

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



Welcome to the 25th edition, Volume 2, of *Physician Health News*. We hope you will find this an informative forum for all aspects of physician health and well-being. *Physician Health News* is the official newsletter of the Federation of State Physician Health Programs (FSPHP) and is published by the FSPHP.

PUBLICATIONS COMMITTEE

Sarah Early, PsyD (CO) Scott Hambleton, MD (MS)
Amanda Kimmel (CO) Ann Kelley, LCSW, LCAC (IN)
Laura Berg, LCSW-C (IL) Linda Bresnahan, MS (MA),
Mary Ellen Caiati, MD (CO) CAADC (IL)
Joyce Davidson, LSW (CO)

The FSPHP is a national organization providing an exchange of information among state physician health programs (PHPs) to develop common objectives, goals, and standards. If you're not a member yet, please consider joining. State, Associate, International, Individual, and Organizational membership categories are available.

We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive FSPHP. For more information on each of the membership categories, including new categories for organizational and individual members, please see our website or contact Julie Robarge.

FSPHP CONTACT INFORMATION AND MAILING ADDRESS

Julie Robarge
FSPHP
668 Main St., Suite 8, #295
Wilmington, MA 01887
Phone: (978) 347-0600
Fax: (978) 347-0603
Email: jrobarge@fsphp.org
Website: www.fsphp.org

Your participation in the submission of material for future issues is vital.

Please send your contributions, comments, news, and updates to:

Linda Bresnahan, MS
FSPHP
668 Main St, Suite 8, #295
Wilmington, MA 01887
Phone : (978) 347-0600
Fax : (978) 347-0603
Email : lbresnahan@fsphp.org

Physician Health News is developed through the volunteer efforts of the Publications Committee with assistance from Misty Horten (design and layout) and Christine Clark (copyediting and proofreading).

IN THIS ISSUE

President's Message	2
Executive Director Message	5
2018 FSPHP Donors	7
STAY 3-D on TV and STAGE: Media and Storytelling Training	8
Use of Controlled Substances as Treatment Modalities for Physicians Being Monitored by PHPs	9
Improved Neurocognitive Functioning Among Healthcare Professionals Initiating Recovery from Addiction: Bradford Health Services	12
Five Best Practices for Behavioral Cases for Clients and the Workplace	13
Implementing Tobacco-Free Policies in Residential Addiction Treatment Settings	14
FSPHP's New Performance Enhancement and Effectiveness Review (PEER) and Safety-Sensitive Professional Provider Accreditation (PA) Programs	14
Physician Wellness and Resilience	15
A Review of the Literature About Physician Health Programs: What We Have Learned About Treatment of Addiction in Physicians	16
Neuropsychological Screening for Physicians in Remediation	17
A Framework for Assessing, Treating, and Monitoring Recovery from Addiction, Psychiatric Illness, and Trauma	17
Answering the Call: Physician Health Programs and Self-Referral Clients	18
Using a Recovery-Oriented Lens When Evaluating Serious Psychiatric Disorders in Healthcare Professionals	19
Treatment Readiness in Physician Assistants in a State Monitoring Program for Substance Abuse Disorders	20
Interpreting Alcohol Biomarker Values—Cautions and Caveats	21
Discussion of Long-Term Alcohol Biomarker Results: Review of the Most Recent Literature and Case Reports	21
Professional Development Utilizing Motivational Interviewing to Improve Outcomes and Reduce Burnout	22
Health-Related Quality of Life Among Physicians, Residents/Medical Students, and Physician Assistants	23
Entering a Peer-Assistance Program	23
The Balancing Act: Confidentiality and Public Safety with Professional Sexual Misconduct	24
Remarks Before the Opening General Session of the 2018 FSPHP Annual Meeting in Charlotte, North Carolina	26
Creating a Statewide Consortium to Combat Burnout: A Cooperative Effort of the NC PHP, Board of Medicine and Medical Society	27
FSPHP Welcomes the Following New Members!	27
FSPHP Member Daniel Perlin Receives Award from the Medical Society of the District of Columbia	28
Physician Health and Other Related Organizations National Meetings	35

PRESIDENT'S MESSAGE

*World in Changes*¹

Paul H. Earley, MD, DFASAM

Change is accelerating. We can feel it in almost every sphere of human endeavor. Some areas are accelerating faster than we can imagine, even if we try very hard to do so (e.g., artificial intelligence), and some are just changing whether we like it or not (e.g., medicine). All are changing. Speaking personally, I have aged to the point where I regularly fall back into lamenting “the good old days” when considering many human endeavors, but none more so than medicine. Don’t get me wrong, I do not prefer the crude rendition of a plain film of my knee to the detail of an MRI. What I miss are the times when my internist actually knew my medical history and communicated it to my specialist via a formal letter. Now I show up for an appointment and the specialist asks, “Why exactly are you here?”



**Paul H. Earley, MD,
DFASAM**

The Physician World

The art and practice of medicine have changed dramatically during my lifetime. The art of a thorough exam followed by a differential diagnosis seems to be lost. Medical technology has rendered many such skills unnecessary and therefore obsolete. Medical records are shared electronically, so, in theory, any specialist I see has my records instantaneously (more on this in a moment). And by the way, the more things change, the faster they change. Take a look at this reference² in the endnotes for a great explanation.

Much of the change affects our participants. The number of physicians working in private practice decreased to 33 percent by the end of 2016, down from 57 percent sixteen years previously.³ In a study by Accenture, 92 percent of physicians chose employment out of necessity. Almost half of physicians reported they will look to sell their private practices within ten years.⁴ The list goes on and on. Physicians in training look at me as if I am from Mars when I foolishly ask: “Are you thinking about private practice?” This is not to say private practice is a panacea. But during the transition from a system of independent practitioners to corporate medicine, much strife occurs. Many participants in my PHP discuss their monthly visits with corporate “efficiency experts” to help them cut costs and work faster.

A second change we all bemoan is the electronic medical record. In full disclosure, I am a computer geek of the strongest sort. In the 1990s I built a company that produced one of the first electronic medical records for psychiatry and addiction treatment. This journey taught me that the problem is not the computer. The problem lies in how the EMR is coded and implemented.

The practice of medicine is complex and often nebulous; the path through a patient visit is not predictable. Conclusions about a case are often hard to distill down to an essential core—especially when the computer screen is staring you in the face asking for information that does not have anything to do with what is happening in the examination room. The computer’s demand for unneeded and irrelevant information, backed by patient care standards that demand completion of multiple screenfuls of irrelevant data, further reduces the physician’s sense of autonomy and relevance in saving lives. Such problems can be solved only by applying deep thought to the human–computer interface. This, I predict, will not occur in our lifetime.

A third change is in the delivery system itself. In our lifetime medical care has exploded and is using more expensive testing and equipment and we have a deeper understanding of thousands of disease states with more effective but costly procedural and surgical interventions. Entire subsectors of medical care were constructed, including the one many of us have worked in: addiction medicine. A new term came to the fore in medicine: *cost containment*—a phrase my father as a surgeon from a previous era never uttered. Third-party payors became vigilant, even indignant, about real and perceived unnecessary and at times fraudulent charges. The tension between practitioner and payer deepened and distressed us all.

We add to these three items a fourth factor: physician personality. I have had the pleasure of working with fine psychologists over the years who repeatedly point out to me that physicians have a surfeit of compulsivity. In fact, compulsive personality traits are normative. In a classic article,⁵ Gabbard points out that doubt, guilt feelings, and an exaggerated sense of responsibility form a compulsive triad in the personality of the physician. These are the very same characteristics that collide with a loss of autonomy that is commonly part of becoming employed. This collision is especially problematic for physicians of our generation, who have moved from independent practitioners to employees.

External drivers that pressure us to work harder and see more patients are not needed in most cases and only serve to exacerbate the physician’s harsh internal critic. This characteristic is stressed to the breaking point

when the EMR asks for pages upon pages of information unrelated to the care of each patient of the buckloads seen in clinic. The dedicated, dutiful physician works long into the night to complete medical records of too many patients crammed into the daylight hours. Physicians who are trained to be independent thinkers often find themselves compressed into a box by EMRs and corporate structures, well-meaning or not.

PHPs witness the final result. Crumbling marriages, burnout, depression, and suicide are the result. It is no coincidence that the hottest current topic in physician health is burnout. The word is on the lips of every concerned leader in organizational medicine. The Maslach Burnout Inventory, pioneered in 1981 by Maslach and Jackson,⁶ has become one of the most talked about instruments in social science—for a second time. New conferences on physician health have emerged with a primary focus on job-related stress and the systemic dysfunction it produces.

Physician suicide (arguably, in some cases, a partial consequence of unfettered workplace dysfunction) has been the subject of several feature articles in major newspapers. A fine meta-analysis by Schernhammer showed the suicide ratio for male physicians was 1.41 when compared with the general population. For female physicians, this ratio is a whopping 2.27.⁷

Lesser markers of stress also abound. The divorce rate among physicians is quite high and seems to be correlated to specialty. The divorce rate for psychiatrists is 51 percent, 33 percent for surgeons, 24 percent for internists, 22 percent for pediatricians and pathologists, and 31 percent for other specialties.⁸ Nonetheless, it is important to remember that such percentages only underscore the extent of the problem and do not impute causation.

Taken together, this means PHPs are more relevant now than we have ever been in our history. We need to change, to become more efficient, to develop standards that improve what we do—while working under significant pressure and budgetary constraints.

The PHP World

In a similar way, PHPs and the FSPHP are in their own world of changes. Early PHPs were constructed *de novo*, and protocols for participant flow, monitoring, and oversight were unique products erupting out of the minds of each PHP pioneer. Soon directors and staff gathered together to discuss cases and procedures and to compare notes on process and procedures. Despite being unified by a desire to help our participants, each

PHP felt unique. An oft-heard trope was, “When you have seen one PHP, you have seen one PHP.”

Soon after being established, the FSPHP subtly shifted the winds. Formed in 1990, the FSPHP evolved rapidly, and our annual meetings and committees increased discussions between states. Each PHP remained unique; however, best practices evolved out of our desire to do better. Many members brought their research and academic interests to the table. PHP research was born.

Discussions in our committees led to standards⁹ that pushed us all to greater conformity.

PHPs are disease-monitoring systems, not treatment, *per se*. Nonetheless, like all of medicine, we are subject to pressures to standardize protocols. We have a distinct advantage to most behavioral health programs in that we have both expert consensus protocols and outcome data that support the efficacy of those protocols. Still we have naysayers. Any system that grows to a certain size has its disgruntled participants and critical observers. Some appear articulate, especially to those who do not comprehend the importance of protecting the public and thus asking much of our participants.

Public safety is complex in and of itself. The press, interest groups, and the public at large have vast and untethered notions about the dangers that could potentially emerge when a medical professional develops a mental health problem. In the real world such dangers are rare, especially when compared to the negative outcomes that result from sleep deprivation, overwork, and poor communication among hospital staff. Thus, we are unceremoniously plopped into the business of managing public opinion. And no opinion is more important (and at times fickle) than that of our medical boards. Any one of our external stakeholders has the potential to construct standards out of their own idiosyncratic notion of what makes up a PHP.

All this has led to an inexorable conclusion. Both positive forces (our science-based interest in best practices, increased communication between PHPs, our creation of an effective parent—the FSPHP—and well-meaning external stakeholders) and negative forces (uninformed and not-so-well-meaning external pressure and the vicissitudes of political bodies) have come together to help us evolve. If we fail to build our own standards, we run the real risk of external organizations forcing less informed practices on us. The time to act is now.

The good news is that we are up to the task. The Accountability, Consistency, and Excellence (ACE) Committee is deep into rewriting best practice protocols and standards for PHPs. The FSPHP has contracted

President's Message

continued from page 3

with Metacred, an Association Management Company (AMC) that specializes exclusively in credentialing.¹⁰ They will work hand-in-hand with the FSPHP to build two review systems.

The first is the Performance Enhancement and Effectiveness Review (PEER™) Program for our member PHPs. We will operationalize the standards set forth by the ACE Committee into a review that will catalog the accomplishments of each PHP and at the same time provide a road map to enhance growth and quality. Some of our member PHPs have already undergone external review, looking to document their successes and point out areas of further growth. The PEER™ will systematize this process, underscoring excellence, and pointing out areas for improvement rather than credentialing.

The second product that will emerge out of our partnership with Metacred is a credentialing process for our external providers. Our first goal here is a review process for external treatment providers that certifies they have expertise in the myriad skills needed to ensure the best long-term outcome for our participants.¹¹ Preliminary discussion of this certification with treatment providers has been very positive. They are excited about being recognized for the specialized services they provide to healthcare professionals.

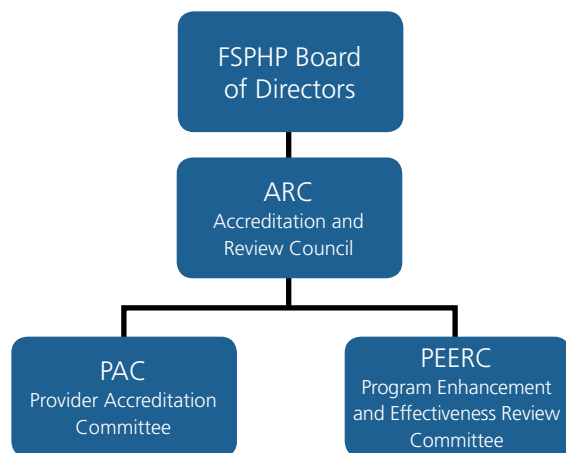


Figure 1

The FSPHP Board has approved a governance and oversight structure for this entire process. FSPHP members, the Metacred team, and select external experts will work on the structure and execution of these two review processes. The Program Enhancement and Effectiveness Review Committee (PEERC™) is charged with the construction, execution, and oversight of the

PEER™ process. The Provider Accreditation Committee (PAC) will do the same for the provider credentialing process. These two committees will report to the Accreditation and Review Council (ARC), who will ensure a smooth implementation process faithful to the overarching goals of the FSPHP itself. The ARC will in turn report to the Board (see Figure 1).

Needless to say, formalizing the process of PHPs and their providers is a huge and rather expensive endeavor. I am happy to report that, thanks to the tireless efforts of our Executive Director, Linda Bresnahan, we have already received donations from organized medicine for half of the initial expenses for this project. The quantity and size of these donations tell us two things: One, medicine believes in us and what we do and two, organized medicine is telling us *this should be done*.

The FSPHP is on a wild ride, a growth spurt that deepens our commitment to the health of healers across North America. Welcome aboard! ■

References

- ¹Mason, Dave. *World in Changes*, released 1970.
- ²Urban, Tim. The AI Revolution: The Road to Superintelligence, <https://waitbutwhy.com/2015/01/artificial-intelligence-revolution-1.html>.
- ³Accenture Staff. *The (Independent) Doctor Will NOT See You Now*. White paper, available at: https://www.accenture.com/t20150608T044420_w_us-en_acnmedia/Accenture/Conversion-Assets/DotCom/Documents/Global/PDF/Dualpub_15/Accenture-The-Doctor-Will-Not-See-You.pdf.
- ⁴Pallardy, C. 2015 Independent Physician Outlook: Nine Key Points, <https://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/2015-independent-physician-outlook-9-key-points.html>.
- ⁵Gabbard, G. O. (1985). "The role of compulsiveness in the normal physician." *JAMA* 254(20): 2926–2929.
- ⁶Maslach, C., & Jackson, S. E. (1981). "The measurement of experienced burnout." *Journal of Occupational Behavior*, 2, 99–113.
- ⁷Schernhammer, E. S., & Colditz, G. A. (2004). Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *American Journal of Psychiatry*, 161(12): 2295–2302.
- ⁸Johns Hopkins Medical Institutions. "Physicians' Divorce Risk May Be Linked to Specialty Choice." *ScienceDaily*, 13 March 1997.
- ⁹FSPHP (2005). "FSPHP Physician Health Program Guidelines," 2016, from https://www.fspHP.org/sites/default/files/pdfs/2005_fspHP_guidelines-master_0.pdf.
- ¹⁰Metacred, About us, <http://metacred.com/about-us>. Accessed 31 July 2018.
- ¹¹Earley, P. H. (2013). Safety Sensitive Workers. The ASAM Criteria: Treatment Criteria for Addictive, Substance-related and Co-occurring Disorders. Ed. D. Mee-Lee. Carson City, Nevada, The Change Companies: 460–483.

EXECUTIVE DIRECTOR MESSAGE

Linda Bresnahan, MS,
Executive Director



Linda Bresnahan, MS

I look forward to sharing this update of current FSPHP progress with our strategic goals. We are well positioned for some exciting progress ahead due to the incredible expertise and leadership of our board of directors, coupled with the dedication so many members' contributions and volunteers.

Please also join me in recognizing our sponsors of the Performance Enhancement and Effectiveness (PEER™) and the Provider Accreditation Process project. To date, we have the **Federation of State Medical Boards (FSMB)**, the **American Medical Association (AMA)**, the **American Psychiatric Association (APA)**, and the **Accreditation Council for Graduate Medical Education (ACGME)** supporting our PEER™ development efforts with contributions of \$10,000. We are having conversations with many other national associations to expand this support.

Within the context of our four Major Strategic Goals for the FSPHP, the following information updates the current priorities of the FSPHP Board of Directors for the FSPHP. This partial list of initiatives in these four key areas focuses on current priorities.

1. Organizational and Membership Development: Maintain and continue to grow an organizational structure and membership services that will help achieve our mission, vision, and strategic goals.

- **Membership**—The FSPHP membership committee continues to examine ways to increase membership.
- **Member Services**—FSPHP has entered into a new partnership with MemberClicks, an integrated website and membership association database provider. With this solution, we will improve our process internally, and we hope to continue to improve your experience as a member. You can look forward to a new website look and feel, a new way to manage your information through an updated portal and login experience, easy event registration, easy online bill pay, and easy management/communication (all in one place) from FSPHP. With this also come some improvements in information tracking and advanced reporting. We anticipate the ability to manage committee activity, an FSPHP shared membership calendar, and improved State PHP pages for the public (and member-only searches by PHP features)! We're very excited about this endeavor. Look for more details to be announced soon!

- **Multi-PHPs in One State Task Force**—FSPHP by-laws do not currently provide clear guidance for the voting rights of state member PHPs in circumstances where a single state has more than one qualified state member PHP (multi-PHP state) or a single entity owns or operates more than one qualified state member PHP. As such, the task force is reviewing the situation and will provide recommendations to the FSPHP Board of Directors for further consideration by the bylaw committee. These states include Arizona, Texas, and Missouri.
- **Ethics Committee**—The FSPHP Ethics Committee moved that the FSPHP adopt the AMA Code of Ethics, Section 9.6.2 (as delineated here <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-9.pdf>, pages 16–17), with the understanding that the term *patients* in the AMA Code refers to PHP participants. The FSPHP Board of Directors has approved this recommendation. More will follow in a committee report in our next issue.

2. Accountability, Consistence, and Excellence (ACE): Improve accountability, consistency, and excellence by utilizing and implementing a Federation-endorsed review process.

- **The Accountability, Consistency, and Excellence Committee**—Under the leadership of Maureen Dinnan, JP, and Doina Lupea, MD, the committee is continuing their incredible writing and editing efforts on the new FSPHP and PHP Guidelines. They have been working on reviewing member feedback on a regular basis with plans for an updated draft to be released to members in a few months.
- **PEER™ and PAC**—FSPHP is forming three committees to develop the PEER™ and PAC with member-driven input via ARC, PEER™, and PAC committees. Send an email to ARC@FSPHP.org to get involved!
- **Sponsorship for PEER™ and PAC**—Funding requests are in progress to increase national sponsorship for the development of PEER™ and PAC.
- **MAT Task Force**—An FSPHP task force is working on guidelines for PHPs monitoring participants who are prescribed Medication-Assisted Treatment.

3. Education, Research, and the Media: Provide ongoing education about the value of PHPs via media relations, communication strategies, and research.

- **Annual Meeting 2019—Perplexing Problems and Effective Solutions for Treating and Monitoring Healthcare Professionals.** The FSPHP 2019 Annual Meeting is taking shape, and the Program Planning Com-

Executive Director Message

continued from page 5

mittee, under the leadership of Martha Brown, MD, and Doris Gundersen, MD, is reviewing abstracts and securing guest speakers. We are happy to announce guest speakers Sarri Gillman, MA, MFT, Transforming Your Boundaries (<http://sarrigilman.com>) and Timothy Brigham, MDiv, PhD, on Physician Well-Being (www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being/Timothy-Brigham-MDiv-PhD-on-Physician-Well-Being). Attorneys Stacy Cook and Chris Sharp will partner to present a dynamic legal panel covering topics impacting Physician Health Programs (www.btlaw.com/stacy-i-cook and <http://sharpcobos.com/attorneys/christopher-sharp>).

- **Annual Meeting 2020**—Save the dates of Thursday, April 30 through Sunday, May 3, 2020, for FSPHP’s annual meeting to be held at the Manchester Grand Hyatt, San Diego.
- **Publication Committee**—The FSPHP publication committee has been a strong supporter of guiding and overseeing newsletter content. I’d like to thank Amanda Kimmel, CO, and Sarah Early, PsyD, for their leadership. This committee recently recommended that FSPHP step into LinkedIn, which has been approved by the FSPHP board. We will be looking for members to suggest content to post to our page once it is launched. This committee also oversees the Yahoo! groups and our website. In this role, they have been valuable advisors to me on our new association management and website solution.

FSPHP Collaborations

- Attendance at the **National Academy of Medicine**, Establishing Clinician Well-Being as a National Priority, <https://nam.edu/initiatives/clinician-resilience-and-well-being>
- Participation in the SAMHSA—**COPE Medical Education Summit**, August 2018 in Boston and Friday, Oct. 19, 2018, Chicago: A Coalition Shaping Addiction and Medical Student Health Education in U.S. Medical Schools
- Presentation at the **National Association of Medical Staff Services** Annual Meeting on October 2, 2018, by Dr. Chris Bundy and Dr. Doris Gundersen, Understanding Physician Health Programs (PHPs) and Considerations for Health Professionals Being Monitored by PHPs
- Presentation at the **New England Professional Group**—November 1–2, 2019
- **Collaboration with the American Medical Association**—AMA Council on Medical Education Report

6-A-18, Mental Health Disclosures on Physician Licensing Applications was adopted in June during the AMA’s Annual House of Delegates Meeting. This report calls for reform in licensure applications to prevent the stigma physicians endure when they seek care for physical or mental health issues, partly due to concerns of career and licensure implications.

- **Collaboration with the American College of Physicians**—Dr. Earley was a reviewer of their pending policy on Physician Health and Well-Being.
- **The Addiction Policy Forum—Physician Health Program’s Recognition as a Spotlight Program.** The Addiction Policy Forum is helping shape the conversation and public policy regarding addiction and its treatment. You can read more about our member PHP model here, www.addictionpolicy.org/blog/physician-health-program-nationally-recognized-for-addressing-addiction-treatment; and here, www.addictionpolicy.org/hubfs/Spotlight_Physician%20Health%20Programs_version4.pdf.
- **Research**—The FSPHP Research committee is now under new leadership and is co-chaired by Dr. Lisa Merlo and Dr. Karen Miotto. This committee is meeting monthly with a robust agenda of moving three projects into development. Efforts to secure research partners are under way, along with the development of a new Physician Health Program study (named PROMPP). More to follow in the next issue!

4. FSPHP Funding: Develop revenue sources to support budget neutrality to ensure the financial sustainability of the FSPHP.

- **Membership Dues**—The FSPHP Finance Committee and Membership Committee have partnered to review FSPHP membership dues for 2019 and considerations for future years.
- **Fundraising**—The FSPHP Fund Development Committee, co-chaired by Kelly Long and Angela Graham, MPA, has been moving forward with successful fundraising initiatives for the FSPHP, guiding the launch of the second annual campaign and raising over \$20,000 in additional funding for FSPHP for the second year in a row! Please consider a donation: www.fspHP.org/donate.

Regional Meetings

Let me wrap up by thanking those involved in hosting the four successful 2018 regional membership meetings. The Western Region hosted their meeting in August by conference call, the Southeast Region meeting was hosted by the Florida PRN and GA PHP, the Central Region was hosted by the Indiana Physician Health Program and the Indiana State Medical Society, and the Northeast Region was hosted by Dr. Dan Perlin in

Toronto at the location of the International Conference on Physician Health. Valuable member engagement and PHP learning were strong at all our regional membership meetings. Dr. Earley and I were grateful to be among all our members at this year's regional meeting.

I look forward to the year ahead to partner with you to help coordinate the 2019 regional meetings. I am grateful to work with you and to be your executive director to help move the mission of supporting our member Physician Health Programs forward. ■

2018 FSPHP DONORS

Since our FSPHP inaugural fundraising campaign and silent auction, FSPHP raised \$22,840 in 2017 and just over \$26,000 so far in 2018.

FSPHP and our fund committee members would like to thank the numerous generous donors for their ongoing support. Board members, FSPHP members, and others invested in physician health have made contributions with a few matching PHP donations. We are proud of our FSPHP Board of Directors Members who have demonstrated 100 percent in giving. This growing support will further our strategic goals to develop a Performance Enhancement Review Program and a Treatment Center Review Program as well as increase member services and support, while furthering our research and education goals. To donate online, you may click here: www.fsphp.org/donate.

We would like to thank our donors who have contributed since our last FSPHP newsletter issue:

THANK YOU TO OUR 2018 DONORS

Leader of Healing (\$10,000–\$24,999)

Accreditation Council for Graduate Medical Education
American Medical Association
American Psychiatric Association
Federation of State Medical Boards

Ally of Hope (\$2,500–\$4,999)

Dr. and Mrs. P. Bradley Hall, MD, DABAM
Scott Hambleton, MD, DFASAM
Warren Pendergast, MD

Advocates (\$1,000–\$2,499)

Chris Bundy, MD, MPH
Dr. and Mrs. Paul H. Earley, MD, DFASAM
Cynthia Gordon, MD, JD
Tracy Zemansky, PhD
Washington Physicians Health Program

Caregivers (\$500–\$999)

Candace Backer, LCSW
Paul Cheng, MD
James Howell, MD, MPH
Greg Jones, MD
Daniel Perlin, MD
Ray Truex, MD
Penelope Ziegler, MD
Healthcare Professionals Foundation of LA
Kentucky Physician Health Program
Ohio Physicians Health Program
Affinity e-Health
Geisinger-Marworth
Recovery Trek
The Farley Center for Healing

Friends (\$1–\$499)

Dan Avery, MD, FACOG, FACS
Kathy Angres, APN, MS, RN
Michael Baron, MD
Kathleen Boyd, MSW, LICSW
Linda Bresnahan, MS
Wendy Cohen, MD
Sarah Early, PsyD
Mary Fahey
Dianne Gay
Angela Graham, MPA
Lynn Hanks, MD
John Jackson, MD
Victoria Jones
David Karney MD, MPH
Fran Langdon, MD
Robin McCown
Lisa Merlo, PhD, MPE
Michael Metcalf, MD
Jes Montgomery, MD
Gerald Perman, MD
Bari Platter, MS, RN
Michael Ramirez, MS
Kimberly Walsh
Michael Wilkerson, MD
Heather Wilson, MSW, CFRE, FCPP
Cecilia Zinnikas, LPC
The Foundation of the Pennsylvania Medical Society,
In Memory of Peter Mansky, MD

A SPECIAL THANK YOU TO OUR SILENT AUCTION DONORS AND WINNERS WHO EACH HAVE MADE A SIGNIFICANT CONTRIBUTION TO THE FSPHP.

Donors

Martha E. Brown, MD
Michael Baron MD

2018 FSPHP Donors

continued from page 7

Dr. and Mrs. Paul Earley
 Erica Frank, MD, MPH, and NextGenU.org
 Doris Gundersen, MD
 Dr. and Mrs. P. Bradley Hall, MD
 Scott Hambleton, MD
 Warren Pendergast, MD
 Acumen Assessment
 Arrowhead Lodge
 BoardPrep Recovery Center, John and Liz Harden
 CeDAR
 Pine Grove
 Positive Sobriety Institute & MCAP of Chicago
 Sierra Tucson
 Talbott Recovery

Winners

Kathy Angres, APN, MS, RN	James Howell, MD, MPH
Candace Backer, LCSW	Fran Langdon, MD
Paul Cheng, MD	Michael Metcalf, MD
Wendy Cohen, MD	Jes Montgomery, MD
Cynthia Gordon, MD, JD	Warren Pendergast, MD
Dr. and Mrs. P. Bradley Hall	Bari Platter, MS, RN
Scott Hambleton, MD,	Kimberly Walsh
DFASAM	Michael Wilkerson, MD
	Tracy Zemansky, PhD ■

STAY 3-D ON TV AND STAGE: MEDIA AND STORYTELLING TRAINING

JAN FOX



Jan Fox, Fox Talks LLC

Fox Talks LLC
 Inspiring BOLD Speaking
 (202) 302-1241
 jan@foxtalks.com



Jan Fox

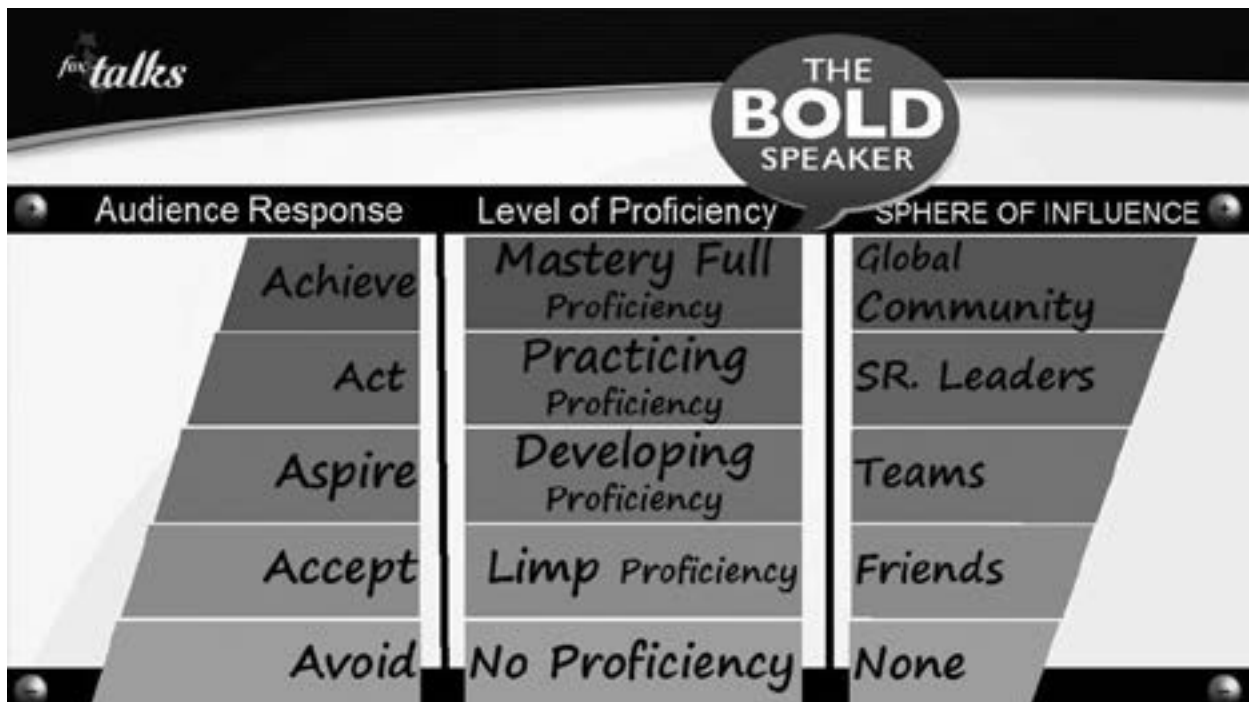
Hi! My name is Jan. Grateful member of Al-Anon for 18 years and grateful for 17 years of sobriety for my husband.

I highly value what you do, and I'm grateful for every life, career, and family you have saved. You are doing God's work.

You are in a difficult position with the media:

- If you say too little, you are distrusted. They accuse you of hiding something.
- If you say too much, they accuse you of covering up for doctors with problems.

If you do agree to speak, researchers say listeners make up their minds about you in 7 seconds. That's why so many people fear speaking in public or with the media.



You have studied your field. You have proof of performance of your work. You stand on solid research. You have every right to speak BOLDly about what you do.

The chart on page 8 shows that your level of speaking proficiency, in terms of simply your presentation skills, determines your audience response and the size of your sphere of influence.

You have to be accountable to regulators, the skeptical public, licensing boards, your teams, and your physician clients. Your level of believability for any of these audiences rests on your SPEAKability. Perhaps the place where BOLD speaking matters most is in soliciting donations to keep your lifesaving work going.

This means using your BOLD voice to tell your BOLD story to effect the BOLD change in the world you want to see.

The fastest way to spread your message is speaking in person, but add video and you increase your impact exponentially.

Try video in your email messages. Your open rate will increase 19 percent and your click rate will increase 65 percent. Using any kind of graphics or video along with the spoken word generates 67 percent higher retainability.

YouTube has 1.3 billion views a day! What can you post? Set up your own channel. Just start.

The problem is that you almost always hate your first video playback. When you see the camera light go on, you go wooden, stiff, afraid to move. You just lost your 3-D-ness. You are on a flat screen and the video takes the real edge off your voice. The worst part—it puts 10 to 15 pounds on you.

If you want to love your video and you want your audiences to believe it, you must think in 3-D. Think teleVISION. What can they see? What can you do, demo, make, move?

You often hear that you just have to “be authentic and show your passion.” For video, you have to take yourself to the furthest end of your fullest potential. The rule is: Use your biggest self, without losing the real you!

Barrel down that camera lens with your eyes and shoot a smile every chance you get. Researchers say, “Smiling makes you look smarter.”

If you get a “gotcha question,” never repeat it. Simply tell what you are doing moving forward.

Tell stories. Make them feel.

You’ve got this! ■

Jan Fox

USE OF CONTROLLED SUBSTANCES AS TREATMENT MODALITIES FOR PHYSICIANS BEING MONITORED BY PHPS

Scott Hambleton, MD, DFASAM;
and Laura Moss, MD



Scott Hambleton, MD,
DFASAM

Objectives for this presentation included identification of risks and benefits associated with utilization of controlled substances as therapeutic modalities for physician participants in PHPs and to formulate consensus by using audience response questions. The opinions expressed in this summary represent the views of the authors of the specific sections and do not represent the views of the FSPHP.



Laura Moss, MD

Opioids

Scott Hambleton, MD

This part of the presentation reviewed the magnitude of the opioid epidemic in the United States and assessed the potential risks and benefits of opioid therapy, for either acute or chronic pain, in actively practicing physicians with an underlying substance use disorder who were being monitored by a Physician Health Program. This presentation did not address the use of partial opioid agonists, such as buprenorphine.

An audience-response question was presented to attendees after the opioid section: “Is it appropriate for an actively practicing PHP participant with a substance use disorder to be prescribed opioids?”

- 6% of the audience responded “Yes”
- 39% of the audience responded “No”
- 55% of the audience responded “Maybe”

Summary

In the opinion of the author, although opioids are extremely beneficial for alleviating suffering associated with acute and chronic pain, their use has not been shown to be safe for actively practicing physicians with an underlying substance use disorder, while that physician is being monitored by a Physician Health Program.¹

continued on page 10

Use of Controlled Substances as Treatment Modalities for Physicians Being Monitored by PHPs

continued from page 9

Additionally, even in patients without a history of addiction, there is a lack of quality scientific evidence that opioid therapy for chronic, nonterminal pain is either safe or effective in producing or maintaining long-term analgesia or improved functionality.² The results of the question to the audience suggest that further examination of this therapeutic modality may be beneficial prior to consideration for utilization by actively practicing physicians with substance use disorders being monitored by PHPs.

References

¹Hegmann, K. T., Weiss, M. S., Bowden, K., et al. ACOEM practice guidelines: Opioids and safety-sensitive work. *JOEM*. 2014; 56(7).

²Centers for Disease Control and Prevention. *CDC Guidelines for Prescribing Opioids for Chronic Pain—United States 2016*. www.cdc.gov/drugoverdose/prescribing/resources.html.

Benzodiazepines

Laura Moss, MD

Benzodiazepines are utilized for management of anxiety or insomnia. Advocates for their use cite relative safety when used in non-substance-using populations, rapid onset of action, and tolerability as reasons to utilize these medications. Best practice guidelines recommend antidepressants as first-line treatment for anxiety and behavioral interventions as first-line treatment for insomnia. There is little data about the safety of benzodiazepine use in populations with substance use disorders. There is good data documenting abuse potential, increased injurious falls in the elderly, and cognitive impairment associated with benzodiazepine use.

Benzodiazepines are often co-prescribed with other psychoactive medications, which increases the risk of accidental overdose and death. Although the prevalence rates for benzodiazepine-use disorders are lower than the rates for alcohol- and opioid-use disorders, emergency room-generated Drug Abuse Warning Network (DAWN) data suggest increasing rates of nonmedicinal use of benzodiazepines associated with ER visits over time.

Audience response question: “Is it ever appropriate for an actively practicing PHP participant with a substance use disorder to be prescribed a benzodiazepine?”

- 3% of the audience responded “Yes”
- 83% of the audience responded “No”
- 14% of the audience responded “Maybe”

Summary

It appears that a majority of attendees are unable to advocate for use of benzodiazepines in working, monitored physicians with a substance use disorder due to risks associated with their use, the safety-sensitive nature of physician work, and the availability of effective, safe, alternative therapies.

References

1. Dupont, R. L. Should patients with substance use disorders be prescribed benzodiazepines? *No*. *J Addict Med*. Mar/Apr 2017; 11(2): 84–86.
2. Olsson, M. et al. Benzodiazepine use in the United States. *JAMA*, Feb 2015; 72(2): 136–142.
3. Park, T. W. Are benzodiazepines appropriate for patients with substance use disorders? *Yes*. *J Addict Med*. Mar/Apr 2017; 11(2): 87–89.
4. Weaver M. F. Prescription sedative misuse and abuse. *Yale J Biol Med*. Sep 2015; 88(3): 247–256.

Anabolic Androgenic Steroids (AAS)

Scott Hambleton, MD

This part of the presentation reviewed the potential risks and benefits of anabolic androgenic steroid (AAS) therapy in actively practicing physicians with an underlying substance use disorder who were being monitored by a PHP.

Testosterone is an anabolic androgenic steroid (AAS) classified as a Schedule III controlled substance. It is approved by the FDA for men with low testosterone levels caused by disorders of the testicles, pituitary gland, or brain that cause hypogonadism; for postmenopausal women with hypoactive sexual desire disorder; and for female-to-male transgender patients.¹ Best practice dictates that testosterone: should not be used by men attempting to initiate pregnancy; should not be used by men with erectile dysfunction who have normal testosterone levels; should not be used without lab confirmation of low total serum testosterone on at least two occasions; and should not be used without biochemical evidence of testosterone deficiency.² AAS abuse is associated with higher scores on measures of paranoia, schizoid, antisocial, borderline, histrionic, narcissistic, and passive-aggressive personality profiles.³ Patients with body dysmorphic disorder and/or muscle dysmorphia are at higher risk of AAS abuse.⁴

Audience response question: “Is it appropriate for an actively practicing PHP participant with a history of substance use disorder to be prescribed anabolic androgenic steroids?”

- 5% of the audience responded “Yes”
- 40% of the audience responded “No”
- 55% of the audience responded “Maybe”

Summary

There is a lack of data related to AAS use by actively practicing physicians with substance use disorders being monitored by PHPs. Five percent of the audience responded that it would be appropriate and 55 percent of the audience responded that it may be appropriate for a physician with a substance use disorder to utilize AAS therapy while being monitored by a PHP. In the opinion of the author, at minimum, the previously mentioned best practice guidelines should be utilized prior to initiating or maintaining AAS therapy in physicians with substance use disorders being monitored by PHPs. Considering the consequences of relapse to active addiction by a PHP participant, a sensitive and cautious approach is warranted for consideration of this therapeutic modality.

References

¹Petering, R. C., Brooks, N. A. Testosterone therapy: Review of clinical applications. *Am Fam Physician*. 2017 Oct 1; 96(7): 441–449.

²Ibid.

³Ries, R. K. *Principles of Addiction Medicine*, 5th ed. Chevy Chase, MD: American Society of Addiction Medicine; 2014.

⁴Pope, H. G., Khalsa, J. H., and Bhasin, S. Body Image Disorders and Abuse of Anabolic-Androgenic Steroids Among Men. *JAMA*. 2017; 317(1): 23–24. doi:10.1001/jama.2016.17441.

Amphetamines

Laura Moss, MD

Amphetamines are often used for treatment of attention deficit hyperactivity disorder (ADHD). ADHD is a neurodevelopmental disorder that typically presents in youth, resulting in difficulties in multiple arenas—home, school, and work. Multiple neuropsychiatric disorders mimic ADHD, including the use of and withdrawal from stimulants, and ADHD frequently co-occurs with other psychiatric disorders, including substance use disorders. ADHD is challenging to accurately diagnose because it requires data from multiple sources—a diagnostic interview, neurocognitive testing, and collateral reports. The diagnosis and frequency rates of late-onset ADHD, also called

adult-onset, are highly debated. In a study by Sibley et al., 95 percent of a cohort that previously received a diagnosis of late-onset ADHD were found to not have ADHD after additional evaluation. The most common confounding variables associated with misdiagnosis were substance abuse, cognitive problems, or presence of another mental health disorder. There are multiple nonstimulant medication and behavioral therapies that can be effective in treating ADHD. Use of rewarding, psychoactive medications can result in misuse or abuse. Predictors for abuse of controlled medications include any history of substance abuse/addiction (especially polysubstance), cocaine use, younger age, childhood sexual abuse, legal problems (especially alcohol- or drug-related offenses), lost or stolen prescriptions, and obtaining drugs from a nonmedical source. If a physician in monitoring has failed nonstimulant options and a stimulant is being considered, there are contingencies that can be put in place to reduce the risk of abuse or relapse to substance abuse.

Audience response question: “Is it ever appropriate for an actively practicing PHP participant with a substance use disorder to be prescribed a stimulant?”

- 9% of the audience responded “Yes”
- 55% of the audience responded “No”
- 36% of the audience responded “Maybe”

Summary

A majority (55%) of attendees were unable to advocate for use of stimulants in working, monitored physicians with a substance use disorder. Thirty-six percent of attendees thought there may be situations that would warrant use of stimulants. This author recommends that preliminary steps be completed before considering use of stimulants in monitored physicians. First, get a standard of care evaluation from a vetted provider to confirm the diagnosis. Second, consider nonstimulant interventions first. If nonstimulant interventions are unsuccessful, evaluate the risks for misuse or abuse of stimulants. Finally, place risk-reduction contingencies before starting amphetamines and monitor closely. ■

References

1. Faraone, S. V., and Wilens, T. Does stimulant treatment lead to substance use disorders? *J Clin Psychiatry*. 2003; 64(suppl 11): 9–13.
2. Mariani, J. J., and Levin, F. R. Treatment strategies for co-occurring ADHD and substance use disorders. *Am J Addict*. 2007; 16(suppl 1):45–56.
3. Sibley, M. H., et al. Late-onset ADHD reconsidered with comprehensive repeated assessments between ages 10 and 25. *Am J Psychiatry*. Feb 2018; 175(2):140–149.

IMPROVED NEUROCOGNITIVE FUNCTIONING AMONG HEALTHCARE PROFESSIONALS INITIATING RECOVERY FROM ADDICTION: BRADFORD HEALTH SERVICES

Joseph E. Schumacher, PhD;
Michael W. Wilkerson, MD,
FASAM; and Brad H. Sokal, PhD

Context

Clinical Addiction Psychological Evaluation (CAPE) is standard care for healthcare professionals at Bradford. The CAPE informs patient care and identifies trends to enhance services. This presentation focuses on changes in neurocognitive functioning after residential addiction treatment. It was hypothesized that improved neurocognitive functioning will be observed at treatment completion.

Methods

The CAPE measures functioning that is related to, caused by, or a consequence of addictive substance abuse. The *CNS Vital Signs* Computerized Neurocognitive Testing Core Battery (VSX) was used to measure 12 neurocognitive domains. From June 2014 to July 2016, 719 patients, including 547 healthcare professionals, were administered the VSX at treatment entry and, if neurocognitively impaired, again after one to three months of treatment. Impairment was defined as below average performance on ≥ 3 VSX domains. Residential treatment consisted of medical, psychiatric, addiction, mental health, and community services. A pre (treatment admission)—post (treatment completion) design using paired t-tests of continuous neurocognitive indices was utilized.



Joseph E. Schumacher,
PhD



Michael W.
Wilkerson, MD,
FASAM



Brad H. Sokal, PhD

Findings

Healthcare professionals (N=547) were Nurses (46%), Medical Doctors (22%), and Other Medical Professionals (32%). Half (52%) resided in Alabama and the rest in 28 other states. Average age was 41 and half were females. The most frequent Substance Use Disorders were for Alcohol (34%) and Opioids (26%) and 10% had no diagnosis. One-third (30%) screened positive for some psychopathology. Of the healthcare professionals, 191 (35%) were neurocognitively impaired at treatment entry and none remained impaired who were tested at treatment completion. The Neurocognitive Index and 10/12 neurocognitive domains (Composite Memory, Verbal Memory, Psychomotor Speed, Reaction Time, Complex Attention, Cognitive Flexibility, Processing Speed, Executive Function, Social Acuity, and Motor Speed) significantly improved ($p < 0.001$) over time. The percentage of patients with below average Neurocognitive Index scores at treatment entry dropped from 50% to 14% at treatment completion.

Conclusion

Adequate neurocognitive functioning is an essential criterion for return-to-work determination. A significant number of healthcare professionals were neurocognitively impaired at addiction treatment entry. The most common deficits were in Reaction Time (speed of responding), Cognitive Flexibility (ability to follow directions), and Executive Function (complex decision making) domains. Neurocognitive deficit etiology in this population is complex, but resilient, consisting of acute and chronic substance abuse, type of substance, withdrawal/detoxification, and co-occurring mental disorders. Neurocognitive functioning significantly improved in almost all patients and all domains as a function of initiating abstinence, residential addiction treatment, and mental health stabilization in a controlled therapeutic milieu. ■

FIVE BEST PRACTICES FOR BEHAVIORAL CASES FOR CLIENTS AND THE WORKPLACE

Joyce Davidson, LCSW, CPHP;
Amanda Brooks, LPC; and
Emily Haase, LPC

High-stress and low-tolerance work environments are reflective in the increase of mandated behavioral referrals at the Colorado Physician Health Program (CPHP). Inherently, these cases are complex with a mixture of anxiety and tension, creating fertile ground for misunderstandings, legal imbroglios, and ongoing conflict. CPHP's goal is to attend to the needs of the referral source and the referred and to improve patient safety, communication, and any behavioral or health problems of the practitioner.

To approach these cases, CPHP recommends taking a dual approach throughout the evaluation, intervention, and monitoring processes by incorporating these five best practices with the workplace and the referred client: Identifying Purpose, Clarifying Expectations, Communication, Support, and Education & Outreach (E&O).

- **Identifying Purpose:** There are often differing perspectives about the perceived workplace problem and severity. Understanding the purpose of the referral from the workplace's and client's perspectives can set the tone and direction of an evaluation, leading to higher or less intensive recommendations. Is there room for improvements to be made, or has it reached a zero tolerance with termination as the next steps?



Joyce Davidson,
LCSW, CPHP



Amanda Brooks, LPC



Emily Haase, LPC

- **Clarifying Expectations:** The expectations for workplace performance must be clearly delineated. The workplace must clearly outline the limits and behavioral expectations and have a forum to discuss these with the client and the PHP. Does the client understand the precariousness of their situation? Do all parties understand the role of the PHP in the case of a mandated behavioral referral?
- **Communication:** Communication (verbal and written) between the PHP and the workplace, workplace and the client, and the PHP and the client are paramount. Feedback within the workplace should be clear, concise, and timely. When necessary, bringing all parties to the table can be a useful approach. The PHP is charged with providing timely updates with regard to evaluation, intervention, and monitoring progress.
- **Support:** Workplaces want to address problem behaviors while preserving team staff and productivity. Physicians are often trying to navigate systems with saturated leaders and systemic challenges. Supports are available to help facilitate communication between parties. PHPs are poised to provide consultation/guidance to leaders looking for systemic improvements.
- **Education & Outreach (E&O):** Ongoing E&O with regard to effective referral processes, specific to local PHPs and services offered, will not only strengthen relationships within the medical community but also potentially increase referrals for those in need. We recommend PHPs check in regularly with primary referral sources to review services, such as E&O opportunities, in addition to assessing ongoing cases. Educating medical students and licensees in your state on PHP services and indicators for referrals (self or for peers) is a proactive way to address problem behavior. Being available for confidential consultations is also recommended.

With the manifestation of disruptive behavior as the face of underlying stress/burnout and untreated physical and mental health problems, we are likely to continue to see similar increases in behavioral referrals throughout PHPs. These five best practices, used congruently, with the referring party and the client, can help avoid some of the more common pitfalls of mandated behavioral cases. ■

IMPLEMENTING TOBACCO-FREE POLICIES IN RESIDENTIAL ADDICTION TREATMENT SETTINGS

Laura Martin, MD, FASAM, DFAPA; Jonathan C. Lee, MD, FASAM, FAPA, FACP; and Brian Coon, MA, LCAS, CCS, MAC

Tobacco use is the leading cause of preventable illness and death in the United States. More than 480,000 deaths in the United States are attributable each year to cigarette smoking. Smoking is more likely to kill patients in recovery than the substance use disorder responsible for their admission to treatment.¹ Ongoing tobacco use in physicians represents an independent risk factor for relapse to drugs and alcohol among monitored physicians.² Ongoing tobacco use in physicians returning to practice negatively impacts their performance regarding prevention of tobacco use in their patients.³

Despite the evidence, most residential-level substance use disorder treatment centers have allowed patients to continue to use tobacco onsite and have incorporated only limited treatment for nicotine dependence into their programs. Beliefs associated with the failure to implement tobacco-free policies have included fears that individuals with tobacco use disorders would lose access to viable treatment because they would refuse to abstain from tobacco. Also, administrators of treatment facilities are concerned that average daily census and completion rates could decline and affect the bottom line. In addition, there is an assumption that staff culture would not support tobacco-free policies.

Due to rising concerns about the number of patients and staff who were exposed to secondhand smoke, the number of patients who were beginning, resuming, or increasing their tobacco use during treatment, and the number of missed opportunities to treat tobacco use disorder, three residential addiction treatment centers implemented tobacco-free policies between 2013 and 2015.

This recent workshop presented methods used in making this organizational change, as well as data on how



Laura Martin, MD, FASAM, DFAPA



Jonathan C. Lee, MD, FASAM, FAPA, FACP



Brian Coon, MA, LCAS, CCS, MAC

implementation of tobacco-free policies had a positive effect on patient care and did not negatively impact admissions and census data. Moreover, tobacco-free policies did not reduce access to care for tobacco users. After implementing tobacco-free policies, outcome data from an inpatient substance abuse treatment center showed improved census, improved treatment, improved quit rates, reduced adverse effects, reduced triggering, and reduced exposure to secondhand smoke.⁴ ■

References

- ¹Hurt, R. D., Offord, K. P., Croghan, I. T., et al. Mortality following inpatient addictions treatment. Role of tobacco use in a community-based cohort. *JAMA*. 1996; 10;275(14): 1097–1103.
- ²Stuyt, E. B., Gundersen, D. C., Shore, J. H., et al. Tobacco Use by Physicians in a Physician Health Program, Implications for Treatment and Monitoring. *Am J Addict*. 2009; 18(2): 103–108.
- ³Frank, E. Physician Health and Patient Care. *JAMA*. 2004; 291(5): 637.
- ⁴Richey, R., Garver-Apgar, C., Martin, L. F., Morris, C., and Morris, C. Tobacco-free policy outcomes for an inpatient substance abuse treatment center. *Health Promotion Practice*. 2017; 18(4): 554–560.

FSPHP'S NEW PERFORMANCE ENHANCEMENT AND EFFECTIVENESS REVIEW (PEER™) AND SAFETY-SENSITIVE PROFESSIONAL PROVIDER ACCREDITATION (PA) PROGRAMS

JDM Rozsa, CAE, ACA; CEO of Metacred, Inc.



JDM Rozsa, CAE, ACA

Metacred is pleased to be partnering with FSPHP on these important initiatives. Over the past year of discussions with the FSPHP Board of Directors, I have learned that Physician Health Programs (PHPs) have been developed over the past 45 years by state medical societies, spurred by a 1958 Federation of State Medical Boards' (FSMB) call for a model PHP, PHP model legislation developed by the American Medical Association (AMA) (first published in 1974, updated in 2016), and a 1973 AMA policy paper acknowledging physician impairment. By 1980, nearly all medical societies in the United States had authorized or implemented PHPs.

The diversity of state law, national law, and other context—such as employer policies and the relationship between PHPs and licensing boards—has led to some necessary differences in PHP characteristics. The Federation of State Medical Boards (FSMB) 2011 Policy on Physician Impairment states that “. . . to gain the confidence of regulatory boards, PHPs must develop audits of their programs

that demonstrate an ongoing track record of ensuring safety to the public and reveal deficiencies if they occur." Great progress has been made. The FSPHP Guidelines were published in 2005 and are currently being updated to improve accountability, consistency, and excellence for all our member states and provinces. The FSPHP published a Performance Enhancement Review (PER) process in 2016 to assist PHPs with their own practical application of a review process. However, a few ill-considered, nonobjective PHP reviews and inconsistent or inaccurate feedback have led us to an opportunity to build a more uniform and objective approach to PHP review.

Through FSPHP's two new initiatives, the Performance Enhancement and Effectiveness Review (PEERTM) program and the safety-sensitive professional provider accreditation program, the umbrella organization of PHPs is striving to enhance the consistency of the review process for PHPs, make those reviews more accurate and valuable to the various PHP stakeholders. In addition, we will develop a reliable standard for the treatment centers and other providers to ensure they are qualified in the treatment of safety-sensitive professionals.

I am honored to assist FSPHP in the development of performance reviews for PHPs and the accreditation of treatment centers specializing in treating safety-sensitive professionals. The PEER™ and provider accreditation programs will increase the quality and uniformity of the PHP model, while at the same time respecting necessary variations in structure and function that are needed to comply with state laws, regulations, and other regional contexts. A review process that is carefully designed by experts in the field, with stakeholder input and utilizing a consensus-building methodology, will be more effective, objective, and valuable than ad hoc reviews, or those done by those less familiar with the PHP model.

For all of these reasons, having consistent evaluation processes will ultimately increase the return on investment of the PHPs and providers that use those FSPHP review tools to enhance their performance, accountability, and effectiveness.

The new FSPHP PEERTM program and provider accreditation program will be developed through a consensus process that harmonizes the best practices among the diverse practices that exist now. This development process will empower PHPs and providers specializing in the treatment of safety-sensitive professionals to share and learn from each other's expertise and experience. There will be opportunities for PHPs and providers to participate in the development of each program; if you are interested in participating, please email: ARC@FSPHP.ORG. ■

PHYSICIAN WELLNESS AND RESILIENCE

Mark L. Staz, MA; Arthur S. Hengerer, MD, FACS; and Humayun J. Chaudhry, DO, MS, MACP, MACOI

Disruptive physician behavior is a persistent issue for state medical boards. It has several manifestations and arises from many different underlying causes. At times, it can be simple for medical regulatory authorities to blame disruptive behavior entirely on the individual physician and assume that both the causes of and remedies for the behaviors are within the physician's control. However, a focus on physician wellness and burnout enables state medical boards to shift their perspective and look beyond those factors that are within the control of the individual physician, and instead look to system factors and external influences that are getting in the way of a healthy approach to the physician's work and life.

This shift in perspective has been central for the Federation of State Medical Boards (FSMB) as it has engaged in the study of physician wellness and burnout from a medical regulatory standpoint. The FSMB's initial steps in this area have involved looking inward at the regulatory processes of our member boards, with particular attention to licensing processes. The FSMB has gained an acute awareness about the ways in which particular questions on licensing applications can present barriers to treatment-seeking among physicians. In particular, recent studies have demonstrated that physicians are either reluctant to report previous treatment sought for mental health or substance use, or avoid this treatment altogether, for fear of negative impacts on their ability to obtain unrestricted licensure or of having their health history made public.^{1,2,3}

After careful consideration of these studies and listening to the suggestions of our partner organizations, the FSMB's Workgroup on Physician Wellness and Burnout made several recommendations for state medical



Mark L. Staz, MA



Arthur S. Hengerer, MD, FACS



Humayun J. Chaudhry, DO, MS, MACP, MACOI

continued on page 16

Physician Wellness and Resilience

continued from page 15

boards and others that attempt to remove barriers to treatment-seeking that arise as part of the licensing process.⁴ These recommendations, all of which were adopted by the FSMB's House of Delegates in April 2018, include focusing only on impairment that is meaningful in the context of the provision of care to patients, rather than on a history of illness or treatment that occurred in the distant past. Stigma-reduction strategies are also recommended, such as regular communication about the importance of self-care, treating physical and mental impairments similarly in licensing processes, and encouraging the availability of private, confidential, and accessible counseling services for physicians. Most important for the Physician Health Program community, the FSMB has recommended that physicians who are monitored by, and in good standing with, the recommendations of a PHP be permitted to apply for medical licensure or license renewal without having to disclose their diagnosis or treatment to the board.

This “safe haven non-reporting” option at the point of licensure or license renewal is emblematic of a nonpunitive approach to licensing, and it also means that state medical boards may need to consider alternate sources of information to help identify risk to patients. In addition to the “duty to report” that is fundamental to medical professionalism, PHPs provide other important sources of information about physician competence. These efforts will help build the FSMB's partnership with the FSPHP and aim to increase the trust that exists between our communities. It is our hope that the data collected through our collaboration will provide novel insights into important areas of our collective work. ■

References

¹Gold, K., et al. “Do US Medical Licensing Applications Treat Mental and Physical Illness Equivalently?” *Fam Med*. 2017; 49(6): 464–7.

²Dyrbye, L. N., et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10): 1486–1493.

³Gold, K., Andrew, L., et al. “I would never want to have a mental health diagnosis on my record”: A survey of female physicians on mental health diagnosis, treatment, and reporting. *Gen Hosp Psychiatry* 2016; 43: 51–57.

⁴Federation of State Medical Boards (2018) *Physician Wellness and Burnout: Report and Recommendations of the Workgroup on Physician Wellness and Burnout*.

A REVIEW OF THE LITERATURE ABOUT PHYSICIAN HEALTH PROGRAMS: WHAT WE HAVE LEARNED ABOUT TREATMENT OF ADDICTION IN PHYSICIANS

**Matthew Goldenberg, DO;
Karen Miotto, MD; and
Greg Skipper, MD**

Dr. Goldenberg, Dr. Miotto, and Dr. Skipper presented the findings of their review of the literature related to PHP outcome data. This is notably the first paper to review all the state-specific and national data related to physicians who have participated in Physician Health Programs. The paper is currently in the submission process. The findings include the following:

The prevalence rate of addiction among physicians is similar to the general population, with up to 12 percent of U.S.-based physicians developing substance abuse disorders (SUDs) during their lifetimes. To address this public health concern, Physician Health Programs (PHPs) have been created to facilitate the early identification, evaluation, treatment, and monitoring of physicians so that they can rehabilitate, return to work, and deliver safe patient care. Although a number of studies have published outcomes from PHPs, there has been no comprehensive review of this data. Our review of the literature related to PHP outcome studies found that physicians who participate in PHPs have more favorable outcomes than members of the general population who receive mainstream treatment. PHPs provide a combination of education, intervention, referral for evaluation and treatment, monitoring, and efficient relapse response protocols for physicians, all of which provide the structure needed to maintain sobriety and protect patient safety. Our findings indicate that PHPs are a reliable path toward ensuring physician rehabilitation and, thus, improved patient safety. However, prospective studies are needed for optimal concurrent monitoring of recovery and to refine performance improvement processes. ■



Matthew Goldenberg, DO



Karen Miotto, MD



Greg Skipper, MD

NEUROPSYCHOLOGICAL SCREENING FOR PHYSICIANS IN REMEDIATION

Philip Flanders, PhD;
Michael V. Williams, PhD;
Dillon Welindt, BS; and
Betsy White Williams, PhD, MPH

Introduction

There is a growing literature suggesting the value of neurocognitive screening in physicians with clinical competency issues. The contribution of such screening in physicians with behavioral compartment issues is not as accepted; however, there is a literature indicating that risk factors for poor interpersonal functioning, such as depression and burnout, are associated with poorer neuropsychological functioning. In previous works, we have examined underperformance in the context of a confluence of health domains, namely biological, psychological/psychiatric, and social functioning. The scope of this work is on neurocognitive performance as a sub-domain of biological functioning. The focus was to explore whether there were differences in neuropsychological test performance on a commonly used neuropsychological screening instrument, the MicroCog™, by referral question.

Methods

Two sets of published data on a computerized neurocognitive screening instrument (MicroCog™) for normative physician samples published data on physicians referred for clinical competency issues, and newly collected data on physicians with behavioral compartment (professionalism issues) were analyzed. A two-way analysis of variance Sample X Index and post-hoc paired comparisons were conducted.



Philip Flanders,
PhD



Michael V. Williams,
PhD



Dillon Welindt, BS



Betsy White
Williams, PhD, MPH

Results

The results indicated significant differences in performance, both between the normative and referred groups, and between the referred groups. The behavioral compartment group performed significantly better than the clinical competence group, but significantly poorer than the non-referred physicians. The behavioral compartment sample performed significantly worse relative to the normative physician sample on the Reasoning/Calculation, Reaction Time, and Information Processing Accuracy Indexes.

Discussion

These analyses are supportive of the potential utility of neurocognitive screening in the fitness-for-duty evaluation process. Screening appears to be relevant to both those referred for clinical competency issues and behavioral compartment. Poor neuropsychological performance can be reflective of a host of medical conditions and mental health issues, including substance use disorders, mood disorders, anxiety disorders, and general distress. Consideration of these factors is important, as at least in our sample of physicians, these issues are often seen in physicians referred secondary to issues of professionalism. These findings have potential implications for recommendations and follow-up. Based on the literature surrounding these issues, further study of the potential role of neurocognitive factors, and, by extension, issues of health and well-being in physicians referred for behavioral compartment issues, is warranted. ■

A FRAMEWORK FOR ASSESSING, TREATING, AND MONITORING RECOVERY FROM ADDICTION, PSYCHIATRIC ILLNESS, AND TRAUMA

Julio I. Rojas, PhD

Addiction, psychiatric illness, and trauma commonly co-occur, making diagnosis, treatment, and monitoring difficult. Dr. Rojas presented a Venn diagram heuristic he developed out of his clinical work (see page 18) that helps him to explain, in general, the relationship among addiction, psychiatric illness, trauma, and

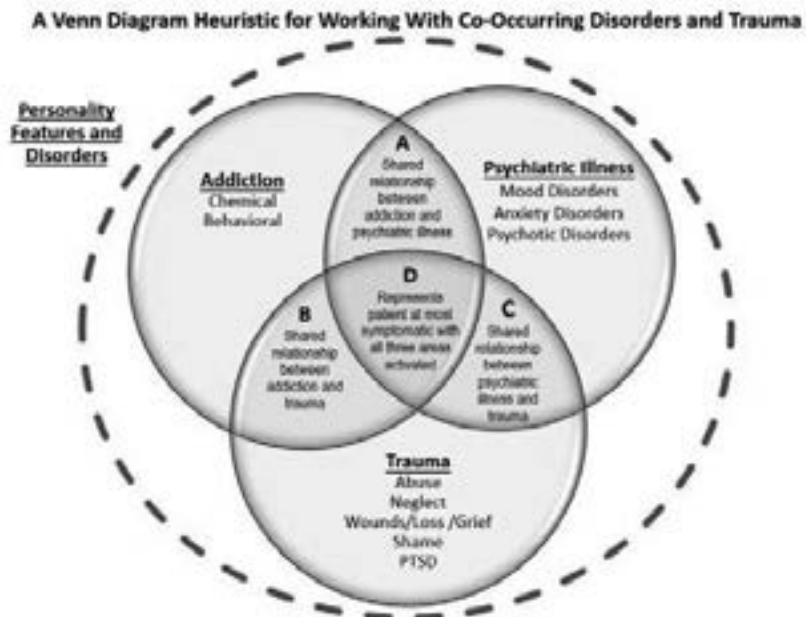


Julio I. Rojas, PhD

continued on page 18

A Framework for Assessing, Treating, and Monitoring Recovery from Addiction, Psychiatric Illness, and Trauma

continued from page 17



Julio I. Rojas, Ph.D., Copyright, The Board of Regents of the University of Oklahoma 2012, All Rights Reserved.

personality features/defenses. Dr. Rojas is also able to use psychological testing to uncover the extent to which addiction, mental illness, trauma, and personality symptoms manifest and to what degree within a particular individual or group of patients. Using this information allows him to make recommendations to patients, families, or stakeholders (e.g., hospitals, licensure boards, treatment centers) that are individualized, integrated, and intentional. Dr. Rojas noted in his presentation that psychological testing is usually emphasized in the diagnostic phase of treatment, but it is as important at discharge to determine the level of recovery from co-occurring disorders and trauma. He encouraged PHPs to insist upon discharge metrics, similar to the ones used to justify extended treatment. He noted, regrettably, that many patients leave treatment feeling better, but they are not always better when examined with repeat psychological testing. Post-testing is an invaluable way to objectively reinforce the patient's progress, identify ongoing clinical needs, or allow for continued monitoring and follow-up. Having a clinical framework to guide assessment, treatment, and monitoring, along with clinical metrics (psychological testing) is both necessary and possible. He encouraged PHPs to utilize this framework (or another) as a cheat sheet for tracking providers in monitoring programs in terms of sobriety, mental illness remission, trauma symptoms, and enduring personality features that pose a challenge in recovery. ■

ANSWERING THE CALL: PHYSICIAN HEALTH PROGRAMS AND SELF-REFERRED CLIENTS

Wendy L. Cohen, MD; and
Steven A. Adelman, MD,
Physician Health Services,
Waltham, Massachusetts



Wendy L. Cohen, MD



Steven A. Adelman,
MD

Self-referred clients (SRCs) to a Physician Health Program (PHP) are often in distress related to problems with mental health, substance use disorders (SUDs), or disruptive behavior. The aim of this pilot study is to explore how different state PHPs respond to SRCs, and to present the outcomes of SRCs at Physician Health Services (PHS) in 2017. A retrospective database and chart review of SRCs presenting to PHS in 2017 was conducted, and a six-question poll was administered to various PHPs. Case review identified health conditions, and recommendations made, including monitoring contracts offered. The poll inquired about: (1) PHP practices

for screening SRCs, (2) whether in-person intakes are offered, (3) resources recommended by phone, (4, 5) reporting requirements before and after intakes, and (6) whether in-person assessment for SRCs is within the scope for their PHP.

In 2017, most SRCs came to PHS for support around untreated or undertreated psychiatric problems (71%) and many had SUDs (17%) or a combination of both (15%), while 12 percent came in for disruptive behavior. The increased attention to physician burnout may be fueling an influx of SRCs to PHPs. Once seen for intake, the heterogeneity of “burnout” became apparent, as depression, anxiety, grief, addiction, and other conditions co-occur with burnout. Rampant occupational stress, time bankruptcy, and poor self-care may fan the flames of burnout and exacerbate health conditions interfering with physician wellness.

It is notable that 32 percent of SRCs were found to have problematic drinking, providing PHS with the opportunity to educate many physicians about treatment and recovery support before they face discipline. Many SRCs were offered names of psychiatric treaters or coaches with whom they voluntarily pursued treatment or coaching. Of the eight SRCs seen for an intake who were offered monitoring contracts, 50 percent signed within one year. This suggests that SRCs may present with severe conditions in need of treatment, and their readiness to engage with monitoring is noteworthy in this small pilot study. Waiting for physicians to face discipline or to be mandated to present to a PHP could be detrimental to their career and patient safety. PHPs have an important role in supporting physician health and safety. SRCs are a unique population who may be more responsive to supportive intervention than previously assumed. It may be time for PHPs to champion a culture of better physician self-care by accommodating self-referred physicians.

Most of the twenty-three PHPs that responded to our survey do offer intakes and assess SRCs, and most (78%) feel this is within the scope of their program. While most (65%) have no reporting requirements to regulatory bodies prior to SRCs being seen, the majority (57%) do/may have reporting mandates if they detect impairment. Practices and mandates vary state to state, but it appears that many PHPs see the assessment of SRCs as a valuable practice. Developing evidence-based practices for evaluation of SRCs may help PHPs continue to optimize the experience of SRCs.

This retrospective study suggests that assessing SRCs is an effective way of engaging at-risk physicians. Directions for future exploration include examining long-

term outcomes of SRCs and establishing data-driven best practices for PHPs. When PHPs accommodate SRCs for early engagement, it may improve the health of the physician population. ■

USING A RECOVERY-ORIENTED LENS WHEN EVALUATING SERIOUS PSYCHIATRIC DISORDERS IN HEALTHCARE PROFESSIONALS

Wm. J. Heran, PhD, LCSW; and
David Steinman, MD

Many in the psychiatric community have moved toward a recovery-oriented approach to psychiatric care.

The recovery-oriented approach offers a new ideology about the way that mental illness is understood and managed and a new way of thinking about how people with mental illnesses are understood and helped.

Our belief is that that recovery orientation can be integrated into a typical PHP evaluation and that the principles of recovery orientation can enrich and improve the outcome of the evaluation.

The recovery-oriented evaluation will have several important characteristics:

- Person-centered approach
- Strengths-based, including taking a strengths-based history
- Support network inclusion (e.g., family, significant others, colleagues, subordinates, superiors, etc.)
- Explore person’s beliefs, values, cultures, goals
- Review history of recovery attempts
- Positive spiritual experiences (individual and communal)
- Explore adaptive, supportive coping skills
- Education during evaluation on mindfulness strategies, psychotherapy, stress reduction, and so forth
- Keep evaluatee informed of impressions up to and including at the time of submission



Wm. J. Heran, PhD,
LCSW



David Steinman, MD

continued on page 20

Using a Recovery-Oriented Lens When Evaluating Serious Psychiatric Disorders in Healthcare Professionals

continued from page 19

In the exploration of the beliefs, values, and cultures of the individual, one will often identify internalized stigma and the influence of the medical culture's stigmatization of substance use and mental illness as problems in encouraging effective treatment:

- Keep aware of the medical profession's attributive stigma toward its own with mental illness and substance abuse.
- Despite substance abuse, depression, anxiety, burnout, sleep deprivation, and suicide being major problems in the United States physician population, physicians tend not to seek help independently. (AOA Task Force on Physician Wellness, 2017)
- Challenge self-judgmental, punitive thoughts about stress and its consequences.
- Avoid stereotyping: "Alcoholics are deadbeats or bums." "Drug addicts are losers."
- Educate on the disease model of addiction and mental illness.
- Advocate for more recovery-friendly workplace and home environments.

Structural competence, or the understanding of the nature of the physician culture, is also critical:

- Recovery-oriented care must take into account the values of the participant.
- Physicians often absorb and identify with the medical subculture.
- Values associated with the medical subculture sometimes conflict with the attitudes around help-seeking behavior and getting one's own medical care.
- When explored, sometimes a skilled evaluator can offer care that pays respect to and is consistent with values of the medical culture.

Finally, attention to positive psychology is critical:

- Positive emotions: contentment with the past, happiness in the present, and hope for the future
- Positive individual traits: the study of strengths, such as the capacity for love and work, courage, compassion, resilience, creativity, curiosity, integrity, self-knowledge, moderation, self-control, and wisdom
- Positive institutions: the study of the strengths that foster better communities, such as justice, responsibility, civility, parenting, nurturance, work ethic, leadership, teamwork, purpose, and tolerance

In conclusion, attention to the essential principles of recovery-oriented care can be integrated into the traditional PHP evaluation to help modernize the evaluation and improve its effectiveness. ■

References

1. Ahmedani, B. (2011). Mental health stigma: Society, individuals and profession. *J Soc Work Values Ethics* 8(2): 4.1–4.16.
2. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Touchstone Books.
3. Hill, A. B. (2017). Breaking the stigma: A physician's perspective on self-care and recovery. *N Engl J Med*, 376: 1103–1105.
4. Kelly, J. and White, W. (Eds.) (2010). *Addiction recovery management: Theory, science and practice*. New York: Springer Science.
5. Seligman, M. (2012). *Flourish*. NY: Atria Books.
6. Sotile, Wayne M., and Sotile, Mary O. (2002). *The Resilient Physician: Effective Emotional Management for Doctors and Their Medical Organization*.

TREATMENT READINESS IN PHYSICIAN ASSISTANTS IN A STATE MONITORING PROGRAM FOR SUBSTANCE ABUSE DISORDERS

Corey Richardson, DHSc, MBA

There has been inadequate peer-reviewed SUDs research on the rapidly growing PA profession. Dr. Corey Richardson presented his research on physician assistants (PAs) in a state Physician Health Program.

The purpose of his primary research study was to examine treatment readiness of North Carolina PAs with substance use disorders (SUDs) in a state monitoring program. Current and previously enrolled North Carolina Physicians Health Program PA participants received an invitation email to complete an anonymous questionnaire, the Circumstances (C1 and C2), Motivation (M), and Readiness (R) (CMR) survey tool. The CMR subscale and total scores were calculated using descriptive statistics. Elevated treatment readiness scores were found.

The elevated treatment readiness scores in current and previously enrolled PA participants predict longer periods of treatment program retention and are associated with improved treatment outcomes. While more research is needed to determine differences in treatment readiness due to varying demographic characteristics and to better describe the target population, these findings do challenge other study findings that suggested PAs have poorer treatment outcomes. ■



**Corey Richardson,
DHSc, MBA**

INTERPRETING ALCOHOL BIOMARKER VALUES—CAUTIONS AND CAVEATS

M. Katherine Jung, PhD

Objective measures for the quantification of alcohol consumption would be valuable in the following contexts: screening for problematic drinking and alcohol-related tissue damage (particularly in the earlier stages of development), for evaluating alcohol treatment progress and outcome, for enhancing individual safety, for monitoring maternal alcohol exposure during pregnancy, and for enhancing public safety in public transportation, medical settings, and the workplace.



M. Katherine Jung, PhD

The most commonly, but not exclusively, used alcohol biomarkers are blood-borne. Traditionally used alcohol biomarkers included gamma glutamyl transferase (GGT), aspartate amino transferase (AST)/alanine amino transferase (ALT), carbohydrate deficient transferrin (CDT), and mean corpuscular volume (MCV). These traditional biomarkers are notoriously nonspecific, as they may reflect liver damage or other pathologies unrelated to alcohol consumption.

A newer generation of alcohol biomarkers, consisting of direct products of ethanol metabolism, have much greater (although not infallible) specificity for alcohol. Ethyl sulfate (EtS) and ethyl glucuronide (EtG) are detected in urine, hair, or fingernails, and can detect the consumption of one or two drinks up to 24 to 48 hours later in the urine. When assessed in hair or fingernails, EtG can provide evidence of excessive alcohol consumption up to six months. However, EtG and EtS also fall prey to physiologically related false positives and false negatives.

Probably the most promising alcohol biomarker is phosphatidylethanol (PEth), with high specificity and high sensitivity. Despite concerted effort by many labs around the world, precise validation of PEth values has proven elusive. PEth values provide qualitative, but not strictly quantitative, information about how much alcohol has been consumed and the timing of the consumption. For example, within a single individual subject, a specific ng/ml PEth value might result from heavy drinking two to three weeks ago,

moderate drinking one to two days ago, or residual PEth from even longer ago. Furthermore, all of the ethanol metabolite biomarkers (Et, EtS, PEth) are subject to variability among individual subjects with respect to the correlation between the amount of alcohol consumed and the observed biomarker value.

With the caveat that the ultimate alcohol biomarker has not yet been discovered, when PEth and other alcohol biomarker values are interpreted cautiously, with full knowledge of their strengths and limitations, alcohol biomarkers can be used effectively to aid in monitoring alcohol consumption or abstinence, with the ultimate goal of supporting the well-being of the physician. ■

DISCUSSION OF LONG-TERM ALCOHOL BIOMARKER RESULTS: REVIEW OF THE MOST RECENT LITERATURE AND CASE REPORTS

Joseph T. Jones, PhD, NRCC-TC

Alcohol abuse is a leading public health concern in the general public as well as in healthcare professionals. Over the past decade, rapid advances in technology have provided substance abuse professionals new and useful tools for monitoring program participants for alcohol use and abuse. Two of the new tools are the detection of phosphatidylethanol (PEth) in blood and dried blood spots (DBS) and the detection of ethyl glucuronide (EtG) in hair and fingernails. The primary focus of this presentation was to review the most recent PEth and EtG hair/nail peer-reviewed literature and relate those findings to those who use these results in clinical practice.



Joseph T. Jones, PhD, NRCC-TC

PEth is a group of abnormal phospholipids that are formed only in the presence of ethanol and once formed are incorporated in cell phospholipid membranes where they may persist for several days to weeks. Recent studies have determined that PEth may be accurately analyzed in DBS, and PEth concentrations originating from both venipuncture and finger-stick blood are comparable (Javors, Hill-Kapturszak, Roache, Dougherty, Cates, & Karns, 2015).

Several years ago, Stewart and colleagues (2009) demonstrated that low (<1 drink/day), moderate (1–3 drinks/day), and high (>3 drinks/day) levels

continued on page 22

Discussion of Long-Term Alcohol Biomarker Results: Review of the Most Recent Literature and Case Reports

continued from page 21

resulted in statistically different PEth observations (Kruskal-Wallis; $P < 0.001$). More recently, Schrock et al. (2017) showed that PEth concentrations were associated to assigned categories (abstinent, moderate, and excessive) using the self-reported Alcohol Use Disorder Identification Test (condensed; AUDIT-C). However, a review of a recent publication that proposed a mathematical model for predicting formation and elimination of PEth using the Michaelis-Menten equation predicted results that were not consistent with the experience of the attendees (Simon, 2018). Lastly, a large study of PEth concentrations observed in women (an under-represented demographic in the current PEth literature) was reviewed (Moore et al., 2018). This study of heavy-drinking incarcerated women showed that qualitatively, the detection of PEth was statically significant when controlling for days of self-reported abstinence (OR: 0.96; 95% CI: 0.91, 0.99) and self-reported average drinks per day (OR: 1.08; 95% CI: 1.03, 1.16). However, the observed concentration of PEth was only predicted by controlling for the number of self-reported days of abstinence ($\exp(b)$: 0.97; 95% CI: 0.93, 0.99).

EtG is another long-term direct alcohol biomarker that is incorporated into hair, where once formed may persist for many months. A very recent case report evaluated the distribution of EtG and caffeine concentration for 104 collection sites (2cm x 2cm) across the scalp of a single donor (Meier, Briellmann, Scheurer, & Dussy, 2017). The mean concentration of EtG at the vertex posterior was 13.6 pg/mg \pm 2.24 pg/mg with results ranging from 6.8 pg/mg up to 20.2 pg/mg. A review of a heat map of concentrations revealed that the concentrations were highest over the left ear of the donor, with the lowest concentrations at the nape of the neck. Caffeine concentrations were similarly varied; however, highest concentrations revealed by the heat map were observed at the forehead. The authors proposed that EtG concentrations were influenced by the most prevalent sleeping position of the donor and that the caffeine distribution was mostly influenced by contact with the hand. These observations reinforce the common practice of avoiding the temptation of trying to backtrack to determine time, dosage, or frequency when interpreting hair drug-testing results. ■

References

1. Javors, Hill-Kapturszak, Roache, Dougherty, Cates, and Karns, (2015). *Phosphatidylethanol: Biomarker of Ethanol Consumption*, presented at the Research Society on Alcoholism 2015 Annual Conference. San Antonio, TX.
2. Meier, U., Briellmann, T., Scheurer, E., & Duggy, F. (2017). Distribution pattern of ethyl glucuronide and caffeine concentrations over the scalp of a single person in a forensic context, *Drug Testing and Analysis*, 9, 1594–1603.
3. Moore, K., Rivera, O., Anderson, B., Johnson, J., Hahn, J., Kurth, M., Reddy, M., Schonbrun, Y., & Stein, M. (2018). *Phosphatidylethanol Levels Among Incarcerated Women: The Influence of Pre-Incarceration Alcohol Consumption and Length of Abstinence*.
4. *Alcoholism: Clinical and Experimental Research*, 42(3): 500–507.
5. Schröck, A., Wurst, F. M., Thon, N., & Weinmann, W. (2017). Assessing phosphatidylethanol (PEth) levels reflecting different drinking habits in comparison to the alcohol use disorders identification test—C (AUDIT-C). *Drug and Alcohol Dependence*, 178, 80–86.
6. Simon, T. (2018). Providing Context for Phosphatidylethanol as a Biomarker of Alcohol Consumption with a Pharmacokinetic Model. *Regulatory Toxicology and Pharmacology*, 94, 163–171.
7. Stewart, S. H., Reuben, A., Brzezinski, W. A., Koch, D. G., Basile, J., Randall, P. K., & Miller, P. M. (2009). Preliminary evaluation of phosphatidylethanol and alcohol consumption in patients with liver disease and hypertension. *Alcohol & Alcoholism*, 44(5): 464–467.

PROFESSIONAL DEVELOPMENT UTILIZING MOTIVATIONAL INTERVIEWING TO IMPROVE OUTCOMES AND REDUCE BURNOUT

Lisa J. Merlo, PhD, MPE; Chad Brazle, MA;
and Alexis Polles, MD



Lisa J. Merlo,
PhD, MPE



Chad Brazle, MA



Alexis Polles, MD

Professional Health Program (PHP) staff face a variety of challenges. They may feel pulled in two directions as they balance protecting the public and advocating for professionals with potentially impairing conditions. In addition, they may face high caseloads, feeling unable

to meet individual participants' needs, participants' preexisting negative beliefs toward PHPs, communicating unpleasant news, and dealing with lawyers, referents, and administrators. Anecdotal evidence suggests that PHP participants are more likely to be successful and satisfied with their participation if they have a cooperative, not adversarial, relationship with the PHP staff. PHP staff are also less likely to burn out if they have positive interactions with participants. However, currently no "best practices" exist regarding ways to address the challenges of working with this unique population.

Motivational interviewing (MI) is a method of interaction that has been used successfully across a multitude of settings to assist individuals in making behavior change. It is a collaborative process of guiding individuals toward healthy behavior change by eliciting and strengthening their personal motivation. Of note, MI has been successfully applied in contexts ranging from healthcare settings to probation offices. Use of MI has been associated with improved adherence, decreased resistance, better engagement, decreased provider burnout, and improved satisfaction with care.

We provided introductory MI training for PHP staff members to increase their ability to work collaboratively with participants, administration, and other staff. Pre- and post-training surveys were administered to assess the PHP staff members' level of comfort, confidence, and satisfaction related to their interactions with participants, PHP administrators, and other staff. Overall satisfaction with the training was high, with participants reporting that they found it helpful and immediately applicable to their work. The staff self-reported improvements in their comfort, efficiency, and effectiveness working with PHP participants. Further, the medical director rated PHP staff as more efficient and effective in their work following completion of the training.

Results of this intervention suggest that even brief training in motivational interviewing may be beneficial to PHP staff, improving their ability to work efficiently and effectively and improving their confidence in their performance. Ongoing/refresher training may help to ensure that training effects are sustained. Other PHPs may also benefit from providing training in MI to their staff. ■

HEALTH-RELATED QUALITY OF LIFE AMONG PHYSICIANS, RESIDENTS/ MEDICAL STUDENTS, AND PHYSICIAN ASSISTANTS ENTERING A PEER-ASSISTANCE PROGRAM

Elizabeth Brooks, PhD;
Sarah R. Early, PsyD; and
Michael H. Gendel, MD



Elizabeth Brooks, PhD

Presentation Abstract

Introduction

Providers, like everyone, struggle with any number of medical or psychological issues that can impact their well-being. Health-related quality of life (HRQoL) is a multifaceted concept that refers to the ways in which health problems can impact one's physical, mental, emotional, and social functioning. Systematic examinations of HRQoL allow organizations to understand differences between groups and, ultimately, strengthen service planning. The purpose of this presentation was to describe how provider type and presenting problem impact HRQoL among clients entering a peer-assistance program.



Sarah R. Early, PsyD

Methods

A group of 2,021 providers at a single Physician Health Program completed the Medical Outcomes Study Short Form 36 (SF-36) as a routine part of the intake process. SF-36 scores were derived by calculating standardized composite scores for physical (PCS) and mental health functioning (MCS). The average score across eight domains was used to understand poorer areas of functioning. We examined the association between (1) provider type (i.e., physicians, physician assistants, medical residents, medical students) and HRQoL scores and (2) primary presenting problem (i.e., stress, behavioral, substance use, physical/medical, general psychiatric) and HRQoL scores.



Michael H. Gendel,
MD

Results

Regardless of provider type, PCS scores were higher than the standardized U.S. population norm of 50.

continued on page 24

Health-Related Quality of Life Among Physicians, Residents/Medical Students, and Physician Assistants Entering a Peer-Assistance Program

continued from page 23

On the contrary, MCS scores fell below the U.S. norm (physicians = 38.4, physician assistants = 37.7, residents = 31.4, medical students = 26.0). MCS scores for residents and medical students were significantly lower than physicians ($p < .001$). Vitality scores ranked lowest of the eight domains across provider type. Clients who presented primarily for stress had significantly lower MCS scores than those with predominately behavioral, substance use, or physical/medical problems but not general psychiatric conditions (stress = 32.9, behavioral = 46.9, substance use = 44.3, physical/medical = 44.8, general psychiatric = 23.8; $p < .001$).

Discussion

Low MCS scores among all providers, and particularly for those with stress, present several clinical considerations for Physician Health Programs. It is important to provide a comprehensive evaluation, including a suicide screener, even in cases where the provider presents for “just stress.” We encourage organizations to talk to *all* clients about the basics of self-care and encourage interventions that target factors such as sleep, time out, exercise, support, and coping. Workplace coaching should consider underscoring the value of scheduling adjustments (e.g., time off, part-time hours, medical leave) as this may help improve providers’ HRQoL. ■

THE BALANCING ACT: CONFIDENTIALITY AND PUBLIC SAFETY WITH PROFESSIONAL SEXUAL MISCONDUCT

Leah Claire Bennett, PhD; and
Scott Hambleton, MD, DFASAM



Leah Claire Bennett,
PhD



Scott Hambleton,
MD, DFASAM

The information provided in this summary is the viewpoint of the authors and does not represent the views of the Federation of State Physician Health Programs,

the Federation of State Medical Boards, or any regulatory agency.

For the purposes of this presentation, professional sexual misconduct refers to doctor–patient sex, particularly in cases in which a doctor–patient relationship preceded the sexual contact.

Whether you work as part of a Physician Health Program (PHP) or Regulatory Agency (RA), there is a balancing act for effectively and appropriately utilizing information. In the case of regulatory agencies, this ensures public safety, and in the case of PHPs, this ensures the physician’s health and well-being. This balancing act is often further complicated when PHPs work with physicians who have engaged in professional sexual misconduct because patient harm occurs in every one of these cases. Additionally, in cases in which physicians return to practice after engaging in professional sexual misconduct, any relapse will result in additional patient harm.

A key point that differentiates professional sexual misconduct cases from cases of physicians with substance use disorders is that physicians who are monitored by PHPs for substance use disorders rarely engage in behaviors that result in direct patient harm. Multiple studies have demonstrated that documented patient harm rarely, if ever, occurs by physicians being monitored by PHPs for substance use disorders, because of the effectiveness of PHPs in managing addictive disorders and expeditiously detecting and managing real or potential relapse to substance use.

When PHPs are authorized to provide “safe-haven” as an alternative to discipline, the effectiveness of PHPs in managing these cases is further accentuated by incentivizing early treatment. In one longitudinal study of 904 physicians being monitored over a 7.2-year period, only one case of patient harm was documented, and this was a result of improper prescribing. Therefore, PHP involvement in cases of physicians with substance use disorders unequivocally enhances public safety.

Recent negative publicity related to physician sexual misconduct has alleged that some medical boards have attempted to conceal information from the public in order to protect doctors who have engaged in these behaviors. Additionally, PHPs who assist with monitoring physicians who have engaged in these behaviors may be exposed to additional risk that could negatively affect the cohort of physicians being monitored for substance use disorders.

One option for PHPs would be to completely withdraw from cases involving physician sexual misconduct and let regulatory agencies fully manage them. However, PHPs have extensive expertise on managing physicians with various illnesses or behavioral problems, and this expertise could be transferred to cases involving professional sexual misconduct, if used appropriately.

It is important to recognize that this does not mean that PHPs should serve as an alternative to discipline in a “diversion” or “safe haven” capacity for physicians who have engaged in these behaviors. In fact, discipline and/or evaluation, treatment, and monitoring are all separate processes, and it is often when these processes are merged that controversy ensues. In particular, the gathering of information and utilization of the information should be clearly understood by all parties, including the physician participant, in order to clarify responsibilities and minimize confusion. For example, when a regulatory agency orders a forensic evaluation for determination of restrictions and discipline, it is usually in response to an investigation resulting from a patient complaint. In this scenario, the expectation for delivery of information is clearly understood by the regulatory agency, the evaluating facility, and the physician. The situation is complicated in a scenario in which a physician voluntarily discloses a sexual boundary violation, for example, while in treatment for an alcohol use disorder. In the latter scenario, the expectations and duties of the evaluating facility for delivery of information to a PHP or regulatory agency are often not clear. In appropriate cases, when these processes are treated separately, and clearly defined, all parties may function more effectively, which can accentuate public safety while helping to ensure the recovery of the physician participant.

The presentation discussed the Washington State Department of Health Sanctions for Sexual Misconduct, which describes a progressive range of disciplinary measures that corresponded to the level of patient harm from the boundary violation. Less egregious boundary violations would result in sanctions ranging from monitoring for a period of years to licensure suspension.

Recommendations for more severe boundary violations, involving force or intimidation, could result in indefinite suspension of licensure or revocation, in addition to applicable criminal and civil repercussions.

Return-to-work recommendations for physicians with professional sexual misconduct should be specifically formulated for each licensee, based on their individual circumstances, by an evaluation and treatment team with extensive expertise in these behaviors. Confronting and effectively addressing the cognitive distortion associated with these behaviors while addressing underlying psychiatric illness or addictive behaviors is a central part of the treatment process, and it depends on an exceptionally competent staff. Effective return-to-work recommendations need to be very specific for each individual and have appropriate restrictions, if indicated. For some physicians, a safe return to work may not be appropriate, but for many it is possible.

Audience polls during the presentation highlighted the audience’s understanding that there are variable degrees of behaviors involving professional sexual misconduct, and thus a “cookie-cutter” approach to these cases will not work. Only 13 percent of respondents believed that PHPs should handle cases equally involving substance use disorders versus cases involving sexual misconduct. Only 5 percent of the audience felt that it would be appropriate for an OB/GYN to return to practice after egregious boundary violations, and 52 percent of the audience responded that PHPs should not function as a “safe haven” in cases of professional sexual misconduct.

In summary, expectations and responsibilities involving disclosure of information by evaluators, treaters, PHPs, and regulatory agencies need to be clearly defined and communicated whenever possible. In the opinion of the authors, PHPs should not function as a “safe haven” or as an alternative to discipline in cases involving physician sexual misconduct. However, PHP involvement in these cases may be effective in certain situations, provided that the PHP is appropriately staffed, and that responsibilities of the PHP are clearly delineated. Ultimately, success is achievable in these cases when there is a balance of information sharing, accountability, and support. ■

REMARKS BEFORE THE OPENING GENERAL SESSION OF THE 2018 FSPHP ANNUAL MEETING IN CHARLOTTE, NORTH CAROLINA

Michael Ramirez, Clinical Director, Montana Professional Assistance Program, Inc.



Michael Ramirez

A wise man sitting in the audience today once told me that the real, unstated number-one job of every medical board, and by extension every Physician Health Program, is to never do anything that will embarrass the governor. I have endeavored to heed that sage advice.

In Montana we have assembled a board of directors that provides governance to the organization. We have endeavored to provide representation of stakeholder interests. We have a certified public accountant who serves as a member of the MPAP board to help steer the course with respect to our fiscal house. We have a family member who is also a registered nurse and gives us the perspective of loved ones of our participants. We have a hospital pharmacist. We have several past participants, physicians and dentists, who are in mature recovery. We have a major malpractice carrier as a representative on our board of directors. We have a retired judge who also is a state senator on our board. We have an attorney who works with a large medical malpractice firm who also serves. What we have endeavored to do is to remain responsive to the constituencies served and to adapt as we grow.

It seems that every challenge that we have faced—once we have gotten past the challenge—in looking back retrospectively, I can see that we have grown in understanding and usefulness. This has actually helped to strengthen the program and improve our ability to serve. At the time, you know, it was terrifying.

One of our values is that we have leadership with the Federation Board of Directors, with Brad Hall, MD, as President, and with all of the various workgroups that are proactively helping us to address all of our concerns before major problems occur. You can anticipate that we will lead from in front, rather than from behind.

So, we do have a formal relationship with the Board of Medical Examiners, Board of Dentistry that we expanded on July 1, 2017, and we now serve the Boards of Nursing and Pharmacy in the State of Montana. This has effectively tripled our caseload, expanded

our staff, and essentially broadened our umbrella to include other groups that I think have challenged us to expand our vision and our reach in lots of different unanticipated ways.

Developing resources within the state of Montana, which is something that we have historically lacked due to our small population density and large geography, has been a particular challenge. We are hoping to accomplish parity across the board for all populations served. Everyone gets the same amount of support, length of monitoring, and type of monitoring that we all do. Everyone gets a good evaluation to begin the process. Hopefully, we are in the process of identifying local resources that are affordable and accessible for nurses and pharmacists who can't always afford to go to one of the premier national centers of excellence that are within the grasp and reach of our physician participants.

In Montana, like with many other PHPs, we take on all conditions that left untreated might impair one's ability to practice with skill and safety. We do and will facilitate evaluation and, if necessary, treatment of practitioners who have committed professional sexual misconduct or have a process addiction or sexual compulsion not otherwise specified. That is not a politically popular position to take. Our experience has been very rewarding along those lines. I think that when we do that with the support of key stakeholders, what has happened is they trust our judgement, so we will never do anything to compromise that trust, within our ability and power to do so.

So, again back to my first remark, the number-one job is to never embarrass the governor. Total numbers for population penetration are good for physicians. It's abysmal for nurses. That just means that we have a lot of work to do.

Primary sources of funding. Proportionate contract payments based upon program participation by each of the contracted boards is a formula that we will revisit every biennium, so that we have equitable payment by all participating boards. We have a provision for donation contributions from benefactors. About 5 percent of our funding comes from that source. Another approximately 20 percent comes from participation fees. The remaining balance comes from participating licensure boards. When the program was created legislatively, the medical board, which took the lead in Montana, raised the license surcharge fee \$50.00 per licensee per year. A review of historical committee minutes from enabling legislation earmarked \$46.35 out of the \$50.00 per licensee per year. Now through the machinations of state government, those monies now disappear into the general fund and sort of magically reappear through some ethereal number from thin air. I won't say where. That formula has changed over the years. ■

CREATING A STATEWIDE CONSORTIUM TO COMBAT BURNOUT: A COOPERATIVE EFFORT OF THE NC PHP, BOARD OF MEDICINE AND MEDICAL SOCIETY

Joseph Jordan, PhD;
Thomas Mansfield, JD;
Clark Gaither, MD, FAAFP;
and Shawn Scott, MBA, CAE

Over the past few years, physician burnout has become such a pertinent issue that it brought together independent health organizations in North Carolina to address this growing problem. When Joe Jordan, PhD; Thomas Mansfield, JD; Clark Gaither, MD, FAAFP; and Shawn Scott, MBA, CEA, gave their presentation at the FSPHP annual conference, they represented three of many organizations in a statewide consortium collaborating to combat physician burnout. "As professional organizations supporting Physicians and Physician Assistants, the NC Medical Society, the NC Medical Board, and the NC Physicians Health Program could not stand by and watch burnout erode the medical community,"

Shawn Scott, Senior VP of Member Services and Business Operations at the NC Medical Society, spoke out about what motivated the creation of the NC Consortium for Physician Resilience and Retention (NCCPRR) "It's thanks to the strong relationships among our organizations that the NCCPRR is tackling this issue together, by aligning our resources, constituencies, and communications."

Physician burnout has serious implications for many different players in the healthcare industry. Physicians who aren't well can't take care of their patients to the best of their ability, and thus burnout has a negative effect on patient satisfaction. Other symptoms of burnout include



Joseph Jordan, PhD



Thomas Mansfield, JD



Clark Gaither, MD, FAAFP



Shawn Scott, MBA, CAE

absenteeism and inflated overhead costs to providers. Dr. Joe Jordan, Chief Executive Officer of the NCPHP, feels that the way to achieve maximum effectiveness to address these symptoms of burnout is to combine efforts with other concerned organizations. "Once I understood the dedication to physician health and wellness that Bob Seligson and Thom Mansfield," of the NC Medical Society and NC Medical Board, respectively, "have, it was clear to see that a collaboration of our organizations would be truly effective," said Dr. Jordan. When asked why burnout is a priority to the Medical Society, Scott replied, "Today, burnout and stress management are ranking at the top of the list of concerns of our members, across specialties and communities. We must help our members stay well so they can help their patients stay well." By devoting energy and resources to this cause, the NCCPRR aims to make practicing medicine a more sustainable and serviceable profession.

The NCCPRR addressed physician burnout on both an organizational and an individual level at their 2018 Physician Wellness Summit this October 17 and 18 in Raleigh, North Carolina. The NC PHP, Medical Board, and Medical Society collaborated to bring together decision makers and influencers of the North Carolina health industry to implement a positive change. Through educational efforts and an outlet for physicians to share their experiences with one another, the aim of the Summit was to provide leaders with the knowledge and tools necessary to improve physician well-being. Increases in productivity and patient satisfaction and thus decreases in costs to providers are the inevitable result of improved well-being. If you have any questions about the 2018 Summit, please contact Sarah Gothard, SGothard@ncmedsoc.org. ■

FSPHP WELCOMES THE FOLLOWING NEW MEMBERS!

These new members have joined FSPHP since the last issue in Spring 2018! Please join us in welcoming our new members.

FSPHP State/Voting Members

Christopher J. Hamilton, PhD

Monitoring Program Director
 Reliant Behavioral Health
 Delaware Voting Member

Lisa Lambert, MD

Medical Director
 Vermont Physician Health Program
 Montpelier, VT

FSPHP Welcomes the Following New Members!*continued from page 27***Ann Leiseth**

Interim Executive Director
North Dakota Professional Health Program
Bismarck, ND

Wendy Welch, MD

Medical Director
Virginia HPMP
Richmond, VA

FSPHP Associate Members**Jennifer Boren**

Oklahoma Health Professionals Program
Oklahoma City, OK

Katherine Grieco, DO

Medical Director
HAVEN
East Berlin, CT

Michelle Harden, Esq.

Colorado Physician Health Program
Denver, CO

Melissa Henke, MD

Medical Director
North Dakota Professional Health Program
Bismarck, ND

Arthur Hildreth, MD

Medical Director
Maryland Physician Health Program
Baltimore, MD

Mary Ann Lentz

Program Coordinator
Hawaii Professional Health Program
Honolulu, HI

Kirsten Mack, Executive Director

Kentucky Physicians Health Foundation
Louisville, KY

Angela Robinson

Compliance Manager
Oklahoma Health Professionals Program
Oklahoma City, OK

Donetta Wolfe

Monitoring Compliance Coordinator
Kentucky Physicians Health Foundation
Louisville, KY

Cecilia Zinnikas

Clinical Coordinator
Montana Professional Assistance Program
Billings, MT

International**Laurie Anne Bentley**

Clinical Case Manager
Alberta Medical Association
Calgary, AB

FSPHP MEMBER DANIEL PERLIN RECEIVES AWARD FROM THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

The Medical Society of the District of Columbia (MSDC) honored Dr. Daniel Perlin with the Dr. Charles Epps, III, Community Service Award at the 2018 Annual Meeting and Reception on Friday, October 19, 2018. Dr. Perlin was recognized for his outstanding public service to the community through his leadership of the MSDC Physician Health Committee and his outreach on the opioid crisis.

**Daniel I. Perlin, MD**

Dr. Perlin is a Past President of the Medical Society of the District of Columbia (2012–13) and joined the Board of Directors in 2010. He has a subspecialty in addiction medicine and has served as the Chair of MSDC's Physician Health Committee since 2012. He is currently a national leader serving his second two-year term on the FSPHP Board of Directors as the Northeast Regional Director.

Dr. Perlin is an anesthesiologist at MedStar Washington Hospital Center, where he serves as Clinical Director of the third-floor operating room and previously served as Director of Obstetric Anesthesia. He is a graduate of Thomas Jefferson Medical College and did his internship in internal medicine and residency in anesthesiology at Georgetown University Hospital. ■



FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS SAVE THE DATE

Wednesday, April 24 to Saturday, April 27, 2019

FSPHP ANNUAL EDUCATION CONFERENCE AND BUSINESS MEETING

Perplexing Problems and Effective Solutions for Treating and Monitoring Healthcare Professionals

Highlights

- Networking opportunities with leaders in the field of professional health and well-being
- Large exhibitor space with all breaks, breakfast, and food service with attendees
- Interactive general and breakout sessions each day to highlight the essentials of Physician Health Programs
- Emphasis on Panel Presentations
- Daily Peer Support Groups
- Poster Session Reception

Topic Areas

- Comparison of case management strategies among PHPs for different complex or relapsing participant situations
- Physician Suicide. Safe Haven and Diversion as an alternative to disclosure and as a therapeutic alternative to discipline
- Best practices regarding anonymity and confidentiality such as privacy protection for participants, PHP records, and Third-Party Information, 42 CFR Part 2, and Peer Review
- Comparison of Professional Health Programs such as nurses, lawyers, pilots, and physicians
- Toxicology Testing Practices for Healthcare Professionals
- Participant Experience: How best to evaluate and improve participant's experience
- Strategies for funding, operational performance, and to improve professional fulfillment in physician health work



200 Main Street
Fort Worth, TX 76102
(817) 870-1000 / Marriott Reservations Line at (800) 433-5677
Visit www.marriott.com to make your reservation online.

TUESDAY

Board of Directors Meeting
Early Exhibitor Registration, 4:00 p.m.

WEDNESDAY

Registration/ Exhibitors Open Luncheon
General Sessions
Committee Meetings
Silent Auction Dinner

THURSDAY

Morning Walk
New Member Meeting
General and Breakout Sessions
Poster Session Reception
Board and Committee Chair Dinner

FRIDAY

General and Breakout Sessions
FSPHP Regional Member Meetings
Exhibitor Session
Annual Business Member Meeting

SATURDAY

FSPHP/FSMB Joint Session
Closing session at noon.

Further Details to Come. . .

2018 FSPHP ANNUAL MEETING









WE NEED YOUR HELP GROWING OUR MEMBERSHIP!

Dear FSPHP Members:

Significant potential benefits are available to those interested in physician and professional health when they join the FSPHP. New members benefit by the experience of our current member PHPs, and in turn, the new and current members can increase the effectiveness of our overall mission: "To support Physician Health Programs in improving the health of medical professionals, thereby contributing to quality patient care," and our vision: "a society of highly effective PHPs advancing the health of the medical community and the patients they serve."

Please consider sharing news of our available membership opportunities with:

- Current PHP staff, board members, and oversight committee members.

While budget considerations may limit the number of FSPHP members a PHP will fund, a designee of the PHP board, or committee may be willing to fund their own membership, especially recognizing the benefits for the following:

- Treatment providers working with the PHP or in the field of healthcare professionals within the state
- Professional coaches of healthcare professionals in the state
- Attorneys on staff of a PHP
- Medical students or residents involved in physician wellness within their institutions
- Residents or fellows who by nature of their training may have a particular interest in physician health (psychiatrist, addiction medicine, occupational medicine, etc.)
- Academic training institutions, deans, associate deans, and attendings
- Medical and specialty societies
- Prior PHP participants working with an interest in the field

The FSPHP develops common objectives and goals in order to promote physician health and to assist state programs in their quest to protect the public through the promotion of health and well-being of medical professionals. FSPHP members have access to exclusive networking, resources, collaboration opportunities, and educational opportunities at the leading edge of physician health. In addition, the FSPHP provides education and exchange of ideas for physician health through its member listserv. Membership provides access to the members-only section of the FSPHP website, which includes a library of PowerPoints shared amongst members. Members have access to FSPHP policies and guidelines, leadership opportunities, new employment opportunities, and up-to-date

information on the latest issues affecting physician and professional health at the state and national levels. FSPHP new members receive a discount on our up-to-date evidence-based, informational annual conference and participation in FSPHP Regional meetings. More information on membership benefits can be accessed on page 38.

The FSPHP currently has six categories of membership: State, Associate, International, Organizational, Honorary, and Individual.

Membership Categories

State/Voting

State programs with compensated staff, and/or compensated Medical Director, and/or voluntary committee chairperson/staff

Associate*

Open to compensated staff and/or non-compensated staff and oversight board or committee members of state Physician Health Programs

International

International programs with compensated staff, and/or compensated Medical Director, and/or voluntary committee chairperson/staff

Individual*

Open to individuals who are engaged in the education, intervention, research, peer assistance, care and treatment of physicians and/or other healthcare professionals with potentially impairing illness in a hospital, office, or other clinical/non-clinical setting. This category is also open to compensated and/or non-compensated staff and oversight board or committee members of an FSPHP Organizational Member in good standing.

Organizational*

Open to organizations who are engaged in the education, intervention, research, peer assistance, monitoring, and advocacy of physicians and/or other healthcare professionals with potentially impairing illness in a hospital, office, or other clinical/non-clinical setting. This category is open to only ONE (1) individual per organization, including a compensated and/or non-compensated staff and oversight board or committee member.

Honorary

Open to outstanding persons after nomination by a state member, and elected by two-thirds of the state members present at the annual meeting.

**Members of state licensing or disciplinary agencies are not eligible for membership.*

Please contact lbresnahan@fsphp.org for a membership application.

PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS NATIONAL MEETINGS

FSPHP

FSPHP MEMBER Regional Meetings 2018

2019 FSPHP Education Conference and Business Meeting
April 24–27, 2019
Worthington Renaissance Forth Worth Hotel,
Ft. Worth TX

2020 FSPHP Education Conference and Business
Meeting, Tentative dates: Thursday, April 30, 2019–
Sunday, May 3, 2019, or Monday, April 27, 2019–
Thursday, April 30, 2019

FSMB ANNUAL MEETINGS

2019

107th Annual Meeting
April 25–27, 2019
Omni Fort Worth Hotel
Fort Worth, Texas

2020

108th Annual Meeting
April 30–May 2, 2020
Grand Hyatt Manchester
San Diego, CA

2019 AMERICAN CONFERENCE ON PHYSICIAN HEALTH (ACPH)

September 19–21, 2019
Sheraton Charlotte Hotel
Charlotte, NC

Hosted by the American Medical Association in collab-
oration with the Stanford University School of Medicine
and the Mayo Clinic

AMERICAN ACADEMY OF ADDICTION PSYCHIATRY

29th Annual Meeting and Scientific Symposium 2018

December 6–9, 2018
Hyatt Regency Coconut Point Resort and Spa
Bonita Springs, FL 34134

30th Annual Meeting and Scientific Symposium 2019

December 5–8, 2019
Rancho Bernardo Inn
San Diego, CA 92128

AMA HOUSE OF DELEGATES ANNUAL MEETING

June 8–12, 2019
Hyatt Regency Chicago
Chicago, IL

June 6–10, 2020
Hyatt Regency Chicago
Chicago, IL

AMA HOUSE OF DELEGATES INTERIM MEETINGS

November 16–19, 2019
Manchester Grand Hyatt
San Diego, CA

November 14–17, 2020
Manchester Grand Hyatt
San Diego, CA

American Psychiatric Association Annual Meeting
May 18–22, 2019
San Francisco, CA

April 25–29, 2020
Philadelphia, PA

AMERICAN SOCIETY OF ADDICTION MEDICINE

ASAM 50th Annual Conference
April 4–7, 2019
Hilton, Orlando
Orlando, FL

ASAM 51ST ANNUAL CONFERENCE

April 2–5, 2020
Gaylord Rockies Resort and Conference Center
Denver, CO

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS (IDAA) ANNUAL MEETING

2019

Knoxville, TN

2020

Spokane, WA

Physician Health and Other Related Organizations
National Meetings

continued from page 35

**AMERICAN BOARD OF MEDICAL SPECIALTIES
ANNUAL CONFERENCE**

ABMS Conference 2019

September 23–25, 2019
Chicago, IL

**NATIONAL ORGANIZATION OF ALTERNATIVE
PROGRAMS**

2019 Annual Education Conference

March 17–20, 2019
World Gold Village Renaissance St. Augustine Resort
St. Augustine, FL

**NATIONAL ASSOCIATION OF MEDICAL STAFF
SERVICES NAMSS**

43rd Educational Conference and Exhibition

October 19–23, 2019
Philadelphia Marriott Downtown
Philadelphia, PA

**AMERICAN ACADEMY OF PSYCHIATRY
AND THE LAW**

50th Annual Meeting
October 24–27, 2019
Marriott Baltimore, MD

ACGME SYMPOSIUM ON PHYSICIAN

2019 Well-Being Symposium in the Fall of 2019

COALITION FOR PHYSICIAN ACCOUNTABILITY

www.physicianaccountability.org/resources.html

**NATIONAL ACADEMY OF MEDICINE—
CLINICIAN WELL-BEING AND RESILIENCE**

<https://nam.edu/initiatives/clinician-resilience-and-well-being>

**INSTITUTE FOR THE ADVANCEMENT OF
BEHAVIORAL HEALTH NATIONAL RX SUMMIT**

April 22–25, 2019



Dr. Chris Bundy (on right) with Barbara McAney, AMA President (center), and Sheila Rege, MD (left), WSMA delegate to AMA who was just elected to the AMA Council on Medical Affairs attending the Washington State Medical Association Foundation Dinner at the WSMA Annual Meeting.



NAMSS, October 2, Dr. Chris Bundy and Dr. Doris Gundersen Understanding Physician Health Programs (PHPs) and Considerations for Health Professionals Being Monitored by PHPs

FSPHP E-GROUPS—PLEASE JOIN!

The Yahoo! e-groups provide a user-friendly capability to share information among our members. As you may know, we have two e-groups. I know there can be confusion on the two groups, so please let me provide an overview. Membership in either e-group is open only to Federation members. This is one of our most valued membership benefits. Visit https://www.fsphp.org/sites/default/files/pdfs/egroup_guidelines_sept_6_2016.pdf for guidelines on the use of the e-groups.

fsphpmembers@yahoo.com is an information-exchange venue for all FSPHP membership categories. These include State PHP members, Associate PHP members (affiliated with state PHPs), Honorary members, International PHP members, and non-PHP member categories such as Individual and Organizational memberships of the Federation of State Physician Health Programs, Inc.

statePHP@yahoo.com is for “PHP” membership categories, including the State PHP members, Associate PHP members (affiliated with a PHP), Honorary members, and International PHP Members.

All PHP membership categories (State, Associate, Honorary, and International members) are eligible for both groups.

- The statePHP@yahoo.com group purpose is for internal, anonymous, case-specific, administrative, or physician health program-specific discussions or questions.
- The fsphpmembers@yahoo.com group purpose is for broader topic-related physician health, such as sharing of articles, information, programmatic updates, resources, and overarching field topics.

There might be times when you want to reach everyone on both groups (such as my email here). To do so, email both groups! Since both groups are optional and members must opt in, not all FSPHP members are in each group. We have 210 FSPHP members. Currently there are 149 members of the StatePHP@yahoo.com and 115 members of the FSPHPMembers@yahoo.com.

For any questions concerning the two e-groups, please call Julie Robarge or Linda Bresnahan at FSPHP (978) 347-0600, or email jrobarge@fsphp.org or lbresnahan@fsphp.org.



FSPHP Fall Board Meeting

Left to right: Jon A. Shapiro, MD, DABAM; Terry Lavery, LCPC; P. Bradley Hall, MD, DABAM; Robin F. McCown; Scott L. Hambleton, MD, DFASAM; Linda R. Bresnahan, MS; Daniel I. Perlin, MD; Warren Penderast, MD; Mary Ellen Caiati, MD; Michael J. Ramirez, MS; Front Row: Chris Bundy, MD, MPH; Paul H. Earley, MD, DFASAM; and Mary Fahey, LCSW. Board members not pictured are Doris Gundersen, MD, and Michael J. Baron, MD, MPH.

PLEASE PREVIEW FSPHP MEMBER BENEFITS AND ENCOURAGE YOUR COLLEAGUES TO JOIN US!

Visit www.fsphp.org/membership/classes-membership to consider your eligibility to join FSPHP.

The FSPHP mission is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

Members of the FSPHP join a community of Physician Health Program professionals across North America, including some international members, dedicated to the health of physicians and healthcare professionals.

- FSPHP members have access to exclusive networking, resources, collaboration opportunities, and education tailored to the needs of Physician Health Program staff and initiatives.
- Access resources that will provide examples of experience and guidelines for your work, inspire new ideas, provide creative solutions, and give you the tools needed to excel in the field.
- Contribute to FSPHP's tradition of collaboration. Connect, network, and exchange ideas, resources, success stories, and lessons learned with your experienced and expert colleagues around the country.
- Participate in unique and specific training that is relevant to your mission. Learn from and with your peers through annual and regional meetings, newsletters, and our member email group covering all areas of physician and healthcare professional health topics.
- Gain the knowledge to assist you in your job through opportunities like the FSPHP Annual Conference and regional meetings. All FSPHP members receive a discount on FSPHP education programs. www.fsphp.org/event/annualeducation-conference-business-meeting-2018
- Connect with other FSPHP members who can help you answer the questions you face. Visit the FSPHP Yahoo! Groups and post your questions online or look up contact information in the online directory for FSPHP members you met at an annual conference.
- Learn about FSPHP Policies and Guidelines and share with your board, committees, staff, healthcare organizations, and stakeholders in your state.
- Post documents to the FSPHP discussion forum relating to standards, regulations, and other newsworthy items, including sample forms and templates.
- Keep up with the latest issues that affect physician or professional health programs.
- Gain personal and professional growth, as well as a broader view of the depth and vision for the organization, by taking on a leadership role, chairing a committee, or serving on the board of directors. The vision and dedication of FSPHP volunteer leaders are our biggest asset.
- Find new employment opportunities or advertise one through the FSPHP Job Center, your one-stop shop for careers in physician or professional health programs.
- Connect with a seasoned professional who will help you navigate the physician health and/or professional health program profession.

ADVERTISING AVAILABLE IN OUR SPRING 2019 ISSUE!

Submit your advertisements by January 2019!

INFORMATION AND SPECIFICATIONS

Dear prospective *Physician Health News* advertisers:

We would like to invite you and your organization to advertise your services in the future editions of *Physician Health News*. *Physician Health News* is mailed to all state programs and state licensing boards. The newsletter is also distributed widely at the FSPHP Annual Meeting. The newsletter includes articles and notices of interest to the physician health community and planning information for the upcoming physician health meetings and conferences, including FSPHP meetings.

We offer ad design and proofreading services for an additional fee. For your convenience, full advertisement specifications and PDF instructions can also be provided upon request. We hope you will consider taking advantage of this opportunity to advertise your facility, services, and contact information.

Become part of a great resource for state PHP professionals. The spring issue each year offers an advertising section.

We look forward to working with you in future editions.

FSPHP Publication Committee

Sarah Early, PsyD (CO)
Amanda Kimmel (CO)
Laura Berg, LCSW-C (IL)

Mary Ellen Caiati, MD (CO)
Joyce Davidson, LSW (CO)
Scott Hambleton, MD (MS)

Ann Kelley, LCSW, LCAC (IN)
Linda Bresnahan, MS (MA),
CAADC (IL)

SPECIFICATIONS

Ad Size

3.125" w x 2.25" h

Guidelines for PDF Ads

Black and White Only

Ads should be submitted as grayscale. They will be printed in black ink only. As a convenience, we are able to turn your ad into grayscale if necessary.

Border

You do not need to include a border with your ad. We will frame your advertisement with a .5-point border during newsletter production.

Font

To reduce registration problems, type should be no smaller than 9 point. Fonts must be embedded and TrueType fonts should be avoided.

Screens

150-line screens are preferred for halftones. Halftone minimum screen tone value is 10%.

File Guidelines

All submissions should be Acrobat PDF files and should be sent at the exact size specified herein. Native files or other file formats will not be accepted.

Guidelines for Word Files

Supply MS Word document and high-resolution logos and graphics (if applicable). Maximum two passes for ad approval.

Submission

Remember to label your file with your company name (i.e., CompanyX.pdf or CompanyX.doc). This will assist us in identifying your ad. Please also double-check that your ad contains the most up-to-date information.

PLEASE CONSIDER A SUBMISSION IN FUTURE ISSUES!

QUESTIONS?

Please contact Linda Bresnahan at lbresnahan@fsphp.org

FSPHP
668 Main St., Suite 8, #295
Wilmington, MA 01887

PHYSICIAN HEALTH NEWS

The FSPHP produces a newsletter twice a year in the Spring and again in the Fall that is sent to all state programs, medical societies, and licensing boards. The FSPHP requests articles (500 words or fewer) and other related information be submitted for inclusion in the FSPHP Newsletter.

SUBMISSIONS FOR NEWSLETTER

By **January 30** for the spring issue

By **May 31** for the summer issue—*the summer issue is typically reserved for content related to our FSPHP annual meeting.*

This newsletter is intended to help members stay abreast of local, state, and national activities in the area of physician health. Please consider a submission to help keep all states informed of your program's activity and progress in the field of physician health.

Please send submissions by email to lbresnahan@fsphp.org.

Items that you may want to consider include:

- Important updates regarding your state program

- A description of initiatives or projects that have been successful, such as monitoring program changes, support group offerings, outreach and/or education programs, and so forth
- Notices regarding upcoming program changes, staff changes
- References to new articles in the field
- New research findings
- Letters and opinion pieces
- Physician health conference postings and job postings

Please limit articles to 500 words or fewer and other submissions to 200 words or fewer.

WE WANT YOUR INPUT!

The FSPHP Board of Directors is very interested in your ideas and suggestions, and we welcome agenda items you would like to bring before the board. But it is important to be organized in our approach in order to make sure ideas are fully explored and vetted. The board established a policy that members are asked to submit written requests for consideration directly to regional directors. You may also write directly to FSPHP Executive Director Linda Bresnahan at lbresnahan@fsphp.org. This will ensure an organized chain of communication between you and your representatives. Thank you for your assistance!