of drugs and/or alcohol or an untreated substance use disorder such that it renders such individuals unable to meet the standards of their professions.[6]

(b) Purpose.—The purpose of this Act is to:

---

[1] This Act contains certain bracketed words and phrases (*e.g.*, "[legislature]"). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

[2] *Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health: Detailed Tables*, U.S. DEP'T OF HEALTH & HUM. SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., Table 5.1A (2024), https://www.samhsa.gov/data/sites/default/files/reports/rpt56484/NSDUHDetailedTabs2024/NSDUHDetailedTabs2024/2024-nsduh-detailed-tables-sect5pe.htm#tab5.2a.

[3] Pauline M. Geuijen, et al, *Success Rates of Monitoring for Healthcare Professionals with a Substance Use Disorder: A Meta-analysis*, 10(2) J. OF CLINICAL MED. at 1 (2021), Success Rates of Monitoring for Healthcare Professionals with a Substance Use Disorder: A Meta-Analysis - PMC.

[4] OR. ADMIN. R. 847-065-0010 (2024).

[5] GEUIJEN ET AL, *supra* note 3, at 16. Follow-up with healthcare professionals varied from 6 months to 8 years after program admittance.

[6] ALA. CODE § 34-38-2 (2024).

Return to Table of Contents

(1) Require healthcare entities to establish policies and procedures for the prevention and detection of drug diversion by healthcare professionals and to ensure that treatment and recovery support services are offered to eligible healthcare professionals;

(2) Require certain individuals and entities to report healthcare professionals suspected of misusing drugs and/or alcohol, diverting drugs for personal use, having an untreated substance use disorder, or practicing while impaired and to establish penalties for failure to make such reports;

(3) Require boards, as defined in this Act, in this state to establish or participate in an alternative to discipline program for eligible healthcare professionals;

(4) Establish legal protections for individuals who make reports as required by this Act;

(5) Provide immunity from civil and criminal liability for specified individuals and entities for actions taken pursuant to this Act;

(6) Establish penalties for healthcare entities that fail to take corrective action after discovering diversion by a healthcare professional;

(7) Establish program reporting and audit requirements;

(8) Establish technology grants for healthcare entities to be used for the prevention and detection of drug diversion; and

(9) Establish funding provisions for alternative to discipline programs.

Commentary

Substance use disorder and the misuse of drugs and alcohol affects people of all socioeconomic statuses, including healthcare professionals who occupy safety-sensitive positions such that impairment among such individuals resulting from drug or alcohol use can have a serious, detrimental impact on others.[7] The rate of substance use disorder among healthcare professionals is similar to that among the general population, ranging from 10-15 percent of individuals.[8] According to the National Institute on Drug Abuse, 40 to 60 percent of individuals

[7] Lisa J. Merlo et al, *Essential Components of Physician Health Program Monitoring for Substance Use Disorder: A Survey of Participants 5 Years Post Successful Program Completion*, 31 AM. J. ADDICTION 115-122, at 116 (Dec. 2021).

[8] GEUIJEN ET AL, *supra* note 3. *See also* Lisa J. Merlo et al, *Essential Components of Physician Health Program Monitoring for Substance Use Disorder: A Survey of Participants 5 Years Post Successful Program Completion*, 31 AM. J. ADDICTION 115-122, at 116 (Dec. 2021); Julie Nyhus, *Drug Diversion in Healthcare: Prevention and Detection for Nurses*, 15(5) Am. Nurse J. at 26 (May 2021), Drug diversion in healthcare - prevention and detection for nurses; and Cynthia Saver, *Substance Use Disorders and Drug Diversion among Nurses: What You Need to Know*, 1(3) ANA-Oh. News J. at 14 (Sept. 2023), SNA_OH0103_SubstanceUseDisorders.pdf.

Return to Table of Contents

with a substance use disorder will return to use.[9] By contrast, healthcare professionals are more successful in treating their substance use disorder and maintaining recovery than individuals with substance use disorder in the general population.[10] In a study conducted of physician health program participants, researchers found that almost 81 percent of program participants completed their five-year treatment agreements, and 79 percent continued to work without restrictions.[11]

Healthcare professionals may have an increased risk of developing a substance use disorder as they have easy access to drugs and "perceived invincibility or immunity to substance-related impairments, and work role-related stress."[12] They may then resort to diverting prescription drugs and controlled substances. While most healthcare professionals who divert drugs do so for personal use, some also divert to third parties for financial or other personal gain. Drug diversion by healthcare professionals occurs when a healthcare professional: (1) tampers with a medication prescribed for a patient by, for example, using the medication and replacing it with another substance (*e.g.*, saline); (2) uses – by injecting, ingesting, or otherwise – medications and reports them as waste; or (3) steals medications from drug storage.[13] Healthcare professionals also commit diversion by writing fraudulent prescriptions. According to a variety of sources, drug diversion by healthcare professionals is substantially underestimated, undetected, and underreported.[14]

Historically, a healthcare professional with a drug or alcohol disorder who was reported to his or her board was disciplined by that board, whether or not the healthcare professional had engaged in diversion or other unprofessional conduct.[15] However, given the current understanding of substance use disorder, healthcare regulatory boards across the country have implemented what are known as alternative to discipline, physician health, or healthcare assistance programs as a non-disciplinary approach to treating these professionals.[16] Currently, the boards of medicine in 47 states and the District of Columbia have implemented physician health programs and are members of the Federation of State Physician Health Programs.[17] Additionally, at least 45 states have alternative to discipline programs for nurses[18] and, as of

[9] *Treatment and Recovery*, Nat'l Inst. of Health (July 2020), https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery.
[10] *Id*.
[11] *Id*. *See also* Linda Bresnahan, T*he Role & Success of Physician and Healthcare Professional Programs*, 24(1) NMA ADVOCATE 14-17, at 14 (2024).
[12] MERLO ET AL, *supra* note 8, at 116.
[13] *See, e.g.,* Julie Nyhus, *Drug Diversion in Healthcare: Prevention and Detection for Nurses*, 15(5) AM. NURSE J. at 26 (May 2021), Drug diversion in healthcare - prevention and detection for nurses.
[14] *See, e.g.*, Keith H. Berge et al, *Diversion of Drugs within Health Care Facilities, a Multiple-victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention*, 87(7) MAYO CLINIC PROC. 674-682, at 674 (July 2012); Julie Nyhus, *Drug Diversion in Healthcare*, 15(5) AM. NURSE J. at 26 (May 6, 2021), Drug diversion in healthcare - prevention and detection for nurses.
[15] Kathleen Russell, *Components of Nurse Substance Use Disorder Monitoring Programs*, 11(2) J. NURSING REG. 20-27, at 20 (July 2020).
[16] *Id*.
[17] FED'N OF STATE PHYSICIAN HEALTH PROGRAMS, FAQs, FAQs (last visited Feb. 23, 2026).
[18] *Alternative to Discipline Programs for Substance Use Disorder*, NAT'L COUNCIL OF STATE BDS. OF NURSING (accessed Feb. 23, 2026), https://www.ncsbn.org/nursing-regulation/discipline/board-proceedings/alternative-to-discipline.page.

Return to Table of Contents

2017, 46 states had programs to assist pharmacists with substance use disorder.[19] As stated above, these types of programs are highly successful in assisting healthcare professionals who are receiving treatment, with participants remaining in recovery at a higher rate than the general population.[20] However, despite their success, they are inconsistent in terms of services provided, minimum length of participation, and other elements crucial to the successful recovery of participants.

This Model Act is designed to implement changes to how healthcare facilities prevent, detect, and respond to diversion and also to require state boards of the healing arts to establish – or, if programs already exist, join – alternative to discipline programs for healthcare professionals under their authority. See the commentary for Section VI for more information on those programs.

SECTION III. DEFINITIONS.

[States may already have definitions in place for some or all of the following terms. In such case, states may use the existing definitions in place of those listed below.]

For purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given to them in this section:

(a) Adversely affecting.—"Adversely affecting" means reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a healthcare entity, but does not include those instances in which a peer review entity requires supervision of a healthcare professional or applicant for purposes of evaluating that individual's professional knowledge or ability;[21]

(b) Aftercare or continuing care.—"Aftercare" or "continuing care" means services that follow the acute phase of intervention and treatment and includes guidance, support, toxicology collection, and accountability through a formal contract concurrent with or following a drug and alcohol use evaluation or treatment process;[22]

(c) Alternative to discipline program or program.—"Alternative to discipline program" or "program" means one or more entities, organizations, programs, or individuals authorized by this Act to provide education, prevention, early identification, intervention, referral

[19] Kim Edward Light, et al., *State Programs Assisting Pharmacy Professionals with Substance Use Disorders*, 57(6) J. OF THE AM. PHARMACISTS ASSN. 704, 705 (2017), State programs assisting pharmacy professionals with substance use disorders.
[20] *See* Richard Smiley and Kyrani Reneau, *Outcomes of Substance Use Disorder Monitoring Programs for Nurses*, 11(2) J. OF NURSING REG. 28-35, at 28 (July 2020).
[21] N.M. CODE R. § 16.10.10.7 (2024).
[22] UTAH ADMIN. CODE r. R156-4a-102 (2024).

Return to Table of Contents

assistance, treatment, and recovery or support services to any healthcare professional credentialed in this state who uses or misuses drugs and/or alcohol to the extent that it affects the individual's ability to practice as a healthcare professional or who has a substance use disorder;[23]

(d) Assessment.—"Assessment" means a formal drug and alcohol use evaluation conducted by an approved provider who is credentialed in substance use disorder to render a diagnosis and professional opinion as to whether the healthcare professional is capable of practicing in his or her field with reasonable skill and safety to patients;[24]

(e) Board.—"Board" means an agency of the state:

(1) Charged with issuing a license, registration, certification, or other credential authorizing an individual to practice as a healthcare professional in this state;[25] and

(2) Authorized to investigate and discipline a healthcare professional holding a credential issued by such authority;

(f) Controlled substance.—"Controlled substance" means a drug, substance, or immediate precursor included in Schedules I – V of the federal Controlled Substances Act, 21 U.S.C. § 812 or 21 C.F.R. § 1308, or the [state] Controlled Substances Act [statutory reference];[26]

(g) Disciplinary action.—"Disciplinary action" means:

(1) Any action by a board that may lead to a fine, probation, reprimand, restriction, limitation, revocation, suspension, denial, or other order relating to the credential of a healthcare professional; and

(2) Any action by a healthcare entity, including reducing, restricting, suspending, revoking, denying, terminating, or failing to renew a healthcare professional's clinical/staff privileges, employment, or contract to practice;[27]

(h) Diversion or divert.—"Diversion" or "divert" means the unauthorized transference of drugs or prescriptions for drugs by a healthcare professional, whether for his or her

[23] ALA. ADMIN. CODE r. 610-X-13-01 (2024).
[24] 30 MISS. ADMIN. CODE Pt. 2826, R. 1.1 (2024).
[25] ARK. CODE ANN. § 17-80-117 (West 2024).
[26] WASH. REV. CODE ANN. § 69.50.101 (West 2022).
[27] LA. STAT. ANN. § 37:1745.13 (2024).

Return to Table of Contents

personal use, distribution, transfer to another individual, or any other unauthorized purpose, and includes, but is not limited to, tampering with packaged medications, theft of discarded medications or wastage, theft of drugs, theft of prescription pads, and writing fraudulent prescriptions;

(i) Drug.—"Drug" means any of the following:

(1) Any substance recognized as a drug, medicine, or medicinal chemical in the official United States Pharmacopoeia, official National Formulary, official Homeopathic Pharmacopoeia, or official Veterinary Medicine Compendium, or other official drug compendium or supplements thereto;

(2) Any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animal;

(3) Any chemical substance, other than food, intended to affect the structure or any function of the body of humans or other animals; or

(4) Any substance intended for use as a component of any items specified in paragraphs (1), (2), or (3) of this subsection, but does not include medical devices or their components, parts, or accessories;[28]

(j) Drug and alcohol use evaluation.—"Drug and alcohol use evaluation" means a clinical assessment, including a mental and physical examination, of a healthcare professional to determine if that professional has been using or misusing drugs and/or alcohol in a manner not authorized by law, has a substance use disorder, and/or has been practicing while impaired and, if so, the severity of the use or misuse, substance use disorder, and/or impairment;[29]

(k) Fitness for duty evaluation.—"Fitness for duty evaluation" means an in-depth evaluation of a healthcare professional conducted by the appropriate person with the alternative to discipline program or the healthcare professional's board to determine the healthcare professional's ability to perform safety sensitive and occupation-specific tasks and duties;

(l) Healthcare entity or healthcare facility.—"Healthcare entity" or "healthcare facility" means:

[28] WASH. REV. CODE ANN. § 69.04.009 (West 2024).
[29] Adapted from *Drug Abuse Evaluations*, ADDICTIONHEALP.COM (last updated June 14, 2024), Drug Abuse Evaluation - Pros & Cons of Drug Addiction Evaluations.

Return to Table of Contents

(1) An entity or facility licensed by the state that provides or arranges for healthcare services and includes, but is not limited to, hospitals; clinics; nursing homes; assisted living facilities; hospice providers, including entities that provide in-home services; veterinary clinics or hospitals; healthcare provider groups; long-term or extended care facilities; ambulatory surgery centers; emergency medical services units; pharmacies; group residential facilities; behavioral health facilities and any other facility in which healthcare services are provided; and

(2) A professional society or association;[30]

(m) Healthcare professional.—"Healthcare professional" means:

(1) An individual who is licensed, certified, registered, or otherwise authorized by a board in this state to provide healthcare services in the ordinary course of his or her business or practice;[31] and

(2) An intern, resident, student, or other individual in the process of becoming licensed, registered, certified, or otherwise authorized by a board of this state to provide healthcare services in the ordinary course of his or her business or practice.

(n) Impaired or impairment.—"Impaired" or "impairment" means the inability or significant potential for the inability of a healthcare professional to practice in his or her field with reasonable skill or safety to patients by reason of illness, inebriation, excessive use of drugs or alcohol, or a substance use disorder;[32]

(o) Intervenor.—"Intervenor" means an individual employed by or affiliated with the alternative to discipline program who is trained in intervention and who participates in a process whereby a healthcare professional alleged to be impaired is confronted to evaluate the presence of impairment and, if indicated, who refers the individual for assessment and treatment;[33]

(p) Intervention.—"Intervention" means a process whereby a healthcare professional who is alleged to be impaired is confronted by his or her board or an authorized intervenor who

[30] ME. REV. STAT. ANN. tit. 24, § 2502 (West 2024).
[31] Adapted from ARK. CODE ANN. § 17-80-117 (West 2024) and OHIO ADMIN. CODE 4726-6-01 (2024).
[32] ALA. CODE § 34-22-101 (2024).
[33] OHIO ADMIN. CODE 4729:4-1-01 (2024).

Return to Table of Contents

provides documentation that a problem exists and attempts to convince the healthcare professional to seek a drug and alcohol use evaluation, assessment, and treatment;[34]

(q) Limit or limitation.—"Limit" or "limitation" means a non-disciplinary action taken by a board that alters a healthcare professional's practice or healthcare activities if there is evidence that the healthcare professional is or may be unable to safely practice in his or her field;[35]

(r) Monitor or monitoring.—"Monitor" or "monitoring" means active oversight and supervision of a healthcare professional's practice by a worksite monitor who is present on the premises of a facility at all times while the monitored individual is practicing;[36]

(s) Patient harm.—"Patient harm" means harm to a patient as a result of medical care or in a healthcare setting that includes adverse events and temporary harm events.

(1) An adverse event is an event in which medical care resulted in an undesirable outcome not caused by the underlying disease or condition that prolonged the patient stay, caused permanent patient harm, required life-saving intervention, or contributed to death.

(2) A temporary harm event is an event in which medical care resulted in patient harm that required medical intervention but did not prolong the patient stay, cause lasting harm, or require life-sustaining intervention;[37]

(t) Peer support group.—"Peer support group" means a group of healthcare professionals that meets regularly to support the recovery of its members, who may represent professionals in a variety of healthcare fields. The group provides a confidential setting with a trained and experienced peer support professional in which participants may safely discuss drug diversion, credentialing issues, return to work, and other professional issues related to recovery;[38]

(u) Peer support professional.—"Peer support professional" means an individual with the lived experience of recovery from a substance use disorder who has obtained a credential

[34] ARK. CODE R. 007.39.10-10-00-0001 (2024).
[35] ARIZ. REV. STAT. ANN. § 32-2501 (2024).
[36] 20-4 VT. CODE R. § 1100:1 (2024).
[37] *Adverse Events*, U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN. (Sept. 7, 2023), Adverse Events | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services.
[38] WASH. ADMIN. CODE 246-853-300 (2024).

Return to Table of Contents

from [state] or an approved national certification body to provide non-clinical, strengths-based support to others experiencing similar challenges;[39]

(v) Professional society.—"Professional society" means a national or statewide healthcare organization and individual practice associations, as defined in 42 U.S.C. 300e-1(5) of the Public Health Service Act, as amended, having as members at least a majority of the licentiates in the area or healthcare facility or agency served by the particular society;[40]

(w) Program participant or participant.—"Program participant" or "participant" means an eligible healthcare professional that has a signed treatment agreement to participate in the alternative to discipline program;[41]

(x) Rehabilitation.—"Rehabilitation" means the process of restoring a healthcare professional to a level of professional performance consistent with public health and safety;[42]

(y) Restrict or restriction.—"Restrict" or "restriction" means a disciplinary action taken by a board that alters a healthcare professional's practice or healthcare activities, including by practice setting, types of clients, hours, or other means, if there is evidence that the healthcare professional is or may be impaired or guilty of unprofessional conduct, as defined in the laws and regulations of the healthcare professional's board;[43]

(z) Retaliatory action.—"Retaliatory action" means termination of or other adverse action against a healthcare professional's employment taken by the healthcare entity at which the healthcare professional works, whether as an employee, contractor, or temporary employee through a staffing agency, because the individual made a report pursuant to this Act;[44]

(aa) Return to use.—"Return to use" means the use of, or obtaining for the purpose of using, drugs, alcohol, or any other substances that impair the ability to practice; a positive drug

[39] Taken from the *Model Substance Use Disorder Treatment in Emergency Settings Act*, LEGIS. ANALYSIS & PUB. POL'Y ASSN. (March 2023), Model Substance Use Disorder Treatment in Emergency Settings Act | LAPPA and the *Model Substance Use during Pregnancy and Family Care Plans Act*, LEGIS. ANALYSIS & PUB. POL'Y ASSN. (March 2023), Model Substance Use During Pregnancy and Family Care Plans Act | LAPPA.
[40] CONN. GEN. STAT. ANN. § 19a-17b (West 2024).
[41] IOWA ADMIN. CODE r. 655-19.2 (2024).
[42] WASH. ADMIN. CODE 246-853-300 (2024).
[43] Adapted from ARIZ. REV. STAT. ANN. § 32-1501 (2024) and LA. ADMIN. CODE tit. 46, Pt. XLVII, § 3405 (2024).
[44] ARIZ. REV. STAT. ANN. § 36-450 (2024).

Return to Table of Contents

test; or a return to a pattern of impairment activities which affects the healthcare professional's ability to practice;[45]

(bb) Staffing agency.—"Staffing agency" means an entity that recruits and facilitates the employment of healthcare professionals in healthcare facilities on a temporary or permanent basis and that is paid a percentage of the healthcare professional's salary or hourly wage;

(cc) State.—"State" means any state of the United States, the District of Columbia, and any territory of the United States. "This state" means the State of [state];

(dd) Student of the healing arts.—"Student of the healing arts" means an individual who is currently receiving education or training to become licensed, registered, or certified to practice a healthcare profession;

(ee) Substance use disorder.—"Substance use disorder" means the recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health or medical problems, and an inability to meet major responsibilities at work, school, or home;[46]

(ff) Suspend.—"Suspend" means to hold a license, registration, certification, or other credential to practice as a healthcare professional in abeyance for a definite period of time. The individual remains a healthcare professional during the period of suspension and retains a credential to practice, but cannot practice, and shall not practice, during the period of suspension. Suspension may be voluntary or involuntary;[47]

(gg) Toxicology testing, drug testing, or testing.—"Toxicology testing," "drug testing," or "testing" means the collection of urine, blood, oral fluid, hair, nails, sweat, or breath used to deter and detect unauthorized drug or alcohol use by a participant;[48] and

(hh) Treatment provider.—"Treatment provider" means an approved healthcare professional or residential, outpatient, partial hospitalization, or other program through which a healthcare professional is treated based on the healthcare professional's diagnosis and treatment contract.[49]

[45] OHIO ADMIN. CODE 4729:4-1-01 (2024).
[46] *Co-occurring Disorders and Other Health Conditions*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS. (March 29, 2024), https://www.samhsa.gov/find-help/disorders.
[47] LA. ADMIN. CODE tit. 46, Pt. XLVII, § 3405 (2024).
[48] UTAH ADMIN. CODE r. R156-4a-102 (2024).
[49] FLA. STAT. ANN. § 456.076 (West 2024).

Return to Table of Contents

Commentary

Many of the terms defined in this section may already be defined under state law, and states are free to use those definitions in lieu of the definitions provided in this section. However, some of the definitions in this section may have been revised to better fit the needs and circumstances of this Act, and changes to such definitions may impact the effectiveness of the Act.

Certain terms (*e.g.*, "board," "healthcare facility," and "healthcare professional") have purposely been defined to be extremely broad for purposes of both brevity in this Model Act and also to ensure that all parties that should be subject to the provisions of this Act are included. States may choose instead to specifically list the individuals and entities in each definition; however, states should be careful to ensure that those lists are exhaustive.

SECTION IV. DIVERSION BY HEALTHCARE PROFESSIONALS.

(a) Policies and procedures.—Each healthcare entity licensed or registered in this state that stores, dispenses, or administers drugs shall have written policies and procedures in place to prevent and detect drug diversion by healthcare professionals, including contractors and temporary employees, and to investigate, adjudicate, and report suspected incidents of drug diversion.[50] Policies and procedures shall represent best practices in the field and be evidence-based and shall include:

(1) Education of healthcare professionals pursuant to subsection (i) of this section, including contractors and temporary employees whose tenure with the healthcare entity is expected to meet or exceed one (1) year, which shall occur at least [quarterly/every six (6) months/annually];

(2) Procedures for monitoring procurement, storage, distribution, and wastage of inventory if drugs, including controlled substances, are stored, dispensed, or administered at the healthcare entity;

(3) Procedures to establish requirements for accounting for medication, documentation of medication administered to each patient, and proper destruction or disposal of medication;

(4) Procedures for documenting wastage of prescription drugs and controlled substances in compliance with subsection (e) below;

[50] N.Y. COMP. CODES R. & REGS. tit. 8, § 64.9 (2024).

Return to Table of Contents

(5) Documented surveillance methods and procedures for early detection of diversion;

(6) Procedures for detecting, reporting to the appropriate facility personnel, investigating, adjudicating, and reporting to state and federal authorities any unexplained loss or theft of drugs and inventory discrepancies;

(7) Confidential and non-punitive procedures for voluntary self-referral to the appropriate individual in the healthcare facility or to an alternative to discipline program by healthcare professionals who have diverted drugs for personal use, are misusing drugs or alcohol, have an untreated substance use disorder, or are working while impaired by the use of drugs and/or alcohol. For purposes of this paragraph, "non-punitive" means that a healthcare professional will not be subject to discipline merely for making a self-referral. It does not prohibit a healthcare entity or board from taking steps necessary to ensure the public health and safety, including by suspending, reassigning, or terminating a healthcare professional, or from making reports related to drug diversion to the appropriate entity or entities as required by state and federal law;

(8) Procedures for mandatory, non-punitive, confidential reporting by a co-worker of suspected diversion or practice while impaired by a healthcare professional;

(9) Procedures for drug testing where reasonable suspicion of diversion and/or impairment exists;

(10) An established process for detecting, investigating, adjudicating, reporting, and resolution of drug misuse or diversion; and

(11) Consequences for violating such policies and procedures.[51]

(b) Review of policies and procedures.—Established policies and procedures shall be reviewed at least annually and following any confirmed instance of significant diversion by a healthcare professional to assess the effectiveness of such policies and procedures.

[51] Adapted from FLA. ADMIN. CODE ANN. r. 63M-2.2026 (2024); 410 IND. ADMIN. CODE 15-1.2-1 (2024); KAN. ADMIN. REGS. § 26-52-20 (2024); N.H. REV. STAT. ANN. § 151:41 (2024); and N.C. GEN. STAT. ANN. § 131E-128.1 (West 2024).

Return to Table of Contents

(c) Drug diversion prevention and investigation response program.—Healthcare entities with [25] or more total employees, including contractors and temporary employees, shall implement a drug diversion prevention and response program.

(1) Program requirements.—Programs shall:

(A) Establish a multidisciplinary drug diversion prevention and investigation response team that includes representatives from both facility administration and healthcare professionals that shall include individuals with lived experience, if available;

(B) Establish a multidisciplinary drug diversion oversight committee. Members shall be made up of individuals with training and experience in conducting drug diversion investigations. No person serving on the drug diversion prevention and response team shall serve on the oversight committee;

(C) Implement policies that address access to controlled substances and other drugs, chain of custody policies, surveillance and reporting provisions, and employee accountability;

(D) Create and maintain a surveillance system that may include the use of modern technologies designed to prevent and detect diversion, including automated dispensing cabinets with built-in reporting features, where financially and operationally feasible. Healthcare entities unable to implement such technologies shall utilize alternative methods to monitor for diversion that are appropriate to their size, resources, and regulatory requirements;

(E) Establish reporting policies that ensure that all instances of drug diversion are reported to the appropriate facility administrators and to local, state, and federal regulatory authorities as required by law, which can include making reports through intermediaries, such as HealthcareDiversion.org, if permitted by such laws; and

Return to Table of Contents

(F) Conduct an evaluation of the program on at least an annual basis to determine if the program is effective in preventing and detecting drug diversion by healthcare professionals.[52]

(2) Drug diversion prevention and response team duties.—The drug diversion prevention and response team shall, at a minimum, have the following duties and responsibilities:

(A) Receive and make reports of suspected and/or confirmed drug diversion within the time required by state and federal law;

(B) Begin investigating reports of suspected drug diversion within twenty-four (24) hours of receiving such report;[53]

(C) Interview individuals suspected of drug diversion, conduct toxicology tests as appropriate, and notify such individuals of resources available to them, including the existence of the alternative to discipline program;

(D) Investigate reports of discrepancies in drug counts;

(E) If the team determines that suspected drug diversion occurred, submit all evidence related to the investigation to the drug diversion oversight committee for adjudication;

(F) Cooperate with law enforcement and other agencies investigating potential drug diversion at the healthcare entity;

(G) Identify goals and recommendations to implement best practices and procedures, including risk reduction technologies, to improve patient safety; and

(H) Any other duties as directed by the healthcare entity.

(3) Drug diversion oversight committee duties.—The drug diversion oversight committee shall, at a minimum, have the following duties and responsibilities:

(A) Receive evidence from the drug diversion prevention and response team;

[52] *Keeping Patients Safe from Harm while Reducing Liability*, HEALTHTRUST PERFORMANCE GROUP (2023), Preventing Drug Diversion - HealthTrust - Performance Improvement For Healthcare.
[53] OHIO ADMIN. CODE 3701-19-06 (2024).

Return to Table of Contents

(B) Work with state drug diversion investigators to make a determination as to whether drug diversion actually occurred and that the individual under investigation is the most likely person to have committed such diversion;

(C) Submit all reports required by local, state, and federal law; and

(D) Cooperate with law enforcement and other agencies investigating potential drug diversion at the healthcare entity.

(d) Healthcare entities with fewer than [25] employees.—Healthcare entities with fewer than [25] total employees, including contractors and temporary employees, that choose not to create a drug diversion prevention and response program shall identify an individual to whom all reports of suspected drug diversion shall be reported and who shall be responsible for reporting incidents of suspected or confirmed diversion to the appropriate entity or entities pursuant to state and federal law.

(e) Wastage.—In the case of a drug in which a prepared dose has been refused by the patient or canceled by the prescriber that cannot be returned to the dispenser; the solution, tablet, ampoule, or substance has been accidentally destroyed; a hypodermic tablet is contaminated or broken or a solution is contaminated; the prescribed dose is not available and a larger dose must be used; or the dose prescribed and administered was smaller than the container and the unused portion cannot be returned to the dispenser, the healthcare professional responsible shall ensure the proper disposal to a non-retrievable state of such drug.[54]

(1) The disposal shall be conducted so that no person can use, administer, sell, or give away the drug.[55]

(2) Prescription drugs that are not controlled substances shall be destroyed or disposed of by a healthcare professional.

(3) [Prescription drugs that are not controlled substances that have been identified by the Drug Enforcement Administration and/or the state pharmacy board as a commonly diverted drug shall be destroyed or disposed of by a healthcare professional and one (1) adult witness who is also a healthcare professional.]

[54] Adapted from S.C. CODE ANN. REGS. 61-4.1910 (2024).
[55] 10A N.C. ADMIN. CODE 13F.1008 (2024).

Return to Table of Contents

(4) Controlled substances shall be disposed of by a healthcare professional and [one (1) adult witness who is also a healthcare professional] [two (2) adult witnesses, at least one of whom shall be a healthcare professional].[56]

(5) All drugs remaining with a patient who dies while receiving in-home care shall be disposed of pursuant to state and federal laws.

(6) If the healthcare entity does not have an electronic logging system through an automated dispensing machine or similar technology, the healthcare professional responsible for the disposal of wastage shall note in a log, which may be electronic, created solely for the documentation of wastage:

(A) The drug wasted;

(B) The date and time of destruction or other disposition;

(C) The quantity dispensed or administered to the patient;

(D) The quantity or estimated quantity wasted;

(E) The source of the drug, including identification of the patient for whom the drug was intended; and

(F) The printed name; title, if applicable; and signature of each witness.[57]

(7) If, for any reason, the destruction or disposal of a drug is not personally observed by a witness, the healthcare professional shall:

(A) Indicate in the log that the destruction or disposal was not personally observed; and

(B) Report the unobserved destruction or disposal to the appropriate individual as identified by the healthcare entity's wastage policies and procedures.

(f) Maintenance of documentation.—Each healthcare entity that stores, dispenses, or administers drugs in this state shall maintain the documentation and logs required by this section for a period of not less than two (2) years, and such documentation shall be made available for review by the [entity responsible for licensing/registering healthcare entities in the state] and the [board of pharmacy] upon request.[58]

[56] Adapted from N.M. CODE R. § 16.19.20.37 (2024) and S.D. ADMIN. R. 44:73:08:06 (2024).
[57] Adapted from ARK. CODE R. § 007.05.12-11 (2024) and IOWA ADMIN. CODE r. 657-11.32 (2024).
[58] D.C. MUN. REGS. tit. 22-B, § 2025 (2024).

Return to Table of Contents

(g) Detection of drug diversion.—In addition to the other duties set forth in this section, when potential drug diversion by a healthcare professional is detected by a healthcare entity, the drug diversion prevention and investigation response program or the individual responsible for receiving reports of drug diversion at a healthcare entity with fewer than [25] total employees shall encourage the healthcare professional to self-report to the appropriate alternative to discipline program.

(h) Contracts with staffing agencies.—Every written agreement or contract between a healthcare entity and a staffing agency shall include procedures for a healthcare entity to provide written notice to the staffing agency of actual or suspected misuse of drugs or alcohol or drug diversion by a healthcare professional employed by or under contract with the staffing agency.

(i) Training and education.—Pursuant to subsection (a)(1), healthcare entities shall implement training and education for healthcare professionals employed by the healthcare entity and those contractors and temporary employees whose tenure with the healthcare entity is expected to meet or exceed one (1) year. Contractors and temporary employees whose tenure with the healthcare entity is expected to be less than one (1) year shall obtain the required training and education from a staffing agency or an approved continuing education provider.

(1) The training and education seminars shall be conducted by an individual with the appropriate expertise and experience. Healthcare entities can outsource the training and education required by this subsection.

(2) Topics covered shall include, but not be limited to,

(A) Recognizing substance use disorder in colleagues;

(B) Recognizing the signs of diversion by healthcare professionals;

(C) Resources available to healthcare professionals, both within and outside of the healthcare entity, including alternative to discipline and peer support programs;

(D) Internal policies and procedures and state and federal laws and regulations related to diversion prevention, detection, and reporting;

(E) Proper medication handling and wastage procedures, including compliance with facility policies and procedures, federal and state

regulations, the importance of timely and proper disposal, and unit-specific education to ensure that healthcare professionals understand their duties and responsibilities within their specific practice setting, including available technologies that facilitate compliance;

(F) Strategies to prevent diversion;

(G) Reducing the stigma surrounding substance use disorder; and

(H) Any additional training topics as necessary to address emerging risks, regulatory changes, or internal policies and procedures.

Commentary

Experts agree that drug diversion by healthcare professionals is under detected and underreported.[59] This section comprises recommendations from several sources regarding the best methods by which diversion can be prevented and detected in healthcare facilities.[60] Both the Mayo Clinic and the American Society of Health-system Pharmacists have set out what they believe to be best practices in detection and prevention of diversion, and the majority of provisions included in this section are based on those recommendations.[61] While this section specifically and the Model Act generally focus on healthcare professionals, legislators should be mindful that other, non-credentialed employees in and visitors to healthcare facilities also divert drugs and may wish to amend the provisions of this section to include those individuals.

Subsection (a) requires that healthcare entities have written policies and procedures in place to prevent and detect diversion by healthcare professionals and sets forth a list of 11 specific topics on which healthcare entities should have such policies and procedures. The first component is the requirement to have policies and procedures in place to educate healthcare professionals, including those individuals who are not employed by the healthcare entity such as contractors and employees of a staffing agency if those individuals are expected to work at the healthcare facility for at least one year. Contractors and temporary employees whose expected tenure is less than one year are required to obtain the education and training from either a staffing agency or an approved continuing education provider. The subsection suggests three time periods during which healthcare professionals must receive the required education – quarterly, every six months, or annually. A working group member suggested that the education occur at least every six months and more frequently for healthcare professionals working in high-risk areas. Subsection (i) sets forth the topics on which healthcare professionals are required to receive education.

---

[59] *See supra* note 13.

[60] *See, e.g.*, Keith H. Berge et al, *Diversion of Drugs within Health Care Facilities, a Multiple-victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention*, 87(7) MAYO CLINIC PROC. 674-682, at 674 (July 2012) and John Clark et al, *ASHP Guidelines on Preventing Diversion of Controlled Substances*, 79(24) AM. J. HEALTH-SYST. PHARM. 2279-2306, at 2279 (Dec. 15, 2022).

[61] *See* John Clark et al, *ASHP Guidelines on Preventing Diversion of Controlled Substances*, 79(24) AM. J. HEALTH-SYST. PHARM. 2279-2306, at 2279 (Dec. 15, 2022) and *Controlled Substance Diversion, Detection and Prevention Program: Elements of Best Practice, eAppendix*, MAYO CLINIC PROC. (March 2012), mmc1.pdf.

Return to Table of Contents

Entities should also have procedures in place to allow a healthcare professional to self-refer to the appropriate person or an alternative to discipline program if he or she has diverted drugs for personal use, is misusing drugs and/or alcohol, has an untreated substance use disorder, or has worked while impaired. To encourage healthcare professionals to self-refer, the procedures should emphasize the confidential and non-punitive nature of alternative to discipline programs while noting that such confidentiality does not extend to required reporting of drug diversion pursuant to federal or state law or the reporting of a healthcare professional to his or her board for diversion pursuant to Section V.

Subsection (b) sets out the requirements for healthcare entities to review their established policies and procedures. A working group member suggested that, in high-risk environments where healthcare professionals have increased access to controlled substances or regularly work in high-stress conditions, the policies and procedures should be reviewed more frequently to ensure ongoing effectiveness and adaptation to emerging risks.

Subsection (c) requires that healthcare entities with more than a certain number of employees create a drug diversion prevention and response program whose duties include receiving, reporting, and, in conjunction with state drug diversion investigators, investigating reports of diversion. The drafters recommend that this subsection apply to entities with 25 or more employees as it may be difficult for entities with fewer employees to have the staff available to fulfill the requirements of this section; however, states may choose to increase or decrease that number. One working group member suggested that healthcare entities with fewer than 25 employees have a simplified, but formalized, oversight program appropriate to their scope of operations, and states may want to include that requirement in their laws or regulations in lieu of, or in addition to, current subsection (d), which requires that healthcare entities with fewer than 25 employees identify an individual to whom reports of diversion are to be reported and who will be responsible for reporting incidents of suspected or confirmed diversion pursuant to state and federal law.

Subsection (e)(3) is bracketed to give legislatures the option of including a requirement that the disposal of certain prescription drugs – that is, prescription drugs that are not controlled substances – that have been identified by the Drug Enforcement Administration or the state board of pharmacy as being commonly diverted be witnessed by another healthcare professional. Several working group members felt that requiring the disposal of non-controlled substance be witnessed would have a detrimental impact on job performance and would increase the likelihood that diversion would be missed due to witness burnout, so the drafters included this bracketed option in lieu of making it a requirement. Additionally, paragraph (4) of subsection (e) contains two options for the number of witnesses required when disposing of controlled substances, and legislatures should choose the option – one witness or two – that best fits the needs of their state.

The remaining subsections include various provisions related to maintaining documentation and duties for healthcare entities that contract with staffing agencies. The last subsection, (i), sets forth seven specific topics on which healthcare professionals must receive

education and training including recognizing substance use disorder in colleagues and reducing stigma.

SECTION V. DUTY TO REPORT.

(a) In general.—In addition to drug diversion reporting requirements under state and federal law, the individuals and entities set forth in this section shall report to the required entity or entities the identity of any healthcare professional meeting the requirements.

(b) Self-reports.—A healthcare professional shall self-report to the alternative to discipline program and undergo a drug and alcohol use evaluation or assessment in any of the following circumstances:

(1) The healthcare professional is misusing drugs and/or alcohol to the extent that it affects his or her ability to practice with reasonable skill or safety to patients;

(2) The healthcare professional has, or is at risk of developing, an untreated substance use disorder;

(3) The healthcare professional has diverted drugs for personal use;

(4) The healthcare professional has practiced his or her profession while impaired;[62]

(5) The healthcare professional has been arrested for an offense related to drugs and/or alcohol;

(6) The healthcare professional voluntarily resigned while being investigated by his or her employer for conduct related to drugs and/or alcohol;

(7) The healthcare professional's employer has, for reasons related to drugs and/or alcohol: (1) reduced, suspended, revoked, or not renewed the healthcare professional's employment or staff membership; (2) involuntarily terminated or restricted the individual's employment or staff membership; or (3) asked the healthcare professional to resign;

(8) The healthcare professional has surrendered a license, registration, or certificate to practice in another jurisdiction due to conduct related to drugs and/or alcohol; or

[62] N.M. CODE R. § 16.10.10.15 (2024).

Return to Table of Contents

(9) A professional association, peer review body, governmental agency, or other organization has taken disciplinary action against the individual for conduct related to drugs and/or alcohol.[63]

(c) Healthcare professionals.—Any healthcare professional licensed, registered, or certified by a board in this state with a reasonable belief or actual knowledge that another healthcare professional has misused drugs or alcohol, has an untreated substance use disorder, has diverted drugs, or suffers from an impairment that affects or may affect the ability of the healthcare professional to practice competently shall have the responsibility to make a report pursuant to this subsection unless an exception exists.

(1) The healthcare professional shall make a report regarding another healthcare professional:

(A) If diversion is suspected, to the drug diversion prevention and response program, if one exists, housed in the healthcare entity at which the healthcare professional who is the subject of the report is employed or practicing. If the healthcare entity does not have a drug diversion prevention and response program, the healthcare professional shall report the suspected diversion to the appropriate person at the healthcare facility as identified in the facility's policies and procedures;

(B) To the alternative to discipline program set forth in Section VI, if no patient harm has occurred and no diversion is suspected; or

(C) To the board with authority over the healthcare professional, if patient harm has occurred and/or diversion is suspected. The board may refer the healthcare professional to the alternative to discipline program.

(2) A report is not required if the individual that would otherwise be required to submit such a report:

(A) Has reasonable cause to believe that such report has already been made;

(B) Obtained the knowledge forming the basis of a report in the course of the healthcare professional-patient relationship where the subject of the report is the patient, unless there is probable cause to believe that the

[63] Adapted from COLO. CODE REGS. § 716-1:1.16-D (2024); DEL. CODE ANN. tit. 24, § 1730 (West 2024); and D.C. MUN. REGS. tit. 22-B, § 2501 (2024).

Return to Table of Contents

healthcare professional patient may constitute a danger to the health and welfare of his or her patients or the public;

(C) Is an approved treatment provider and the healthcare professional that would be the subject of such a report is in compliance with a treatment agreement;

(D) Is a member of a committee, program, or organization, established by a healthcare entity, board, professional association, or other organization to provide services to affected healthcare professionals, and the affected healthcare professional has self-referred or been referred to such organization, is cooperating with the referral, and the healthcare professional's ability to practice competently has not been affected or the healthcare professional is not currently treating patients;

(E) Maintains a good faith belief that the practitioner has self-referred or been referred by another individual to the alternative to discipline program, is cooperating with such referral, and the healthcare professional's ability to practice competently has not been affected or the healthcare professional is not currently treating patients; or

(F) Is otherwise prohibited from reporting by federal law.[64]

(3) Reports under this paragraph may be made anonymously but must include sufficient information, including the name of the healthcare professional who is the subject of the report and a description of the circumstances leading to the report, to allow the entity to which such report was made to take action.[65]

(4) A healthcare professional who makes a report to a drug diversion prevention and response program or an alternative to discipline program shall be deemed to have discharged his or her professional obligation under statute or regulation and shall not be deemed to have committed unprofessional conduct for failure to make such report to the appropriate board.[66]

[64] Adapted from ALASKA STAT. ANN. § 08.64.336 (West 2024); GA. COMP. R. & REGS. 410-12-.01 (2024); and S.C. CODE ANN. REGS. 36-19 (2024).
[65] N.M. CODE R. § 16.10.10.14 (2024).
[66] N.J. ADMIN. CODE § 13:35-11.6 (2024).

Return to Table of Contents

(e) Healthcare entities.—A healthcare entity that employs, contracts with, or grants privileges to a healthcare professional shall report any action adversely affecting the clinical privileges of such healthcare professional to the appropriate board within [ten (10)] days of taking action.[67] Actions required to be reported include, but are not limited to:

(1) Any professional review action adversely affecting the clinical privileges of the healthcare professional, except as otherwise provided by this paragraph;

(2) The healthcare entity's acceptance of the surrender of clinical privileges or any restriction on such privileges as a result of or relating to possible diversion or impairment and while the healthcare professional is under investigation or in return for the healthcare entity's agreement not to conduct such investigation;[68]

(3) A healthcare professional's voluntary resignation from staff or voluntary limitation of his or her staff privileges at such healthcare entity as a result of a complaint made about such healthcare professional; and[69]

(4) A positive toxicology test for alcohol or illegal or legal drugs for which the healthcare practitioner does not possess a valid prescription.

(5) A report under this paragraph is not required if the healthcare professional has self-referred or otherwise been referred to an alternative to discipline program, is compliant with such program, and is either not currently treating patients or the healthcare professional's ability to practice safely has not been affected as determined by either a fitness for duty evaluation or the healthcare professional's treatment provider.[70] This exception does not apply if the healthcare professional has been terminated or voluntarily resigned from employment with the healthcare entity.

(6) A copy of a report filed with the National Practitioner Data Bank shall satisfy the reporting requirement of this paragraph.[71]

[67] MICH. COMP. LAWS ANN. § 331.531 (West 2024).
[68] N.M. CODE R. § 16.10.10.9 (2024).
[69] 10 GUAM CODE ANN. § 12212 (2024).
[70] N.M. CODE R. § 16.10.10.9 (2024).
[71] Adapted from MO. CODE REGS. ANN. tit 10, § 2200-4.040 (2024) and OHIO ADMIN. CODE 4731-15-02 (2024).

Return to Table of Contents

(f) Staffing agencies.—Staffing agencies shall notify the appropriate board within [ten (10)] days of the date the agency becomes aware that a healthcare professional employed by or under contract with the agency is suspected of abuse, theft, tampering, or other diversion of drugs or is unable to practice with reasonable skill and safety to patients as a result of the misuse of drugs and/or alcohol or an untreated substance use disorder.[72]

(g) Professional associations.—A professional association or society that suspends or revokes an individual's membership in that association or society or takes other disciplinary action for violations of professional ethics related to the misuse of drugs or alcohol or for reasons of professional incompetence as the result of practicing while impaired shall report that action to the appropriate board within [ten (10)] days after a final decision.[73]

(1) The report shall include situations in which membership or privileges have been revoked, suspended, limited, or otherwise adversely affected by action of the healthcare professional while the healthcare professional was under investigation or the subject of proceedings, or where membership or privileges have been revoked, suspended, limited, or otherwise adversely affected by an act of the healthcare professional in return for the professional association or society's not conducting or for ceasing an investigation or proceeding. It shall also include situations under which a healthcare professional resigns during an investigation or proceeding.[74]

(2) A copy of a report filed with the National Practitioner Data Bank may satisfy the reporting requirements under this paragraph.[75]

(h) Educational and clinical training programs.—An educational or clinical training program that has reasonable cause to suspect that the ability of a student of the healing arts, resident, or fellow to perform the duties of the health profession would be, or would reasonably be expected to be, impaired by the misuse of drugs and/or alcohol or has an untreated substance use disorder shall refer the student, resident, or fellow to an alternative to discipline program.[76]

---

[72] 105 MASS. CODE REGS. 157.220 (2024).
[73] OHIO ADMIN. CODE 4731-15-04 (2024).
[74] ME. REV. STAT. ANN. tit. 24, § 2507 (West 2024).
[75] OHIO ADMIN. CODE 4731-15-04 (2024).
[76] Adapted from 225 ILL. COMP. STAT. ANN. 60/23 (West 2024) and TEX. OCC. CODE ANN. § 301.404 (West 2024).

(i) Court clerks.—The clerk of the court wherein a healthcare professional is convicted of or pleads guilty or nolo contendere to any felony or misdemeanor involving:

(1) the use, sale, distribution, administration, or dispensing of a controlled substance;

(2) alcohol or chemical impairment; or

(3) substance abuse

shall, within ten (10) days after such conviction or plea, report such judgment to the appropriate board.[77] Such reports shall be made on forms prescribed and provided by the board.[78]

(j) Permissible reporting.—Any person not otherwise specifically required by the terms of this section who has personal knowledge that a healthcare professional has diverted drugs or has the inability to practice with reasonable skill and safety by reason of the misuse of alcohol and/or drugs or has an untreated substance use disorder may report that information to an alternative to discipline program or to the appropriate board.[79]

(k) Reporting mechanisms.—Reporting pursuant to this section may be completed online or through compliance hotlines, risk lines, or other reporting mechanisms, as available.

(l) Computation of time.—Unless otherwise indicated, when the period is stated in days or a longer unit of time, the computation of time excludes the day of the event that triggers the period; counts every day including weekends and legal holidays; and includes the last day of the period, unless the last day is a weekend day or legal holiday, in which case the period continues to run until the end of the next day that is not a weekend day or legal holiday.[80]

(m) Exception to reporting requirement.—No individual or entity shall be obligated to submit a report required pursuant to this section regarding a healthcare professional who is a participant in an alternative to discipline program unless the healthcare professional is not compliant with such program and/or is not competent to continue to practice or is a danger to himself or herself, his or her patients, or the public.[81]

---

[77] Adapted from NEB. REV. STAT. ANN. § 38-1,137 (West 2024) and R.I. GEN. LAWS ANN. § 5-31.1-20 (West 2024).
[78] OHIO REV. CODE ANN. § 4723.34 (West 2024).
[79] MINN. STAT. ANN. § 214.33 (West 2024).
[80] 30 MISS. CODE R. Pt. 2826, R. 1.1 (2024).
[81] GA. CODE ANN. § 43-1-36 (West 2024).

Return to Table of Contents

(n) Report without merit.—Upon a determination by the alternative to discipline program or a board with authority over a healthcare professional who has been reported pursuant to this section that a report or complaint submitted by any individual or entity is without merit, the report or complaint shall be kept confidential or non-public in the healthcare professional's individual record in the board's office.

(1) A healthcare professional subject to a report or complaint under this section or the healthcare professional's authorized representative shall be entitled upon written request to examine the healthcare professional's individual record, including any report submitted regarding the healthcare professional, and to place into the record a statement of the healthcare professional's view with respect to any information existing in the report, in accordance with rules established by the board.[82]

(o) Board action.—Nothing in this section prohibits a board with authority over a healthcare professional from taking disciplinary action against such healthcare professional upon receipt of a report submitted pursuant to this Act.[83]

(p) Notice to mandatory reporters.—Within [six (6) months] of the effective date of this Act, each board in this state responsible for licensing, registering, or certifying any individual to practice as a healthcare professional or any entity to provide healthcare services to the public shall notify, in a manner determined by each such board, every individual and entity of their duty to submit a report pursuant to this section.[84]

(q) Penalties.—

(1) Any healthcare professional required by this section to file a report who willfully and intentionally fails to file such a report has committed unprofessional conduct and is subject, after notice and an opportunity to be heard, to a fine not to exceed [$] per violation and may be subject to discipline by the healthcare professional's credentialing board. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any board having authority over the person who filed or should have filed the report.[85] The penalties in this paragraph

[82] N.H. REV. STAT. ANN. § 326-B:36-a (2024).
[83] 10 GUAM CODE ANN. § 12212 (2024).
[84] 25 GUAM ADMIN. R. & REGS. § 61102 (2024).
[85] Adapted from CAL. BUS. & PROF. CODE § 805.01 (West 2024) and KAN. STAT. ANN. § 65-28,121 (West 2024).

Return to Table of Contents

do not apply to a healthcare professional required to self-report pursuant to this section.

(2) Any healthcare professional who willfully impedes or obstructs the filing of a report required by this Act or by state or federal law, or induces another person to do so, has committed unprofessional conduct and is subject to discipline by the board with authority over such healthcare professional.[86]

(3) Any healthcare entity or staffing agency required to file a report pursuant to this section that knowingly and intentionally fails to file such report shall be subject, after notice and an opportunity to be heard, to a civil penalty in an amount not to exceed [$] for a first offense and a civil penalty of up to [$] for each subsequent offense and may subject the healthcare entity or staffing agency to criminal penalties.[87]

(A) Repeated failure to file required reports may result in the license, registration, or certification of the healthcare entity or staffing agency being suspended or revoked and/or criminal penalties.

(4) The failure of any professional society or organization to file a report pursuant to this section is a civil violation for which a fine of not more than [$] may be adjudged.[88]

(5) A healthcare entity or staffing agency that willfully impedes or obstructs the filing of a report required by this Act or by state or federal law, or induces an employee, agent, or other person to do so, shall be subject, after notice and an opportunity to be heard, to a civil penalty in an amount not to exceed [$] for a first offense and a civil penalty of up to [$] for each subsequent offense and may result in the license, registration, or certification of the healthcare entity or staffing agency being suspended or revoked.

(6) Any person who knowingly and intentionally makes a false report under this section, or who induces another person to make such report, is guilty of a class A

[86] FLA. STAT. ANN. § 464.018 (West 2024).
[87] KAN. STAT. ANN. § 65-28,121 (West 2024).
[88] ME. REV. STAT. ANN. tit. 24, § 2507 (West 2024).

Return to Table of Contents

misdemeanor and, if such person is a healthcare professional, may be subject to discipline by the board with authority over such person.[89]

(7) Fines collected pursuant to this subsection shall be paid into the alternative to discipline fund established in Section XIV.

Commentary

This section imposes a duty on a variety of individuals and entities to report a healthcare professional, who meets the requirements, to the alternative to discipline program established in Section VI or to that professional's credentialing board. Included in this is the requirement that healthcare professionals self-report. Subsection (c) requires healthcare professionals who have a reasonable belief or actual knowledge that another healthcare professional meets the requirements of this section to make a report to either a drug diversion prevention and response program, the alternative to discipline program established in Section VI if no patient harm has occurred, or to the healthcare professional's regulatory board if patient harm has occurred. The board can then refer the healthcare professional to the alternative to discipline program if it chooses.

This subsection also sets forth when reports under this subsection are not required (*e.g.*, when the reporter is aware that a report has already been made or if the reporter obtained the information pursuant to a practitioner-patient relationship where the individual who would be the subject of a report is the patient). A working group member suggested that there should be no exceptions to the reporting requirement so as to normalize reporting and open discussions about substance use disorder to help reduce stigma, promote early intervention, and protect both patients and healthcare professionals. The drafters elected to keep the exceptions for a few reasons, one of which was to make the best use of available resources by preventing duplicate or multiple reports regarding the same individual and by excepting reports for healthcare professionals already engaged in treatment. Additionally, the drafters felt it was important to maintain the trust between a healthcare professional and his or her healthcare providers, whether that provider is a primary care physician or a substance use disorder treatment provider by including exceptions for those providers who obtain knowledge of the healthcare professional's potential substance use disorder during the course of treatment. A healthcare professional may be less inclined to be honest about misusing drugs and/or alcohol if he or she knows that it could make the healthcare professional the subject of a report. Therefore, the drafters elected to keep the reporting exceptions in this subsection; however, states are free to exclude the exceptions if they choose.

Subsection (c) also provides that healthcare professionals who make a report to a drug diversion prevention program or alternative to discipline program have discharged their duty under the rules of professional conduct governing their profession requiring that such reports be made to their regulatory board.

[89] Adapted from DEL. CODE ANN. tit. 16, § 1132 (West 2024) and FLA. STAT. ANN. § 464.018 (West 2024).

Return to Table of Contents

This section also requires that various non-healthcare entities make reports, including court clerks and educational programs. The purpose of these provisions is to ensure that all bases are covered with respect to providing an avenue for assistance to healthcare professionals who may be misusing drugs and/or alcohol or who may have a substance use disorder.

Subsection (n) provides that, upon determining that any report made pursuant to this section is without merit, the records of the report or complaint shall be kept confidential in order to protect the confidentiality and reputation of the healthcare professional who is the subject of the report. A finding that a report is without merit means that the investigation did not find any wrongdoing on the part of the healthcare professional and, therefore, the records of the complaint and investigation should not be disclosed for any reason.

Finally, this section includes a variety of penalties for failure to comply with the reporting requirements or knowingly making a false report. Pursuant to subsection (q)(1), a healthcare professional (excluding those healthcare professionals required to self-report) who fails to make a report required by this section is subject to a fine and may be subject to discipline. The statutory language leaves the amount of the fine up to each state; however, the amount should be sufficient to discourage healthcare professionals from intentionally failing to make a report. The same is true for the amount of the civil penalty to be assessed against a healthcare entity or staffing agency pursuant to paragraphs (3) and (5) and professional societies and organizations pursuant to paragraph (4). Healthcare entities and staffing agencies that fail to file a report or willfully obstruct or impede the filing of a report may also be subject to criminal penalties and the suspension or revocation of their license, registration, or certification, although those penalties should only be imposed in cases of repeated failure or egregious actions on the part of the facility or agency to obstruct the filing of a report.

SECTION VI. ALTERNATIVE TO DISCIPLINE PROGRAMS.

(a) Establishment of program.—Except as otherwise provided by this Act, each board in [state] shall establish an alternative to discipline program for healthcare professionals subject to such board's authority. The purpose and intent of the alternative to discipline program is to protect public health and safety by acting as both an advocate for the health of a healthcare professional and to be a confidential, non-punitive, and evidence-based alternative to disciplinary action for healthcare professionals who misuse drugs and/or alcohol, are impaired due to the use of drugs and/or alcohol, have diverted drugs for personal use, and/or have an untreated substance use disorder, and who are referred or reported to the alternative to discipline program, or who self-report to such program, seeking intervention, a drug and alcohol use evaluation, treatment, or counseling for such impairment.[90]

[90] Adapted from ALA. ADMIN. CODE r. 540-X-13-.05 (2024) and IOWA ADMIN. CODE r. 650-35.1 (2024).

Return to Table of Contents

(1) In lieu of establishing a program, boards may contract with any nonprofit corporation, treatment provider, or professional association for the purpose of establishing, administering, and operating an alternative to discipline program so long as such program meets the requirements of this Act and which shall be subject to the same oversight and audit provisions as board administered programs.[91]

(2) If a board has an alternative to discipline or similar program already in existence, such program shall meet all requirements and provisions of this Act.

(b) Joint program.—Two or more boards may agree to jointly establish an alternative to discipline program that meets all of the requirements of this Act.

(1) A board may elect to join an already established program at any time upon the signing of memorandum of understanding with such program.

(2) A board may elect to cease participating in a joint program at any time upon written notice to the program and all other participating boards. If a board elects to cease participating, it shall establish its own alternative to discipline program or join another alternative to discipline program prior to ceasing participation in the joint program to avoid interruptions in services to healthcare professionals currently participating in the joint program.

(A) If a board elects to cease participating in a joint program, a healthcare professional currently participating in the joint alternative to discipline program may elect to continue receiving services from the joint program for the duration of his or her treatment agreement or aftercare agreement.

(3) Joint programs shall meet the following requirements:

(A) A joint program shall be administered by a single board with input from all boards party to the agreement;

(B) Boards shall enter into a written memorandum of understanding setting forth the duties and responsibilities of each participating board; and

[91] Adapted from ARIZ. REV. STAT. ANN. § 32-1452 (West 2024).

Return to Table of Contents

(C) Fees collected to fund the program shall be deposited with the alternative to discipline program fund created in Section XIV.

(c) Alternative to discipline program requirements.—Every alternative to discipline program, whether currently in existence or created pursuant to this Act, shall:

(1) Make services available to all eligible healthcare professionals;

(2) Employ a program coordinator to organize and administer the program;

(3) Ensure that the program coordinator and all program staff possess the requisite knowledge, training, and/or personal, professional, or academic experience as applicable to their position in the program;

(4) Develop policies and procedures regarding:

(A) Receiving referrals or reports of misuse of drugs and/or alcohol, impairment, diversion of drugs for personal use, or suspected untreated substance use disorder by a healthcare professional;

(B) Eligibility requirements for participants;

(C) Making treatment referrals and referrals to other support services including, but not limited to, peer support groups;

(D) Establishing individualized treatment agreements and aftercare agreements including supporting the use of medications for addiction treatment;

(E) Establishing criteria for the approval and periodic review of intervenors, evaluators, and treatment providers, including examinations of intervenor, evaluator, and provider outcomes and operations; and

(F) Educating healthcare professionals with respect to the recognition and treatment of the misuse of drugs and/or alcohol, substance use disorder, and impairment and the availability of the alternative to discipline program for eligible healthcare professionals;

(5) Develop outreach and awareness programs which promote and publicize the services available through the alternative to discipline program;

(6) Offer assistance to any person in referring a healthcare professional for purposes of intervention, assessment, and/or treatment;

(7) Receive and evaluate reports of suspected misuse of drugs and/or alcohol, impairment, diversion of drugs for personal use, or untreated substance use disorder by a healthcare professional;

(8) Intervene in cases of verified impairment;

(9) Establish and/or approve treatment and aftercare agreements between the program, approved treatment providers, and eligible participants;

(10) Where appropriate, enter into voluntary agreements with participants providing that such participants will refrain from professional practice or limit or restrict their practice for a specified period of time and subject to specified conditions;

(11) Approve and periodically reapprove intervenors, evaluators, and treatment providers on at least a biennial basis;

(12) Enter into contracts with approved treatment providers, intervenors, evaluators, testing laboratories, healthcare entities, healthcare professionals, government agencies, and any other individual or entity necessary to perform its responsibilities and duties pursuant to this Act;

(13) Monitor the status of a healthcare professional participating in the alternative to discipline program through the individual's discharge from the program;

(14) Provide referrals to family support services;

(15) Make recommendations regarding the suspension, limitation, or restriction of a healthcare professional's credential;

(16) Immediately report to the healthcare professional's board the name of any participant whom the program believes to be a danger to the participant or others;

(17) Immediately report to the healthcare professional's board the name of any participant who refuses to submit to treatment, enter into a treatment agreement, or whose impairment is not substantially alleviated through treatment;

(18) Conduct fitness for duty evaluations and make recommendations regarding a healthcare professional's return to practice;

(19) Approve worksite monitors for healthcare professionals who continue to practice or have returned to practice;

(20) Provide or make referrals to support services, including to peer support groups, to healthcare professionals in recovery who have successfully completed the program upon request;

(21) Comply with the reporting requirements contained in Section V;

(22) Receive and disburse appropriate funds from the alternative to discipline fund created pursuant to Section XIV for use in the establishment, administration, and operation of the program;

(23) Maintain the confidentiality of all participants and records, except as otherwise provided by this Act;

(24) Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements of this Act; and

(25) Perform such other activities as agreed upon by the program and all participating boards.[92]

(d) Program coordinator.—Program coordinators shall:

(1) Possess a combination of education and experience necessary to complete the duties required pursuant to this Act. Preference should be given to individuals with lived experience with substance use disorder;

(2) Develop a policy and procedure manual;

(3) Facilitate the referral and intake process;

(4) Review all reports from intervenors, evaluators, treatment providers, providers of aftercare services, and worksite monitors;

(5) Report non-compliance with program requirements to a healthcare professional's board as required by this section;

(6) Hire appropriate staff;

(7) Have access to and the right to obtain copies of all records and other healthcare information relating to the condition and treatment of participants;

[92] Adapted from ALA. CODE § 34-22-102 (2024); ALA. CODE § 34-24-401 (2024); ALA. ADMIN. CODE r. 270-X-4-.13 (2024); ALA. ADMIN. CODE r. 540-X-13-.04 (2024); ARIZ. REV. STAT. ANN. § 32-2209 (2024); ARK. CODE ANN. § 17-87-804 (West 2024); CAL. BUS. & PROF. CODE § 2340.2 (West 2024); CAL. BUS. & PROF. CODE § 2340.4 (West 2024); OHIO REV. CODE ANN. § 4723.351 (West 2024); UTAH ADMIN. CODE r. R156-4a-111 (2024); and W. VA. CODE ANN. § 30-3D-2 (West 2024).

(8) Maintain complete and accurate participant files and provide copies of such files without cost to the participant or his or her personal representative upon request; and

(9) Prepare and submit all information required by this Act.[93]

(10) The program coordinator may delegate any of the requirements of this subsection to appropriate program staff.

(e) Approved treatment providers.—The alternative to discipline program shall designate treatment providers authorized to treat healthcare professionals participating in the program and shall maintain a listing of such approved providers. Such treatment providers shall meet the following criteria to be eligible for designation as an approved provider:

(1) Conduct or provide for, by a qualified individual, assessment, drug and alcohol use evaluations, diagnosis, and treatment of substance use disorder or dependence;

(2) Provide inpatient or outpatient treatment, both in person and via telehealth, and have regular hours of operation;

(3) Clearly state and define the costs of treatment services and provide such information to the program and participant seeking treatment;

(4) Accept medical insurance;

(5) Review and determine whether a participant is eligible for release from treatment or continuing care, if applicable;

(6) Conduct, as required by a participant's treatment agreement, random and for-cause supervised biological testing for drugs, chemicals, and alcohol that are analyzed by qualified medical and laboratory personnel and notify the program of any toxicology test deemed positive;

(7) Communicate, in a timely manner, with authorized program officials, through electronic communications and written reports:

(A) Compliance and non-compliance with treatment requirements;

[93] Adapted from MONT. CODE ANN. § 50-16-202 (West 2024); MONT. ADMIN. R. 24.159.2004 (2024); N.D. CENT. CODE ANN. § 43-17.3-03 (West 2024); OKLA. ADMIN. CODE § 435:12-1-5 (2024); and S.D. ADMIN. R. 20:48:17:01 (2024).

Return to Table of Contents

(B) All information required in this section, including reports regarding participants' attendance at treatment and aftercare and results of any biological testing or screening for drugs, chemicals, and alcohol; and

(C) Changes in treatment plan based on the progress of the participant.

(8) Provide individualized written treatment plans including assessment and diagnosis, treatment goals, discharge criteria, guidelines for continuing recovery, and recommendations for continuing to or returning to practice;

(9) Be certified by the [state agency charged with certifying treatment providers] or approved by a board-recognized approving body;

(10) Enter into aftercare agreements with participants or make referrals to organizations that provide such services;

(11) Make written recommendations to the program regarding a healthcare professional's readiness to return to practice. The recommendation shall be made by the participant's treatment provider and shall be based on documented evidence and facts which are set forth in the written recommendation;

(12) Provide testimony in any disciplinary proceeding involving a participant reported to the individual's board for non-compliance;

(13) Submit progress reports for all participants to the program on at least a quarterly basis; and

(14) Provide all written records requested by the program in a timely manner. Failure to respond to requests for written records may result in the removal of the treatment provider from the list of approved treatment providers.[94]

(f) Conflicts of interest.—The alternative to discipline program and any individual associated with it may not:

(1) Refer a participant to a treatment facility in which the program or individual has an investment interest, unless no financial benefit is received from the referral;

(2) Have an investment interest in any laboratory which participants will be mandated to use for toxicology testing during the period of their participation;[95] or

[94] Adapted from ALA. ADMIN. CODE r. 610-X-13-.04 (2024); ARK. CODE R. 007.34.1-10-IV (2024); D.C. CODE ANN. § 3-1251.10 (West 2024); and OHIO ADMIN. CODE 4731-16-19 (2024).
[95] 18 VA. ADMIN. CODE § 76-10-100 (2024).

(3) Accept compensation for referrals including, but not limited to, pay, anything of value, or any other form of benefit or consideration.[96]

(g) Worksite monitors.—The program shall approve a worksite monitor who:

(1) Is a healthcare professional in good standing;

(2) Has received appropriate training to ensure the monitor can effectively support and oversee the participant's job performance;

(3) Agrees to conduct routine observation and monitoring of the participant's work performance; and

(4) Submits written reports to the program and treatment provider, as set forth in the participant's treatment or aftercare agreement.[97]

(h) Participant rights.—Participants shall have the following rights:

(1) To select an approved evaluator or treatment provider from the list of approved evaluators and treatment providers maintained by the program and to change evaluators or providers in order to improve their chance of success in the program;

(2) To fair and respectful treatment throughout their involvement in the program;

(3) To report mistreatment and/or abuse to the program coordinator or the board or boards operating the program, as appropriate, and to be free from retaliation for making such reports;

(4) To file a complaint against the program pursuant to the Administrative Procedures Act [reference to state act] and to appeal the outcome of such complaint as provided by such Act.

(i) Participant confidentiality.—Notwithstanding any other law to the contrary, except as otherwise provided by this Act, a healthcare professional's participation in an alternative to discipline program, treatment program, or receipt of aftercare monitoring by an approved treatment provider is confidential and shall not be disclosed, is not subject to the public records law [reference to state public records law], and is not subject to discovery or subpoena.[98]

[96] 26 TEX. ADMIN. CODE § 8.119 (2024).
[97] OR. ADMIN. R. 851-070-0075 (2024).
[98] W. VA. CODE ANN. § 30-3D-2 (West 2024).

Return to Table of Contents

(j) Program fee.—Programs shall not charge a fee for participating in the program. All costs of administering and ongoing operation of the program shall be covered by the alternative to discipline program fund established in Section XIV.

(k) Access to [prescription drug monitoring program].—The program coordinator of the alternative to discipline program or his or her delegate may access the state [prescription drug monitoring program] for the purpose of reviewing the [prescription drug monitoring program] report of a healthcare professional participating in or referred to the alternative to discipline program.[99]

(l) Referrals.—Healthcare professionals may be referred to the alternative to discipline program via:

(1) Self-referral;

(2) Reports submitted or referrals made pursuant to Section V;

(3) A judge or prosecutor in a criminal case against the healthcare professional related to drugs and/or alcohol;[100] and

(4) Disciplinary action by the healthcare professional's board.[101]

(m) Interventions.—If a healthcare professional reported pursuant to Section V refuses to submit to a drug and alcohol use evaluation and there is probable cause to believe, after an investigation by the program, that the healthcare professional has diverted drugs for personal use, has misused drugs and/or alcohol, has an untreated substance use disorder, or has practiced while impaired, the program shall cause an intervention to be conducted using specialized techniques designed to assist the individual in acknowledging the impairment and accepting services from the program.

(1) The program shall decide the methods and objectives of interventions on a case-by-case basis.

(2) The program shall arrange and conduct interventions as soon as possible upon receipt of a referral or report from any source.[102]

(3) The intervenor shall assess the individual and, if the healthcare professional is showing evidence of diversion of drugs for personal use, misuse of drugs and/or

[99] Adapted from FLA. STAT. ANN. § 893.055 (West 2024) and KAN. STAT. ANN. § 65-1685 (West 2024).
[100] Adapted from MICH. COMP. LAWS ANN. § 750.430 (West 2024).
[101] LA. ADMIN. CODE tit. 46, Pt. XLVII, § 3419 (2024).
[102] W. VA. CODE R. § 15-10-7 (2024).

Return to Table of Contents

alcohol, impairment, or an untreated substance use disorder, shall refer the individual for a drug and alcohol use evaluation.[103]

(n) Evaluations.—Upon receipt of a referral or report from any source, and upon determining that there is sufficient reason for action, the alternative to discipline program may order a drug and alcohol use evaluation and/or a fitness for duty evaluation of the healthcare professional who is the subject of such report at any time following such referral or report.[104]

(1) Drug and alcohol use evaluations shall be conducted by an independent third party approved by the alternative to discipline program to evaluate substance use disorder.[105]

(2) Fitness for duty evaluations shall be conducted by an independent third party approved by the program to evaluate the healthcare professional's ability to perform his or her duties with the requisite skill and ability.

(3) Evaluators shall submit evaluation reports according to program criteria.[106]

(4) Every person holding a credential issued by a board in this state is deemed, by so practicing or by applying for an initial or renewal of the person's credential, to have:

(A) Given consent to submit to a drug and alcohol use evaluation and/or a fitness for duty evaluation when directed in writing by the program; and

(B) Waived all objections to the admissibility of the evaluator's testimony or examination reports on the ground of privileged communication.[107]

(5) The program shall report to the board with authority over such individual, the name of any healthcare professional who fails or refuses to submit to a drug and alcohol use evaluation or fitness for duty evaluation, unless the failure is due to circumstances beyond the individual's control.[108]

[103] OHIO ADMIN. CODE 4729:4-1-03 (2024).
[104] Adapted from KAN. STAT. ANN. § 65-2842 (West 2024); KY. REV. STAT. ANN. § 314.171 (West 2024); and W. VA. CODE R. § 15-10-4 (2024).
[105] OR. REV. STAT. ANN. § 676.190 (West 2024).
[106] ARK. CODE R. § 007.34.1-10-IV (2024).
[107] COLO. REV. STAT. ANN. § 12-220-206 (West 2024).
[108] Adapted from COLO. REV. STAT. ANN. § 12-220-206 (West 2024).

Return to Table of Contents

(A) The board may take such action it deems necessary for the protection of the public, including, but not limited to, summary suspension of the healthcare professional's credential.

(6) A healthcare professional who submits to a drug and alcohol use or fitness for duty evaluation pursuant to this subsection has the right to designate an individual to be present at such evaluation and make an independent report to the program.[109]

(7) Should an evaluator determine that a healthcare professional has not diverted drugs for personal use, misused drugs and/or alcohol, or does not have an impairment or untreated substance use disorder, all records and other information related to the referral or report regarding such individual held by the program shall be destroyed and no other action shall be initiated unless another investigation produces reliable, substantial, and probative evidence of the diversion of drugs for personal use, misuse of drugs and/or alcohol, impairment, or an untreated substance use disorder.[110]

(o) Eligibility to participate.—In order to encourage voluntary participation in the alternative to discipline program and in recognition of the fact that substance use disorder is an illness, any healthcare professional is eligible to participate in the alternative to discipline program if he or she has misused drugs and/or alcohol, has diverted drugs for personal use, has or may have an impairment, has an undiagnosed or untreated substance use disorder, or is unable to practice with reasonable skill and safety by reason of the use of alcohol, drugs, chemicals, or other materials.[111]

(1) A healthcare professional may not be eligible to participate in the alternative to discipline program if he or she:

(A) Is not currently a student of the healing arts in this state or eligible for a credential in this state;

(B) Has diverted drugs for other than personal use;

(C) Has engaged in behavior that resulted in patient harm or death;

[109] N.M. CODE R. § 16.5.2.9 (2024).
[110] S.C. CODE ANN. REGS. 36-20 (2024).
[111] Adapted from MINN. STAT. ANN. § 214.32 (West 2024) and W. VA. CODE ANN. § 30-7-11a (West 2024).

Return to Table of Contents

(D) Will not substantially benefit from participation in the program as determined by the program coordinator;

(E) Has entered into [n] treatment agreements within the past [n] years and been discharged each time prior to successful completion; or

(F) Is currently under investigation by his or her board or is subject to a board disciplinary order or corrective action agreement, unless referred to the alternative to discipline program by such board.[112]

(2) Eligibility to participate in the alternative to discipline program is at the sole discretion of the program.[113]

(3) The [legislature] recognizes that return to use is a characteristic of substance use disorder; therefore, a healthcare professional is eligible to participate in the program even if he or she has previously participated in this or another program, unless the healthcare professional is otherwise ineligible pursuant to this subsection.

(p) Requirements for participation in program.—A healthcare professional accepted to the alternative to discipline program shall:[114]

(1) Undergo a drug and alcohol use evaluation and assessment;

(2) Abstain from the use of alcohol and drugs, unless prescribed to the participant by an authorized prescriber familiar with the participant's history of substance use;

(3) Sign consent forms for the release of information related to the healthcare professional's participation in the program, including treatment records;

(4) Authorize the program to communicate directly with the participant's primary care provider, treatment provider(s), current and prospective employers, probation departments, drug court personnel, recovery community programs and support individuals, toxicology testing laboratories, and third-party monitoring and aftercare services providers;

[112] Adapted from ALA. ADMIN. CODE r. 610-X-13-.05 (2024) and MINN. STAT. ANN. § 214.32 (West 2024).
[113] IOWA ADMIN. CODE r. 655-19.4 (2024).
[114] ALA. ADMIN. CODE r. 610-X-13-.03 (2024).

Return to Table of Contents

(5) Cease practicing until or unless approved to continue or return to practice by the approved treatment provider or submit to any restrictions or limitations on the participant's practice;

(6) Enter into and comply with all terms and conditions of a treatment agreement;

(7) Enter into and comply with all terms and conditions of an aftercare agreement;

(8) Submit to compliance monitoring;[115] and

(9) Be responsible for all costs relating to participation in the program, including a drug and alcohol use evaluation, treatment, toxicology testing, monitoring, and aftercare services.[116] Such costs shall be paid by the participants' health insurance, if available. Participants may be eligible for assistance from the alternative to discipline fund if funds are available and the participant shows need.

(q) Treatment agreements.—Upon acceptance into the alternative to discipline program, the healthcare professional shall enter into a treatment agreement with an approved treatment provider. Treatment agreements shall be tailored to each participant's needs and shall include the following provisions, as applicable:

(1) Requirements for inpatient and/or intensive outpatient treatment;

(2) Periodic, random, unannounced toxicology testing at least four times per month for the first year and at a frequency determined by the treatment provider thereafter for the duration of the treatment agreement;

(3) Attendance at drug and alcohol support group meetings or peer support group meetings at a frequency determined by the treatment provider;

(4) Treatment and therapy plan;

(5) Continuing care participation;

(6) Case management;

(7) Any restrictions or limitations on the participant's credential;

(8) The ability of a participant who is compliant with the treatment agreement to request amendments to the agreement at reasonable intervals;

(9) Duration of monitoring, which may be adjusted as needed;

[115] Adapted from 30 MISS. ADMIN. CODE R. Pt. 2826, R. 1.5 (2024); MO. CODE OF REGS. ANN. tit. 20, § 2110-3.030 (2024); N.D. ADMIN. CODE 54-10-01-02 (2024); and OHIO ADMIN. CODE 4731-16-17 (2024).
[116] Adapted from OHIO ADMIN. CODE 4723-6-03 (2024).

(10) Procedures for reporting any return to use;

(11) Consequences for failure to comply with the treatment agreement;

(12) Grounds for discharge from the program; and

(13) Any costs associated with treatment.[117]

(r) Copies of treatment agreement.—A copy of the initial and any subsequent treatment agreements shall be provided to the healthcare professional, the alternative to discipline program, and, if the healthcare professional was referred by his or her board or as part of a disciplinary proceeding, to the participant's board.

(s) Aftercare agreement.—Within [*n*] [weeks/days] prior to a healthcare professional's completion of treatment, he or she shall enter into an aftercare agreement with the alternative to discipline program or approved aftercare provider. The aftercare agreement shall be individualized to the participant and shall include the following provisions, as applicable:

(1) Group therapy, support groups, peer support, or individual counseling, or a combination thereof, at a frequency determined by the program or aftercare provider;

(2) Periodic, random, unannounced toxicology testing at a frequency determined by the program or aftercare provider, but at least monthly, for the duration of the aftercare agreement;

(3) Any practice restrictions or limitations of practice during aftercare;

(4) Provisions for reporting a return to use;

(5) Monitoring by a worksite monitor for a period determined by the program or aftercare provider;

(6) Duration of the aftercare agreement, which shall be a minimum of [three (3)] years; and

(7) Referral to other forms of continuing care services, as indicated.[118]

(t) Leave of absence or pause of toxicology testing.—

[117] Adapted from 848 IND. ADMIN. CODE 7-1-3 (2024); OHIO ADMIN. CODE 4729:4-1-04 (2024); and OHIO ADMIN. CODE 4731-16-17 (2024).
[118] Adapted from OHIO ADMIN. CODE 4729:4-1-04 (2024).

Return to Table of Contents

(1) Participants may request a leave of absence from the program, and the program shall approve a leave of absence for good cause. Upon completion of such leave, the participant may return to the program if such individual still meets the eligibility requirements of this section.

(A) The participant's treatment agreement or aftercare agreement may be amended or lengthened as a condition of reentry to the program.

(B) A healthcare professional granted a leave of absence shall not be reported to his or her board for non-compliance.[119]

(2) Participants may request that they be granted a short-term pause from any required toxicology testing for a period not to exceed [fourteen (14)] days, and the program shall grant such request for good cause. Good cause shall be determined by the program and includes, but is not limited to, a pause to permit the participant to take a vacation outside the jurisdiction of the program.

(A) Upon the expiration of the pause, the participant shall submit to a hair follicle or nail toxicology test to verify continued adherence to the treatment agreement.

(u) Participants leaving state or applying for credential in another state.—

(1) A participant who moves from this jurisdiction to another state where an alternative to discipline or similar program is in place shall be transferred to that program.

(2) A participant who moves to a state where there is no alternative to discipline program shall have the participant's program records transferred to the appropriate board in that state.

(3) If a healthcare professional applies for a credential in another jurisdiction and continues to practice in this state, and the jurisdiction has an alternative to discipline or similar program in place, the program shall notify the alternative to discipline program in that jurisdiction that the healthcare professional is participating in an alternative to discipline program in this state.

[119] S.D. ADMIN. R. 20:48:17:11 (2024).

Return to Table of Contents

(A) If there is no alternative to discipline program in the other jurisdiction, the program in this state shall notify the appropriate board in the other jurisdiction that the healthcare professional is participating in an alternative to discipline program in this state.[120]

(v) Single state credential.—Healthcare professionals who hold a multistate credential pursuant to a multistate compact and who are accepted into the program will be issued a single state credential, and notice will be provided to the other jurisdiction(s) of the individual's participation in the program.[121] Participants may not resume practice in any other state without prior written authorization from the alternative to discipline program.[122]

(w) Out-of-state credential holders.—If a healthcare professional's primary residence or work site is located outside of the state, the healthcare professional may choose to be monitored by an alternative to discipline program in the other state if the following conditions are met:

(1) The other program is substantially similar to the program in this Act;

(2) The other program, quarterly and upon request, sends reports on the healthcare professional's participation in the program to the alternative to discipline program in this state; and

(3) The other program promptly reports any substantial non-compliance with the healthcare professional's treatment agreement or aftercare or monitoring agreement to the program in this state.[123]

(x) Reports to board.—

(1) The program shall report to the appropriate board the name of any healthcare professional credentialed by such board if such healthcare professional:

(A) Refuses to cease practice when he or she has been found to be unable to practice with reasonable skill and safety and/or refuses to comply with any limitations or restrictions on his or her credential;

(B) Discontinues evaluation and/or treatment against medical advice;

[120] D.C. CODE ANN. § 3-1251.12 (West 2024).
[121] S.D. ADMIN. R. 20:48:17:05 (2024).
[122] N.D. ADMIN. Code 54-10-01-02 (2024).
[123] OR. ADMIN. R. 847-065-0070 (2024).

Return to Table of Contents

(C) Repeatedly fails to abide by the terms and conditions of a treatment agreement or an aftercare agreement;

(D) Has been terminated from treatment by an approved treatment provider for failure to comply with the provisions of a treatment agreement;

(E) Has [three or more] unexcused, missed, tampered with, or abnormal toxicology tests;

(F) Engages in conduct that caused harm or death to a patient; or

(G) Diverts medications for other than person use.[124]

(2) The program may report to the appropriate board the name of any healthcare professional issued a credential by such board when the program learns that such healthcare professional:

(A) Fails or refuses to follow the recommendations of the program for a drug and alcohol use evaluation, fitness for duty evaluation, and/or treatment;

(B) Has an impairment that is not substantially alleviated through treatment and who, in the opinion of the evaluator or treatment provider, exhibits professional incompetence;

(C) Violates a restriction or limitation on the healthcare professional's credential; or

(D) Has a single unexcused, missed, tampered with, or abnormal toxicology test.[125]

(3) Reports submitted pursuant to this subsection shall include all relevant evaluations, treatment records, medical records, progress reports, documents, and other information relevant to the healthcare professional who is the subject of such report. All such documentation shall be privileged and confidential and, except as otherwise provided by this Act, shall not be public records nor available for court subpoena or for discovery proceedings but may be used by the board in

[124] Adapted from ALA. ADMIN. CODE r. 540-X-13-.05 (2024); ARK. CODE ANN. § 17-80-205 (West 2024); MD. CODE ANN. HEALTH OCC. § 8-208 (West 2024); OR. ADMIN. R. 851-070-0100 (2024); and W. VA. CODE R. § 5-15-10 (2024).

[125] Adapted from S.D. ADMIN. R. 20:48:17:10 (2024).

Return to Table of Contents

the course of its investigations and may be introduced as evidence in administrative proceedings conducted by the board.[126]

(y) Return to practice.—A healthcare professional who has agreed to refrain from practice as part of his or her treatment or aftercare agreement, may return to practice upon:

(1) Submission of evidence of compliance with the signed treatment and/or aftercare agreement;

(2) Identification and approval of a worksite monitor. Preference shall be given to worksite monitors who have specialized education or training in substance use disorder;

(3) Receipt by program personnel of a signed statement from the healthcare professional's employer that such employer has been notified of the healthcare professional's participation in the alternative to discipline program;

(4) Receipt by program personnel of a signed release of information from the participant to allow program personnel to communicate with the worksite monitor and access employment information; and

(5) Receipt by program personnel of a signed agreement from the worksite monitor or employer agreeing to supervise the participant according to any requirements set forth in the healthcare practitioner's aftercare agreement and submit reports regarding the participant's work performance to program personnel upon request.[127]

(z) Discharge from program.—

(1) A healthcare professional who successfully completes the recommended course of treatment and aftercare services for the required period of time shall be discharged from the alternative to discipline program and shall receive written notice of formal release and successful completion of the program.[128]

(A) If the healthcare professional has not been practicing during his or her tenure in the program, successful completion of the program shall be

[126] Adapted from ALA. ADMIN. CODE r. 540-X-13-.05 (2024) and GA. COMP. R. & REGS. 360-11-.03 (2024).
[127] S.D. ADMIN. R. 20:48:17:08 (2024).
[128] Adapted from ALA. ADMIN. CODE r. 540-X-13-.05 (2024) and ALA. ADMIN. CODE r. 610-X-13-.06 (2024).

Return to Table of Contents

evidence that the healthcare professional is able to resume practice with reasonable skill and safety.

(B) If the healthcare professional's participation in the program was anonymous, the program shall ensure that such participant's identity remains confidential.

(C) If the healthcare professional's participation in the program was the result of a referral due to disciplinary action from his or her board, the program shall provide written notice to such board of the individual's successful completion of the program.

(D) A participant who successfully completes the program shall not be reported to the national practitioner data bank unless the board imposed disciplinary action against the participant.[129]

(2) A healthcare professional may be discharged from the alternative to discipline program prior to successful completion at the discretion of the program for any of the reasons for which the program is required or permitted to submit a report to the healthcare professional's board as set forth in subsection (x).

(A) The program shall immediately notify the board with authority over the participant that he or she has been discharged from the program, with the reasons therefor, and the board shall take such action it deems necessary for the protection of the public including, but not limited to, initiating disciplinary action or summarily suspending the healthcare professional's credential.[130]

(B) Due to the nature of substance use disorder, a return to use should not automatically result in discharge from the program if the participant either:

(i) Reports the return to use to his or her treatment provider, aftercare services provider, or worksite monitor; or

(ii) Admits to the return to use upon request.

[129] OHIO ADMIN. CODE 4723-6-04 (2024).
[130] Adapted from ARK. CODE R. 007.34.1-10-V (2024) and MD. CODE ANN. HEALTH OCC. § 8-208 (West 2024).

Return to Table of Contents

(C) A discharge pursuant to this paragraph does not constitute disciplinary action.[131]

(D) The program's decision to discharge a participant is subject to the administrative procedures act [reference to state law].

(3) If a participant voluntarily withdraws from the program prior to completion without applying for a leave of absence, he or she shall immediately report such withdrawal to the board with authority over such individual with the reasons therefor, and the board shall take such action it deems necessary for the protection of the public including, but not limited to, initiating disciplinary action or summarily suspending the healthcare professional's credential.

(4) All records pertaining to a healthcare professional's participation in the alternative to discipline program shall be maintained for a period of [n] years after which time all such records shall be destroyed.[132]

(aa) Impermissible restrictions.—A healthcare professional who is participating in or who has successfully completed a program pursuant to this section shall not be limited or restricted in his or her professional practice except as set forth in a treatment agreement, aftercare agreement, or limitation or restriction of a credential issued by the healthcare practitioner's board, or excluded from the staff of any healthcare entity solely due to such participation.[133] This provision does not prohibit a healthcare entity from implementing reasonable workplace practice restrictions, including restricting a healthcare professional's access to drugs, based on the facts and circumstances that led to the healthcare professional's participation in the program and patient safety considerations.

(bb) Confidentiality of records.—

(1) The following are privileged and confidential and not subject to public records laws [insert state statutory reference] and may only be disclosed as provided in this Act:

(A) All reports, drug and alcohol use and/or fitness for duty evaluations, treatment records, medical records, monitoring records, and any other

[131] N.M. CODE R. § 16.12.13.12(C) (2024).
[132] Adapted from CAL. BUS. & PROF. CODE § 1698 (West 2024).
[133] ARK. CODE ANN. § 17-90-509 (West 2024).

Return to Table of Contents

information created by or furnished to an alternative to discipline program, and all communications to or from the program, relative to the intervention, evaluation, treatment, or monitoring of a healthcare professional participating in such program;[134]

(B) All records and proceedings of the program which pertain or refer to a healthcare professional who may be, or who actually is, impaired;[135] and

(C) All board, division, committee, and program records relating to a healthcare professional's application or referral to the program or participation in the program, including interviews, statements, and other information provided by the healthcare professional or other person making a referral.[136]

(D) These provisions do not apply to any records made in the regular course of business of a treatment provider and information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any civil proceedings merely because they were furnished to the alternative to discipline program.[137]

(2) Information and documents deemed confidential pursuant to this Act may only be disclosed as follows:

(A) In a disciplinary proceeding before a board or in any subsequent trial or appeal of an action or order;

(B) To boards tasked with granting, limiting, or denying licenses, certificates, or registrations to practice a health profession, whether in this state or in another state where the healthcare professional holds a credential or has submitted an application for an initial or renewal credential;

(C) Pursuant to a court order;

(D) To qualified personnel for bona fide research or educational purposes, provided that such information is deidentified and the information is

[134] KY. REV. STAT. ANN. § 311.619 (West 2024).
[135] *Id*.
[136] Adapted from CAL. CODE REGS. tit. 16, § 1357.8 (2024).
[137] ALA. CODE § 34-24-404 (2024).

Return to Table of Contents

released pursuant to a written agreement that ensures compliance with this section;[138]

(E) When disclosure of the information is essential to the intervention, treatment, or recovery needs of the healthcare professional; and

(F) When such release is authorized in writing by the individual who is the subject of the records or information.[139]

(cc) Program promotion.—Boards shall promote alternative to discipline programs by:

(1) Engaging in wellness education and outreach to credential holders, students, and the community in order to make them aware of the existence and purpose of the program;

(2) Partnering with healthcare organizations, universities, trade/professional associations, peer support bodies, and other stakeholder groups to promote professional awareness and wellness; and

(3) Providing guidance to employers, colleagues, and family members on initiating conversations with credential holders about substance use.[140]

Commentary

As mentioned in the commentary to Section II above, the vast majority of state boards of medicine, nursing, and pharmacy have either a physician health program or alternative to discipline program (although they may be known by another name), and those programs are highly successful in getting healthcare professionals with a substance use disorder into treatment and sustaining recovery.[141] According to the Federation of State Physician Health Programs (FSPHP), long-term recovery rates for participants in physician health programs "are markedly higher than the general population."[142] One study showed that after five or more years, 81 percent of participants had zero positive toxicology tests and 95 percent were practicing.[143] According to the FSPHP, the success of physician health programs is due to a combination of factors, including the confidential nature of the programs, peer support, and oversight of participants.[144] A study published in the *American Journal on Addictions* found that key elements for successful completion included frequent random drug tests, participation in group meetings and peer support, and post-program recovery supports.[145]

---

[138] VA. CODE ANN. § 4.1-1606 (West 2024).
[139] Adapted from D.C. CODE ANN. § 3-1251.07 (West 2024) and KY. REV. STAT. ANN. § 311.619 (West 2024).
[140] UTAH CODE ANN. § 58-4a-103 (West 2024).
[141] *See supra* note 9.
[142] Linda Bresnahan, T*he Role & Success of Physician and Healthcare Professional Programs*, 24(1) NMA ADVOCATE 14-17, at 14 (2024).
[143] *Id*.
[144] *Id*., at 15-16.
[145] MERLO ET AL, *supra* note 8, at 116-119.

Return to Table of Contents

Based on the outcomes reported in those and other studies, this section includes provisions designed to both promote successful outcomes for participants and provide protection for the public. It is not intended to replace existing programs but to ensure that existing programs meet or exceed the requirements set forth in this section and to require that boards without existing programs establish one. The requirements apply not just to boards of medicine, nursing, or pharmacy but to all boards of the healing arts.

Subsections (a) and (b) require that each board (as defined in this Act) in a state establish an alternative to discipline program, ensure that an existing program meets the standards set forth in this section, or join with one or more other boards to establish a joint program. Because so many boards of medicine, nursing, and pharmacy have existing programs in place, the drafters felt it was important to allow other boards (*e.g.*, dental, psychiatry, chiropractor boards) to join existing programs. The program requirements as set forth in subsection (c) are not specific to a particular profession; therefore, it did not make sense to the drafters to require each regulatory board to establish its own program. It is also more cost effective to permit boards to share the expenses related to operating and administering a program.

Subsections (c) through (g) set forth the requirements for alternative to discipline programs including regular program evaluation to ensure program quality and adherence to best practices, eligibility requirements, staff requirements, outreach programs, receiving reports regarding healthcare professionals, and approving evaluators, intervenors, and treatment providers. Subsection (f) requires that programs and individuals associated with alternative to discipline programs avoid any conflicts of interest, including by not referring healthcare professionals to a treatment provider in which the program or individual associated with the program has a financial interest.

Subsection (g) sets forth the requirements for worksite monitors. Working group members suggested that worksite monitors have some sort of training, with one working group member suggesting that worksite monitors be required to obtain board-mandated certification, training, or specialized qualifications to ensure consistent, knowledgeable oversight of participants and that offering incentives such as continuing education credits or professional recognition through the monitor's regulatory board might encourage individuals to become worksite monitors. As initially drafted, the Act required that worksite monitors have relevant education or training related to substance use disorder; however, that provision was deleted on the recommendation of another working group member who emphasized that it is already difficult to find willing worksite monitors and a requirement that the monitor have specialized education or training related to substance use disorder might make that even more difficult and limit where a participant can work. As such, the drafters determined that not including specialized training or education at this time would result in better outcomes for both program participants and the public.

Subsection (h) sets forth the rights that a healthcare professional participating in an alternative to discipline program has, including the right to choose from a list of approved treatment providers rather than being arbitrarily assigned to a provider and the right to file a complaint pursuant to the state Administrative Procedures Act. Subsection (i) provides that no

information related to a healthcare professional's participation in an alternative to discipline program shall be a public record or subject to discovery or subpoena in a civil case.

Subsections (m) and (n) address interventions, which should take place if a healthcare professional refuses to participate in the program and is determined, after an investigation by the program, to meet the requirements for admission to the program, and drug and alcohol use evaluations, which should take place after a healthcare professional is referred to the program in order to determine what services, including treatment, the individual should receive.

While subsection (c)(4) requires that programs establish policies regarding eligibility requirements for participants, subsection (o) sets out specific parameters for eligibility to participate in an alternative to discipline program. These specific parameters are included to address disparities across state laws and regulations regarding who is eligible to participate in existing programs. For example, some states provide that healthcare professionals who have previously participated in a program are no longer eligible to participate without regard to how long ago that previous participation may have been.[146] Paragraph (1)(E) of subsection (o) leaves the option to states as to how many previous treatment agreements within a certain number of years should make an individual ineligible for current participation in an alternative to discipline program. Although specific numbers are not included, in recognition of the fact that substance use disorder is a disease and return to use is common among individuals with substance use disorder, states should carefully consider when a healthcare professional should be barred from participating in an alternative to discipline program. With that in mind, the drafters elected to make exclusions discretionary with programs rather than absolutes so that programs can consider individual circumstances when deciding whether or not to admit a healthcare professional to the program.

Subsections (p) through (v) set out the requirements for program participants, including the components of treatment and aftercare agreements. Subsection (t) permits participants to request a leave of absence from the program or a temporary pause on any toxicology testing requirements for good cause. Good cause could include any number of reasons, including family

[146] *See, e.g.*, ALA. ADMIN. CODE r. 610-X-13-.02 (2024) (in order to be admitted to the voluntary disciplinary alternative program must not have had any "previous disciplinary action against the nursing license in any state or jurisdiction nor have been terminated from any alternative disciplinary program participation for noncompliance"); ARK. CODE R. 007.34.1-10-II (2024) (nurses will be denied admission to the alternative to discipline program if he or she has prior discipline by any board of nursing for substance abuse or diversion or demonstrated unsuccessful participation resulting in termination from the program or similar program in another jurisdiction); IOWA ADMIN. CODE r. 655-19.4 (2024) (the program will determine on a case-by-case basis if a nurse is eligible; reasons for ineligibility include participating in the program or a similar program in another state without success); LA. ADMIN. CODE tit. 46, Pt. XLVII, § 3419 (2024) (admission criteria includes that the nurse have no previous disciplinary action within the past two years and "no previous peer assistance/alternative program participation unless first relapse uncomplicated by previous history"); MASS. GEN. LAWS ANN. ch. 112, § 24H (West 2024) ("only a registered pharmacist, pharmacy intern or pharmacy technician who has requested rehabilitation and supervision shall be eligible to participate in the program"); MINN. STAT. ANN. § 214.32 (West 2024) (admission in the program shall be denied to health professionals "who have been terminated from this or any other state professional services program for noncompliance in the program"); N.M. CODE R. § 16.12.13.9 (2024) (limits admission to the program to nurses "who have had a complaint filed against their nursing license alleging the use or abuse of drugs or alcohol, or who voluntarily submit a written request"); OKLA. ADMIN. CODE § 435:12-1-6 (2024) ("professionals previously disciplined by the Board shall be ineligible unless referred to the Program by the Board").

Return to Table of Contents

obligations that require the participant to leave the state for a period of time to, for example, take care of an ailing parent or participation in an out-of-state training program that would interfere with the healthcare professional's responsibilities under his or her treatment agreement. The short-term pause in toxicology testing requirements would permit the participant to, for example, go on a family vacation. In such case, the participant is then required to undergo hair follicle or nail toxicology testing upon return to ensure adherence to the participant's treatment agreement.

Subsection (x) sets out the circumstances for when a program must report a participant to his or her board. Paragraph (1) sets out the mandatory triggers for reports to an individual's credentialing board while paragraph (2) sets out the discretionary triggers for submitting reports. Pursuant to paragraph (1)(C), programs are required to report to a board when a participant "repeatedly" fails to abide by the terms and conditions of a treatment or aftercare agreement. The drafters did not include a specific number of times in that paragraph as a determination as to whether certain conduct rises to the level of a "failure to abide" is subjective. One program coordinator might consider *any* failure to attend a support group meeting a failure to abide by the terms of a treatment agreement while another program coordinator might determine that a failure to attend due to car trouble or illness does not rise to the level of "failure to abide." Therefore, since such determinations are subjective, the drafters chose not to include a specific number.

Paragraph (2)(D) under subsection (x) states that the program may report a participant to his or her board if he or she has a single "unexcused, missed, tampered with, or abnormal toxicology test." For purposes of this Act, an "abnormal" toxicology test means a positive test, but it also means a test that comes back positive for drugs prescribed to the participant, but in an amount that suggests either the participant is taking too much or too little.

Subsection (z) sets out the provisions related to discharge from the program, whether due to completion of all of the terms of the treatment and aftercare agreements or prior to successful completion for the reasons set forth in subsection (x). A healthcare professional who is terminated from the program prior to successful completion shall be reported to his or her credentialing board for further action. It should be noted that this subsection provides that a return to use should not result in discharge from the program. As stated above, return to use is endemic to substance use disorder, and a healthcare professional who returns to use and reports or admits to that return to use should be permitted to continue in treatment.

In addition to ensuring that programs are non-punitive, in order to encourage self-reporting and participation, this section includes extensive provisions related to confidentiality of a participant's records relating to the alternative to discipline program and to whom, and under what circumstances, such information can be disclosed.

Finally, subsection (cc) requires that boards promote their alternative to discipline programs through a variety of methods.

SECTION VII. DISCIPLINARY PROVISIONS.

(a) Deferral of action.—A board may, by regulation, defer disciplinary action with regard to a healthcare professional over whom it has authority who agrees to participate in the

alternative to discipline program and who enters into a treatment and/or monitoring agreement with such program.[147]

(b) Imminent danger.—The credential of a healthcare professional who is practicing or has practiced while impaired, has diverted drugs, or poses a danger of immediate and serious harm to others due to the misuse of drugs and/or alcohol may be summarily suspended without a prior hearing.

(c) Report from alternative to discipline program.—The credential of a healthcare professional may be summarily suspended without a prior hearing if the board receives a report from the program pursuant to Section VI, subsection (x) and, in the opinion of the board, the healthcare professional poses a danger of immediate and serious harm to others.[148]

(d) Voluntary surrender, restriction, or limitation of credential.—

(1) A healthcare professional who is impaired due to the misuse of drugs and/or alcohol or who has an undiagnosed or untreated substance use disorder and which impairment or substance use disorder has not resulted in patient harm may:

(A) Voluntarily surrender such credential to his or her board during the period of such impairment, which board may accept the surrender of such credential; or

(B) Voluntarily limit or restrict such credential upon the agreement of his or her board during the period during which the healthcare professional is a participant in the alternative to discipline program and is compliant with such program. Limitations on the credential shall be agreed to by the board and subject to monitoring by a worksite monitor.[149]

(C) A healthcare professional subject to a pending or current disciplinary action may voluntarily surrender, restrict, or limit his or her credential. If such voluntary surrender, restriction, or limitation is accepted by the board, it shall defer further proceedings as long as the healthcare

[147] Adapted from LA. STAT. ANN. § 37:1241 (2024).
[148] Adapted from ALA. ADMIN. CODE r. 630-X-14-.02 (2024) and OHIO ADMIN. CODE 4729:4-1-07 (2024).
[149] Adapted from N.Y. EDUC. LAW § 6510-b (McKinney 2024).

Return to Table of Contents

professional is compliant with a treatment agreement or aftercare agreement.

(D) The board shall notify the healthcare professional's employer of any such surrender or limitations of an individual's credential.[150]

(E) A surrendered credential shall be restored upon a report from the alternative to discipline program that the healthcare professional is able to practice with reasonable skill and safety. The board may impose reasonable limitations on the healthcare professional if the board determines that, due to the nature and extent of the healthcare professional's former impairment, such conditions are necessary to protect the health, safety, and welfare of the public.[151]

(2) Prior to accepting the voluntary surrender, restriction, or limitation of a credential, the board shall provide the healthcare professional with the following:

(A) Reasonable opportunity to consult with legal counsel;

(B) Information regarding:

(i) Alternatives to the surrender, restriction, or limitation of the credential;

(ii) Required reporting of certain actions against a credential by the board to the National Practitioner Databank and/or the Office of the Inspector General as required by federal and state law; and

(iii) The potential impact on the healthcare professional's career, including difficulty securing future employment and participation in healthcare programs.

(C) The required information shall be provided to the healthcare professional in writing prior to accepting the voluntary surrender, restriction, or limitation of the credential.

(e) Reinstatement of credential and/or removal of limitations or restrictions.—A healthcare professional whose credential has been limited, suspended, restricted, modified, revoked, or otherwise subject to discipline may petition, under such procedures as established by

[150] *Id*.
[151] *Id*.

rule, to have such credential reinstated and all limitations and/or restrictions lifted upon successful completion of the alternative to discipline program, including any post-treatment monitoring, and a finding by such program after a fitness for duty evaluation that the individual is able to practice again with reasonable skill and safety.[152]

(1) A healthcare professional whose credential has been limited, suspended, restricted, modified, revoked, or otherwise subject to discipline has the right to petition the appropriate board at reasonable intervals for reinstatement of the credential and to demonstrate that he or she can resume practice with reasonable skill and safety.[153]

(2) Upon reinstatement, the board may place the reinstated healthcare professional on probation for a specified period of time.[154]

(f) Exceptions.—A board may not discipline a healthcare professional solely because the healthcare professional:

(1) Self-refers to or is participating in, and is compliant with, the alternative to discipline program;

(2) Has been diagnosed with a substance use disorder, mental health disorder, or co-occurring disorders;

(3) Is a participant in an alternative to discipline program in another jurisdiction, notified the individual's board of such participation, and is in compliance with such program; or

(4) Misused controlled substances or alcohol [or cannabis] or was diagnosed with a substance use disorder before applying for a credential or entry into the alternative to discipline program, if such use did not result in patient harm.[155]

(g) Program reports.—Boards shall review reports received from the alternative to discipline program pursuant to Section VI, subsection (x). If the board finds that a healthcare professional over which it has authority is substantially non-compliant with the treatment or aftercare agreement or is otherwise a risk to the health or safety of the public, the

[152] Adapted from IDAHO CODE ANN. § 54-1835 (West 2024) and N.M. CODE R. § 16.10.5.10 (2024).
[153] N.M. STAT. ANN. § 61-5B-9 (West 2024).
[154] LA. ADMIN. CODE tit. 46, Pt. LIII, § 327 (2024).
[155] Adapted from IOWA CODE ANN. 653-23.1 (2024); OHIO REV. CODE ANN. § 4731.253 (West 2024); and ORE. REV. STAT. ANN. § 676.200 (West 2024).

Return to Table of Contents

board may limit, suspend, restrict, modify, or revoke the healthcare professional's credential.[156]

(h) Judicial review.—All orders of a board to revoke an individual's credential or deny a petition for reinstatement shall be subject to administrative or judicial review pursuant to the [reference to state administrative procedures act]. The decision of the board shall not be stayed or enjoined pending review.[157]

Commentary

Although the preference is that healthcare professionals who have diverted medications due to a substance use disorder participate in the alternative to discipline program, that is not always possible, either because the healthcare professional refuses to engage with the program or fails to comply with the program requirements. This section sets out the disciplinary actions a board can take against those healthcare professionals. Additionally, this section sets out the provisions related to reinstating a credential or removing any restrictions or limitations on a credential. It further provides that any decision by a board to revoke an individual's credential is subject to administrative or judicial review.

SECTION VIII. WHISTLEBLOWER PROTECTIONS.

(a) In general.—No healthcare entity, staffing agency, or other third-party contractor for a healthcare entity shall discharge, threaten to discharge, or in any manner discriminate or retaliate against any person, by any means whatsoever, who in good faith makes, or causes to be made, a report under this Act, or who testifies or is about to testify or provide other evidence in any proceeding concerning patient harm and/or medication diversion that occurred on the premises of the healthcare entity.[158] This subsection does not apply to a healthcare professional who self-reports.

(b) Protected actions.—Actions protected by this section include, but are not limited to, the following:

(1) Making a report to the healthcare entity regarding a healthcare professional pursuant to this Act;

(2) Making a report to a board or alternative to discipline program as required by this Act; or

[156] OR. REV. STAT. ANN. § 676.200 (West 2024).
[157] N.M. STAT. ANN. § 61-7-10 (West 2024).
[158] DEL. CODE ANN. tit. 16, § 1135 (West 2024).

Return to Table of Contents

(3) After giving opportunity for the healthcare entity to address the report, making a report to a private healthcare accreditation organization or governmental agency concerning the activity that was the subject of the report.[159]

(c) Damages and fees.—Any healthcare entity that discharges, discriminates, or retaliates against an individual because the individual reports, testifies, or is about to testify concerning patient harm and/or medication diversion is liable to the individual for treble damages, costs, and attorney fees.[160]

(d) Rebuttable presumption.—If a healthcare entity discharges, demotes, restricts an individual's duties, or takes other adverse action against an individual who made a report, testified, or is subpoenaed to testify as a result of a report made pursuant to this Act, there is a rebuttable presumption that the facility discharged, demoted, or retaliated against the individual as a result of the report, testimony, or anticipated testimony.[161]

Commentary

It is essential that individuals who make a report regarding a healthcare professional pursuant to this Act have protection against retaliation by their employers for making such reports, particularly if making a report might result in civil liability on the part of the healthcare entity. For example, under subsection (b)(3), if an employee makes a report to a healthcare entity that he or she suspects that a healthcare professional is diverting medications and the healthcare entity employer does not take action on the report, this section protects the reporting employee from retaliation if he or she then makes a report to the governmental agency that licenses the healthcare entity. It also provides that the healthcare entity will be liable for treble damages in a civil action by the employee against whom the healthcare entity retaliated.

SECTION IX. IMMUNITY.

(a) In general.—Any individual or entity, including, but not limited to, a healthcare professional or other individual employed by or under contract with a healthcare entity, a healthcare entity, professional association, staffing agency, third party organization, alternative to discipline program, peer review body, patient, or other person who in good faith and without malice makes a report as required by this Act or provides information, or assists another in making a report or providing information, to a board, alternative to discipline program, or law enforcement agency indicating that a healthcare professional

[159] ARIZ. REV. STAT. ANN. § 36-450.02 (2024).
[160] DEL. CODE ANN. tit. 16, § 1135 (West 2024).
[161] *Id*.

Return to Table of Contents

may have diverted drugs, may be guilty of unprofessional conduct as a result of a substance use disorder, or may be impaired because of drug or alcohol misuse, is immune from civil or criminal liability or disciplinary or administrative actions for making such report.[162]

(b) Board immunity.—Nothing in this Act creates any liability of any board, members of a board, or the state of [state] for the actions of the board in making awards to treatment providers or an alternative to discipline program or in designating healthcare professionals to participate in an alternative to discipline program.[163]

(1) Notwithstanding any other provision of law, no board or its members shall be held liable in damages to any person for any acts, omissions, or recommendations made by them in good faith while acting within the scope of their duties pursuant to this Act.[164]

(2) No civil action may be brought or maintained against a board, its members, or the state for an injury alleged to have been the result of an act or omission of a healthcare professional participating in or referred to an alternative to discipline program.[165]

(3) The state remains liable under the [reference to state governmental tort liability act] if an injury alleged to have been the result of an act or omission by a healthcare professional participating in or referred to an alternative to discipline program occurred while the healthcare professional was performing duties as an employee of the state.[166]

(c) Contractor immunity.—Any treatment provider, professional association, or other individual or entity that contracts with or receives funds from a board for the creation, support, or operation of an alternative to discipline program shall, in so doing, be immune from any civil or criminal liability that might otherwise be imposed.[167]

(d) Banning.—In response to a request by a prospective or current employer of a healthcare professional, it is neither unlawful nor a violation of any statute or regulation for an

[162] Adapted from ARK. CODE ANN. § 20-7-708 (West 2024) and CAL. BUS. & PROF. CODE § 2318 (West 2024).
[163] COLO. REV. STAT. ANN. § 12-280-205 (West 2024).
[164] ARK. CODE ANN. § 17-80-210 (West 2024).
[165] COLO. REV. STAT. ANN. § 12-280-205 (West 2024).
[166] *Id*.
[167] ALA. CODE § 34-24-403 (2024).

employer, when acting in good faith, to disclose information known regarding any involvement in drug diversion, drug tampering, patient harm, violation of employer drug or alcohol policies, or crimes related to drugs by the healthcare professional who is a current or former employee of the responding employer.

(1) An employer who provides information in accordance with this subsection is immune from civil liability for providing such information or for any consequences that result from the disclosure unless the healthcare professional shows by a preponderance of the evidence that the information is false and the employer providing the information knew or reasonably should have known that the information is false.

(2) The provision of information pursuant to this subsection does not constitute an unfair labor practice in violation of [insert reference to state code].

(3) There is a presumption that an employer or any officer, director, employee, or representative of the employer who discloses information under this subsection is acting in good faith unless it is shown by a preponderance of the evidence that the facility, officer, director, employee, or representative of the employer intentionally or recklessly disclose false information about the employee or former employee.[168]

Commentary

This section provides immunity from civil and criminal liability for individuals and entities who take certain actions pursuant to the provisions of this Act, including reporting healthcare professionals for suspected drug diversion. Immunity applies regardless of whether the healthcare professional actually engaged in the behavior for which he or she was reported, as long as the report was made in good faith and without malice.

Additionally, this section provides that an employer or former employer that honestly, or with belief that the information disclosed is true, discloses information regarding a healthcare professional related to drug and/or alcohol use, diversion, patient harm, or impairment is immune from any laws related to "blacklisting" (referred to as "banning" in the statutory language) that might exist in the state.

[168] COLO. REV. STAT. ANN. § 8-2-111.6 (West 2024).

Return to Table of Contents

SECTION X. LIABILITY AND PENALTIES.

(a) Subject to the [state administrative procedures law], on an initial finding that diversion occurred at a healthcare entity and an investigation by the [state healthcare entity licensing agency] determines that a member of the board of directors, a high managerial agent, or medical director knew that the diversion occurred and failed to take action, the state agency that licensed the entity:

(1) May suspend or revoke the entity's license;[169]

(2) Shall issue a civil penalty of no less than [$]; and

(3) May suspend or revoke the entity's registration to store, dispense, or administer controlled substances in this state.

(b) On a finding by the [state healthcare entity licensing agency] that a healthcare entity has violated subsection (a) more than once and subject to the [state administrative procedures law], the state agency that issued the entity's license shall:

(1) Suspend or revoke the entity's license for a period of not less than [one (1) year];

(2) Issue a civil penalty of no less than [$] per violation; and

(3) Suspend or revoke the entity's registration to store, dispense, or administer controlled substances in this state for a period of not less than [one (1) year].

(c) A healthcare entity that has failed to comply with local, state, and federal laws regarding reporting drug diversion may also be subject to criminal sanctions.

Commentary

This section is intended to provide penalties for healthcare entities that knowingly and intentionally fail to take action after diversion is found to have occurred at the facility. That is, the entity failed to submit the reports required by state and federal law and this Act and also failed to take any action to investigate the suspected diversion or take action against the healthcare professional suspected of diverting. As with other civil penalties in this Act, the amount of the penalty should be sufficient to deter the behavior.

Subsection (b) sets forth the penalties for healthcare entities who have violated this provision more than once. The suspension or revocation of the healthcare entity's license to operate and controlled substances registration is mandatory for repeat violators. The drafters have recommended a one-year suspension or revocation period in order to deter the behavior, but legislators are free to choose a shorter or longer time period. Note also that the penalties set forth in this subsection are subject to the state administrative procedures law, including for the purpose of appealing the decision of the state agency.

[169] DEL. CODE ANN. tit. 16, § 1138 (West 2024).

Return to Table of Contents

SECTION XI. NOTIFICATION TO PATIENTS.

Every healthcare entity with knowledge that a healthcare professional diverted drugs and that such diversion resulted, or may have resulted, in patient harm shall provide notice to each patient deemed by [the institutional head of infection control or equivalent person] to be at risk of transmissible infection as a result of such diversion within [n] days of reporting the diversion.

SECTION XII. DATA COLLECTION AND PROGRAM AUDIT.

(a) Program reports.—On at least a quarterly basis, the alternative to discipline program shall submit a deidentified report to each board or boards under which it operates. Such report shall include, for each reporting period, statistics and demographics including:

(1) The total number of healthcare professionals referred to the program and the reason(s) for the referral – diversion of drugs for personal use, misuse of drugs and/or alcohol, untreated substance use disorder, and/or practicing while impaired;

(2) If the healthcare professional diverted drugs for personal use, the name of the drug(s), the estimated quantity diverted, and the method of diversion (*e.g.*, fraudulent prescription, tampering, improper wastage);

(3) The number of healthcare professionals accepted to the program by credential type;

(4) The number of self-referrals by credential type;

(5) The number of referrals by mandatory reporters by type of reporter;

(6) The number of interventions completed and the number that resulted in program acceptance;

(7) The number of drug and alcohol use evaluations completed and the number that resulted in program acceptance;

(8) The number of fitness for duty evaluations completed and the outcomes of such evaluations;

(9) The number of new treatment agreements entered into and the number of healthcare professionals who successfully completed their treatment agreement;

(10) The number of healthcare professionals currently participating in the program who are receiving treatment from an approved treatment provider;

Return to Table of Contents

(11) The number of new aftercare agreements entered into and the number of healthcare professionals who successfully completed their aftercare agreement;

(12) For healthcare professionals who successfully completed the program, the length of time spent in the program;

(13) The number of healthcare professionals currently being monitored by the program;

(14) The number of healthcare professionals participating in the program who have been suspended from practice or had restrictions or limitations placed on their credentials;

(15) The number of healthcare professionals recommended for a return to practice or removal of restrictions or limitations placed on their credentials;

(16) The number of healthcare professionals reported to their board for non-compliance;

(17) The number of healthcare professionals who experienced a return to use, the number who self-reported a return to use, and the number who entered into a new treatment agreement; and

(18) The number of healthcare professionals who were discharged from the program for non-compliance.[170]

(b) Deidentified information.—The program shall not disclose any personally identifiable information relating to any healthcare professional participating in, and who is compliant with, the program in any report submitted pursuant to this section.[171]

(c) Program financial reports.—Each alternative to discipline program shall submit an annual report to each board under which it operates with a complete financial breakdown of cost for each participant by usage and a complete annual audited financial statement.[172]

(d) Reports to legislature.—Each board shall, on an annual basis, submit a report to the legislature that includes an aggregate of the data provided to it by the alternative to discipline program.

[170] Adapted from 21 N.C. ADMIN. CODE 32K.0207 (2024) and W. VA. CODE ANN. § 30-3D-2 (West 2024).
[171] W. VA. CODE R. § 5-15-11 (2024).
[172] WASH. ADMIN. CODE § 246-817-820 (2024).

Return to Table of Contents

(e) Audits.—The board or boards participating in an alternative to discipline program shall arrange for an independent third party to conduct an audit of the alternative to discipline program at least [annually/biannually] for the purpose of examining quality control and to ensure compliance with program requirements. The results of the audit shall be reported to each board participating in the program, the legislature, and the governor. The report shall not include personally identifiable information about participants.[173]

(1) Any audit conducted pursuant to this subsection shall consist of a random sampling of at least twenty (20) percent of the program's files or ten (10) files, whichever is greater.[174]

(2) Prior to conducting the audit, the auditor shall agree in writing:

(A) Not to copy or remove any program files or records;

(B) To destroy all personally identifiable information about participants upon completion of the audit;

(C) Not to disclose any personally identifiable information to any person or entity other than individuals authorized to receive such disclosure; and

(D) Not to disclose in any audit report any personally identifiable information about participants.[175]

Commentary

This section requires that each alternative to discipline program submit quarterly reports to each board under which it operates. The information required to be reported is designed to provide an overview of program operations, including the number of new participants and the number who have successfully completed the program. Additionally, this section requires programs to undergo an audit to ensure that programs are operating pursuant to the requirements of this Act. It was recommended by a working group member that auditors be required to have specialized training or certification relevant to the patient populations treated by alternative to discipline programs in order to ensure a more informed, meaningful evaluation of the program.

SECTION XIII. TECHNOLOGY GRANTS FOR HEALTHCARE ENTITIES.

(a) In general.—There is created a grant program under the supervision of the [state agency charged with licensing and oversight of healthcare entities] for healthcare entities licensed or registered in this state for the purpose of purchasing new methods for the

[173] OR. REV. STAT. ANN. § 676.190 (West 2024).
[174] CONN. GEN. STAT. ANN. § 19a-12a (West 2024).
[175] *Id*.

Return to Table of Contents

prevention, detection, and reporting of drug diversion including, but not limited to, equipment and computer software using artificial intelligence and machine learning. Priority shall be given to those healthcare entities with limited resources, in rural areas, that treat vulnerable patient populations, or with limited regulatory oversight.

(b) Regulations.—The [state agency charged with licensing and oversight of healthcare entities] shall adopt regulations to implement this section.

(c) Appropriations.—The legislature shall appropriate [$] to the [state agency charged with licensing and oversight of healthcare entities] to fund such grant program.

Commentary

This section requires the legislature to establish a grant program for the purpose of providing funds to healthcare entities in the state to purchase equipment and software designed to help with the prevention and detection of diversion. Such equipment might include automated medication dispensing systems, artificial intelligence programs, and electronic monitoring tools to track medication usage.

SECTION XIV. PROGRAM FUNDING.

Alternative to discipline program fund.—Each board shall establish a dedicated, non-lapsing fund to be known as the alternative to discipline program fund for the establishment, administration, and ongoing costs related to alternative to discipline programs including the actual cost of overhead and personnel expenses.[176]

(a) If one or more boards have established a joint alternative to discipline program, such boards shall establish a joint alternative to discipline program fund.

(1) The board charged with oversight of the alternative to discipline program shall track funds received from each participating board. If a board elects to cease participating in the joint program, any money remaining in the fund from such board shall be returned to that board.

(b) The fund shall initially be established by an assessment to all healthcare professionals who are licensed, registered, or certified by a board in this state as determined by such boards.[177]

[176] ALA. CODE § 34-38-2 (2024).
[177] N.M. STAT. ANN. § 61-5B-11 (West 2024).

Return to Table of Contents

(c) Each board that issues a license, registration, or certification to a healthcare professional shall charge a fee at the time that the board issues an initial or renewal license, registration, or certification or reinstates a license, registration, or certification to be paid into the fund, which fees shall be sufficient to cover the cost of the administration and ongoing costs related to the alternative to discipline program.[178]

(d) The fund may accept, transfer, and expend funds made available by the federal or state government or by another public or private source, including any funds that might be available from opioid litigation settlement funds.[179]

(e) Fines assessed pursuant to Section V, subsection (q) and Section X, subsection (b) shall be deposited into each alternative to discipline program fund on a pro rata basis.

(f) If money is available, the fund may be used to assist healthcare professionals with costs incurred for participation in the alternative to discipline program.[180]

Commentary

Funding sections in model laws can be complicated, as states fund projects through legislation in a variety of ways, and there is no "one size fits all" solution. However, if the Model Act omits the funding discussion altogether, the legislation gives the appearance of an unfunded mandate.

Since each board in a state is required to establish an alternative to discipline program, either singly or jointly with other boards of the healing arts, the drafters determined that the best solution for funding such programs would be to require that each board add an additional fee for their credential holders that would be paid into the alternative to discipline program fund created in this section. The provisions in this section are taken from several states, notably Alabama, Iowa, New Hampshire, and New Mexico, though several other states include similar provisions.

Subsection (a)(1) requires that, in situations where two or more boards have jointly established a program, the board charged with overseeing the program also keep track of each board's contributions to the alternative to discipline fund and refund that portion of the fund to a board if the board elects to stop participating in the joint program. This provision was added to ensure that any board leaving a joint program has funds available to establish its own program.

Subsection (e) requires that any fines assessed pursuant to Section V, subsection (q) and Section X, subsection (b) be paid into each alternative to discipline fund on a pro rata basis so that each program benefits from the fines assessed. Finally, subsection (f) permits funds to be used to assist healthcare professionals participating in an alternative to discipline program with the payment of costs associated with such participation if such funds are available. This is

[178] N.H. REV. STAT. ANN. § 310-A:1-e (West 2024).
[179] IOWA CODE ANN. § 155A.39 (West 2024).
[180] *Id*.

Return to Table of Contents

especially crucial for those healthcare professionals who may have lost their health insurance coverage as a result of being terminated from their employment or who may have been suspended from practice and are no longer receiving a salary.

A working group member suggested the addition of funding for state boards in order to assist with costs related to investigating healthcare professionals under this Act. However, the drafters felt that legislatures would be hesitant to appropriate funds for this purpose and boards would be resistant to further increasing the fees assessed against the healthcare professionals under their authority.

SECTION XV. RULES AND REGULATIONS.

The appropriate boards shall promulgate such rules and regulations as are necessary to effectuate this Act.

SECTION XVI. SEVERABILITY.

If any provision of this Act or application thereof to any individual, entity, or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provisions or applications and, to this end, the provisions of this Act are severable.

SECTION XVII. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effective date].

Return to Table of Contents

ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

The Legislative Analysis and Public Policy Association (LAPPA) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to model laws and policies that can be used by national, state, and local criminal justice and substance use disorder practitioners who want the latest comprehensive information on law and policy. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorders, medication for addiction treatment in correctional settings, and the involuntary commitment and guardianship of individuals with alcohol or substance use disorders.

For more information about LAPPA, please visit: https://legislativeanalysis.org/.


LAPPA
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION