Improving Addiction Outcomes: Lessons from the Physician Health Program Model

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Moderator: Julie Miller, Editor in Chief, Behavioral Healthcare Executive and Addiction Professional
Disclosures

- P. Bradley Hall, MD, FASAM, DABAM, MROCC, AAMRO; Doris Gundersen, MD; and Julie Miller have disclosed no relevant, real, or apparent personal or professional financial relationships with proprietary entities that produce healthcare goods and services.

- Paul Earley, MD – Royalty: Book-RecoveryMind Training; Ownership Interest: DynamiCare, Inc.
Disclosures

- All planners/managers hereby state that they or their spouse/life partner do not have any financial relationships or relationships to products or devices with any commercial interest related to the content of this activity of any amount during the past 12 months.

- The following planners/managers have the following to disclose:
  - Kelly J. Clark, MD, MBA, FASAM, DFAPA – Consulting fees: Braeburn, Indivior
Learning Objectives

- Identify the basic components of physician health and similar disease management programs.
- Apply components from the physician health program model that have broad application to addiction management.
- Recognize how each of these identified components improve outcomes.
Overview Physician Health Programs (PHPs)
Conflict of Interest Disclosures
Brad Hall and Doris Gunderson

- No relevant financial relationships with any commercial interests.
Conflict of Interest Disclosures
Paul Earley

- Principal, Earley Consultancy, LLC
- Part-time Salary, DynamiCare, Inc.
- No financial, but perhaps attitudinal biases:
  - President-elect American Society of Addiction Medicine (ASAM)
Applicability

- Federation of State Physician Health Programs – www.fsphp.org
- Federation of State Medical Boards, Impaired Physician Policy – www.fsmb.org
- American Society of Addiction Medicine, Physician Health Policies – www.asam.org
- American Board of Medical Specialties – www.abms.org
- Physicians, Nurses, Pharmacists, Dentists, etc.
- Conscious awareness
- Patients

Healthcare & other Licensed Professionals

HUMANNESS

STIGMA
Special Populations – Safety Sensitive

- Examples of Safety Sensitive Workers:
  - Power company employees, especially in the nuclear power industry.
  - Defense contractors in selected areas (e.g., missile defense, drone and aircraft manufacture and highly classified weapons systems).
  - Public servants in the police and fire areas
    - Special attention must be paid to officers in undercover and drug enforcement
  - Airline Pilots
    - Even private pilots must be identified and treated with special attention
  - Attorneys and Judges
  - Healthcare workers (Physicians, PAs, nurses, pharmacists and nuclear medicine staff)
  - Employees of pharmaceutical companies (especially in manufacturing)
  - Politicians (?)
Special Populations – Safety Sensitive

The extent of the effect on the public comes from three factors:

1. The **size** of the population they affect,
2. The **depth of damage** on a single person that arises from potential impairment, and
3. The amount of **public trust** that is implied in that worker's occupation.
Why We Do What We Do

• 2 paths
• 1 versus 10
• Making a difference in the lives of the addicted patient

Changing a CULTURE
Illness VS. IMPAIRMENT

- FSPHP Public Policy on Illness vs. Impairment
  Physician illness and impairment exists on a continuum with illness typically predating impairment, often by many years.

- Illness is the existence of a disease

- Impairment is a functional classification implying the inability of the person affected by disease to perform specific activities

www.fsphp.org
Impaired Physician
Addiction & Mental Illness are NON-DISCRIMINATORY & POTENTIALLY IMPAIRING
An estimated 30% of Physicians will have a condition that impacts their ability to practice with reasonable skill and safety at some point in their career.” (AMA)

Addiction, alone, impacts 10-15% of the general population. Slightly higher in health care professions.
Historical Perspective

- **1953** – FSMB calls for model physician assistance programs
- **1980** – almost all state medical societies had authorized or implemented a state PHP and PHPs were communicating.
- **1990** – Several state Physician Health Program’s organized the Federation of State Physician Health Programs
- **1995** – FSMB published guidelines for a model Physician Health Program
- **2004** – Federation of State Physician Health Programs (FSPHP) Guidelines
- **2011** – American Society of Addiction Medicine 11 Policies on Physician Health
- **2012** - FSMB updated the guidelines for a model Physician Health Program
- **2016** – AMA Model Physician Health Program Act (1985 policy revision)
- **2017** – ACGME – Symposium #3 on Physician Wellbeing
- **2017** – National Academy of Medicine
- **2018** – National Rx Drug Abuse & Heroin Summit

*Cultural Shift*
FSPHP Mission

To support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.
FSPHP Vision & Principals in Development:

A society of highly effective PHP’s advancing the health of the medical community and the patients they serve.

- **Membership:** FSPHP is dedicated to enhancing the value of membership and upholding an environment of fellowship and networking.

- **Advocacy:** FSPHP strengthens PHPs by promoting best practices and providing guidelines, advocacy, and other resources that enhance their effectiveness. FSPHP encourages partnership between physician health programs, regulatory boards and other appropriate components of organized medicine.

- **Collaboration:** FSPHP fosters collaboration and engagement with other national and international medical organizations.

- **Equality:** FSPHP opposes discrimination against physicians and the medical community solely based on the presence of a particular diagnosis and/or other discriminatory factors and supports the use of PHP services in lieu of disciplinary action whenever possible.

- **Education:** FSPHP supports education and research designed to establish best practices for the prevention, treatment and monitoring of physicians experiencing substance use disorders, mental illness, physical illness, and other potentially impairing conditions.
FSPHP Collaboratives

• Federation of State Medical Board & Federation of State Physician Health Program Conferences
• American Society of Addiction Medicine’s Drug Testing Appropriateness Document
• Federation of State Medical Board’s Burnout Task Force
• Federation of State Medical Board’s Ethics and Professionalism Committee
• Coalition for Physician Enhancement, CPE
• American Osteopathic Association, AOA
• Coalition of Physician Education, COPE
• American Medical Association, AMA
• ASAM Text (6th Edition) Chapter on PHPs & Physician Addiction (Paul Earley, M.D.)
• Physician Mental Health and Well-Being: Research and Practice Textbook (28 authors)
• FSPHP Guidelines update
• California Legislation SB1177– Physician Health Program enabling legislation
• The Council on Medical Education Report 1-I-16, Access to Confidential Health Services for Medical Students and Physicians, was adopted as amended at I-16 and the final recommendations are now official AMA policy (H-295.858)
Medical Students & Resident

- ACGME – Symposium on Physician Wellbeing
- World Medical Association, Physician Wellbeing Policy
- The AMA Council on Medical Education Report 1-I-16, Access to Confidential Health Services for Medical Students and Physicians, was adopted as amended at I-16 and the final recommendations are now official AMA policy (H-295.858)

* Cultural change
AMA

Mission
To promote the art and science of medicine and the betterment of public health.

Vision
To enhance the delivery of care and enable physicians and health teams to partner with patients to achieve better health.
AMA Physicians Health Program Act

- Legislation
- Therapeutic Alternative to Discipline
- Confidentiality Extended
- Dual Purpose – public safety/rehabilitation
- Early Detection
- Mitigate Barriers
- Discrimination
- Adequate Funding
- **PHP Model Endorsement**
- **Principles of Accountability, Communication, Collaboration & Transparency**
What is a Physicians Health Program
PHPs are a model for confidential chronic disease management through enhancing early detection, intervention, evaluation, treatment and monitoring for healthcare professionals with potential impairing conditions longitudinally over time.
Legislation

- Voluntary / Confidential*
- Provided PHP existence*
- Protected Records*
- Immunity*
- Populations Served
- Qualifying Illness/Services

Senate Bill # 573 – March 8, 2007 (WV)

* Critical
What next?

- Refer medical professional to the PHP for intake interview
- A comprehensive evaluation will be done.
- A treatment plan is constructed based on the evaluation and treatment recommendations of qualified professionals (cohort specific).
- An agreement with the PHP is executed.
- The individual is monitored throughout the agreement and provided support and documentation of compliance.
Essentials of PHPs

- Networking of all State PHPs
- Legislation
- Confidentiality
- Evidence-Based
- Physician to Physician (Peer to Peer)
- Qualified Staff
- Professional Referrals for evaluation/treatment
- Monitoring (behavioral and forensic)
- Networking of participants
- Documentation of Wellbeing & Compliance
- Quick response to concerns
- Education
- Funding*
RELATIONSHIPS

PHP Model

Collaboration
Communication
Accountability
Transparency

Participant (Patient)

Licensure Board (alternative)
WVMPHP Program Volume
Substance of Choice - WV

Alcohol  40%
Alcohol + Drugs  34%
Drugs Alone  26%

Drugs of Abuse - WV

Opiates  44%
Marijuana  12%
Amphetamines  0%
Benzodiazepines  0%
Polysubstances  44%
2016 NSDUH Report Illicit <30 days
28.6 Million Adults (10.6%)

- Marijuana – 24 million (8.9%)
- Prescription Drugs – 6.2 million (2.3%)
- Prescription Pain Relievers – 3.3 million (1.2%)
- Cocaine – 1.9 million (0.7%)
- Hallucinogens – 1.4 million (0.5%)
- Inhalants - 0.6 million (0.2%)
- Methamphetamines – 0.7 million (0.2%)
- Heroin - 0.5 million (0.2%)
PHP GOALS

Early detection

Thorough assessment & evaluation

Abstinence based treatment

Long-term monitoring

Documentation (abstinence, compliance, etc.)
Prevention

- **Primary Prevention** - avoid the development of disease

- **Secondary Prevention** - diagnose and treat an existing disease in its early stages before significant morbidity and patient harm

- **Tertiary Prevention** - treatments aim to reduce the negative impact of established disease by restoring function and reducing disease-related complications

**Cultural shift through education**
**SUPPORT and ACCOUNTABILITY**
Physicians with potentially impairing conditions who come forward are given the opportunity for evaluation, rehabilitation, treatment and monitoring with or without disciplinary action in an anonymous, confidential and respectful manner.
Physician Health Programs and Recovery WORK!!
PATIENT Support & Accountability

- Therapists
- Legal System
- Family
- Employer
- Co-Workers
- *Friends
- Urine Drug Screening
- Mutual Support Groups
- Spirituality

*Cohort specific
The RIGHT Question

“Why NOT?”

vs

“HOW to?”
THANKS TO EACH AND EVERY ONE OF YOU .....

FOR WHO YOU ARE AND FOR WHAT YOU DO !!

BRAD HALL
Doris Gundersen, MD
Immediate Past-President, Federation of State Physician Health Programs
Medical Director, Colorado Physicians Health Program
# Research Highlights

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Blueprint PHP Study

- April 2005: FSPHP and noted researches began the first national study of state PHPs
- Phase I
  - Comprehensive questionnaire sent to PHPs with 86% response rate (42 PHPs)
- Phase II
  - 16 participating PHPs
  - Retrospective chart reviews
  - N = 904 consecutively admitted participants from September 1, 1995 through September 1, 2001 who met diagnostic criteria for SUD
A National Survey of Physician Health Programs

- First national study of distinctive treatment approach of PHPs
- 86% of PHP medical directors completed comprehensive questionnaires

Results

- PHPs provide early detection, assessment, evaluation and referral to intensive primary treatment
- Very positive outcomes with low relapse rates and high percentage of physicians remaining licensed and employed

Conclusion: Several aspects of this continuing care model could be adapted and used for the general population

DuPont et al, How are addicted physicians treated? A national survey of physician health programs, Journal of Substance Abuse Treatment 37, March 2009
Five Year Outcome Study

- 16 PHPs participate
- N = 904 physicians with SUD
- 78% successful completion with no relapses
- Including those with relapse and further intervention, over 90% doing well at 7.2 years
- One report of patient harm (over prescribing)

“Such programs seem to provide an appropriate combination of treatment, support, and sanctions to manage addiction among physicians effectively.”

McClellan et al, Five year outcomes in a cohort study of physicians treated for substance use disorder in the United States, BMJ, November 2008
Relapse Study:
Years in Program

![Graph showing relapse rates by years in program](image-url)
Treatment Outcomes for Physicians with Opioid Dependence

- Treatment outcomes for PHP participants:
  - Alcohol use only (n = 204)
  - Any opioid use with or without alcohol use (n = 339)
  - Non-opioid use with or without alcohol use (n = 159)
  - No agonist pharmacotherapy was used

- Five-year retrospective chart reviews of 16 PHPs

- Results
  - 75-80% across the 3 groups never tested positive
  - 14.5% had one positive UDS
  - 7.6% had more than one positive UDS
  - Treatment outcomes similar for all 3 groups
Treatment Outcomes for Physicians with Opioid Dependence

Conclusion

Individuals with OUDs who are managed by PHPs (i.e. ABPT followed by intensive care management) can achieve long-term abstinence without agonist pharmacotherapy.

Merlo et al, Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in physician health programs, J of Substance Abuse Treatment Treatment (2016)
Drug overdose deaths per 100,000 population by state, US 2015.
PHP Outcomes for Mental and Behavioral Health Problems

- **Objective:** Determine the outcomes of a PHP monitoring SUDs and MBH problems and compare success rates.

- **Results:**
  - 43 of 58 (74%) of MBH participants completed monitoring successfully.
  - 90 of 120 (75%) of SUD participants completed monitoring successfully.
  - Time to relapse was shorter for women in both groups.

- **Conclusion:**
  - Positive outcomes can be achieved for MHB participants with the PHP model. Possibly need to examine gender differences in terms of needs.

Knight et al, Outcomes of a Monitoring Program for Physicians with Mental and Behavioral Health Problems, Journal of Psychiatric Practice Vol.13, No 1, Jan 2007
Colorado Physician Health Program Malpractice Study

- To examine whether and how medical malpractice claims were associated with monitoring by a PHP.

- Retrospective examination of administrative data.

- N = 818 of current and previous PHP participants who were also insured by COPIC.

- A business-model analysis of malpractice risk examined RR ratings between PHP participants and a matched physician cohort.

- Wilcoxon analysis examined differences in annual rates of pre and post monitoring claims for PHP participants only.
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Colorado Physician Health Program Malpractice Study

Results of Risk Relativity Rating:

- Prior to monitoring, PHP participants 111% worse than the physician cohort.
- In other words, for every $1 spent, this group would require $2.12 more than their peers.
- Relative risk fell dramatically during the monitoring period although still 28% worse than the physician cohort.
- After monitoring, this pattern reverses. PHP participants 20% better than cohort.
- In other words, for every $1 spent on the physician cohort, the CPHP group would require $.20 less than their peers.

Brooks et al, Physician health programmes and malpractice claims: reducing risk through monitoring, Occupational Medicine April 2013
Possible Explanations

1. Health problem treated effectively

2. Participants learned skills during health monitoring which improved their ability to practice effectively

3. Experience with PHP may have led participants to make use of other professional supports or seek consultation earlier/proactively

4. Adverse consequences (sanctions, losses) motivated participants to practice more conservatively.
Physicians Contemplating Suicide

- 400 physicians complete suicide each year
- Comorbidity between SUDs and other mental illnesses
- CPHP Study objective: Document current risk factors associated with suicide ideation
- Retrospective cohort study based on chart review
  - Suicide ideation in last month (n = 70)
  - No thoughts of suicide in last month (n = 1572)
- Findings: Multiple stressors, even absent a mental illness, creates an independent risk factor for suicide.

Brooks et al, When Doctors Struggle Current Stressors and Evaluation Recommendations for Physician Contemplating Suicide, Archives of Suicide Research, DOI, Jan 2018
Paul Earley, MD
President-Elect, Federation of State Physician Health Programs
Medical Director, Georgia Physicians Health Program
Chronic Tapering Care

- **Intake and Acute care** – defined as a period of time where the individual dramatically tapers or even discontinues daily life to focus on containing their addiction illness and learning self-care skills that promote long term recovery.

- **High Intensity Disease Monitoring** – During this phase, the individual enters an agreement with family, her or his medical and therapeutic team, law enforcement, employer or other group. Recovery skills are rarely self-directed at this point, but the individual must be engaged enough to comply. Disease monitoring begins.

- **Low Intensity Disease Monitoring** – The participant has less frequent recovery activities but continues with disease monitoring. Engagement increases with increasing health and disease insight.

- **Post-monitoring** – In this stage, the active external disease monitoring has been dramatically tapered or discontinued. Recovery is mostly self-guided with input from peers and mentors.
Initial Treatment Dose

- Physicians often arrive in treatment hiding behind a façade of intellectualism and competence.
- Early pioneers in physician treatment combined elements of twelve step facilitation (TSF) therapeutic community (TC, peer confrontation & social norming). Length was shorter than most TCs and balanced by psychotherapeutic understanding.
- Increased therapeutic sophistication resulted in less confrontation and more insight-oriented and cognitive-behavioral interventions.
- Physicians cannot be treated with “fail-first” protocols as failures weaken faith in the system by medical boards and the public.
- Specialty centers are used in most cases where staff understand physician personality structure, workplace setting and risks, legal issues, etc.
Timeline: Physician Treatment
Chronic Disease Management

- Initial Treatment
- Stabilization and Withdrawal Management
- Initial high-intensity treatment
- High intensity monitoring
- Low intensity monitoring
- Caduceus Meetings
- Mutual Help Meetings
- Substance Screening
- Family Therapy?
- Group Therapy
- Individual Therapy?
Philosophy of PHP Care Management

- Relapse is seen as a part of the illness. Relapse = Do more
- We strive to decrease relapse rates, intervening early to mitigate damage when it does occur.
- This increases patient safety.
- In most states in the US and Canada, we are able to eliminate or mitigate punitive action by our medical boards in situations where no breach of patient safety occurs.
- Includes attention to work/life balance, co-occurring conditions, trauma, physician personality issues, healthy boundaries with patients, etc.
Philosophy of PHP Care Management

- Participants know their responsibilities because they are outlined in a monitoring agreement signed by the PHP and the physician-participant.
- An extended care model helps the individual internalize the chronic nature of their illness, one that requires ongoing attention similar to other chronic conditions.
- As in diabetes, for example, the illness is a lot of work to manage at the outset. Management becomes second nature after a period of time.
- PHP participants progress through the three Cs:
  - Conflict
  - Compliance
  - Commitment

  Difficulty with recognition and disease ambivalence
  Cognitive acceptance battles primitive addiction drives
  Internalization of recovery and decreased primitive drive

Common Topics in Monitoring Groups

- How and when to disclose recovery status to peers, supervisors and even patients.
- Difficulties with credentialing bodies, medical staff credentialing third party payers, etc.
- How to manage burnout and work/life balance.
- Family and marital conflict
- Shame about having a substance use disorder.
- Dealing with difficult patients
  - Those with pain, on opioids
  - Those with Substance Use Disorders.
Central Elements of PHP Monitoring

- Data collection using a distributed and protected database.
- An assigned Case Manager works with individual participants remotely (primarily through phone and web).
  - Tracking attendance at PHP groups, physician visits and self-help meetings
  - Following drug screens
  - Tracking behavioral data
  - Feedback on the submission of needed data
  - Identification of emerging issues
  - Data drives frequency of contact with participant, frequency of screens
- PHPs make decisions using team-based staffing.
- All decisions have to take into account patient safety and, unfortunately, the political and social issues around safety-sensitive workers.
Stakeholders in Physician Health

- Hospital Liability
- Patient Safety
- Staff Wellness

- Public Safety
- Limited Confidentiality

- License Protection
- Confidentiality
- Effective Treatment

Hospital

Treatment Program

Ill Physician

PHP

Licensing Board

- Public Safety
- Effective Treatment
- Confidentiality

- Public Safety
- Limited Confidentiality
PHPs have Evolved

- Use of third party administrators to manage sophisticated and ready access to substance screening.
- Increased attention to personality issues, co-occurring disorders, management of familial discord and workplace stress and burnout.
- Increased use of therapy and monitoring tools
  - Relapse prevention training
  - Mindfulness training
  - Trauma resolution and DBT
  - Group, individual and family therapy as needed
  - Interaction with workplace monitors
  - Support group attendance and involvement
- SUD medications prescribed by an ongoing relationship with an addiction psychiatrist or addiction medicine physician.
  - Injectable NTX
  - Medications for unipolar and bipolar mood disorders
  - Medications for other conditions
  - Disulfiram
# Components of Monitoring

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<td>Check-In - 07:33 AM Attendance (Self Help Meeting)</td>
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(Semi) Big Data

- Modern PHPs collect a wide variety of behavioral and medical data on their participants
- All PHPs use electronic databases
- Medical / Sociological data
  - Diagnoses
  - Psychological testing
  - Marital status
  - Work settings
- General Medical
  - Current Diagnoses
  - Medical Procedures
  - Medical and Psychiatric Medications
(Semi) Big Data

- Substance screening
  - Multiple substrates (urine, hair, blood)
  - Addition of ethanol markers (EtG, EtS, PEth, hair EtG, etc.)
  - Detection of a wide variety of abusable substances including profession-specific (e.g., propofol, fentanyl) and commonly abused substances (e.g., tramadol).

- Care Monitoring
  - Attendance at PHP-sponsored therapy and support groups
  - Attendance at 12-step meetings
  - Attendance at required individual, couples and family therapy if required.

- Behavioral monitoring
  - Timing of daily check-in
  - Screens are pull driven, i.e. the participant checks daily by phone call, on the web or via a mobile app. Check-in reliability is tracked, deterioration is considered as a possible early warning sign of relapse.
  - Attendance at support group and therapy sessions increasingly tracked using geolocation (cell phone app).
  - In some states, prescribed medications may be tracked using PDMP tools.
Automatic Geolocation of Appointments & Meetings
Elements of Contingency Management
Addiction Among Physicians

- Case managers regularly interact with participants
  - Feedback on the submission of needed data
  - Identification of emerging issues
  - Data drives frequency of contact with participant, frequency of screens

- Increased data collection tracks
  - Screen results
  - Addition of ethanol markers (EtG, EtS, PEth, hair EtG, etc.)
  - Check-in reliability
  - Attendance at support group and therapy sessions
  - Tracking of properly prescribed medications
Elements of Contingency Management
Addiction Among Physicians

- Complex drug screening is managed by a third party administrator and carefully reviewed by the PHP.

- Use of positive reinforcement
  - Screens decrease according to compliance with check-ins and periods of no detected substance use.
  - Some PHPs are experimenting with decreased contract length in individuals with sustained abstinence and high compliance.

- Use of negative reinforcement
  - PHPs have the ability to remove the physician from the workplace or report to their medical board.
Measured Response to Lapses and Disease Recurrence

- Any violation of abstinence is seen as well into a rapidly escalating relapse cycle.
- The measured response is not eviction from the program, but does involve a reevaluation of care.
- Decisions about a change in care include outside providers.
- Any confirmed positive screen results in care modification through a personalized plan containing any combination of the following:
  - Increasing screen frequency
  - Increasing use of support groups
  - Focused or therapy or manualized relapse prevention training
  - Protective housing
  - Move to higher level of care for additional therapy and disease containment.
Is Physician Treatment Applicable to the General Population?

- Critics of generalizing from the PHP experience often argue that physicians are an unrepresentative patient population.
- “Doctors are not representative of anything in the ‘real world’ of addiction!”
Using Contingency Management in a Distinctly Different Population

- Consider a very different population, the Criminal Justice System
  - Heavy drug users
  - Users who create the highest societal costs
  - Users with the poorest prognoses
- Example: Hawaii’s Opportunity Probation with Enforcement (HOPE) CJS program reduces recidivism and incarceration through a reduction in drug and alcohol use.
HOPE Probation

- This randomized controlled study compared probationers assigned to HOPE to individuals assigned to standard probation.
Outcome Data

- PHPs make this population easier to track with 90+ percent follow-up rates.
- They have unusual characteristics:
  - Very high incidence of suicide in substance abusing physicians
  - Almost constant access to drugs of abuse, often the very drugs they use.
- Treatment protocols differ but are more consistent than treatment in the general U.S. population.
- Physicians who participate in the PHP model have the high recovery rates (between 70 and 86%), measured over prolonged periods of time (3 to 5 years).†

Cost

- The financial burden for the monitoring part of some PHP programs is approximately the same as the cost of trade name Suboxone plus a monthly physician visit for a physician to obtain that prescription.
- This estimate does not take into account the cost of drug screening as buprenorphine maintenance should include drug testing as well.
Take Home Points

- Long-term contingency management, combined with guidance and support are utilized in this chronic disease management model.
- Multimodal drug testing is employed and regarded as protection from the illness.
- Exacerbations of the disease are met with substantive but compassionate intervention and heightened management for a period of time.
- Consequences are meaningful and swift.
- Support of the participant is increased during disease exacerbations (relapse).
- Extended duration of engagement with the participant.
- Long-term recovery (5-years or more) is the expected outcome.
Thank you
Improving Addiction Outcomes: Lessons from the Physician Health Program Model

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THANK YOU

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