

# PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



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## MESSAGE FROM THE PRESIDENT

### *Growth Opportunities*

Working in the field of physician and general professional health is an honor, as well as tremendously rewarding and challenging. This has been my experience in North Carolina, and at the national level. Since being given the privilege of serving as your Federation President, I've become more acutely aware of the opportunities and challenges we face nationally. The opportunity to work with some incredibly dedicated and talented people in the Federation has also been greatly energizing.

Earlier this year, each FSPHP-member state received a list of our Federation's accomplishments in 2012, as part of membership renewal. In reflecting on the past year and looking ahead to 2013, I want to focus on three areas that are critical to our future success: FSPHP administrative support, our work with other national organizations, and membership expansion.

The Federation has had a number of "growth opportunities" in the last several years. The biggest of which came in 2012, with the end of administrative support from the American Medical Association (AMA). As difficult as this has been, I believe it will prove to be a positive, watershed point in the history and development of the Federation. As a result of this external change, we've matured as an organization, reviewed our administrative structure, and taken steps to become more self-sufficient and politically independent.

Towards this end, in order to replace the services provided by the AMA, the FSPHP Board of Directors voted to sign an administrative services contract with the Massachusetts Medical Society (MMS), effective January 2013. The MMS subsidiary Physician Health Services, Inc., will provide administrative support to FSPHP leadership, members, and to our Executive Director Jon Dougherty. As I've noted on the listserv, we are truly fortunate to have Debbie Brennan and Jessica Vautour join the FSPHP family.

Two other important projects in 2012 were our work with the Federation of State Medical Boards (FSMB) the American Board of Medical Specialties (ABMS). Advocacy for recovering physicians and other professionals has become increasingly complex since the "physician health"



Warren Pendergast, MD

movement first started. In 2013, a medical license is necessary to practice medicine, but not sufficient in and of itself to earn a living. Credentialing decisions by specialty boards, health insurers, and other entities now effectively determine an individual licensee's ability to practice. This has made FSPHP's national work with FSMB and ABMS critically important to our individual and collective missions.

In October, Carole Hoffman and Lynn Hankes represented FSPHP in the ABMS Disciplinary Alert Notices (DANs) workgroup in Chicago. The meeting went very well, and represented an important first step in working with individual specialty boards to allow continued certification for licensees under board orders requiring PHP monitoring. The next step is for the Federation to reach out to the specialty boards individually, and encourage them to see PHP monitoring in a positive light.

A related effort, and an outgrowth of our continued relationship with the FSMB, was FSPHP participation on the Special Committee on Reentry for the Ill Physician. Lynn Hankes and Michael Gendel were invited to the committee meeting in October, as well. They continue to participate in this initiative, which looks like it will result in a FSMB document that is very supportive of physician health and rehabilitation. This dovetails very well with the ABMS workgroup agenda, and I'm optimistic that their work will provide significant dividends at the national and state levels.

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Welcome to the 18th edition 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, with production and printing assistance from the Massachusetts Medical Society.

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The FSPHP is a national organization providing an exchange of information among state physician health programs to develop common objectives, goals, and standards. If you're not a member yet, please consider joining. State membership is \$400 per year, and individual (associate) membership is \$100. We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive Federation of State Physician Health Programs.

For more information on each of the membership categories, please contact Debbie Brennan of Physician Health Services in Massachusetts at (781) 464-4802.

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Another area of focus for 2012 was membership expansion. It has been difficult to strike a balance between maintaining our core identity in physician health, and reaching out to potential members who can help us grow in new directions. The Membership and Bylaws Committees put in many hours discussing how to achieve this balance, while also protecting ourselves from possible ethical dilemmas as a result of our expansion. By offering membership to others who work in professional health, we'll not only be providing the benefit of our experience, but benefitting from a new infusion of energy and perspective for our Federation, as well.

Our steadfast progression in the areas of administrative support, work with other national organizations, and membership expansion owes a debt of gratitude to Jonathan Dougherty for his continued leadership as our executive director and the countless hours of dedication by our committee chairs and members.

We're sure to have another great meeting this year, and I welcome you to join us in Boston. Please let a board member or me know via phone, email, or in person if you have any input or thoughts on the event or any other FSPHP business!

— *Warren Pendergast, MD*

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## MESSAGE FROM THE EXECUTIVE DIRECTOR

### *Evolution*

*"Evolution is the only science in which multiplication and division mean the same thing."*



**Jonathan Dougherty, MS**

I'm going to wear my medical society hat for a moment: The changing face of medicine is creating a great deal of angst amongst physicians and those of us who serve you. It's no surprise that we are creatures of predictability and habit, and when the course ahead is unclear we may feel an uneasy feeling in the pit of our stomachs. I speak for myself by saying that even when I logically conclude that change is good, the process of getting from here to there can still be uncomfortable.

Medical societies have endured a decline in membership for several years. The value proposition traditionally associated with medical societies just hasn't resonated with the younger, more diverse generation of physicians. As described by

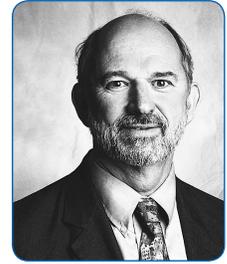
Steve Smith, CAE, Jim Swartwout, and Barbara Greenan in the American Association of Medical Society Executives' *AAMSE Trends Report*, "A successful medical society must do more than simply provide resources, programs, services and representation through advocacy in order to attract and retain members. Decisions to join or renew are increasingly based upon whether the membership experience offers considerable value, unique access and sustainable support." The good news is that medical societies have begun to take advantage of modern technology in order to sufficiently transition into diverse, contemporary, and high-tech organizations, where value will again be measured and memberships will stabilize. Growth must be a priority.

As a professional association, the FSPHP shares much of the DNA of a medical society. The value proposition is readily identified; in my four years with the organization I have never heard anyone say, "I see no value in membership." In fact, the opposite has been the case. The key question has been to what extent the value proposition can be exploited to: a) further enhance the science of physician health, and, b) help generate badly needed revenue for the FSPHP. The membership committee has been wrestling with these objectives for the last couple of years. It has been arduous, involving meeting the objectives of membership expansion without changing the scope and character of the Federation. Our representation of state physician health programs specifically limits the number of members we can have, as we are currently constituted. But service to your programs is what we are all about and nothing we do can ever adversely affect that.

Our membership and the intellectual hardware you all provide to the organization are assets that many ancillary professionals in the world of physician health cherish greatly. Conceptually, we can meet our objectives while, at the same time, share knowledge throughout the health care system. By using Web-based and social networking, we could create an ongoing blog or chat room for the physician health community, allowing us to expand our knowledge of physician health and stay true to our mission. Concurrently, we could also be building alliances and reaching out to allied professionals wanting to learn more about the challenges state physician health programs face. This would serve to boost our value proposition by providing measurable value, unique access, and sustainable support, as well.

I am confident that your societies' leadership will value any thoughts you may have as to how the FSPHP can evolve and address the needs of state physician health programs effectively. As we continue to explore other avenues for membership, please let your regional directors know of any ideas you may have about where you would like to see the FSPHP progress in the coming years. — **Jonathan H. Dougherty, MS**

## AMA OBSERVER SUMMARY — JANUARY 17, 2013



**Luis T. Sanchez, MD**

As the FSPHP observer to the AMA, I attended the AMA 2012 annual and interim meetings in June and November, respectively. During the annual meeting, there were several resolutions regarding physician health, whereas the interim meeting had no specific resolutions or actions regarding the topic.

There were six resolutions at the June meeting that had relevance to us. ASAM, Delaware, and the medical student section were respective sponsors. They were all discussed at a reference committee, which I attended and commented. The discussions were lively and supportive of physician health programs.

One resolution called for continuing and expanding AMA support to the FSPHP. The committee recommended that previous AMA policies on physician health be reaffirmed in lieu of the resolution, which the House later approved. The other five resolutions involved destigmatizing mental health disorders in health professionals, ending discrimination against physicians enrolled in PHPs, and eliminating barriers to credentialing, certification, specialty board rejection, and other agency problems when a substance use disorder (SUD) or mental health issue is involved. There was considerable discussion involving these issues, but generally all were in favor of the resolutions. The committee recommended that the five resolutions be combined as a matter of physician health and that it be forwarded to the AMA Board of Trustees (BOT) for its review and further decision, while also noting that physician health is of importance in recognizing the considerable discussion in the committee hearing. The House approved the recommendation. I will be tracking the referral to the BOT as to its future decisions.

In contrast to the annual meeting, the interim meeting had no resolutions or actions specifically related to physician health. Other resolutions and discussions seemed to focus on the Affordable Care Act, ACOs, the EHR and its issues, the implementation of ICD 10, and other broad areas of interests. I encourage those interested to review the report, resolutions, and discussions online at [ama-assn.org/ama/pub/meeting/reports-resolutions.shtml](http://ama-assn.org/ama/pub/meeting/reports-resolutions.shtml). I continue to find the observer role at the AMA meetings to be worthwhile and important to our Federation. It provides many opportunities to describe the role of observer and to discuss the FSPHP and the importance of its mission. I'm also able to speak with state delegates who speak highly of their state PHP and its usefulness to doctors. There are interactions

with the ASAM delegate, the FSMB board chair, and other AMA delegations, as well.

Through a task force, our Federation has an ongoing project of developing AMA model guidelines for state PHPs with recommendations as to educating physicians and medical students on physician health and wellness. The taskforce will continue its work over the next months. — *Luis Sanchez, MD, FSPHP Observer to AMA*

## STATE PHPS PROTECT THE PUBLIC — AND SAVE CAREERS

It's not credible or productive to pretend that physicians are not subject to the same range of impairing disorders as others. That attitude leads to a deadly combination of denial, followed by excessively punitive actions when forced to confront problems that cause physician impairment. A better way is to foster systematic early detection and intervention that prioritizes public safety while balancing this concern with an interest in promoting successful functioning of physicians in practice. This has been the mission of physician health programs in the United States. This proactive and balanced approach is necessary to preserve public confidence in physicians and to encourage physicians and others to report problems so they can be investigated and dealt with in an effective and timely manner. An accusatory stance and draconian punishments discourage early detection and is not in the public interest or in the interest of physicians in general. It would be helpful to have specific evidence demonstrating the benefit of physician health programs as an aid to regulatory boards in early detection of licensees with disorders that if untreated can cause impairment. Forty-six (46) regulatory boards in the United States endorse and support PHPs in their states.<sup>1</sup> The remaining states do not have PHPs, either because of funding issues or, as was the case in California, public relations issues. In that state, the PHP was abolished following media attention and public criticism that “bad” doctors were being poorly managed.

### Method

This study compares two adjacent states with and without PHPs. Data regarding number of licensees and disciplinary actions were obtained from the Federation of State Medical Boards website.<sup>2</sup> Information regarding total numbers of physicians identified with substance abuse and numbers of physicians in monitoring were obtained from both the Georgia and Alabama boards and the Alabama PHP.

### Results

Based on the number of practicing physicians in each state, in 2009 Alabama identified 284% more physicians with substance abuse problems, per 1,000 physicians, than Georgia. (See table below.)

#### Comparison of two adjacent and demographically similar states, one with a PHP (Alabama) and one without (Georgia).

Data from 2009	Alabama	Georgia
Total physicians practicing in-state	10,518	18,422
Total disciplinary actions	64	132
Disciplinary actions per 1,000	6.08	7.17
Total new substance abuse cases	52	30
New substance abuse cases per 1,000 licensees	4.95	1.63
Total number of physicians in active monitoring	270	132
Physicians in active monitoring per 1,000 licensees	25.7	9.9

### Discussion

From this data, potentially impaired physicians are referred more often where there is a state PHP. This is likely because PHPs promise a non-punitive, clinically oriented approach. Hospitals or colleagues understand (through the educational efforts of PHPs) that a clinically oriented confidential evaluation will occur and treatment and/or support will be provided. In contrast referents are less likely to “snitch” on a colleague to the regulatory board until pressure to do so becomes intolerable, such as following overt harm to a patient. By detecting potentially troubled physicians earlier and obtaining assistance for them, the public is protected and best served.

In addition to encouraging early referral, PHPs' devotion to recovery and the large number of physicians who have successfully overcome problems and returned to practice encourages physicians to accept PHP care management. The testimony of physicians in the community who have benefited from PHP care management is vital to both early referral and to physician acceptance.

PHPs also assist boards in their ability to respond more rapidly, as they are not burdened with “due process” requirements. State PHPs function as a clinical arm for regulatory boards. When credible symptoms are first reported an effective PHP can immediately intervene, without a lengthy investigation. The PHP can “strongly encourage” the licensee to “voluntarily” stop practice and enter the “safe harbor” of an evaluation process. PHPs report that over 95 percent of licensees fully cooperate.<sup>7</sup> Physicians almost always prefer a clinical approach, which encourages their cooperation, especially considering they are informed that if they refuse to

comply, they will likely be referred to the regulatory board. The promise of relative confidentiality, of course, plays a role as well in the licensee's willingness to cooperate.

Physician health programs have a proven record of success without patient harm. PHPs were mostly established in the late 1970s to address the rising awareness that physicians have significant unaddressed substance abuse and mental health problems.<sup>3</sup> Many PHPs are run by recovering physicians who are dedicated to this "calling." Over the past four decades the current PHP system has evolved based on experience and continues to evolve an extraordinary ability to evaluate, perform interventions, and conduct long-term monitoring. Almost all PHPs report serious relapses and/or incidents of patient harm to the regulatory board, however, remarkably once physicians enter PHPs they rarely harm patients — even if they relapse.<sup>4,5</sup>

There are very good, practical reasons to separate the care management PHP functions from the regulatory board. To succeed, however, this teamwork between PHPs and their respective regulatory boards must have explicit guidelines regarding the circumstances under which relapses and other non-compliance is reported to their boards. PHPs themselves have no power to restrict or remove physicians from practice. But, they do offer welcomed assistance and support for physicians who are willing to voluntarily withdraw from practice and enter evaluation or treatment and then consent to active long-term monitoring. This balance of complementary roles of protecting the public by early and swift intervention has worked well for decades. It's a record that deserves respect even as both PHPs and the licensing boards work to improve the current practices with dual goals in mind: First, protect the public, second, protect the careers of physicians.

National organizations focusing exclusively on protecting the public, such as Public Citizen, rank medical boards by rates of disciplinary actions rather than by rates of early intervention and prevention. Ironically, this approach can make it less safe for patients. When scrutinized, some of the PHP practices (e.g., drug testing) have not been perfect, but overall their programs are effective and there is no evidence that patients are harmed.<sup>4,5</sup>

## Conclusion

By encouraging early referral, rapid intervention, and successful treatment and monitoring, PHPs fulfill a vital role in protecting the public. In the process, long-term recovery is promoted and physician careers are preserved. — *Gregory Skipper, MD, and Tom Specht, MD*

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- <sup>2</sup>fsmb.org/pdf/2009-summary-board-actions.pdf (last accessed March 31, 2011)
- <sup>3</sup>"The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence." *JAMA*, 1973;223(6):684–687.
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## CONTINUING THE COMMITMENT: RESEARCH AT THE COLORADO PHYSICIAN HEALTH PROGRAM

During 1996, in Estes Park, Colorado, a group of state physician health programs organized a national conference to discuss research issues related to physician well-being. The dialogue centered on the need for development of empirical studies as a means to understand PHP effectiveness and address public concerns of physicians' abilities to competently practice medicine during monitoring. Participants identified 12 priority areas for research, including prevention, risk factor identification, treatment effectiveness, and programmatic differences. (Dilts, Goldman, and Shore, 1999) The conference also birthed the Physician Health Research Planning Group (chaired by Michael Gendel, MD), which included representatives from Physician Health Programs, Federation of State Physician Health Programs, American Medical Association, American Psychiatric Association, American Academy of Addiction Psychiatrists, American Society of Addiction Medicine, Federation of State Medical Boards, and various treatment centers. The group promoted the 12-point research agenda and worked with a psychiatric epidemiologist to design a national database to encourage the systematic collection of information among PHPs. Sixteen (16) years later, the Colorado Physician Health Program (CPHP) continues to embrace the practice of research to help improve PHP performance and examine issues of public safety. CPHP strengthened its commitment to this effort in 2008 by formalizing an in-house research committee, in cooperation with an investigator at the University of Colorado Anschutz Medical Center.

Recent committee efforts targeted several of the gaps in knowledge identified by the Estes Park conference. *Comparing Substance Use Monitoring and Treatment Variations among Physician Health Programs* (Brooks, Early, Gundersen, Shore, and Gendel, 2012) examined physician-client outcomes between CPHP and other peer assistance programs. This research study built upon data collected through the Blueprint Project (McLellan,

Skipper, Campbell, and DuPont, 2008), and led to a better understanding of the impact of programmatic differences between PHPs. The Physician Boundary Project explored the scope, correlates, and outcomes associated with physicians who reported to CPHP for boundary violations. In a unique effort to document in terms of their violation category (i.e., non-patient, patient non-sexual, and patient sexual), the study determined — by self-study report and external sources — that between 83 to 90 percent of physicians reported no further violations. (Brooks, Gendel, Early, Gundersen, & Shore, 2012) The impact of physician health program monitoring was an area in particular need of further research. To address this, CPHP recently concluded an investigation documenting the relationship between monitoring and physicians' subsequent risk of malpractice claims. The study's results, which also found that malpractice risk decreased after monitoring, suggest the potential for PHPs to improve physicians' ability to safely practice medicine. CPHP is currently conducting a program evaluation effort in order to understand issues of treatment effectiveness from the client's perspective. This project will examine several service aspects, such as prior knowledge of the program, barriers to care, satisfaction, and effectiveness.

Through these projects, CPHP continues to commit itself to strengthening a research base that can be used to better understand physician illness and improve care. As acknowledged at the 1996 conference, improving care for physicians often results in improved care for the patient. As we are better able to meet the research agenda set forth by the conference, we believe our efforts can positively impact this admirable goal.

— **Elizabeth Brooks, PhD, CPHP Principal Researcher**

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## THE WEST VIRGINIA MEDICAL PROFESSIONALS HEALTH PROGRAM: AN EXAMPLE OF "SUCCESS"... IRRESPECTIVE OF HOW YOU DEFINE SUCCESS!!!

The West Virginia Medical Professionals Health Program (WVMPHP) has been operational for just over five years. The WVMPHP continues to be the only physician health program recognized by the WV Board of Medicine and the WV Board of Osteopathic Medicine. Since its inception, the WVMPHP has provided 70 educational lectures to over 5,000 physicians, medical students, and residents. As an independent 501(c)(3) not-for-profit corporation, its 11-member board of directors represents the majority of organized medicine including the WV Mutual Insurance Company, the WV Hospital Association, the WV State Medical Association, the WV Society of Osteopathic Medicine, the WV Society of Addiction Medicine, and other societies representing the three populations served (i.e., physicians, podiatrists, and physician assistants). As of this date, funding has been largely provided through licensure-board fees. The WVMPHP also depends on donations by the WV Hospital Association, Healthcare Authority, WV Mutual Insurance Company, WV State Medical Association, and individuals, as well as from individual participant fees and their respective pro bono services. The WVMPHP's continued availability after five years of operation is considered one measure of success. The limitations of how we define and/or others perceive our success results in an under-realization of our importance.

Statistics alone are a measure of WVMPHP success. We have provided assistance and guidance to 113 participants representing a growth rate in excess of 1,200 percent and an abstinence rate of approximately 88 percent. This brings to mind the definition of success itself, which should not be limited to growth and/or abstinence rates irrespective of their impressiveness.

The impact of education about addiction and the work PHPs do positively benefits the health care profession and the patients we serve, which is yet another example of PHP success. This is not limited to the number of presentations and to whom they are presented, but the impact on the care provided and the stigma addicted patients face. The stigma associated with addictive illness is lessened by understanding the disease model and associated successful outcomes of treatment evidenced by PHPs. Addressing this health care population in this manner provides the "Leading by example" effect to other members of society outside of the populations served by PHPs. This education also functions to some degree as an antidote to the stigma associated with the addicted

patient. Furthermore, the “experiential education” of recovering participants in PHPs beneficially impacts families, colleagues, and patients.

Having a greater number of ill or recovering health care professionals within a “safe harbor” of support and monitoring, as represented by the WVMPHP, is an obvious benefit when compared to the significantly fewer number represented by the state prior to the WVMPHP’s availability. Without our work, the number of individuals seeking assistance and guidance would be less than it is today, which is indeed at least anecdotal evidence of success.

Physician and professional health programs report a high rate of abstinence, which is one of many components determining how we view success. When researchers bear this concept in mind during data analysis, their results from peer-reviewed articles accurately report an overall success rate defined by abstinence rates over 90 percent at 5 years. This overly simplistic definition is defined as abstinence from mind and/or mood altering substances, including alcohol, upon completion of the full treatment experience (i.e., intervention, evaluation, treatment, post-treatment stabilization, and re-entrance into the practice of medicine in a safe, monitored manner under the auspices of a PHP). Albeit definable, accurate, and impressive, this definition of success — based on abstinence alone — doesn’t capture other benefits to the health care profession and the public at large resulting from PHP operations and long-term availability.

Health care professionals with substance use disorders are responsible for addressing their illness, including relapses, which then benefits and enhances public safety. A relapse does not, in and of itself, constitute failure or lack of success, nor does it equate with impairment. Illness and impairment exists on a continuum, with illness predating impairment for often a period of years (See FSPHP Policy on Illness vs. Impairment at FSPHP.org). PHPs have a mechanism in place to promptly identify, intervene and address relapse if and when it occurs. These often include notification of the regulatory agency, when evidence of overt impairment and/or non-compliance could potentially place the public at risk. This reporting of non-compliance and associated collaboration with regulatory agencies benefits the health care profession and the public we serve.

While abstinence rates are exceptional, we can further discuss PHP success with respect to those who experience relapse. Relapse — in and of itself — should not be construed as a failure of the PHP, or the affected health care professional. It is simply a loss of disease remission (exacerbation) similar to other chronic illnesses (diabetes, cancer, etc.). It is not unexpected

for a patient experiencing illness to question their diagnosis and treatment, and/or to experience an exacerbation of disease. Exacerbation includes addictive illness and relapse with a brief return to use of prohibited substances. Its often the result of an undetected, and therefore untreated, co-morbid underlying condition (i.e., psychiatric illness). Detection of these underlying issues and co-morbid diagnosis is associated with re-evaluation and/or treatment often occurring as result of relapse. The resulting true engagement in recovery could be deemed the result of a therapeutic relapse.

This is analogous to a well-controlled diabetic who becomes ill with sepsis and associated DKA (disease exacerbation). A return to the active disease state, and associated consequences, requires redirection by treatment professionals in order to regain an optimal disease state (i.e., stability with ongoing monitoring). For those who relapse, the re-engagement in a corrective action plan and recovery in a supportive system may very well lead to long-term sustained remission.

There are individuals who have potentially impairing conditions in addition to the illnesses for which they sought assistance and guidance. In those cases, when discovery of such co-morbid illnesses reveals true impairment, the affected individual doesn’t returned to the practice of medicine and is provided support, assistance, and guidance for adjustment, acceptance, and exploration of alternatives to the practice of medicine. This period of supported adjustment helps to minimize the potential travesty of participant suicide, which is another benefit from PHPs.

Successful rehabilitation and advocacy provided by a PHP, on behalf of the compliant recovering health care professional with a disease state in successful remission, helps to preserve an already declining health care workforce in the face of increased need for it. The cost and resultant benefit of professional health programs collaborating with regulatory agencies is significant; salvaging careers is more cost-effective than training replacements. There’s also the benefit of improved public safety when represented by such a collaborative model, which is invaluable and immeasurable.

In closing, whether PHP success is measured in terms of program availability, growth rates, abstinence rates, education, stigma, earlier detection of impairment, life balance, earned advocacy, cost benefit of careers saved or public safety, recovering health care professional “success” is most likely to occur, irrespective of how you define success, when they participate in a PHP. This is especially true when PHPs operate with the principles of confidentiality, professionalism, respect, collaboration, communication, accountability, and transparency.

## Personal Note

*“My most memorable case example illustrating success was when I intervened on an individual in an intoxicated, SUICIDAL state while at his cabin in the mountains of West Virginia the day after his third DUI. Six days later, following the intervention, escort (committal) to a mental institution and subsequent door-to-door transfer to a qualified residential treatment center, he noted the beneficial experience of ‘coming to’ as result of the WVMPPH’s availability. He is doing quite well today... ALIVE... a success. Sadly, a different participant chose to continue drinking... is now deceased... a personal measure of success is my acceptance that we can’t save them all. I am still working on this one...”*

— **P. Bradley Hall, MD, DABAM, FASAM,**  
**Executive Medical Director, WVMPPH**

## MEDICATION ASSISTED THERAPY (MAT)-INSURANCE RULES AND REGULATIONS

*Medication Assisted Therapy for addiction treatment, especially opiate addiction, has proven to be safe and effective in successful treatment outcomes and cost. (Center Substance Abuse Treatment TIP#43 Medication Assisted Therapy for Opiate Addiction).*

Medication Assisted Therapy has given patients with addiction new hope and a better prognosis for ongoing sustained recovery over the past decade. The research conducted by NIDA (National Institute on Drug Abuse), NIAAA (National Institute on Alcohol Abuse and Alcoholism), SAMHSA (Substance Abuse and Mental Health Services Administration), and other organizations discovered that addiction is a chronic medical illness, much like diabetes and hypertension, with distinctly genetic components, measurable physiologic changes, and yes, it can be addressed and put into remission. Recently medications have been developed and are FDA-approved for the treatment of addiction. The unfortunate development is that many of these FDA-approved medications for the treatment of addiction, especially those approved for opiate addiction, are subject to pre-approval. Their use and dosage is time limited or restricted, as well. This is not typical with other FDA-approved medications for other chronic medical illnesses.

When opiate or other addicted patients present for help, this must be recognized as a small and finite window of opportunity. It is clinically imperative that all of the available tools, interventions, and medications be available. Any delay in providing care for patients with an addiction can be and has been life threatening. Oftentimes, *the prior authorization process can be burdensome for patients and providers, ultimately resulting in untoward outcomes and death from overdose.* Some patients go on to commit crimes to sustain their habits or otherwise injure themselves or others fatally.

There have also been reported instances where patients — *who are finally stable on a maintenance medication — are forced to discontinue* after an insurer-determined time for just of detoxification, or a period of 6–12 months. *Many of these patients relapse and some die.* The FDA has actually approved these medications for detoxification and maintenance! Insurers trying to limit use for just detoxification and seek to define the length of time for maintenance disregard FDA and CSAT recommendations. It has been reported in other cases that insurers also seek to limit the dose of medication beyond that which has been set by the FDA. The FDA and CSAT have indicated that dosages of buprenorphine in the form of Suboxone or Subutex has efficacy between 2–32 mg daily. While it is acknowledged that the average dose prescribed is 16 mg, there are some individuals that require 32 mg — these people should not be denied.

This fact is clearly stated in the CSAT TIP#40: *Insurers should not dictate or restrict the dosages or length of opiate maintenance treatment that are well established and determined to be efficacious and in line with the best practices recommendations by the FDA and other agencies (CSAT, NIDA, and National Quality Forum) solely to manage cost concerns.*

## Conclusions and Recommendations

Our nation’s current opiate abuse and opiate overdose epidemic is real and undoubtedly the cause of an increased morbidity and mortality rate that has surpassed the number of people killed as a result of motor vehicle accidents over the past several years. While there are many contributing factors involved, the interface of access to appropriate addiction treatment and affordability for the both is fertile ground to plant seeds of solutions. The federal, state, and local governments are taking vigorous actions to stem the availability of illegal opiates, and are thus inappropriately prescribed medication. It’s time that the treatment and managed care communities examine the issues on the treatment side of the equation and develop policies that will lead to better access to clinically indicated treatment and better treatment outcomes with patients who suffer from opiate and other addictions.

*Health insurance should pay for all the costs of professional addiction treatment.* There is some variance of opinion with regard to whether health insurance should cover the costs of recovery support services, such as the use of recovery coaches, or the use of sober-living services (e.g., halfway houses or even structured housing made available to participants in PHP and IOP levels of care). These additional components are very important in terms of increasing the success rate of recovery for many individuals; however, more research and data collection needs to occur to quantify the actual value of these services.

## Selection of Treatment Levels of Care

Insurers need to rely upon trained and certified addiction treatment professionals to determine the level of care that a patient requires, based upon evidenced-based and peer-reviewed standards that are readily available for use, today. These standards of care have already been vetted by NQF, SAMHSA, CSAT, and others. The American Society of Addiction Medicine Patient Placement Criteria-2 has specific guidelines to determine the appropriate levels of care for patients with addiction. The adoption and the monitoring of adherence to these guidelines by managed care agencies should be sufficient in terms of their need to be assured that resources are being appropriately allocated and spent.

## Medication Assisted Therapy (MAT)

Physicians trained and certified in addiction medicine, or who are otherwise wavered and trained to prescribe FDA-approved medications to assist or maintain a patient's recovery, should have the ultimate authority for issues determining which medication, FDA-approved dosage, and length of use is clinically required to appropriately treat a patient. The selections of medications and FDA-approved dosages, and length of treatment should be left of to the practitioner, not the insurance company.

## Prior Authorization Requirements for Medication and Program Admission

At the time a patient presents for treatment and help for an addiction, it is imperative that he/she receives that care. When patients are denied access to treatment, whether it is for medication or admission into a treatment facility, the results are devastating; many of them continue to use or they die (various related reasons). It is recommended that these patients seeking help are allowed to enter treatment and have their situations evaluated by trained, certified addiction professionals for a comprehensive evaluation and assessment. The findings can then be reported to the insurers for approval.

## Co-Occurring Mental Health Treatment

As it is well known and documented, successful addiction treatment is not guaranteed when co-occurring psychiatric issues are not identified and simultaneously treated. We encourage recognition and treatment of co-occurring disorders. ([samhsa.gov/co-occurring/topics/healthcare-integration/index.aspx](http://samhsa.gov/co-occurring/topics/healthcare-integration/index.aspx))

## Prescription Opiate Abuse

Prescription drug abuse is already being addressed by federal, state, and local officials. More needs to be done in terms of prescriber education about addiction and pain

issues, appropriate prescribing of opiates in general, and the ethics of appropriate prescribing. Prescribers and dispensers need to be encouraged to make use of the prescription monitoring programs available in their states to help curb the prescribing to patients that are abusing Controlled Dangerous Substances.

It is our belief that these recommendations, if seriously reviewed and accepted, will significantly change our experience with opiate abuse, misuse, and addiction treatment. While it is generally expected that federal, state, and local agencies will address the illegal aspects of this epidemic, the treatment side of the equation is part of the solution, as well. Patients who suffer from addiction are entitled to the same full, evidenced-based treatment as any other patient who suffers from a chronic medical illness. Patients with addiction should not have evidence-based treatment practices nor FDA-approved medications withheld because of non-clinical concerns. The implementation of just a few recommendations will surely make an impact on this current epidemic and treatment crisis in our nation.

— *Louis E. Baxter, Sr, MD, FASAM*

*Immediate Past President*

*American Society of Addiction Medicine Director  
American Board of Addiction Medicine*

— *Alan Stevens, MSW, LSW, ACSW*

*Behavioral Health of the Palm Beaches*

## THE IMPACT OF MANAGED CARE ON ADDICTION TREATMENT: AN ANALYSIS

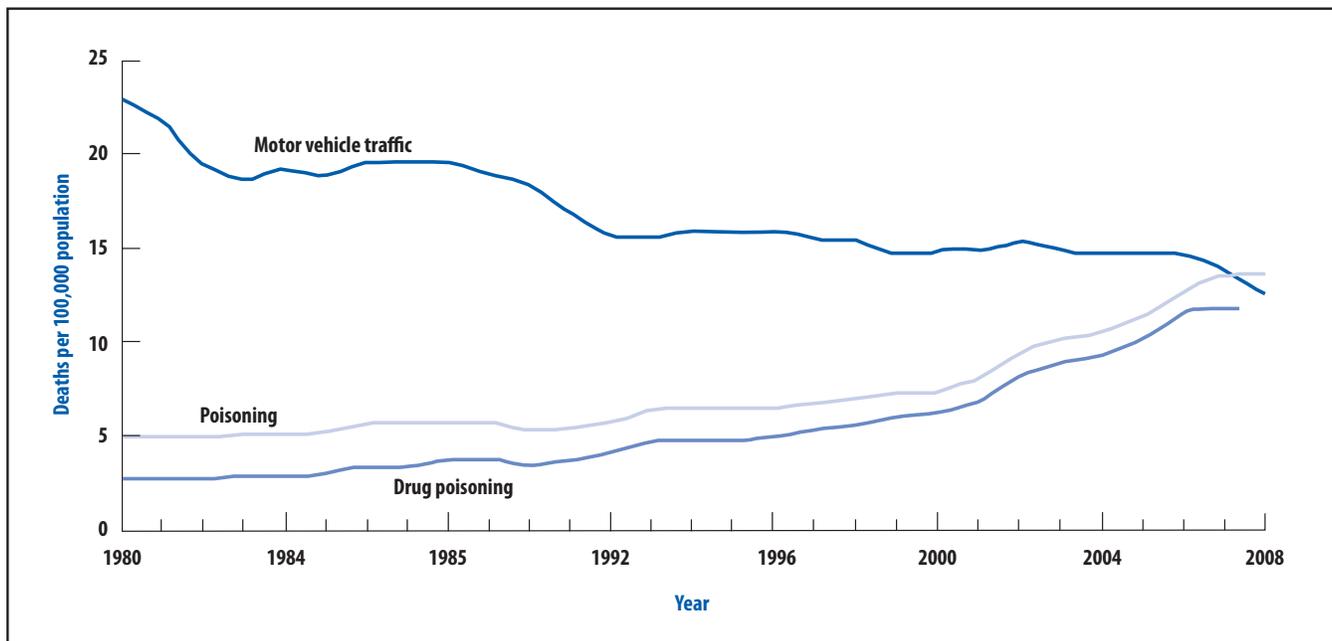
### Introduction

*Opiate addiction and the treatment of opioid dependence has received increased attention in recent years, associated with the epidemic rise in cases of opioid misuse, abuse, dependence, and overdose deaths in the United States.*

In our society as a whole, we are losing productivity in the workplace and the classroom; experiencing increasing societal costs as a result of crimes and the costs of incarceration; and increasing the financial burden on federal and state budgets; all of which is due to poorly conceived policies for paying for addiction treatment services. Addiction to opioids — both prescription drugs and heroin — is a national epidemic.

There is a significant rise in the number of cases presenting to addiction treatment facilities where opioid dependence is the primary diagnosis. Associated with the increase in cases of abuse and dependence — and, arguably one of the contributing factors to the recent epidemic — is the dramatic increase of number of prescriptions for opioid analgesics

### Motor vehicle traffic, poisoning, and drug poisoning deaths rates: United States, 1980–2008



**More needs to be done in terms product development and safety, prescribing and marketing education, and prescription drug monitoring and regulation. Equally important is the need for better patient access and appropriate level of addiction treatment.**

authorized in the past 15 years. According to the *National Survey on Drug Use and Health*, as highlighted by the White House Office of National Drug Control Policy (ONDCP), there has been more than a 400 percent increase 1997–2007 in the number of cases of opioid abuse and dependence, which has led to increases in the need for treatment.

According to the Centers for Disease Control and Prevention, *accidental deaths by poisoning and drug overdosing have now exceeded deaths from motor vehicle accidents (MVs)*. They have been on the decrease due to a national crackdown on driving under the influence of alcohol and increased safety demands on auto manufacturers, as well as laws to increase seatbelt usage. In contrast to policy initiatives that have reduced the number of highway deaths, policy changes regarding opiate pain medications have not yet impacted the increases in the number of prescription drug-related deaths. Public policy reforms are needed across all levels of government (federal, state, local) to stop this rampant epidemic that has killed more Americans in the past two years than died during the entirety of the Vietnam War. (See figure above.)

#### **Insurance Company Denial of Access to Appropriate and Clinically Indicated Opiate Addiction Treatment Levels of Care**

While interventions can be made on many levels to reduce the rates of inappropriate prescribing of opioids, to improve the education of both prescribers and patients about this epidemic, to target overdose deaths directly via

the use of overdose reversal medications, to increase the use of safe prescription drug disposal and “take-back” programs for unused opioid pill supplies, no one should ignore the role of addiction treatment services in addressing the epidemics of opioid addiction and opioid overdose deaths. Clinical interventions for the best possible outcomes must include four basic elements: detoxification, rehabilitative counseling, continuing care, and medication assisted therapy (when indicated). (*National Quality Forum Standards for the Treatment of Substance Use Disorders 2007*). Detoxification services are essential in assisting patients to achieve a state of abstinence, but the ultimate goal of sustained abstinence cannot be obtained by detoxification only. Unfortunately, too many stakeholders in addiction treatment represent that detoxification alone is treatment. Detoxification alone only increases the probability of relapse into active use and overdose deaths. Studies on the outcome of detox-only interventions are not promising with regard to the rates of sustained abstinence and recovery achieved after such services.

A recent study of inpatient detoxification versus outpatient detoxification for opiate treatment shows that *inpatient detoxification for opiate addiction is superior to outpatient detoxification (51.4% versus 36.4%)* in terms of completing treatment. (*Journal Substance Abuse Treatment*. 2011 Jan; 40(1):56–66)

Furthermore, it is vitally important that individuals with any addiction be able to access the appropriate level of addiction care. The levels of care for addiction treatment vary. The *American Society of Addiction Medicine Patient*

*Placement Criteria 2-R (ASAMPPC-2R)* is the only beta tested peer-reviewed patient placement tool that is widely accepted in the addiction treatment field by treatment providers and managed care agencies. Concisely, it can predict, with reasonable clinical accuracy the level of care a patient requires. The levels range from *level 0.5* (brief intervention); *level I* (traditional individual outpatient); *level II* (Intensive Outpatient); *level III* (Residential); and *level IV* (Hospital based). The appropriate selection of the next level of care after detoxification is critical to the entire treatment outcome.

*When patients are limited to detoxification only or are not allowed access to the next indicated level of care, the result is predictably less than optimal.* These patients fail and may need to start treatment all over again or they die from overdose due to an ineffective “treatment” that they underwent as a result of denied access to the appropriate level of care. In a study published in the *Journal of the American Medical Association (JAMA)* 2004 A. Thomas McLellan, PhD) it was learned that when patients receive the aforementioned four essentials of addiction, their treatment outcomes were equal to or better than treatment outcomes of other chronic medical illnesses (diabetes, hypertension, and asthma). Surprisingly to many, *opiate dependent patients recovered at a rate of nearly 80% at one year compared with a 50% recovery rate for diabetics.* Most of those successful opiate dependent patients underwent *inpatient detoxification and residential rehabilitation stays.*

The application of multiple episodes of detoxification-only services will drive up health care costs without reducing the overall rates of addiction or the rates of disability or death attributable to opioid addiction. Studies show that inpatient detoxification and residential treatment have completion rates of up to 81% while outpatient detoxification treatment have completion rates that are much lower (Outpatient versus inpatient opioid detoxification: a randomized controlled trial. Day, E. *Journal Substance Abuse Treatment.* 2011 Jan; 40(1); 56–66).

While inpatient treatment is more costly when compared to outpatient detoxification only and outpatient treatment, repeat detoxifications and outpatient treatment, as a result of an inappropriate initial selection, is wasteful and ultimately costs more. *Inappropriate treatment selection is detrimental to patient health and is a waste of already limited financial resources available for addiction treatment.*

We firmly believe that offering a medical necessary continuum of psychosocial, as well as medication assisted therapy when indicated, following of Levels of Care as outlined in the American Society of Addictive Medicine (ASAM) Patient Placement Criteria, results in an enhanced likelihood of success, greater compliance and less chance of recidivism. Thus, for “drug free treatment” of opioid

addiction, this could include several weeks of residential treatment where detox could be accomplished on a non-outpatient basis; followed by step-down to several weeks of *Partial Hospitalization Program (PHP)*; followed by up to *90 days of Intensive Outpatient Program (IOP) care; followed by six or more months of professional follow-up via individual and group recovery-oriented therapy.* Some patients benefit from *halfway house or sober-living-house services* to provide a stable recovery environment when they are stepped down from Level III (residential care) to Level II (PHP and IOP care) and Level I (ongoing individual and group therapy) care. This continuum of care presents the best model for achieving abstinence via psychosocial therapies, and supplementing this professional help with peer support through the self-help programs of Narcotics Anonymous or other 12-Step groups, can improve outcomes even more. Because of the chronic nature of the illness of addiction, *12-Step participation* for a lifetime is the commitment that many persons in recovery make and uphold.

*Continued misguided denial of access to the appropriate levels of care established by national expert organizations Substance Abuse and Mental Health Services Administration (SAMHSA), National Quality Forum (NQF), and ASAM and controlled best practice studies is not cost effective or clinically prudent in the care of patients with addictions.*

—**Louis E. Baxter Sr., MD, FASAM**  
**Immediate Past President**  
**American Society of Addiction Medicine Director**  
**American Board of Addiction Medicine**

—**Alan Stevens, MSW, LSW, ACSW**  
**Behavioral Health of the Palm Beaches**

## **SOUTHEAST REGION MEETS ON AMELIA ISLAND, FLORIDA**

Representatives from the Federation’s southeast region met on September 15 and 16 in Amelia Island, Florida, hosted by Judy Rivenbark, MD, Medical Director of the Florida Professionals Resource Network. The conference included continuing medical education presentations on several topics related to physician health, with a focus on the assessment and monitoring of physicians with cognitive issues. Southeast programs were represented by Eric Hedberg, MD, from Alabama, Judy Rivenbark, MD, and Lynn Hanks, MD, from Florida, Scott Hambleton, MD, FASAM, Medical Director, Mississippi Professionals Health Program, Warren Pendergast, MD from North Carolina, Roland Gray, MD, from Tennessee, and Penny Ziegler, MD, from Virginia.

Dr. Pendergast presented an update on the Federation, focusing on changes that will be needed at year’s end (2012),

when no further financial support will be available from the American Medical Association. This will include making decisions about administration of the FSPHP and identifying new sources of revenue. The membership committee is working on a plan for the organization to become more inclusive in its membership, while avoiding potential conflicts of interest. Plans for the next annual meeting in Boston are coming together.

Dr. Gray discussed the Tennessee Medical Foundation's (TMF) efforts to contract with Tennessee Blue Cross Blue Shield (BCBS) to institute advocacy for participating physicians, to encourage referral of possibly ill physicians to TMF, and to prevent physicians with board of medicine action, and, in the monitoring program, from being automatically dropped from the panel of approved providers. Lynn Hanks discussed return to work issues for PHP participants and his participation, along with Michael Gendel, MD, from Colorado, in a Committee of the Federation of State Medical Boards, which is working on criteria for return to practice and practice restrictions. FSPHP is also in discussions with the American Board of Medical Specialties to address the automatic action of some specialty boards to revoke board certification of physicians with formal disciplinary action.

There was an open discussion of various regional state medical boards' attitudes toward addiction and recovery, mental health, and other issues that bring physicians to the attention of their respective boards. There was general agreement that no one can predict the impact of the Affordable Care Act and other changes in medical care delivery on the overall field of physician health.

## 2012 NORTHEAST REGION FALL CONFERENCE

The Rhode Island Physician Health Program and Rhode Island Medical Society graciously hosted the fall northeast regional conference in Providence, Rhode Island on October 5, 2012. Virtually all the northeastern states and the Ontario program sent representatives, making this an exceptionally collegial and dynamic conference. Representatives included our Rhode Island hosts, Herbert Rakatansky, MD, Martin Kerzer, DO, Robert Crausman, MD, and Rosemary Maher, LICSW, ACSW; Washington, D.C.: Daniel Perlin, MD; Pennsylvania: Shirley M. Stuppy, Lois H. Verna, MAC, LPC, and Jon Shapiro, MD; Ontario: Michael Kaufman, MD; New York: Terry Bedient, FACHE, and Jeffrey Selzer, MD; New Hampshire: Sally Garhart, MD, and Deanne Chapman, PA-C; Maine: Cathy Stratton; Massachusetts: Luis Sanchez, MD, Linda Bresnahan, MS, Debra Grossbaum, JD; Maryland: Chae Kwak, LCSE, Stephen Johnson, JD, Susan Bailey, MD; Connecticut: Maureen Sullivan Dinnan, JD, and Linda Barile, PhD, RN.

As the Connecticut medical marijuana law became effective October 1, 2012, Maureen Dinnan gave a presentation on the impact of medical marijuana on PHP programs. Revisions to the agreements with professionals and other forms in the Connecticut and Rhode Island programs were shared as examples of ways to address some of the concerns medical marijuana raises. States who have been facing the challenge of medical marijuana shared their experiences and perspectives.

Dr. Jeffrey Selzer and Dr. Herbert Rakatansky presented on the challenges of returning physicians to practice and how to deal effectively with specialty boards. A particular concern is the effect of losing specialty board status on a physician's privileges within a health care organization. Loss of this status can result in loss of privilege and insurance eligibility even in the case of a physician who was never viewed by the PHP or the licensing board as being unsafe to practice. The role of the Federation in helping state programs work with specialty boards was highlighted.

The "art of transferring cases" and how to more effectively collaborate on multi-state monitoring was demonstrated in a panel discussion with Rosemary Maher, Rhode Island PHP, Sally Garhart, MD, New Hampshire PHP, and Cathy Stratton, Maine PHP. The panel used experiences where multi-state monitoring worked well and where it did not to suggest a pathway drafted by Cathy Stratton for the region's consideration.

While the formal presentations generated thoughtful discussion, the open sharing of each program's successes and challenges in the past year was the highlight of the conference for many participants. The conference also provided a great opportunity to recognize Dr. Luis Sanchez upon his retirement as Massachusetts' PHP Medical Director. Dr. Sanchez not only served as a leader in the Federation and the Northeast Region, he is also a recognized expert in physician health and impairment nationally and internationally. Perhaps Dr. Sanchez's most important contribution to our field is his generosity as a mentor, whose insightful advice has helped to so many of us. We hope Dr. Sanchez will stay involved in physician health while enjoying retirement.

Sometime after the regional conference, Rosemary Maher, LICSW, who has been the administrator for the Rhode Island Physician Health Program (RI PHP) for 12 years, a former northeast regional director, and active member of the Federation, resigned from her position at RI PHP and accepted a hospital-based social work position. Rosemary always made herself available for advice and as a mentor new members of the Federation, offering much practical advice and wisdom. Her influence on this conference's agenda underscores her passion for solving any problem presented to her. She will be missed by physicians in Rhode Island, as well as by her friends within the FSPHP.



**Dr. Luis T. Sanchez (left) with Dr. Jeff Selzer, Director of the NY PHP, was recognized for his dedication and service to the FSPHP. Dr. Sanchez will be retiring as Director of the Massachusetts' Physician Health Services in the spring of 2013.**

## NEWS FROM PHYSICIAN HEALTH SERVICES, INC., (PHS) AND THE MASSACHUSETTS MEDICAL SOCIETY

### ***Steven Adelman, MD, Named Director of Massachusetts' Physician Health Services***

Steven Adelman, MD, director of behavioral health and addiction medicine at Harvard Vanguard Medical Associates, has been named Director of Physician Health Services, Inc., a nonprofit corporation founded by the Massachusetts Medical Society, and which provides confidential consultation and support to physicians, residents, and medical students facing behavioral, mental, or physical health concerns. He succeeds Luis Sanchez, MD, who announced his retirement in April 2013 after 14 years of service to the organization.

Dr. Adelman's appointment, effective March 18, 2013, was announced by Edward J. Khantzian, MD, President and Chairman of the Board of Directors of Physician Health Services, Inc., a practicing psychiatrist, and a clinical professor of psychiatry at Harvard Medical School.

"Physician Health Services has grown and thrived under Dr. Sanchez," said Dr. Khantzian. "We are deeply indebted to him, and his dedication and leadership will be sorely missed. But we are excited to have Dr. Adelman join us, as his wealth of knowledge and experience in the field of behavioral health and addiction medicine will help us maintain the high standard of excellence and national

recognition in the field of physician health for which our organization has become known. We welcome him and look forward to his stewardship of Physician Health Services."

"I have worked with Dr. Luis Sanchez for more than a decade," Dr. Adelman said, "and I have greatly admired him, his work, and the PHS organization. I am fortunate to have been chosen for this position, and I regard this as a once-in-a-lifetime opportunity. I look forward with enthusiasm to continuing the excellent work of PHS in caring for our colleagues facing serious health issues."

Board certified in psychiatry and addiction psychiatry, Dr. Adelman is currently the director of behavioral health and addiction medicine at Harvard Vanguard Medical Associates (HVMA), where he manages a staff of 130 mental health professionals and where he has practiced for nearly 20 years. He is also a founding trustee of HVMA.

A graduate of Harvard College and the University of Pennsylvania School of Medicine, Dr. Adelman completed his internship, residency, and chief residency at McLean Hospital and was a fellow in addiction medicine at UMass Memorial Medical Center.

He is currently a clinical associate professor of psychiatry at the University of Massachusetts School of Medicine, where he was the director of outpatient psychiatry and the primary psychiatrist on the Physicians' Health Committee. He has also served as an addiction consultant to the National Institute of Alcoholism and Alcohol Abuse, as well as a number of health care organizations, law firms, and sports franchises.



The Northeast Region FSPHP Conference on October 5, 2012, hosted by the Rhode Island Physician Health Program and the Rhode Island Medical Society.



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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 required to submit written requests for consideration directly to regional directors instead of to the board. This will ensure an organized chain of communication between you and your representatives. Thank you for your assistance!



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## OBJECTIVES

The conference is being organized around six objectives:

- ▶ Describe different models and best practices of physician health programs for the benefit of professionals and patients alike through education and monitoring.
- ▶ Evaluate controversies of the use of controlled substances including the use or prescribing of medical marijuana for professionals being monitored for substance use disorders.
- ▶ Examine the latest research on the efficacy of physician health programs today and how programs promote patient safety.
- ▶ Evaluate and compare outreach, education, and health monitoring practices and their outcomes.
- ▶ Summarize testing methodologies available for monitoring and how monitoring enhances patient safety.
- ▶ Analyze the impact that implementation of the DSM-V will have on treatment and monitoring of health care professionals.

## HIGHLIGHTS

- ▶ Extensive opportunity to visit a wide range of exhibitors offering services in the field.
- ▶ A forum for education and exchange of information among state PHPs.
- ▶ Opportunity to network with professionals from the United States, Canada, and other parts of the world.
- ▶ Dedicated to assessing, monitoring, and treating physicians with potentially impairing conditions.
- ▶ FSPHP regional membership meetings.
- ▶ FSPHP committee meetings.
- ▶ FSMB joint session providing an opportunity to interface with your state board.

## GENERAL SESSIONS

- ▶ **General Session 1** — Program Development: Two Key Initiatives to Strengthen Patient Safety and Continuous Quality Assurance  
Sarah R. Early, PsyD., Patty Skolnick, and Cae L. Allison, LCSW
- ▶ **General Session 2** — Long-term Follow-Up of Physician Health Program Participants: An Ongoing Study  
Scott Hambleton, MD, Robert L. Dupont, MD, Lisa J. Merlo, PhD, MPE, and Gregory Skipper, MD
- ▶ **General Session 3** — Joint FSPHP/FSMB Meeting
- ▶ **General Session 4** — Substance Abuse Monitoring of Physicians  
Michael Kaufmann, MD, Cynthia MacWilliam, MBA, Ann Davidson, MSW and Sherri Klein, MA
- ▶ **General Session 5** — Exploring the Reliability, Frequency and Methods of Drug Testing: What Is Enough to Ensure Compliance?  
Martha E. Brown, MD, Judy Rivenbark, MD, Debbie Troupe, LMHC, CAP, Jean D'Aprix, BA, RN, CARN, and Gregory Skipper, MD
- ▶ **General Session 6** — Professionalism and Peer Support  
Jo Shapiro, MD
- ▶ **General Session 7** — Design of an Auditing System for a Monitoring Program  
Penelope P. Ziegler, MD, and Janet S. Knisely, PhD

***PLAN TO ATTEND OR EXHIBIT!! FOR MORE INFORMATION VISIT FSPHP.ORG.***



MASSACHUSETTS  
MEDICAL SOCIETY

## SAVE THE DATES

**WEDNESDAY, OCTOBER 2, 2013**  
**10:00 AM TO 4:00 PM**

Northeast Federation of State Physician  
Health Programs Administrators Meeting

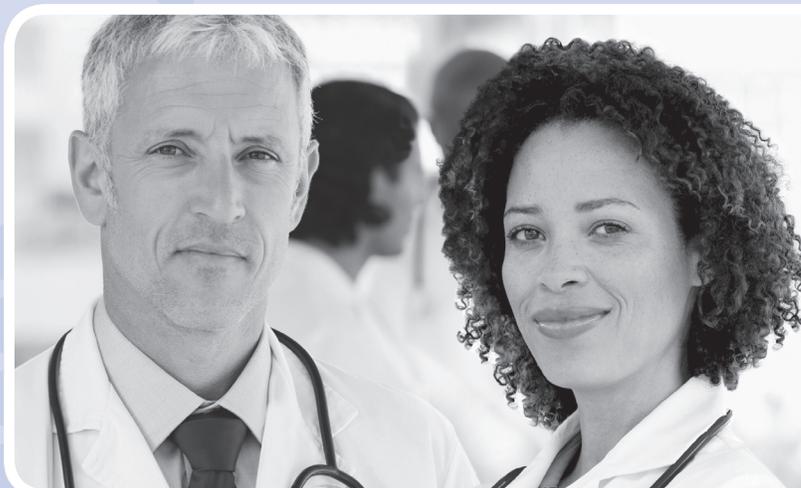
**THURSDAY, OCTOBER 3, 2013**  
**8:00 AM TO 4:00 PM**

Caring for the Caregivers IX  
Educational Sessions

Massachusetts Medical Society  
Headquarters at Waltham Woods  
Waltham, Massachusetts

## PHYSICIAN HEALTH SERVICES, INC.

A Massachusetts Medical Society corporation



## Caring for the Caregivers IX

WHAT ARE WE GOING TO DO ABOUT PHYSICIAN STRESS AND BURNOUT?

For more information on these events or if you are interested in learning methods to improve your health or that of colleagues, please call PHS at (781) 434-7404. You may also visit us online at [www.physicianhealth.org](http://www.physicianhealth.org). If you are interested in individual or corporate sponsorship or exhibiting, please call (781) 434-7404. Contributions to Physician Health Services, Inc., in all amounts, are welcome and are tax deductible.

## PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS' NATIONAL MEETINGS

### FSPHP Annual Meeting

April 19–22, 2013  
Hyatt Regency  
Cambridge, MA

### FSMB Annual Meetings

April 18–20, 2013  
Sheraton Boston Hotel  
Boston, MA

April 24–26, 2014  
Hyatt Regency Denver at Colorado  
Convention Center  
Denver, CO

### 2013 Canadian Conference on Physician Health

November 15–16, 2013  
Hyatt Regency Calgary Hotel  
Calgary, Alberta, Canada

### 2014 International Conference on Physician Health

London, England

### American Academy of Addiction Psychiatry Annual Meeting & Symposium

December 5–8, 2013  
Scottsdale Resort and  
Conference Center  
Scottsdale, AZ

### AMA House of Delegates Annual Meeting

June 15–19, 2013  
Hyatt Regency Chicago  
Chicago, IL

### AMA House of Delegates Interim Meeting

November 16–19, 2013  
Gaylord National  
National Harbor, MD

### American Psychiatric Association Annual Meeting

May 18–22, 2013  
San Francisco, CA

### American Society of Addiction Medicine

April 25–28, 2013  
Chicago, IL

April 10–13, 2014  
Orlando, FL

### International Doctors in Alcoholics Anonymous (IDAA) Annual Meeting

July 31–August 4, 2013  
Keystone Resort  
Keystone, CO

### Northeast FSPHP Membership Meeting

October 2, 2013  
Waltham, MA

### Caring for the Caregivers

October 3, 2013  
Waltham, MA

### Managing Workplace Conflict

March 7–8, 2013  
Waltham, MA

## FSPHP NEWSLETTER ADVERTISING 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. Articles and notices of interest to the physician health community, the newsletter includes planning information about the upcoming physician health meetings and conferences including FSPHP meetings.

**NEW!** We offer ad design and proofreading services for an additional fee. For your convenience, full ad specifications and PDF instructions can also be provided upon request.

We hope you will consider taking advantage of this once-a-year opportunity to advertise your facility, services, and contact information. Become part of a great resource for state physician health program professionals.

We look forward to working with you in future editions.

### FSPHP Publication Committee

Linda Bresnahan, MS (MA)	Carole Hoffman, PhD, LCSW, CAADC (IL)
Sarah Early, PsyD (CO)	Linda Kuhn (TX)
John Fromson, MD (MA)	Charles Meredith, MD (WA)
Scott Hambleton, MD (MS)	

### 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 1-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 Word document and high-resolution logos and graphics (if applicable). Maximum 2 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@mms.org](mailto:lbresnahan@mms.org)