PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs

Welcome to the 21st edition, Volume 1 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.

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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.

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PRESIDENT'S MESSAGE

P. Bradley Hall, MD

P. Bradley Hall, MD

I attended my first Federation Annual Meeting in 2006 and never before had I been so openly and warmly welcomed by a group with such experience, expertise, and passion toward the work they do. I was new in developing a physician health program (PHP) in West Virginia. Over the next two years I was the recipient of incredible guidance of many "lions in the field" of physician health, the FSPHP guidelines and many other state PHP documents which were openly shared

continued on page 2

IN THIS ISSUE

President's Message 1
Message from the Executive Director 3
FSPHP Updates 4
Results from the WPHP Client Exit Survey: What Graduating Participants Are Really Saying on the Way Out the Door 7
Designing Client Exit Surveys to Capture Program Effectiveness Data 8
Comparing the Commercial Airline Pilots Monitoring, the HIMS Program, with the PHP Model 8
Risk Management of Physician Health Programs 9
Physician Health Program Risk Management: Day-to-Day PHP Practices 10
An Overview of the Ontario Medical Association's Physician Health Program Assessment Service 11
The Role of the Polygraph in Independent Comprehensive Evaluation for Professional Sexual Misconduct 12
FSMB And FSPHP: "Where are We Headed?" 13
To Bupe or Not to Bupe: That Is the Question 13
Essential Components of Physician Health Program Participation: Perspectives of Participants Five Years Post-Graduation 14
Use of Polygraph in the Assessment, Treatment, and Monitoring of Physicians 15
Five Fundamentals of Civility for Physicians 16
Creating a Cooperative Family Approach to Lasting Sobriety by Expanding the Essentials of the Physician Health Programs 17
Being Prepared: Relapse Prevention and Occupational Hazards for Healthcare Professionals 18
Psychological Assessment Data of Healthcare Professionals Presenting for Evaluation 18
In Their Own Words: Stressors Facing Medical Students in the Millennial Generation 19
Implementation of a Fitness Assessment and Optimization of an Exercise Program for Physicians in Substance Use Disorder Recovery 21
Outcomes for Physicians with Opioid Dependence 22
Multidisciplinary Perspective on Making Reasonable Suspicion Drug Testing More Efficient and Effective 22
Physician Health and Other Related Organizatons National Meetings 29

President's Message
continued from page 1

without expectation beyond the simple goal of developing the West Virginia Medical Professionals Health Program (WVMPHP) as an independent not-for-profit 501(c)3. In 2007, Senate Bill 573 was passed, allowing for the existence of a PHP and also the successful incorporation of the WVMPHP. With hesitancy and great trepidation (and no regrets), I became the founding medical director and we were up and running, taking in our first participant November of that year. My experience in the development of the WVMPHP with you all is the epitome of "I can't, but we can," and for that, I thank you.

Without the FSPHP and its membership, there would have been no trail to follow. West Virginia did not have to reinvent the wheel but learned from others who had gone before and were so graciously willing to share their knowledge and experience. I cannot fathom the numerical dollar value of the FSPHP membership to West Virginia. Since that time, the value has only increased. I would be willing to pay $5,000 per year to maintain West Virginia's membership and my access to this esteemed group. Today, I find myself writing my first "Message from the President," wondering how I got here. Well, I had a lot of help from YOU! I now want to give back to the organization and its members which gave so freely to me.

In the last ten years, I've never had greater fortune to work with such talented and dedicated friends and colleagues. The hard work of leadership, committee chairs, and volunteers is contagious to the betterment of our organization and the professionals we serve. This collective represented by the "we" puts the "I" of West Virginia in its proper perspective as part of the organization I have grown to love and respect.

During my presidency, my hope is to continue building upon the success of those who have brought the FSPHP to where it is today. I hope to further our organizational infrastructure stability in order to best serve our membership. I hope to work to continue to change the culture of society and the house of medicine to evolve PHPs with positive messaging through increased education of the benefits of the good work we do. On a parallel track we will continue to develop and strengthen our current relationships with national organizations such as the American Medical Association, the Federation of State Medical Boards, the American Board of Medical Specialties, and the American Psychological Association toward increased communication and resulting collaborations, while also fostering new relationships with more organizations who benefit from the work of PHPs such as the American Osteopathic Association, the American Hospital Association, and the National Organization of Alternative Programs.

As part of furthering our organizational transition to complete independence, this will include continuing the strategic goals established during the presidency of Doris Gundersen, MD. With the help of the FSPHP membership and leadership, full-time Executive Director Linda Bresnahan, and the administrative support of Julie Robarge, I believe our goals can continue to move forward. These goals are worthy of our continued commitment.

The first goal is to increase funding. The FSPHP board of directors formed a **funding work group** *committed to increasing our organization's revenue significantly over a two-year period*. The group's plans include the following:

- Developing a Funding Development Committee to design a case for FSPHP financial support
- Identifying and soliciting donors, including associations, foundations, and organizations invested in the health of physicians and healthcare professionals
- Increasing sponsorship and grant opportunities

Secondly, the board formed an **Accountability, Consistency and Excellence (ACE) work group** *to improve accountability, consistency, and excellence by developing and implementing an FSPHP-endorsed review process*. This comes following the successful development of sound guidelines for performance enhancement reviews (PER) of PHPs. It is the FSPHP's goal to provide a tool to measure the quality of each respective PHP's work and create an opportunity for improvement where and when needed.

The work groups objectives include the following:

- Developing member-endorsed PER guidelines for PHPs
- Securing funding and identifying of a partner to develop an FSPHP-endorsed PER process
- Developing and piloting an FSPHP-endorsed PER program
- Updating FSPHP guidelines via the ACE Committee
- Developing a review process for identifying a range of evaluation and treatment options for the safety-sensitive professional

The third major goal involves the newly formed **Education, Communication, and Research in Physician Health** work group, which is looking to *increase education about the value of PHPs via media relations, communication strategies, and research by October 2018*. Over time, through our successful networking efforts, educational presentations at national meetings, and growing research, FSPHP has gained credibility and respect for our expertise in physician health. As a public organization, we must develop media relations and continue to expand our representation of the good

work of PHPs at the state and national level. Research supporting our efforts along with education will be invaluable. This goal includes the following:

- Offering media training to FSPHP members
- Developing a library of physician health education presentations
- Developing a speakers' bureau
- Partnering with researchers in academic institutions to design and implement PHP studies
- Developing a PHP Leadership Education Program

During my tenure as president, I hope to facilitate the FSPHP's ability to fulfill its mission *"to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care."* As president the most gratifying thing I can do is focus on the FSPHP organizational maturation and associated goals in hopes of leaving it improved, financially and strategically, during my limited time of service. To do so I will continue to need your help with the power of "WE." I am so blessed to be a part of this organization!

Your president, colleague, and friend,
P. Bradley Hall, MD ■

MESSAGE FROM THE EXECUTIVE DIRECTOR

Linda Bresnahan, MS, Executive Director

Linda Bresnahan, MS

Since our last FSPHP newsletter issue in the spring of 2016, a lot has changed for the organization! I am still amazed at how much change has occurred for me. While leaving the Massachusetts Medical Society after 25 gratifying years with so many wonderful friendships and peers was difficult, I couldn't be more pleased or feel more fortunate to be where I am with all of you.

It is an incredible privilege to work with individuals in our membership who possess such purposeful dedication, expertise, and passion. I recognize that I am blessed to work for such a meaningful mission with such tremendous impact to the health of physicians and healthcare providers. The current progress particularly at the FSPHP strategic retreat, coupled with the intense dedication of the FSPHP leadership and board of directors, resulted in the motivation for me to make this change. So many board members provide countless hours, evenings, and weekends to the FSPHP; this was especially true over the past nine months while we navigated this organizational change.

Just as I did over the past years at the Massachusetts Medical Society, I continue to relish and learn from the relationships I have with those I work with, and look forward to having more time to connect with FSPHP members this way and build stronger relationships with all the professional organizations interested in the work of physician health programs (PHPs) and the FSPHP.

In summary, I want to briefly highlight some of the key priorities for FSPHP:

- **FSPHP website:** While we went live last January and our site has a fresh new look, more opportunity exists to improve the content and develop our member content.
- **The FSPHP Annual Meeting:** This continues to be a major priority for FSPHP, and plans are in full swing for the 2017 Meeting! Many thanks to the Florida Medical Association's assistance with our CME process.
- **Launch of the FSPHP strategic goals:** As outlined, the three top priorities to further strengthen FSPHP are to increase funding; develop an FSPHP-endorsed review process to enhance accountability, consistency, and excellence; and increase education and research in the field.
- **Transition plans for FSPHP infrastructure:** While many of the transition specifics are behind us, there are still several internal processes and corporation matters under review.
- **Committee support:** Great efforts by FSPHP leadership have been in progress to increase committee participation to respond to members' requests to be involved. Recognizing FSPHP needs your help, many of the committee memberships have expanded, and we are seeking more ways to help support the work of FSPHP committees.
- **Membership:** In the fall and winter of 2016, FSPHP memberships will be available for renewal for 2017. New members can join starting October 1 and receive three additional free months of membership for 2016 along with their 2017 membership. This year ahead, the FSPHP, under the leadership of the Membership Committee, looks forward to growing our membership by gathering potential new member information from you. So please encourage your committee, staff, board members, therapists, professional coaches, and others aligned with the FSPHP mission in your state to join FSPHP. Membership information is available at www.fsphp.org/membership. We currently have 47 state PHP members, 113 Associate Members (13 new members!),

continued on page 4

Message from the Executive Director
continued from page 3

14 International Members (3 new members), 6 honorary members, 13 individual members, and 3 organizational members for a total of 16 new members this year, and 196 total members! We look forward to growing this number with you. ■

FSPHP UPDATES

AMA International Conference on Physician Health Highlights

Many FSPHP members recently attended this conference in Boston, during which key learning points focused on restoring the joy in medicine and methods to restore the satisfaction in medicine.

Some favorite sessions from our FSPHP members who attended included the following:

- **Dr. Christine Sinsky's plenary session "Joy in Practice: Why It's Missing, Why It Matters and What Can Be Done."** Dr. Sinsky highlights ***"Care for Patients Requires Care of the Provider."*** She also conveys a powerful message about the shared responsibility of physicians and the system to address changes. She pointed attendees to her website, www.drsinsky.com, to review her work. A variation of her slides can be found on this page of her site: http://static1.squarespace.com/static/527a6f47e4b06d382162aed0/t/529d5a37e4b0731715b283a7/1386043959079/STFM.11.22.13.handout.pdf.

  Her website also provides the study in which she demonstrated the tremendous burden and percent of time physicians place on administrative work, including electronic medical records, along with some examples of effective solutions implemented into practices to restore physicians' time with their patients and lessen some of these burdens.
- Suzie Brown, *"My Life as a Guitarologist"*: She inspired us to live to its fullest. You can read about her here: www.suziebrownsongs.com.
- Jon Kabat-Zinn, PhD (www.mindfulnesscds.com) and Saki Santorelli, EdD, MA (www.umassmed.edu/cfm/about-us/people/2-meet-our-faculty/santorelli-saki): Their mindfulness presentations were well received.
- Minda Miloff's well-received presentation, *"Energize Your Time: How to Be a Better Manager of Your Most Important Resource,"* focused on time management and the importance of looking at it from the perspective of energy-draining or energy-producing tasks. More of her work can be found at www.coachminda.com.
- M. Rosenberg and R. Hawkins' talk, *"Changing the Face of Health Care through Compassionate Physician Leadership,"* was mentioned.

A few strong messages arose from the conference:

- Technology is here to stay, yet the message is loud and clear that the current electronic medical records are not well done, and remedies need to be afforded as soon as possible.
- **Quadruple Aim:** The health of the physician matters in patient care!
- **Unity:** Physicians are coming together on the subject of burnout, self-care, and renewal.
- Care of the patient requires care of the provider.
- Shared responsibility with the provider and the system are needed to develop remedies. ■

California Legislation Passes — Statewide PHP to be Established! What we have all been waiting for — the reestablishment of a CA PHP!

In September 2016, California Governor Jerry Brown approved a statewide program for early identification and treatment of physicians! On September 24, 2016, the California Society of Addiction Medicine issued a press release, and you can read it here: www.prweb.com/releases/2016/09/prweb13682141.htm#.V-cdJ-i0GLY.email.

You can read the full text of the bill — now part of the Business and Professions Code (commencing with Section 2340) — here: www.leginfo.ca.gov/cgi-bin/postquery?bill_number=sb_1177&sess=CUR&house=B&author=galgiani_%3Cgalgiani%3E. ■

American Psychiatric Association (APA) Work group on Physician Health

The FSPHP was invited to meet with the APA on September 16 in Washington, DC, during their mid-year meeting to review emerging issues. Dr. Doris Gundersen represented the FSPHP at this meeting with members of the three APA committees, which have joined on the topic Physician Health, including the APA Council on Psychiatry and Law, the APA Committee on Judicial Action, and the APA Council on Addictions. During this session, members of the FSPHP board of directors participated by conference call. Feedback from the APA on this session was positive, and further collaboration is anticipated. Dr. Gundersen did an

outstanding job representing the FSPHP and providing education to the APA. ■

FSPHP Strategic Plan Achievements to Date

With the assistance of a skilled nonprofit strategic retreat consultant, the FSPHP board of directors met September 16 and 17 to review and update the strategic goal plans formed last year. The board members are divided into work groups to address each of these goals to help the organization with specific action items identified to align with each of these goals. The different work group members have roles with various FSPHP committees, which have a part in carrying out these same goals through the work of their committees.

As a review, here are the FSPHP Strategic Goals, a few key action items within each plan, and the achievements to date:

I. The FSPHP formed a funding work group committed to increasing the organization's revenue significantly for the purposes of achieving much needed growth and enhancements of FSPHP services outlined in the strategic plan.

Key Action Items

- Develop a Funding Development Committee to design a case for FSPHP financial support
- Identify and solicit to donors to diversify revenue including associations, foundations, and organizations invested in the health of physicians and healthcare professionals
- Increase sponsorship and grant opportunities
- Review of FSPHP membership dues as compared to other organizations

Achievements

- **Members of the board of directors have personally donated just over $9,500 to FSPHP! Please join me in expressing our gratitude for the generosity and dedication of our board members to the FSPHP mission.**
- **FSPHP is able to receive donations on-line at www.fsphp.org/donate.**
- An FSPHP case for support has been developed by the FSPHP Funding Committee and approved by the board.
- Vision and Guiding Principles for FSPHP have been created to be shared soon.
- An FSPHP Fund Development Plan has been written.
- An annual donor campaign strategy has been developed for 2017.
- Expanded sponsor opportunities designed for 2017.
- The board was engaged in a three-hour workshop on fundraising to better position FSPHP for fund development.
- The FSPHP Finance and Membership Committees have merged to analyze FSPHP membership dues as compared to other professional associations and provide recommendations to the board for the October renewal of membership dues.

II. Accountability Consistency and Excellence

The FSPHP will aim to *improve accountability, consistency, and excellence by utilizing and implementing a Federation-endorsed review* process. Following the successful development of sound guidelines for performance enhancement reviews (PER) of PHPs, the FSPHP will take steps to develop a program to measure quality of each respective PHPs work and create an opportunity for improvement where and when needed. PERs can be used to measure quality and also prepare PHPs for any external reviews they may be subjected to.

Key Action Items

- An FSPHP board work group to oversee the development of a PER review process
- Member-endorsed PER guidelines for PHPs
- Securement of funding and identification of a partner to develop an FSPHP-endorsed PER process
- Develop and pilot an FSPHP-endorsed PER program
- Update of FSPHP guidelines
- Develop a review process for identifying a range of evaluation and treatment options for the safety-sensitive professional

Achievements

- PER guidelines were developed by the ACE Committee and approved by the board and members
- Expansion of the ACE task force to a committee.
- Request to organizations for funding of an FSPHP-endorsed Performance Enhancement Review program in progress
- Several consultants engaged and proposals ready for selection
- ACE Committee designed a plan for updating FSPHP guidelines.

continued on page 6

FSPHP Updates

continued from page 5

III. Education, Communication, and Research in Physician Health

This group's goal is to increase education about the value of PHPs via research, communication, and media relations strategies by October 2018.

Over time, through our successful networking efforts, educational presentations at national meetings, and growing research, the FSPHP has gained credibility and respect for our expertise in physician health. As a public organization, we must develop greater media savvy and continue to expand our representation of the good work of PHPs at the state and national level.

Research supporting our efforts with education will be invaluable.

Key Action Items

- Offer media training to FSPHP members
- Offer media training to FSPHP board of directors
- Develop a library of physician health education presentations for members
- Partner with researchers in academic institutions to design and implement PHP studies in collaboration with the research committee
- Develop a speakers' bureau
- Develop a PHP Leadership Education Program

Achievements

- Collected and vetted three media consultant proposals for the work group and board's review
- Selected a media firm to align with FSPHP for consultation, for an annual presentation to members, and for the board training
- Designed and implemented a media education program at the 2016 annual meeting
- Continuous professional collaboration with media consultant for time sensitive media issues with *BMJ* and *AJC*
- Established collaboration with FSMB press professionals on media issues
- Established a Library Task Force, the LTF; designed a process for review of presentations for a member-only website section; is designing a consent form and guidelines for authors posting content and user guidelines of the content
- New newsletter resources established during organizational transition
- New publication committee chairs transitioning into role of the publication committee
- New research committee chairs transitioning into role and asked to address two areas of research with PHP participant experience and outcomes
- Public Policy Committee drafting articles related to physician health topics for FSPHP website and for members

IV. Growth of FSPHP Organization

This new goal is being developed to maintain and continue to grow an organizational structure that will help achieve FSPHP mission, vision, and strategic goals.

- Develop FSPHP board member work groups and committee guidelines
- Develop regional meeting guidelines
- Maintain and regularly assess the FSPHP website and membership database to align with organizational needs
- Identify charitable and nonprofit resources available to FSPHP to support organizational needs
- Develop member services
- Develop support to new members and developing PHPs
- Expand collaborations with these national organizations: Federation of State Medical Boards, American Medical Association, American Psychiatric Association, American Osteopathic Association, Administrators in Medicine, American Society of Addiction Medicine, American Board of Medical Specialties, American Academy of Psychiatry and Law, Legal Action Center, American College of Surgeons, and National Practitioner Databank

Achievements

- Designed and implemented a successful 2015 and 2016 strategic retreat to address emerging issues in the field
- First member survey conducted in 2015
- Addressed an unanticipated organization change and implemented a transition of FSPHP organization to full-time ED and part time administrator
- Expanding committee member involvement
- Conducted first committee chair meeting
- Secured FSPHP legal support
- Confirmed new website support proposal

- Collaborated with American World Association on Physician Well-being Policy
- First leadership meeting with the Federation of State Medical Boards
- First leadership meeting with the American Psychiatric Association
- Partnered with the AMA on PHP Model Act passed in June 2016
- Collaboration with FCB Health on Suicide Prevention and the American Foundation for Suicide Prevention
- Ethics Committee developed a conflict of interest policy for board and members of committees

FSPHP and FSMB Collaboration Continues

FSPHP and FSMB conversations are underway to discuss plans for the FSPHP/FSMB Joint Session to occur in Fort Worth in April 2017. Ongoing conversations continue with the FSPHP and FSMB regarding ways to collaborate further on topics of mutual interest. Please share any ideas you have for the FSPHP/FSMB Joint Session! ■

2016 ANNUAL MEETING

RESULTS FROM THE WPHP CLIENT EXIT SURVEY: WHAT GRADUATING PARTICIPANTS ARE REALLY SAYING ON THE WAY OUT THE DOOR

Chris Bundy, MD, MPH, and Charles Meredith, MD

Chris Bundy, MD, MPH

Charles Meredith, MD

Synopsis: Learning objectives for this session included a review of the goals, benefits, limitations, and challenges of exit surveying PHP participants at program discharge and consideration of variables of interest to PHPs in exit surveys. The Washington Physician Health Program (WPHP) shared summary survey data from its program graduates to illustrate these objectives and highlight participants' high level of satisfaction with, and beneficial impact from, program participation.

Identified goals of exit surveying included quality and performance improvement, marketing and outreach, accountability with stakeholder groups, and staff feedback. Limitations of exit surveying include lack of data from program non-completers, self-report and retrospective bias, cohort effects, and no opportunity for improving the experience of the exiting participants. The primary identified challenge was lack of resources to implement surveying among competing priorities.

Anonymous, electronic surveys were completed by participants at the program exit appointment. The proportion of WPHP exit survey participants reporting on impact of program participation are as follows:

- 40%: improved charting, fewer complaints, and decreased errors
- 45%: decreased absenteeism
- 50%: less marital conflict
- 55%: better professional boundaries
- 75%: higher satisfaction and less professional stress; less irritability
- 80%: less burnout and anxiety at work; improved relationships
- 85%: less stressful personal life; improved overall health
- 90%: improved work/life balance and lifestyle choices
- 100%: described their general health as good, very good, or excellent

The overall program experience was rated as useful by 95% of WPHP survey respondents, with 90% describing it as extremely useful or lifesaving. One hundred percent of respondents reported being treated with courtesy and respect by WPHP staff. The large majority of respondents rated their experiences with initial PHP contact, participation in a formal assessment program, substance use disorder (SUD) treatment, and PHP enrollment process as moderately or extremely useful (85%, 68%, 100%, 84% respectively). Random toxicology testing was felt to be moderately or extremely useful by 67% of respondents. Facilitated group meetings were felt to be beneficial by 90% of the respondents, with 64% rating groups as moderately or extremely useful. Data on groups are likely an underestimate of true benefit as it included diagnostic monitoring clients (10% of the respondents) who do not participate in WPHP groups.

continued on page 8

Results from the WPHP Client Exit Survey: What Graduating Participants Are Really Saying On the Way Out the Door
continued from page 7

Overall, the data is reassuring that WPHP completers receive substantial perceived benefit from program participation and are very satisfied with their program experience. Critics of PHPs, who often cite the anecdotal experience of individuals not completing their PHP program, may find systematically collected data on program completers a valid source of additional information. Through FSPHP collaboration and the sharing of skills, tools, and experience, PHPs can assist one another in overcoming challenges to implementing systematic measurement of performance and quality. Such data is critical to demonstrating the accountability, consistency, and excellence that exists in our programs. ■

DESIGNING CLIENT EXIT SURVEYS TO CAPTURE PROGRAM EFFECTIVENESS DATA

Elizabeth Brooks, PhD, and Scott Humphreys, MD

Elizabeth Brooks, PhD

Scott Humphreys, MD

To date, few evidence-based reports document the impact of physician health programs (PHPs) involvement on client outcomes. The lack of empirical reports undermines the good work that PHPs carry out. To address this deficit, the Colorado Physician Health Program (CPHP) recently developed a client exit survey to collect nuanced information about client outcomes and service satisfaction. Our presentation shared the development process, focus areas, and content of the exit survey.

An interdisciplinary team of CPHP administrators, clinicians, researchers, and staff developed the exit survey. Over the course of a year, the team executed a series of steps to create the survey that included the following: 1) determining the purpose/intent of exit survey, 2) resolving survey administration and data collection issues, 3) establishing survey domains, 4) establishing domain categories, and 5) developing, testing, and finalizing survey questions and response options.

The final product, the exit survey, is a 40-item self-reporting tool designed to measure CPHP's impact on clients' professional, personal, and interpersonal behavior, as well as client satisfaction. Satisfaction questions evaluate internal and external services and CPHP practices. Data collection began late 2015 and, to date, we have 42 completed surveys. Analysis of the survey data will occur later. Since the FSPHP conference, CPHP has shared the exit survey with approximately ten other organizations.

The exit interview tool lends itself to prospective data collection and may be a valuable resource for other PHPs interested in carrying out similar program evaluation activities. The questions-and-response options should be considered a guide; organizations may tailor the survey to meet their specific needs. Wider use of this tool, even modified, allows PHPs to speak specifically—with evidence—about the impact their organization has on client outcomes. Ideally, data from the instrument could be combined from all participants to demonstrate the work of PHPs as a whole. The CPHP Exit Survey is freely available to other organizations upon request by contacting CPHP Principal Researcher Elizabeth Brooks at elizabeth.brooks@ucdenver.edu. ■

COMPARING THE COMMERCIAL AIRLINE PILOTS MONITORING, THE HIMS PROGRAM, WITH THE PHP MODEL

Lynn Hankes, MD, FASAM, Past FSPHP President, and Captain Chris Storbeck, Immediate Past HIMS Chairman and Retired Delta Airlines Pilot

Lynn Hankes, MD, FASAM

Captain Chris Storbeck

The Human Intervention Motivation Study (HIMS) is a program developed to treat chemical dependency illness in the professional pilot population. Dr. Richard Masters, acting as the Air Line Pilots Association's (ALPA) aeromedical advisor, proposed the program to the ALPA Board of Directors. Following some information gathering, the board approved the development of the program in 1972. The program became active in 1974, two years before the establishment of the first physicians health program (PHP).

The HIMS program initially dealt only with alcohol dependence and had several fundamental assumptions: 1.) alcoholism is a primary treatable disease characterized by chronicity and relapse, 2.) early identification and treatment is possible and it works, 3.) total abstinence is essential to successful rehabilitation, and 4.) the intensity of job motivation will yield a higher recovery rate for airline pilots.

The establishment of the HIMS was originally supported by a grant from the National Institute on Alcohol Abuse and Alcoholism. In later years, Congress funded the program. Throughout the program's forty-plus year history, it has evolved and expanded as our understanding of chemical dependency disease has changed. Studies of PHP results have provided an impetus to this change as longer periods of monitoring and more rigorous testing improved patient outcomes.

While both HIMS programs and PHPs serve highly educated, professional populations for similar conditions, a number of differences exist in their approach. HIMS programs are regulated nationally while PHPs vary widely state to state. HIMS program regulators have access to national DUI records. HIMS program participants are known to the regulator and to their employer. PHPs generally have a higher level of patient confidentiality. PHPs treat other medical conditions in addition to chemical dependency while HIMS programs deals only with chemical dependency. PHPs include a higher percentage of multi-drug and drugs other than alcohol patients than HIMS programs do. PHPs generally have longer treatment periods, longer monitoring periods, and more compliance testing than HIMS programs do.

While dissimilar in some respects, HIMS programs and PHPs share similar results. Both programs have an approximate penetration of 1% of their respective populations, and both have similar success rates of approximately 80%. One should remember the nature of HIMS programs varies significantly from airline to airline, and of PHPs from state to state. Nonetheless, both programs have achieved remarkable success in an area of treatment that is known to be extraordinarily difficult. With continued research and dialogue between leaders, both programs should continue to improve their treatment outcomes for their respective populations. ■

RISK MANAGEMENT OF PHYSICIAN HEALTH PROGRAMS

Legal Panel Speakers: Thomas A. Crabb, JD, Debra Grossbaum, Esq., and James Wilkinson, Esq.

Thomas A. Crabb, JD   Debra Grossbaum, Esq.

State physician health programs (PHPs) face unique legal risks. Managing and mitigating the effects of risk is critical to the long-term success of a program. Legal risk management focuses on those potential adverse impacts on a program from failure to comply with the law, contracts, and other obligations. The stakes are high. Potential adverse impacts include legal liability (e.g., being forced to pay money or take remedial action), litigation expense, reputational damage, resource drain, and the failure to achieve program goals or maximize program effectiveness.

An important prelude is identifying the team in your program that will have direct involvement with legal issues. This may be as few as two or three people with a deep knowledge of the program, ideally approached from different perspectives, such as a medical director and operations director. Attorney involvement is critical.

Legal risk management requires your "dream team" to have a basic understanding of the framework of laws to which the program is subject. Are you subject to the federal drug and alcohol abuse patient records regulations (42 CFR Part 2)? For all participants? Are you a HIPAA-covered entity? What about state laws unique to your program? What are your contractual obligations? You must know the "rules of the road" and those rules can be complicated and nuanced.

It also requires the identification of program activities that carry legal risk. Many of these may unfortunately be identified for you through complaints to your program and pushback by program participants and others. But ideally legal risk management involves a proactive review of program operations and the real time evaluation of legal risk in program decisions before they are made.

continued on page 10

Risk Management of Physician Health Programs
continued from page 9

There are some recurring areas of legal risk. Lack of clarity is problematic. The less a referral knows about the program and his or her obligations, the more chance there is for litigation or other adverse outcomes. The failure to be attuned to the unreasonable increases legal risk. Does your program or its approved providers place unjustified, arbitrary, or unreasonable demands on referrals and participants?

Would an objective and impartial outsider agree? These are only a few examples of the type of self-evaluating critical questions that must be asked.

Once a risky activity is identified, it can be stopped or modified, or its impact could be mitigated. If an activity carries legal risk but is not required for the successful operation of your program, it may be able to be discontinued altogether. Other activities may be able to be modified to remain effective yet with reduced risk. You will not, however, be able to remove all legal risk. Organizations with optimal legal risk management processes are still unable to eliminate it entirely. The unavoidable, residual risk to a program can be addressed with mitigation such as insurance, funding and financial reserve increases, and perhaps state law changes, among other strategies. As the impact of legal risk can be substantial, its proactive management is a key component of success. ■

PHYSICIAN HEALTH PROGRAM RISK MANAGEMENT: DAY-TO-DAY PHP PRACTICES

Debra Grossbaum, Esq.,
Massachusetts Physician Health Services, Inc.

Debra Grossbaum, Esq.

Physician health programs (PHPs) are able to provide an essential supportive role to physicians and other professionals in distress, but this role comes with the risk of legal challenge. This may be because distressed individuals can be more litigious, or because there is so much on the line for these professionals that they feel they must resort to push back leading to legal threats or action. There are several approaches that PHPs can take to minimize the likelihood of legal challenges.

Probably the most important risk management practice that a PHP can implement is a focus on strong and regular communication. When PHP participants know what to expect and what the potential outcomes are for any given scenario, they are less likely to feel blindsided and less likely to feel antagonistic toward the program. One effort that helps foster strong communication includes meeting directly with the participant whenever possible. While face-to-face contact is not always an option, it does provide the best opportunity for direct connection and clear communication. These meetings can be used to explain the details of monitoring contracts, review consent forms, share difficult recommendations, and give participants an opportunity to ask questions and confirm mutual understanding.

A second important risk management focus is to regularly clarify expectations. This includes making sure that a participant knows, in advance, the anticipated costs of any services being recommended, the potential outcomes of such services, and his or her options going forward. For hospitals or other referral sources, clarification of expectations may include addressing confidentiality parameters, anticipated time frames, and the scope of any "deliverables" such as recommendations or compliance letters.

In addition to strengthening communication and expectations, it is important for PHPs to provide options when making referrals so as to avoid actual or perceived conflicts of interest. Programs should not direct business to one or two entities, but should try, whenever possible, to offer at least three choices for services that would be appropriate for the participant's situation. In those cases where choices are necessarily limited, it is important to explain why there is a limited number of options available, and why only one or two programs "fit the bill" for what is being sought. It is also important to use empirical evidence to support offered resources to help participants understand why certain programs or services are being offered. Examples of such empirical resources include the American Society of Addiction Medicine guidelines for safety sensitive professions, the Federation of State Medical Boards and FSPHP guidelines on state PHPs, as well as other objective published academic studies and bulletins from such organizations as the Substance Abuse and Mental Health Administration.

Finally, programs can help insulate themselves from liability by focusing on the essential elements of confidentiality that PHPs must maintain. Train PHP staff in understanding the relevant confidentiality laws (both state and federal) and ways to implement confidentiality in the workplace. This may include having policies and

procedures for secure storage of client information, for where and when to make phone calls so one is not overheard, and for who has access to documents on a fax machine. It is even important to train on such basic concepts as consideration of which way a computer screen faces and whether there is the potential that any passersby could see the information on the screen. The number of areas for consideration are endless (What does the caller ID for the PHP reveal? Who has access to client mail? What does the return address on the mailing envelope indicate?), but a strong program will consider how information is processed and stored, from beginning to end, to determine if optimal privacy considerations are being met.

Spending time to consider these daily issues, and implementing policies that increase strong communication, manage expectations, and protect private health information are important steps a PHP can take to help minimize risk and increase client confidence and satisfaction. ■

AN OVERVIEW OF THE ONTARIO MEDICAL ASSOCIATION'S PHYSICIAN HEALTH PROGRAM ASSESSMENT SERVICE

Joy Albuquerque, MD, FRCP, Lisa Lefebvre, MDCM, CCFP, MPH, DABAM, Doina Lupea, MD, MHSc, Derek Puddester, MD, MEd, FRCPC, ACC

Joy Albuquerque, MD, FRCP

Lisa Lefebvre, MDCM, CCFP, MPH, DABAM

Doina Lupea, MD, MHSc

The Ontario Medical Association Physician Health Program (PHP) is often called upon to conduct or facilitate clinical assessments related to a health professional's health, behavior, and/or fitness to practice. Requests for such assessments occur with the understanding that treatable health conditions should be assessed and managed while taking into consideration patient safety. While it is clear that not all health professionals deemed to have health or behavioral problems require comprehensive assessment, the PHP has developed an assessment service to assist regulators, workplaces, educational institutions, and others by providing arms-length assessment of a referred health professional.

Derek Puddester, MD, MEd, FRCPC, ACC

Prior to the creation of the PHP assessment service, the PHP provided assessments via a two-client model (a health professional and their workplace). After several years of experience in this model, it was decided that a one-client (health professional) model was preferable. A dedicated assessment team was formed and through an iterative process, policy, and procedures were created to support the PHP assessment service.

The assessment process is flexible and commences once a referral is received from the referral source or when the individual health professional makes contact. A first interview is conducted by an associate medical director and clinical coordinator to take a history of the problem at hand as well as the individual's health history. This interview informs the next steps, which include collection of collateral information by the clinical coordinator and, in many cases, a referral for an independent clinical evaluation (ICE). All of these components are included in summary form in the PHP assessment report, which is reviewed first by the referred health professional and released to the referral source with consent.

Early outcomes reveal that more referrals have come from residents and students than from practicing health professionals. Most referred individuals are 20–40 years of age. Approximately half of referrals come from a regulatory body, while others come from schools, workplaces, or lawyers.

Not surprisingly, assessments requiring an ICE took significantly longer than those that did not. The initial problem type of assessments that did not require an ICE was overwhelming mental health–related, while those that did require an ICE presented initially as substance use or behavioral problems. Most of the referrals that did not require an ICE came from a regulatory body and were frequently related to individuals whose mental health was stable but who were required to declare gaps in training or any potentially impairing mental health diagnoses to the regulatory body.

Our early experience suggests that having clear policy and procedures to guide this service is useful not only to the PHP clinical staff but also to the referral source and to the health professional being assessed. ■

THE ROLE OF THE POLYGRAPH IN INDEPENDENT COMPREHENSIVE EVALUATION FOR PROFESSIONAL SEXUAL MISCONDUCT

Alistair James Reid Finlayson, MD, Kimberly P. Brown, PhD, ABPP, and Ron Neufeld, BSW, LADAC

Alistair James Reid Finlayson, MD | **Kimberly P. Brown, PhD, ABPP** | **Ron Neufeld, BSW, LADAC**

Federation of State Medical Boards guidelines suggest use of the polygraph in evaluating the fitness for duty of physicians referred for sexual boundary violations. The FSPHP presentation focused on research by the Vanderbilt University Comprehensive Assessment Program regarding the utility of the polygraph in such evaluations. In particular, the study focused on whether the polygraph added additional information to the evaluation and if so what type of information was added.

The sample consisted of 18 non-randomized physicians out of a sample of 60 physicians referred for fitness for duty evaluations between 2007 and 2014 due to sexual boundary violations. The 18 (30%) who received a polygraph examination were all men and mostly Caucasian (72%) and middle-aged (72%). They were generally referred by a state medical board (28%) or a PHP (33%). The same examiner administered the polygraph using the control question technique to all 18 subjects.

The majority of the sample had at least one alleged physical sexual violation with a patient (78%). Half of the sample (50%) had an alleged physical sexual boundary violation with staff. A large number (61%) had an alleged verbal sexual boundary violation with a patient and 39% had an alleged verbal sexual boundary violation with staff.

In about half of the cases (56%), the polygraph added new information regarding sexual boundary problems above and beyond all other information obtained for the evaluation (e.g., interviews, psychological testing, records, collateral interviews). The polygraph elicited new information in 73% of physicians found unfit to practice. Deception was indicated on the polygraph in 31% of the cases in which a deception rating was made. In addition to the polygraph eliciting more information about the allegations against the 18 physicians, it also added information about sex with additional staff and/or patients (39%) and provided additional details about general compulsive sexual behavior.

Based on the study results, the polygraph is a useful component of comprehensive fitness for duty evaluation related to sexual misconduct. The polygraph can enhance the accuracy of assessment by providing additional information and can inform recommendations aimed at reducing future risk. The findings of the study were limited by a small sample size and non-randomized assignment of polygraph examination to sexual boundary cases. Future research should build upon the current study and perhaps consider varying the order of the polygraph in the examination, considering what factors led participants to reveal more information in the polygraph than during clinical interviews, and randomly assigning participants to the pre-polygraph interview with and without the polygraph instrument present.

All results can be found here:

Finlayson AJR, Brown KP, Iannelli RJ, et al, Martin PR. Profession sexual misconduct: the role of the polygraph in independent comprehensive evaluation. *Journal of Medical Regulation*. 2015;101(2):23–34

Also, see “Use of Polygraph in the Assessment, Treatment and Monitoring of Physicians: Tips for Success” by Philip Hemphill, PhD, and David Clayton, BS, on page 15. ■

FSMB AND FSPHP: "WHERE ARE WE HEADED?"

Art Hengerer, MD,
Chair-elect, Federation of State Medical Boards

Art Hengerer, MD

As the chair of the Federation of State Medical Boards (FSMB), it was a pleasure to address your annual session to share some of my vision of our collaborative opportunities next year and for the future. Presently the relationship between our state boards and PHPs is a varied structure both financially and operationally for various reasons. We have created a work group to look at state medical board structure, operations, and training of members for best practices. Part of their effort could go toward evaluating these different scenarios to see how to improve their value to all members.

This is an important effort as the changes and challenges of medicine continue to impact every aspect of the physicians' role often adversely in their lives. This leads to increasing numbers of physicians who seek personal assistance but many avoid these steps and develop behaviors leading to core competency evaluations and/or referrals to PHPs for monitoring and recovery. The problems are now affecting a majority of the nation's physicians in at least some form of burnout from medical school through their years of medical practice, often in the productive middle career years. The problem is not only an issue of the physicians' own health, which needs protecting, but if the physicians aren't healthy, how can we be protecting the public as well?

This is a responsibility for all of us to become engaged and our two organizations have an opportunity to accept this challenge and develop effective beneficial steps to assist the physicians in need without creating an onerous stigma.

The FSMB will be forming a work group on physician wellness and burnout and will be calling on and including the FSPHP in those efforts as we go forward over the next several years.

I look forward to the opportunity to continue these efforts which began this spring with a first time meeting in March of 2016 with the executive board members of the two organizations in Washington, DC. ■

TO BUPE OR NOT TO BUPE: THAT IS THE QUESTION

Scott Hambleton, MD, Paul Earley, MD, Penelope P. Ziegler, MD, Michael Kaufmann, MD, and A. Kennison Roy, III, MD

Scott Hambleton, MD

Paul Earley, MD

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The presentation was conducted using a debate format with four nationally recognized physicians with expertise in physician health program (PHP) monitoring as well as expertise in the field of addiction medicine, including use of buprenorphine for opioid replacement therapy. The debate was moderated by Scott Hambleton, MD, medical director of the Mississippi Physician Health Program. Penny Zeigler, MD, medical director of the Florida Professionals Resource Network, and Paul Earley, MD, medical director of the Georgia Professionals Health Program, argued against using buprenorphine for treatment of physicians monitored in a PHP. Michael Kaufmann, MD, medical director of the Ontario Medical Association Physician Health Program, and A. Kenison Roy III, MD, medical director and president of Addiction Recovery Resources, Inc. in Metarie, LA, argued in favor of using buprenorphine for treatment of physicians monitored in a PHP.

A primary objective was to identify key issues, including potential risks and benefits of using buprenorphine for opioid replacement therapy or chronic pain in physician participants monitored by PHPs.

The Drug Addiction Treatment Act of 2000 enabled qualified physicians to prescribe and/or dispense Schedule III, IV, and V opioid medications for the treatment

continued on page 14

To Bupe or Not to Bupe: That Is the Question

continued from page 13

of opioid addiction. Previously, use of opioids to treat opioid addiction was only permissible in federally approved opioid treatment programs using methadone, a Schedule II opioid.

Buprenorphine, a Schedule III opioid, is a semisynthetic, partial μ-opioid agonist and kappa-receptor antagonist approved by the FDA for treatment of opioid addiction and chronic pain. Partial agonists activate receptors, but not to the same degree as full agonists. Therefore, maximal effects of buprenorphine are less than those of full agonists like heroin, hydrocodone, and methadone. The kappa-receptor antagonism results in blocking of dysphoria associated with opioid withdrawal. The net effect is that drug cravings and opioid withdrawal is blocked with less euphoria, less respiratory depression, and less sedation. Additionally, buprenorphine has decreased risk of opioid-induced hyperalgesia, compared to full agonists, when used to treat chronic pain.

Currently, consensus is lacking regarding use of buprenorphine in physicians being monitored in physician health programs. Although some guidelines, such as "ACOEM Practice Guidelines: Opioids and Safety-Sensitive Work" (2014), state that acute or chronic opioid use is not recommended for patients who perform safety sensitive jobs, there are no guidelines related to use of buprenorphine either for opioid replacement therapy or for chronic pain by physicians in monitoring programs.

The primary argument in favor of buprenorphine as a modality was to provide treatment to physicians who might not respond to other traditional forms of treatment. Additionally, because of the unique properties of buprenorphine, it could be a potentially legitimate form of treatment for physicians suffering from chronic pain, or both pain and opioid addiction. The arguments against use of buprenorphine in physicians monitored by PHPs included the historical success of traditional, abstinence-based PHP participation. Evidence was presented that buprenorphine was potentially impairing to safety sensitive workers. Differences in viewpoints of individual PHPs and their responsibilities to their respective shareholders was a primary concern, as was protection of the entire cohort.

The conclusion of the debate was that additional research is necessary in order to develop a consensus regarding use of buprenorphine as a treatment modality by physicians being monitored in PHPs. Both teams expressed hope that consensus could be developed, so that eventually guidelines might be established. ■

ESSENTIAL COMPONENTS OF PHYSICIAN HEALTH PROGRAM PARTICIPATION: PERSPECTIVES OF PARTICIPANTS FIVE YEARS POST-GRADUATION

Lisa J. Merlo, PhD, MPE, and Robert L. DuPont, MD

Lisa J. Merlo, PhD, MPE

Robert L. DuPont, MD

The physician health program (PHP) model of care management has demonstrated impressive long-term outcomes for physicians suffering from substance use disorders (SUDs). Results of a national study of 16 PHPs showed that outcomes are consistent across various medical specialties, and that physicians with opioid use disorders have the same outcomes as their peers with alcohol or other SUDs. As the PHP system of care management is currently being criticized as coercive and conflicted, now is the time to highlight and extend the evidence on the effectiveness of PHPs.

To identify the essential components of PHP care management and to determine whether outcomes are long-lasting, we conducted a preliminary follow-up study of physicians who successfully completed contracts for SUDs five or more years ago. Following approval by the Chestnut Institutional Review Board, without funding and thanks to the dedicated leadership of eight PHPs, physicians were invited to complete an anonymous online questionnaire regarding their experiences in the PHP, as well as the five years since their graduation. The PHPs successfully contacted 42% of eligible physicians, of which 89% agreed to participate.

Participants rated components of PHP care on a Likert scale from "extremely unhelpful" to "extremely helpful." The top-rated components were formal SUD treatment, signing a PHP contract, and attending 12-step meetings. "Attending 12-step meetings" was selected as most valuable by 35% of physicians surveyed, followed by "formal SUD treatment" (26%). When ranking the least valuable element, "none of the above—all were valuable" was selected by 33% of physicians, followed by worksite monitor (23%), caduceus/doctor "self-help" group meetings (16%), and random drug and alcohol testing (10%).

Five or more years after successfully completing their contracts, 96% of physicians reported being licensed to practice currently, with none of the non-licensed physicians reporting lack of licensure as due to substance use. The vast majority (91%) of licensed physicians reported currently practicing medicine. Thirty-eight percent (38%) had voluntarily extended their monitoring contracts at some point, and 20% were currently being monitored.

Relapse and recovery rates were encouraging: 89% reported that they completed their contract without any relapse during the monitoring period, with nearly 10% reporting only one relapse, which is comparable to the national PHP study outcomes. Notably, 96% of respondents reported that they consider themselves to be "in recovery" now. Eight-five percent (85%) of respondents reported they believed the total financial cost of the PHP participation (personal cost ranging from $250–321,000) was "money well spent."

The limitations of this study include a small sample size, self-report data (with no verification of abstinence), and possible recall bias by respondents. While preliminary, study strengths include its long-term focus, variety in location and programming among PHPs, and good response rate, with 95% of respondents indicating they were "completely honest" and 5% "mostly honest" when answering the survey.

This study will add to the body of evidence that PHPs are a national model for SUD management. We strongly encourage PHPs to conduct and publish research on long-term outcomes to counter the ongoing critics of this impressive care management system. ■

USE OF POLYGRAPH IN THE ASSESSMENT, TREATMENT, AND MONITORING OF PHYSICIANS

Philip Hemphill, PhD, and David Clayton, BS

Philip Hemphill, PhD

David Clayton, BS

This presentation focused on our experience of including and conducting polygraphs for the past ten years, which has allowed us to gain more information to aid in assessment, treatment planning, and assisting with the monitoring process rather than solely relying on an individual's self-report. As clinical decisions are increasingly scrutinized by licensing bodies, legal entities, and administrative authorities, more reliance on evidence-based strategies that provide clear data points enhances these collaborative efforts. Also, this strategy can expedite recovery as well. A literature review revealed that the standard polygraph administrated in the clinical setting is approximately 88–90% accurate, and the U.S. Supreme Court has upheld the use of post-conviction sex offender testing (PCSOT) as a vital tool for monitoring for almost forty years. Therefore, the integration of the "containment approach" warrants strong consideration when probabilistic opinions of risk are expected and one is able to draw better-informed conclusions. However, the utility and usefulness of these results must be viewed realistically and not over-valued.

An explanation of what a standardized test includes (e.g., measuring reactions to assessing lying or truth) was presented. Also, definitions of testing norms, validity, and reliability, and the two purposes of the test were presented for discussion. This was followed by case consultation and a spirited discussion.

Finally, this presentation offered a guide of basic points to consider when integrating polygraph testing:

1. Have the examiner fully explain to the team how the test is conducted
2. Have the team discuss with individual upcoming polygraph assessment before the date you increase pre-test disclosure
3. Use great care in choosing the polygraph examiner preferably one with PCSOT training
4. Examiner must understand that treatment and public safety are the ultimate goal
5. Examiner must be involved in developing questions due to their expertise
6. Ensure the examiner only uses validated techniques with video or audio
7. Make sure examiner has graduated from an accredited polygraph school and has professional liability insurance
8. Voice Stress Analyzers are not recommended
9. Schedule polygraph test later in treatment process and encourage group discussion of results
10. Be cautious with bringing sanctions on one failed polygraph test and conduct a second test for validation if feasible

continued on page 16

Use of Polygraph in the Assessment, Treatment, and Monitoring of Physicians

continued from page 15

Ultimately, the purpose of a diagnostic or monitoring polygraph test is to form a conclusion that serves as a basis for action. This action will often affect the future of an individual in term of rights, liberties, privileges, or health. For this reason, the highest achievable level of decision accuracy is required. Therefore, adding incremental validity to one's risk management decisions serves participants and the public. This can be accomplished both by gathering information and by investigating the possible involvement of an individual in one or more issues of concern via physiological testing. Polygraph works! Trust the results! You will be amazed at how much more information you gain through simply adding this tool to your battery of tests. ■

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FIVE FUNDAMENTALS OF CIVILITY FOR PHYSICIANS

Michael Kaufmann, MD, and Joy Albuquerque, MD, FRCP

Michael Kaufmann, MD

Joy Albuquerque, MD, FRCP

At the 2016 annual meeting of the FSPHP, Michael Kaufmann, MD, and Joy Albuquerque, MD, FRCP medical director and associate medical director of the Ontario Medical Association Physician Health Program (PHP), presented a plenary workshop entitled "The Five Fundamentals of Civility." This workshop was based upon a series of articles written by Dr. Kaufmann and published in the *Ontario Medical Review* (http://php.oma.org/FiveFundamentals.html).

In recent years, there has been increasing attention placed upon physician behavior in the workplace, mostly in a negative sense. As a result, a variety of approaches have been developed to address so-called "disruptive behavior" by doctors. PHPs are often called upon to help resolve these problems and to teach about the management of disruptive behavior by physicians. Less has been written about the understanding and promotion of a desired style of physician behavior which can be conceptualized as civility.

Civility is about more than politeness and courtesy, although it begins there. High quality professional comportment is essential for healthcare teams to function effectively. Physician incivility, often revealed at times of tension, can cause stress, distress, and poor productivity in coworkers of all kinds. Incivility can propagate itself and erode the very culture of a workplace, and, indeed, a profession.

On the other hand, civil behavior results in positive social interactions. Civility among colleagues is associated with lower rates of professional burnout. Civil collegial relationships create comfortable and energizing workplaces with lower turnover rates and higher worker satisfaction. Everyone, including patients, benefits from civil professional behavior.

The impacts of civility (and its absence) in the professional environment, even if self-evident, have been demonstrated by research and the evidence was reviewed in the workshop. Still, the various dimensions of civility are not always surfaced in a deliberate manner in medical training and beyond. It appears, then, that a civil approach to physician behavior in the workplace has merit, but there are questions to explore. When the many dimensions of civility are reviewed, it appears that there are specific strategies that can be adopted to foster civil behavior in doctors, even at times of risk. A practical selection of these strategies, grouped into five categories as "Five Fundamentals of Civility for Physicians," are as follows:

1. Respect others.
2. Be aware.
3. Communicate effectively.
4. Take good care of yourself.
5. Be responsible.

These five fundamentals are offered as a framework for the promotion of civil professional behavior in doctors at all career stages. This is a strategy that moves away from the "disruptive behavior" paradigm as being the chief means of exploring professional behavior. A variety of ideas as to how PHPs and others can build upon this framework were explored in an interactive manner. It is noted how this paradigm offers a refreshing look at

many of the key physician health messages of concern to PHPs and the medical profession, including mindfulness, leadership, resilience, and effective intervention in support of colleagues in distress.

Participants were invited to provide feedback and suggestions as to how the civility conversation in the medical profession could be encouraged more broadly. Many good ideas, such as developing teaching modules, toolkits, and webinars, were received. There was also encouragement to blog and use social media such as Twitter. Watch for the "Civility Tweet of the Day" coming soon to your favorite devices! ■

POSTERS

CREATING A COOPERATIVE FAMILY APPROACH TO LASTING SOBRIETY BY EXPANDING THE ESSENTIALS OF THE PHYSICIAN HEALTH PROGRAMS

Debra Jay

Debra Jay

Structured Family Recovery™(SFR) creates a recovery team using family members and friends who have close personal relationships with an addicted person, providing a weekly action plan based on the essential elements of physician health programs (PHP), the science of behavior change, and 12-step recovery programs. Rather than launching an individual alcoholic or addict into recovery, SFR launches the entire family into the recovery process using a structured, yet simple, program, which is easily accessible in trade book format published by Hazelden.[1]

Relapse rates are high for addicts who access care as part of the general public (with a statistical range of 50 to 90% relapsing in the first year), as compared to five-year PHPs that offer impressively high recovery success rates for impaired physician participants: approximately 78% have a zero relapse rate during five-year programs.[2] Perhaps more importantly, five-year PHPs, due to their structure and programming length, make it more likely that those who do relapse will eventually succeed.

Structured Family Recovery™ offers a family recovery program that recreates the PHP to address the challenges and fit the needs specific to families beset by addiction. The SFR program offers a year of structured meetings that take place by telephone conferencing and can be repeated for multiple years of family participation. While family members (including the addicted family member) work as a team, each member focuses on their own recovery using the ubiquitous network of 12-step meetings. SFR offers a framework that creates structured behavioral expectations, simplicity of use, and positive social norms. This framework is based upon decades of social science research as well as behavior design developed at Stanford.[3]

Informal observation among family members who engage in SFR has shown an increased ability to begin working as a team in a short period of time (defined as an adherence to the expectations of SFR, occurring within two to five weeks of SFR meetings on average), an increase in family unity, a reduced number of addicts leaving treatment against medical advice, a reduction of family-induced crisis affecting the addict during treatment, a greater understanding and acceptance of addiction as a disease by the family unit, a reduction of relapse or shorter periods of relapse before reengaging with treatment and recovery, and higher rates of ongoing 12-step recovery among multiple family members (Al-Anon or other family 12-step programs).

One of the greatest blocks to SFR is a long-held myth that family members are expected to remain outside the "recovery sphere" of their addicted loved ones. With the severity of the opiate epidemic as well as families compelled to finance multiple treatments due to relapse, this is beginning to change.

As the number of treatment centers recommending SFR to families and patients grows, we are experiencing a move toward achieving a critical mass of families participating in SFR needed to begin designing and implementing research to track results in a meaningful way. ■

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BEING PREPARED: RELAPSE PREVENTION AND OCCUPATIONAL HAZARDS FOR HEALTHCARE PROFESSIONALS

Chip Abernathy, LPC, MAC

Chip Abernathy, LPC, MAC

Healthcare professionals who have completed treatment for addiction or psychiatric disorders face challenges when returning to work. Following treatment for addictive disease most people experience warning signs that reactivate denial and cause so much pain that using alcohol or other drugs for relief seems like a good idea (Gorski, Miller, 1986). With a psychiatric disorder such as major depression a very similar pattern is experienced, but rather than thoughts about substance use, ideas for relief may be a familiar escape such as spending all day in bed sleeping, or worse, consideration of suicide. Relapse prevention involves bringing warning signs and high risk situations for relapse into conscious awareness, and then creating effective management strategies for those. A meta-analysis evaluating the effectiveness of relapse prevention summarized that relapse prevention was overall effective in reducing substance use and improving psychosocial adjustment (Irvin, et al, 1999).

Occupational Hazards for Healthcare Professionals

Many occupational hazards for healthcare professionals in recovery can be identified as high-risk situations. This applies to recovery from addiction, a mental disorder, or co-occurring disorders. High-risk situations either directly or indirectly put a person at increased risk of relapse. They typically have some things in common: they lead us away from people who will help us in our recovery, toward isolation, or toward people who will be detrimental to us in our recovery; they often promote the keeping of secrets; they involve distorted perceptions; and they often involve decisions that seem irrelevant but that are actually quite relevant.

When identifying high-risk situations, either in a group or individually, it is usually necessary to ask clarifying questions to accurately determine what the specific problem is. For example, someone might say their high-risk situation is "Returning home after treatment," and some discussion may need to get more specific: "Professional and social stigma following treatment." Once the high-risk situation is identified, this question needs to be answered with either a "yes" or "no": Can it be avoided? If the answer is "yes," the task is to identify how it will be avoided. If the answer is "no," the task is to identify how it can be managed effectively while recovery is protected. This process is especially effective in a group setting where others can participate and offer feedback and suggestions. This helps not only the person working on their high-risk situation but it also helps group members in the same or similar position and keep recovery their top priority. ■

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PSYCHOLOGICAL ASSESSMENT DATA OF HEALTHCARE PROFESSIONALS PRESENTING FOR EVALUATION

Gregory L. Futral, PhD, and
James "Jes" Montgomery, MD

Gregory L. Futral, PhD

James "Jes" Montgomery, MD

Problematic physicians are an important but understudied population. Given the imperative concern of public welfare in the safety-sensitive positions of physicians, behaviors such as sexual violations, inappropriate interpersonal interactions, and substance-related impairment in physicians put the public at risk. Few empirical studies have directly addressed psychological testing data in this population. One relevant previous study[1] contrasted psychological testing data of physicians presenting for fitness-for-duty evaluations across three types of offense: sexual boundary violations, disruptive behaviors, and other (including substance-related) based on results of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and Personality Assessment Inventory (PAI). The primary purpose of the current study was to further examine psychological test results from physicians referred for evaluation with a larger sample size and across referral reason.

Archival data from a total of 252 physicians presenting for evaluations at the Outpatient Evaluation Center at Pine Grove Behavioral Health and Addiction Services between 2009 and 2015 were recorded and examined, including further subdivisions into those referred for substance (n = 139), sexual boundary (n = 73), or behavioral (n = 41) concerns. The primary assessment measures of interest included the PAI, Millon Clinical Multiaxial Inventory-III (MCMI-III), and the Paulhus Deception Scales (PDS).

Results of this study found that across measures and reason for referral, physicians undergoing evaluation produced profiles suggesting questionable validity related to possible social desirability concerns (ranging from 46 to 72% of protocols). They also showed very few significant scale elevations in areas of psychopathology (ranging from 60 to 70% of protocols showing no significant elevations on any clinical-related scale). Physicians commonly elevated at least one personality disorder scale on the MCMI-III. However, approximately 75% of these elevations were found on one or more of the Obsessive-Compulsive, Narcissistic, or Histrionic scales, which are scales noted as commonly elevated in defensive protocols and/or potentially reflective of some adaptive traits at moderate levels of elevation.

Overall, relatively few scale differences were found between physicians across referral reason, although those referred for substance concerns scored higher or more commonly in some expected areas (e.g., substance use; antisocial traits). In comparison to the results of Roback et al.[1], somewhat fewer differences between groups of physicians based on referral reason were found, though direct comparisons were precluded. Generally similar rates of validity concerns and PAI profiles containing no significant elevations were found in the present study.

These findings highlight some of the challenges involved in assessing physicians referred for psychological evaluations in these types of situations. Consistent with prior findings, indications of possible socially desirable responding and few significant scale elevations were commonly found. The results underscore the importance of contextual considerations in test score interpretation and obtaining collateral data when evaluating physicians, as well as the need for additional research. Some limitations of the current study include the lack of a non-problematic physician control group and the use of archival data. ■

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IN THEIR OWN WORDS: STRESSORS FACING MEDICAL STUDENTS IN THE MILLENNIAL GENERATION

Lisa J. Merlo, PhD, MPE

Lisa J. Merlo, PhD, MPE

High levels of stress among medical students are associated with depression (1), burnout (2), somatic distress (3), decreases in empathy (4), serious thoughts about dropping out of medical school (5), suicidal ideation (6) and poor academic performance (7). Various interventions aimed at managing medical student stress have been studied (8–9), including the implementation of a pass/fail grading system (10), mindfulness training (11–12), and curricular changes (13–14). However, it is unclear to what extent these programs match medical students' desires for wellness intervention. We surveyed students from the nine medical schools in Florida to assess students' perceptions regarding their greatest stressor(s) and students' own ideas regarding ways that medical schools could help improve overall student wellness. Following IRB approval, medical students were invited to complete an anonymous online questionnaire. Qualitative data were analyzed using the grounded theory method of data analysis.

Results demonstrated several themes related to both primary and secondary stressors, including 1) workload, 2) time constraints, 3) financial concerns, 4) expectations/pressure, 5) competition among medical students, 6) anxiety about residency match, 7) academic grading, 8) efforts to achieve school/life balance, 9) board exams, 10) relationship difficulties, 11) fear of the future, 12) negative health impact of school, 13) administration and scheduling, and 14) faculty and quality of education.

With regard to suggestions for improvement, results included a variety of creative ideas regarding ways to improve student wellness. The primary themes that emerged regarding potential interventions included the following:

1. Improve scheduling
2. Promote exercise
3. Provide wellness resources

continued on page 20

In Their Own Words: Stressors Facing Medical Students in the Millennial Generation

continued from page 19

4. Provide counseling resources
5. Improve teaching quality
6. Promote healthy eating
7. Decrease intensity of workload
8. Incorporate wellness into the curriculum
9. Use pass/fail grading
10. Improve student-faculty relations
11. Encourage life balance
12. Reduce financial concerns
13. Provide protected time off
14. Provide academic support
15. Promote cooperation rather than competition
16. Provide guidance in career planning
17. Improve communication

Analysis of student responses demonstrated that stressors were hierarchical in nature and likely created or contributed to additional sources of reported stress. For example, while several medical students cited board examinations as a source of stress, many attributed this concern to a primary, overarching concern of getting a residency position. This interplay of medical student stressors is likely dynamic and different for each individual student and at each medical school. However, there is benefit to future research exploring the relative impact on stress levels with interventions at the level of primary stressors compared to intervening on stressors that are more secondary in nature. Similarly, results indicated that there is no "one size fits all" solution to improving wellness. Though students overwhelmingly indicated that wellness is an important area of concern, there was a lack of consistency across student suggestions, based on individual need/preference. In particular, conflicting responses emerged regarding whether wellness program components should be mandatory or elective. Schools implementing new changes and programs should test the impact of these interventions and share their results with other schools. ■

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IMPLEMENTATION OF A FITNESS ASSESSMENT AND OPTIMIZATION OF AN EXERCISE PROGRAM FOR PHYSICIANS IN SUBSTANCE USE DISORDER RECOVERY

Patricia Pade, MD, Nicholas Edwards, and Laura Martin, MD

Patricia Pade, MD Nicholas Edwards Laura Martin, MD

Background: Physical exercise is acknowledged to be an important part of addiction recovery and a significant component of whole health and wellness. Epidemiological studies consistently report that aerobic exercise is inversely related to substance use and abuse. While exercise in recovery has a number of benefits including relief of stress, natural endorphin release, improved sleep, and enhanced overall well-being, there can be some dangers as well, such as over-exercising, switching addiction to exercise, and ignoring other aspects of recovery. Often physicians entering treatment have just completed detoxification, have long ignored their physical health, and are severely deconditioned. While many treatment programs encourage exercise as part of the rehabilitation process, this often is undertaken without a scientific approach to guide, quantify, and prescribe the proper amount of exercise patients can perform safely considering their unique metabolic conditions. For physicians, this can be challenging considering their often competitive and perfectionistic nature, but exercise can be essential for sustained continued recovery and perhaps successful return to health and practice. We will describe results of the implementation of fitness testing and assessment prior to prescribing an exercise program for patients attending a treatment program for health professionals and early in recovery.

Methods: After successful detoxification, patients meet with exercise physiologists to collect baseline measures, including resting vital signs, oxygen saturation, and resting blood lactate. A functional screen including balance, mobility, and flexibility is completed. The patient participates in a structured, incremental submaximal exercise test (CRA-Testing). The structured test increases speed or resistance in 3-minute intervals where at the end of each, exercise metrics are taken. Repeat measurements of vitals, oxygen saturation, and blood lactate concentration are taken. Outcomes are tracked and together yield a scope of work around the body's transition from a resting aerobic state to anaerobic respiration. Outcome data was collected on 30 patients with alcohol use disorders, 20 patients with cocaine use disorders, 20 patients with opioid use disorders, 15 patients with methamphetamine use disorders, and 20 controls with no substance use disorders.

Results: All substance use disorder patients in the professional's treatment program demonstrated significant deconditioning in their body's ability to transition from aerobic to anaerobic state during exercise from the control group. Individuals with alcohol and methamphetamine have the most impairment and exhibited metabolic dysfunction similar to patients with diabetes, obesity, and other metabolic syndromes. Patients demonstrated a marked improvement in exercise tolerance and capacity over the course of 90 days with abstinence and an appropriately monitored exercise regimen.

Discussion: Our aim is to improve knowledge and assessment of physical fitness in early recovery, as well as provide an evidence-based evaluation process for development of safe and effective exercise programs in addiction treatment of health professionals. Ultimately, restoring physical health and improving exercise habits that can be sustained throughout recovery will be important for long-term health and wellness of physicians returning to practice. Monitoring exercise capacity and tolerance could be used as a tool to detect early relapse and deviation from healthy recovery habits. ■

OUTCOMES FOR PHYSICIANS WITH OPIOID DEPENDENCE

Greg Skipper, MD, and Lisa J. Merlo, PhD, MPE

Greg Skipper, MD

Lisa J. Merlo, PhD, MPE

Many patients with opioid dependence have been warned to avoid seeking abstinence-based psychosocial treatment (ABPT), due to fears that ABPT is not as effective as opioid substitution therapy (OST) with methadone or buprenorphine. Research has suggested that OST is better at promoting treatment retention, reducing heroin use, and decreasing mortality than ABPT alone. However, study limitations mitigate the generalizability of these findings. In addition, due to concerns about potential side effects and impact on patient safety, OST is not the gold standard treatment (or even considered standard of care) for physicians participating in a physician health program (PHP) for monitoring of an opioid use disorder.

In order to evaluate whether an abstinence-based approach to treatment of opioid dependence is as effective as abstinence-based approaches for other substance use disorders, we analyzed the Blueprint Study data. Specifically, we compared treatment outcome of physicians referred for 1) opioid use disorders, 2) alcohol use disorders, and 3) other drug use disorders. Medical records from 16 PHPs were reviewed. A five-year, intent-to-treat analysis was conducted for eligible participants (N = 702; 85.5% male; age range = 24–75), divided into three groups based on their substance(s) of abuse (i.e., "Alcohol Only" [n = 204], 2. "Any Opioid" with or without alcohol use (n = 339), and 3. "Non-Opioid" drug use with or without alcohol use [n = 159]).

Results demonstrated that 75–80% of participants remained abstinent throughout five years of monitoring (i.e., never tested positive for alcohol or drugs), with no difference among substance use groups. Physicians with opioid dependence who did not receive opioid substitution therapy were as likely as other participants to remain alcohol and drug free (as verified by random drug testing). Further, results demonstrated that OST with opioid agonist or partial agonist medication is not routinely offered to physicians with opioid dependence; however, opioid antagonist medication was commonly used.

These results show that abstinence-based treatment for opioid dependence can be effective for individuals who undergo psychosocial treatment with extended, intensive care management (including random drug testing) following discharge. ■

MULTIDISCIPLINARY PERSPECTIVE ON MAKING REASONABLE SUSPICION DRUG TESTING MORE EFFICIENT AND EFFECTIVE

Karen Miotto, MD, T. Warner Hudson, MD,
Rebecca Wilkinson, MSPH, and Shari Faris, MD

Karen Miotto, MD

T. Warner Hudson, MD

Rebecca Wilkinson, MSPH

Reasonable suspicion drug and alcohol testing is a vital component of any effective physician health program (PHP). It is an essential method for finding new cases for PHPs and assisting those individuals in entering recovery. Other industries, particularly for those in safety-sensitive positions, employ a streamlined, consistent, and expert process for reasonable suspicion testing. In contrast, the nature and procedure of reasonable suspicion testing is infrequent and variable across the health system, often creating concern and confusion in initiating testing.

A multidisciplinary team analyzed the current state of reasonable suspicion drug and alcohol testing at a major academic medical center, and found various issues. Firstly, there was inconsistency in procedures. For example, during typical business hours from Monday to Friday, testing was conducted in Occupational Health. However, after hours, it was conducted in the Emergency Department (ED). Due to the variable procedure, chain of custody forms could be lost, creating a delay in obtaining test results. An additional

concern resulting from inconsistency was that individuals expressed hesitancy regarding when and how to request reasonable suspicion testing. Secondly, when testing was conducted in the ED, it was treated as a medical test rather than a forensic one. As such, not only was a breathalyzer test unavailable, but a medical visit was created, impacting confidentiality. Finally, the non-healthcare-specific urine test utilized had the potential for false negatives as it did not include many of the substances to which healthcare personnel have access (e.g., synthetic opioids, benzodiazepines, etc.).

In response to these issues, the work group hired an external firm, Collections Plus, to proceed with reasonable suspicion testing. Their many benefits include following the same procedure 24/7, not being connected to medical records, a foolproof chain of custody procedure, and utilization of a breathalyzer test and healthcare-specific panel. For additional streamlining, the work group also identified key individuals in security and nursing supervision to own the testing procedure.

The development process for reasonable suspicion drug and alcohol testing was not without obstacles, and many lessons were learned along the way. Primarily, it was found that having partners across the organization is key. At our institution, buy-in was developed from key stakeholders such as Nursing, Security, Social Work, Administration, Human Resources, the Dean's Office, the Medical Staff Health Program, and Occupational Health. Additionally, it became apparent that conducting dry runs of the procedure is vital because unforeseen issues may arise in the actual application of the written process.

For any institution planning on revamping its own reasonable suspicion drug and alcohol testing policy, it is essential that the work group expect a long process of trial and revision. Lastly, once the procedure is finalized, it is essential to provide education for key staff members. When adequate procedures and proper education is available, a standardized, efficient reasonable suspicion drug test collections and alcohol testing procedure may be successfully developed. ■

FSPHP WOULD LIKE TO THANK OUR 2016 CONFERENCE EXHIBITORS FOR THEIR SUPPORT TO THE MISSION OF FSPHP

DIAMOND
Caron Treatment Centers
CeDAR/University of Colorado Hospital
First Lab
UF Health Florida Recovery Center

PLATINUM
Bradford Health Services
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Ridgeview Institute
Sante Center for Healing
Sovereign Health Group
The Farley Center at Williamsburg Place
UC San Diego PACE Program
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2016 FSPHP ANNUAL MEETING

FEDERATION OF
STATE PHYSICIAN HEALTH

DORIS C. GUNDERSEN, M.D.
SPEAKER

2016 FSPHP ANNUAL MEETING *(CONTINUED)*

Mel

STATE MEDICAL BOARDS
Dr. Gundersen
Dr. Gifford

FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS

SAVE THE DATE

Wednesday, April 19, to Saturday April 22, 2017

FSPHP ANNUAL EDUCATION CONFERENCE AND BUSINESS MEETING

PHPs Restoring Physician Satisfaction and Wellness in an Era of Burnout, Mental Illness, Addiction, and Suicide

Highlights

- General and breakout sessions each day to highlight the essentials of physician health programs
- Networking opportunities with leaders in the field of professional health and well-being
- Daily peer support groups
- Large exhibitor space
- Poster sessions

Topic Areas

- Burnout Prevention
- Satisfaction in Medicine
- Mental Health
- Suicide Prevention
- PHP Best Practices
- PHP Funding Strategies
- The Aging Physician Population

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WEDNESDAY

Board of Directors Meeting
Registration/Exhibitors Open
Luncheon General Sessions
Committee Meetings
Opening Reception

THURSDAY

New Member Meeting
General Sessions
Poster Session
Board and Committee Chair Dinner

FRIDAY

Administrator Topic Meeting
General Sessions
FSPHP Regional Meetings Exhibitor Session
Annual Business Meeting

SATURDAY

FSPHP/FSMB Joint Session

PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATONS NATIONAL MEETINGS

FSPHP Annual Meetings

April 19–22, 2017
Worthington Renaissance Fort Worth Hotel
Fort Worth, TX

April 26–29, 2018
Embassy Suites by Hilton
Concord, NC

FSMB Annual Meetings

April 20–22, 2017
Omni Fort Worth Hotel
Ft. Worth, TX

April 26–28, 2018
Le Meridien
Charlotte, NC

American Academy of Addiction Psychiatry Annual Meeting and Symposium

December 8–11, 2016
Hyatt Regency Coconut Point Resort and Spa
Bonita Springs, FL

December 4–11, 2017
Rancho Bernado Inn
San Diego, CA

AMA House of Delegates Annual Meeting

June 10–14, 2017
Hyatt Regency Chicago
Chicago, IL

June 9–13, 2018
Hyatt Regency Chicago
Chicago, IL

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

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

AMA House of Delegates Interim Meeting

November 12–15, 2016
Walt Disney World Swan/Dolphin
Orlando, FL

November 11–14, 2017
Hawaii Convention Center
Honolulu, HI

November 10–13, 2018
Gaylord National
National Harbor, MD

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 20–24, 2017
San Diego, CA

May 5–9, 2018
New York, NY

May 18–22, 2019
San Francisco, CA

American Society of Addiction Medicine

ASAM State of the Art Course in Addiction Medicine
October 6–8, 2016
Washington Hilton
Washington, DC

ASAM 48th Annual Conference
April 6–9, 2017
Hilton New Orleans Riverside
New Orleans, LA

ASAM 49th Annual Conference
April 12–15, 2018
Hilton San Diego Bayfront
San Diego, CA

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

International Doctors in Alcoholics Anonymous (IDAA) Annual Meeting

August 2–6, 2017
The Cliff Lodge, Snowbird Resort
Salt Lake City, Utah

2018—Reno, Nevada
2019—Knoxville, TN
2020—Spokane, WA

continued on page 30

Physician Health and Other Related Organizatons National Meetings

continued from page 29

National Organization of Alternative Programs
March 28–31, 2017
Omni La Mansión del Rio Hotel
San Antonio, Texas

Medical Group Management Association
October 30–November 2, 2016
Moscone Center
San Francisco, CA

American Board of Medical Specialties Annual Conference
September 26–28, 2016
Hilton Cleveland
Cleveland, OH

NAMSS 41st Educational Conference and Exhibition
The Broadmoor
October 21–25, 2017
Colorado Springs, CO

NAMSS 42nd Educational Conference and Exhibition
Long Beach Convention Center
September 29–October 3, 2018
Long Beach, CA

NAMSS 43rd Educational Conference and Exhibition
Philadelphia Marriott Downtown
October 19–October 23, 2019
Philadelphia, PA

American Academy of Psychiatry and the Law

47th Annual Meeting
October 27–30, 2016
Hilton Portland and Executive Tower
Portland, OR

48th Annual Meeting
October 26–29, 2017
Hyatt Regency
Denver, CO

49th Annual Meeting
October 25–28, 2018
Marriott
Austin, TX

AMERSA—Association for Medical Education and Research in Substance Abuse
40th Annual National Conference
November 3–5, 2016
The Fairmont Hotel
Washington, DC, Georgetown

FSPHP E-GROUPS— PLEASE JOIN!

An extraordinarily valuable tool for our members is the FSPHP e-groups, providing a user-friendly capability to share information among our members. As you may know, we now have two e-groups. FSPHS e-groups are a forum for discussion of issues, problems, ideas, or concerns, relevant to state PHPs.

Membership to the e-groups is only open to Federation members.

Visit **www.fsphp.org/FSPHPEGroupGuidelines 11.14.pdf** for guidelines on the use of the e-groups.

For any questions concerning the two e-groups, please call Julie Robarge or Linda Bresnahan at FSPHP (p) (978) 347-0603, or email jrobarge@fsphp.org or lbresnahan@fsphp.org.

There are currently many FSPHP members who are not yet enrolled on the **fsphpmembers@yahoogroups.com**. We'd like to change this to ensure all are enrolled. Please watch for an email invitation to join this group, if you are not already on it.

fsphpmembers@yahoogroups.com

An information exchange venue for ALL FSPHP MEMBERSHIP CATEGORIES. These include State, Associate, Honorary, and International for both Individual and Organizational memberships of the Federation of State Physician Health Programs, Inc.

statePHP@yahoogroups.com

A group limited to the following membership categories—State, Associate, Honorary, and International categories. All State, Associate, Honorary, and International members are eligible for both groups. Please join both.

ADVERTISING AVAILABLE IN OUR NEXT SPRING 2017 ISSUE!

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 twice yearly. 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 once-a-year 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.

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PLEASE CONSIDER A SUBMISSION IN FUTURE ISSUES!

QUESTIONS?

Please contact Linda Bresnahan at lbresnahan@fsphp.org

FSPHP
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PHYSICIAN HEALTH NEWS

The FSPHP produces a newsletter twice a year in March/April and again in August/September which is sent to all state programs, medical societies, and licensing boards. The FSPHP requests articles (500 words or less) 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, etc.
- 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 required 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!