Burnout and Recovery: Lessons Learned from Physician Health Programs

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Disclosures

- No relevant financial relationships with any commercial interests.
- Physician Education Grant #G180529

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OBJECTIVES

- Burnout & Resilience
- Opioids & Doctors
- Good News
- PHP Model of Chronic Disease Management
- Lessons Learned

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Health and Wellbeing Issues

- Life / Work Balance
- Satisfaction
- Lack of joy / unhappiness
- Stress
- Distress
- Burnout
- Behavioral Health (interpersonal)
- Mental Health
- Physical Health
- Substance Use / Addiction
- Suicide

* Professionalism/Boundaries

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Stigma

- Illness resistant
- God complex
- Knowledge is not protective
- Training how and who to ask for help

*Education is the key

Physician Wellness

"Wellness goes beyond merely the absence of distress and includes being challenged, thriving, and achieving success in various aspects of personal and professional life."

Shanafelt TD, Sloan JA, Haberman TM. The well being of physicians. *Am Med J* 2003; **114:** 513–17.

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Burnout

AMA / Mayo Clinic –
6,880 physicians surveyed 2011 & 2014

- At least one symptom of burnout increased 2011-2014 (45.5-54.4%)
- Work / Life balance satisfaction declined 2011-2014 (48.5-40.9%)
- Burnout rates higher for all specialties in 2014
- Nearly a dozen specialties increased greater than 10%
- More prevalent when compared to the general US working population even when adjusted for age, sex, hours and educational level

Burnout

- Emotional exhaustion
- Loss of meaning in work
- Feelings of ineffectiveness
- Depersonalization - viewing people as objects rather than human beings

Burnout impacts the quality of care physicians provide and physician turnover.

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DOCTOR AND PATIENT | AUGUST 23, 2012, : http://well.blogs.nytimes.com/2012/08/23/the-widespread-problem-of-doctor-burnout/

The Widespread Problem of Doctor Burnout

By PAULINE W. CHEN, M.D.

1 in 2 US physicians burned out implies origins are rooted in the environment and care delivery system rather than in the personal characteristics of a few susceptible individuals.

Courtesy: Christine Sinsky, MD

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Burnout: Demands, Resources, Control

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Healthy Physicians Give Better Care!

- Decreased medical errors
- Increased patient satisfaction
- Better treatment recommendations
- Increased treatment adherence
- Lower malpractice risk
- Better attitudes toward work
- Higher team functioning
- Lower turnover

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Individual Drivers of Physician Burnout

- Perfectionism
- High achievement orientation
- Difficulty setting boundaries
- Intellectualization
- Delay of gratification
- Compartmentalization
- Materialism

Environmental Drivers of Physician Burnout

- Workload and time constraints
- Inefficiencies/frustration (EHR)
- Lack of autonomy/control
- Ineffective leadership
- Mission/values mismatch (loss of meaning)
- Culture of incivility
- Perception of fairness and respect
- Diminished rewards

Building Wellness into the Practice Environment

Practice Environment

Professional

Tension

System Redesign

Wellness

The way out is to get "all in"

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How Do You Prevent Burnout?

- Accept shared responsibility for burnout
- Elevate personal wellness to a core professional value, starting in medical school
- Make wellness and satisfaction a quality outcome and incentivize it accordingly
- Muster the will to address burnout generators and ask for help
- Create opportunities for peer support and decrease isolation
- Nurture the brain through meditation and application of mindful practice to clinical work

Individual Wellness: Key Targets

- Awareness
- Self-Care
- Resilience
- Engagement

Self-Awareness & Self-Monitoring

- Recognizing stressed-ness
- Fatigue & irritability
- Outside comfort zone
- Emotional, mental, physical & spiritual "temperature"

Self-Regulation & Resilience

- Cognitively
- Emotionally
- Somatically
- Spiritually

Attending To Self

- Resilience is about wholehearted engagement with and not withdrawal from the often difficult realities of the workplace.
- Paradoxically the loss of resilience can result from seemingly energy saving measures of withdrawal.

The way out is to get all in

Resilience

The ability of an individual to respond to stress in a healthy, adaptive way such that personal goals are achieved at minimal psychological and physical costs….. the “Bounce-Back”.

Finding Balance in the Medical Life

Lee Lipsenthal, M.D.

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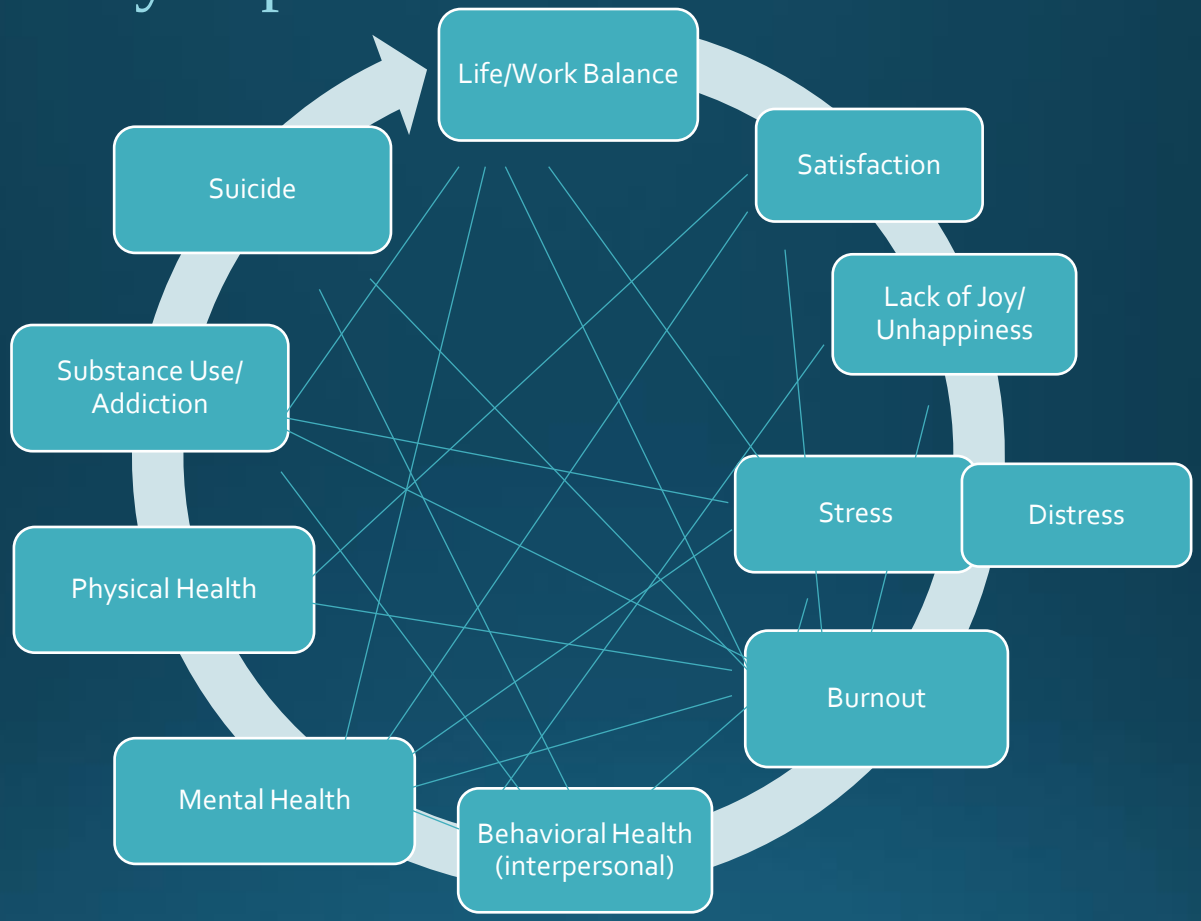
An example of unhealthy cycle that healthcare professionals may experience



PHPs can intervene and *help* at any point!

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OBJECTIVES

- Burnout & Resilience
- Opioids & Doctors

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OPIOIDS OVERVIEW

- Kill more than illegal drugs
- Kill more than gun homicides and car crashed combined
- US life expectancy dipped-for the 1st time in decades-2 years in a row!

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OPIOIDS OVERVIEW

- US=5% world population
- US=consumes 80% opioids
- Americans report > levels of pain
- Drug companies make lots of $$$
- Risk of OUD increases in 4-5 days of use

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CARTOON VIEW DANA SUMMERS

This is a **false dichotomy**
Aberrant drug use behaviors are common in pain patients

63% admitted to using opioids for purposes other than pain[1]

Pain Patients

35% met DSM V criteria for addiction[2]

"Drug Abusers"

92% of opioid OD decedents were prescribed opioids for chronic pain.

1. Fleming MF, Balousek SL, Klessig CL, Mundt MP, Brown DD. Substance Use Disorders in a Primary Care Sample Receiving Daily Opioid Therapy. J Pain 2007;8:573-582.

2. Boscarino JA, Rukstalis MR, Hoffman SN, et al. Prevalence of prescription opioid-use disorder among chronic pain patients: comparison of the DSM-5 vs. DSM-4 diagnostic criteria. J Addict Dis. 2011;30:185-194.

3. Johnson EM, Lanier WA, Merrill RM, et al. Unintentional Prescription Opioid-Related Overdose Deaths: Description of Decedents by Next of Kin or Best Contact, Utah, 2008-2009. J Gen Intern Med. 2012 Oct 16.

CONTRIBUTING FACTORS 1980

- Unsubstantiated claims:

  "Addiction Rare in Patients Treated with Narcotics"

Porter & Jick. 1980. NEJM. 302(2): 123

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CONTRIBUTING FACTORS

- Pain=5th Vital Sign 1995 -American Pain Society
- Strong public demand-pain is #1 reason for Dr visit
- Insurance reimbursement for Rx opioids-sales quadrupled 1999-2014
- Lack of foresight about unintended consequences
- Big PHARMA 20,000 educational events assuring all that opioids had low addiction potential

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CONTRIBUTING FACTORS

- Insufficient addiction treatment-less than 10% get any Tx, and only half of those achieve sustained recovery
- Insufficient medical education
  - Pain management
  - Opioid prescribing
  - Screening for addiction
  - Treating addiction
- Lack of patient education

DOCTOR'S DILEMMA

- Pain is a subjective symptom
- Balance under-treating pain vs. potential Medical Board discipline
- Managed care pressure for short duration visits sways Doc to easily write an Rx rather than get too involved.
- Checking an inefficient PMDP is cumbersome and time consuming

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West Virginia Today
EPICENTER

"Approximately 198 in 2017, people die each day in the United States of a drug overdose." "The CDC's Vital Signs illustrates two significant factors partly fueling that alarming number - the misuse of prescription drugs and a related increase in heroin use." …..ADDICTION ???

EPIDEMIC

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Controlling the epidemic:
A Three-pronged Approach

- **Prevent** new cases of opioid addiction.
- **Treatment** for people who are already addicted
- **Supply control-** Reduce over-prescribing and black-market availability.

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- Burnout & Resilience
- Opioids & Doctors
- Good News

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GOOD NEWS

% of 12th graders using Opioids

- 9.2 % in 2009
- 4.2 % in 2017

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GOOD NEWS

- # of written prescriptions for opioids has decreased 13.1% between 2012 and 2015 Still triple 1999 level !

- Too many-too much-too long !

CDC

WV Greatest Change in Opioids Filled

Percent Change in Filled Prescriptions, 2016 vs 2015 Opioid Products					
Rank	State	% Change	Rank	State	% Change
1	Florida	0.3%	27	Washington	-5.6%
2	Georgia	-0.3%	28	New York	-6.2%
3	Louisiana	-2.2%	29	Iowa	-6.5%
4	Arkansas	-2.2%	30	Kentucky	-6.6%
5	Wyoming	-2.3%	31	California	-6.6%
6	Texas	-2.9%	32	Virginia	-6.6%
7	Alaska	-3.4%	33	New Jersey	-6.6%
8	Alabama	-3.5%	34	Delaware	-6.7%
9	Utah	-3.6%	35	Maryland	-7.0%
10	Nebraska	-3.9%	36	Michigan	-7.0%
11	Mississippi	-3.9%	37	New Mexico	-7.8%
12	Idaho	-4.1%	38	Oregon	-7.9%
13	Kansas	-4.2%	39	Colorado	-8.1%
14	Illinois	-4.2%	40	District of Columbia	-8.2%
15	South Carolina	-4.3%	41	Wisconsin	-8.3%
16	South Dakota	-4.7%	42	Pennsylvania	-8.6%
17	Nevada	-4.9%	43	Ohio	-9.0%
18	Montana	-5.0%	44	Minnesota	-9.7%
19	Missouri	-5.0%	45	Vermont	-10.2%
20	North Carolina	-5.1%	46	Rhode Island	-10.5%
21	Hawaii	-5.2%	47	Connecticut	-10.8%
22	North Dakota	-5.2%	48	Maine	-12.0%
23	Oklahoma	-5.2%	49	Massachusetts	-12.7%
24	Indiana	-5.3%	50	New Hampshire	-13.8%
25	Arizona	-5.5%	**51**	**West Virginia**	**-15.6%**
26	Tennessee	-5.6%	52	Puerto Rico	N/A
All states = -5.6% annual percentage of change					

U.S. total Opioid prescriptions 2015 = 227,780,915

U.S. total Opioid prescriptions 2016 = 215,051,279

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Opioid Utilization per Capita by State, 2016

A State Comparison: Annual Prescriptions per Capita 2016 Opioid Products					
Rank	State	Rx per Capita	Rank	State	Rx per Capita
1	Alabama	1.2	27	South Dakota	0.6
2	Tennessee	1.1	28	Wyoming	0.6
3	Arkansas	1.1	29	Iowa	0.6
4	Mississippi	1.0	30	Wisconsin	0.6
5	Louisiana	1.0	31	Washington	0.6
6	Oklahoma	1.0	32	New Mexico	0.6
7	**West Virginia**	**1.0**	33	District of Columbia	0.6
8	Kentucky	0.9	34	Virginia	0.6
9	Michigan	0.9	35	Rhode Island	0.6
10	South Carolina	0.9	36	Florida	0.6
11	Indiana	0.8	37	Maryland	0.6
12	Kansas	0.8	38	Illinois	0.6
13	North Carolina	0.8	39	North Dakota	0.6
14	Missouri	0.8	40	Colorado	0.6
15	Ohio	0.8	41	Connecticut	0.6
16	Nevada	0.8	42	New Hampshire	0.6
17	Georgia	0.8	43	Vermont	0.6
18	Delaware	0.8	44	Texas	0.6
19	Pennsylvania	0.7	45	Alaska	0.5
20	Idaho	0.7	46	Massachusetts	0.5
21	Oregon	0.7	47	New Jersey	0.5
22	Nebraska	0.7	48	Minnesota	0.5
23	Utah	0.7	49	New York	0.5
24	Montana	0.7	50	California	0.4
25	Arizona	0.7	51	Hawaii	0.4
26	Maine	0.7	52	Puerto Rico	N/A
All states = 0.7 annual prescriptions per capita					

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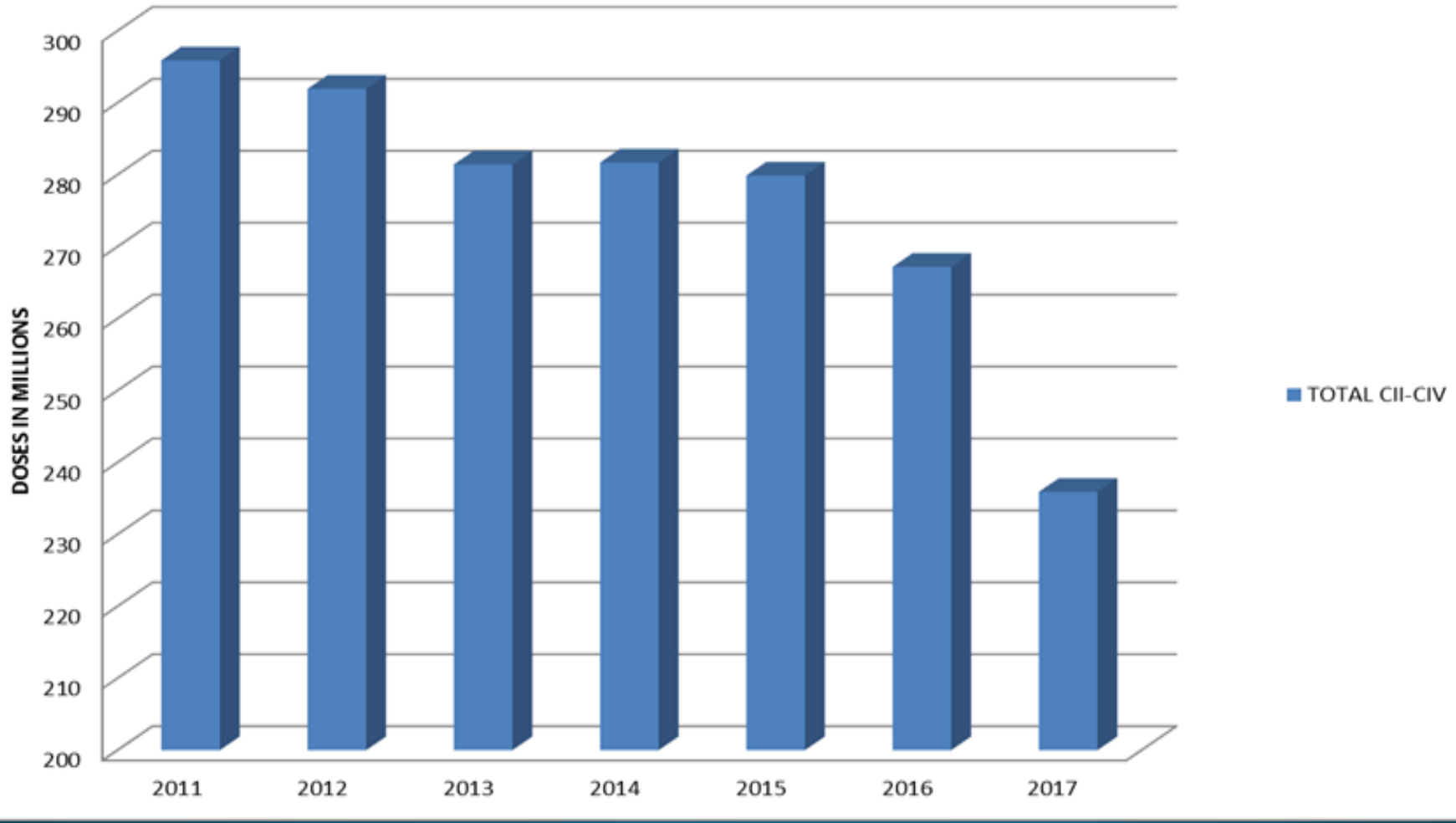
WV TOTAL CONTROLLED SUBSTANCE DOSES DISPENSED



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WV CONTROLLED SUBSTANCE DOSES (IN MILLIONS)

	YEAR						
DRUG PRODUCTS	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Hydrocodone	99.61	94.75	82.78	76.19	63.83	60.15	**51.75**
Oxycodone	40.3	43.99	42.79	42.76	40.59	36.18	**26.85**
Tramadol	0.95	9.81	10.83	21.08	35.53	35.68	**31.86**
Codeine	4.07	3.58	3.11	3.22	4.37	4.56	**4.32**
Alprazolam	42.28	40.22	37.78	36.84	35.25	32.14	**27.35**
Clonazepam	17.41	17.53	17.36	18.11	18.01	17.39	**15.50**
Lorazepam	17.17	16.85	16.46	16.34	15.69	15.83	**14.43**
Diazepam	11.36	10.88	10.22	9.97	9.5	8.83	**7.14**
Zolpidem	10.73	10.51	9.72	6.98	8.98	8.22	**7.59**
Amphetamine	7.86	6.87	6.99	7.27	7.46	7.82	**8.01**
Buprenorphine	3.52	4.58	4.72	5.61	6.26	7.12	**8.14**
Methylphenidate	2.13	4.13	4.62	4.5	4.46	4.74	**4.08**
All Other C II - IV	38.51	28.25	34.06	32.83	29.96	28.54	**28.90**
Total	**295.9**	**291.95**	**281.44**	**281.7**	**279.89**	**267.2**	**235.92**

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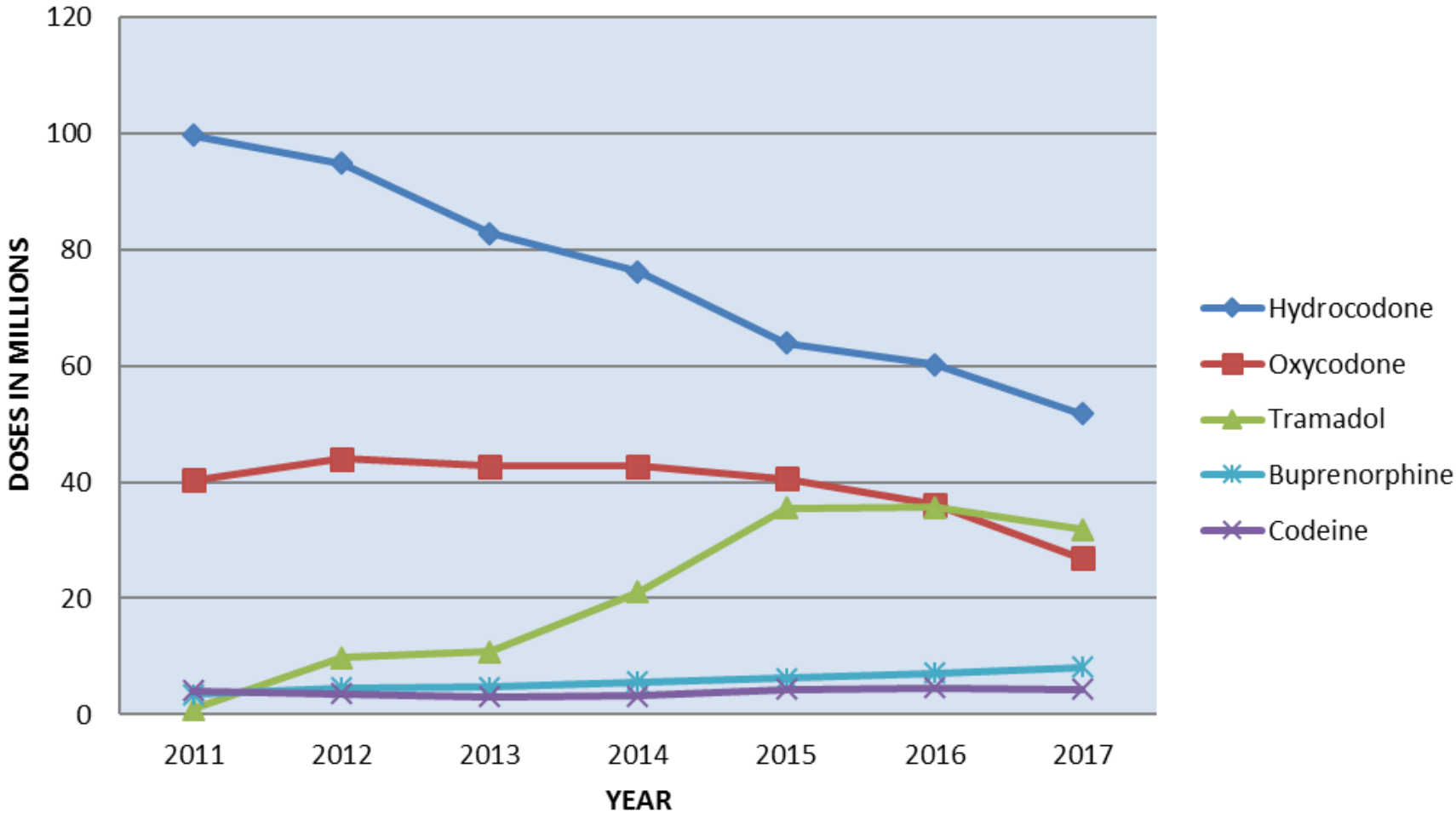
WV OPIOID DRUG DOSES DISPENSED



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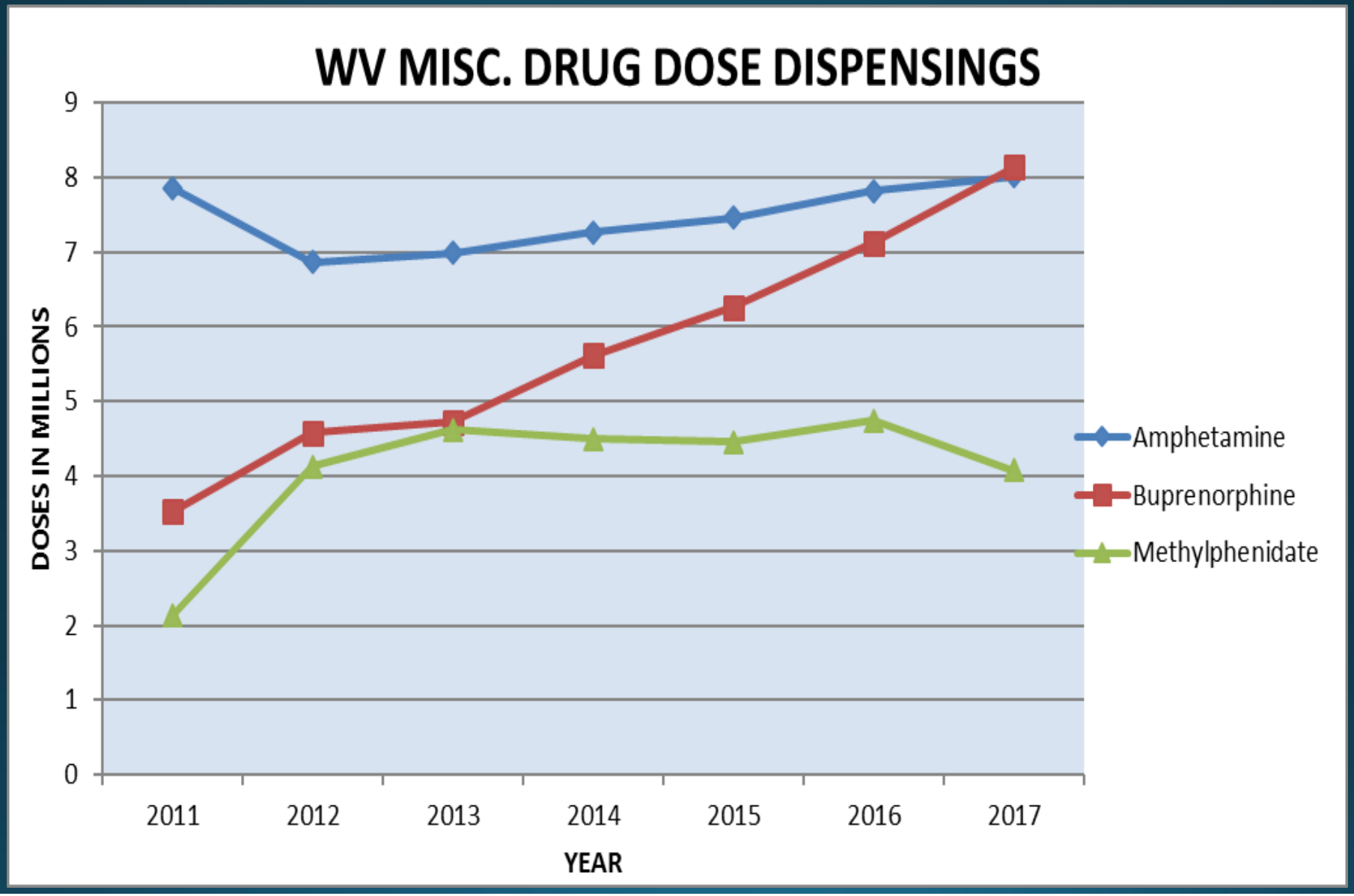

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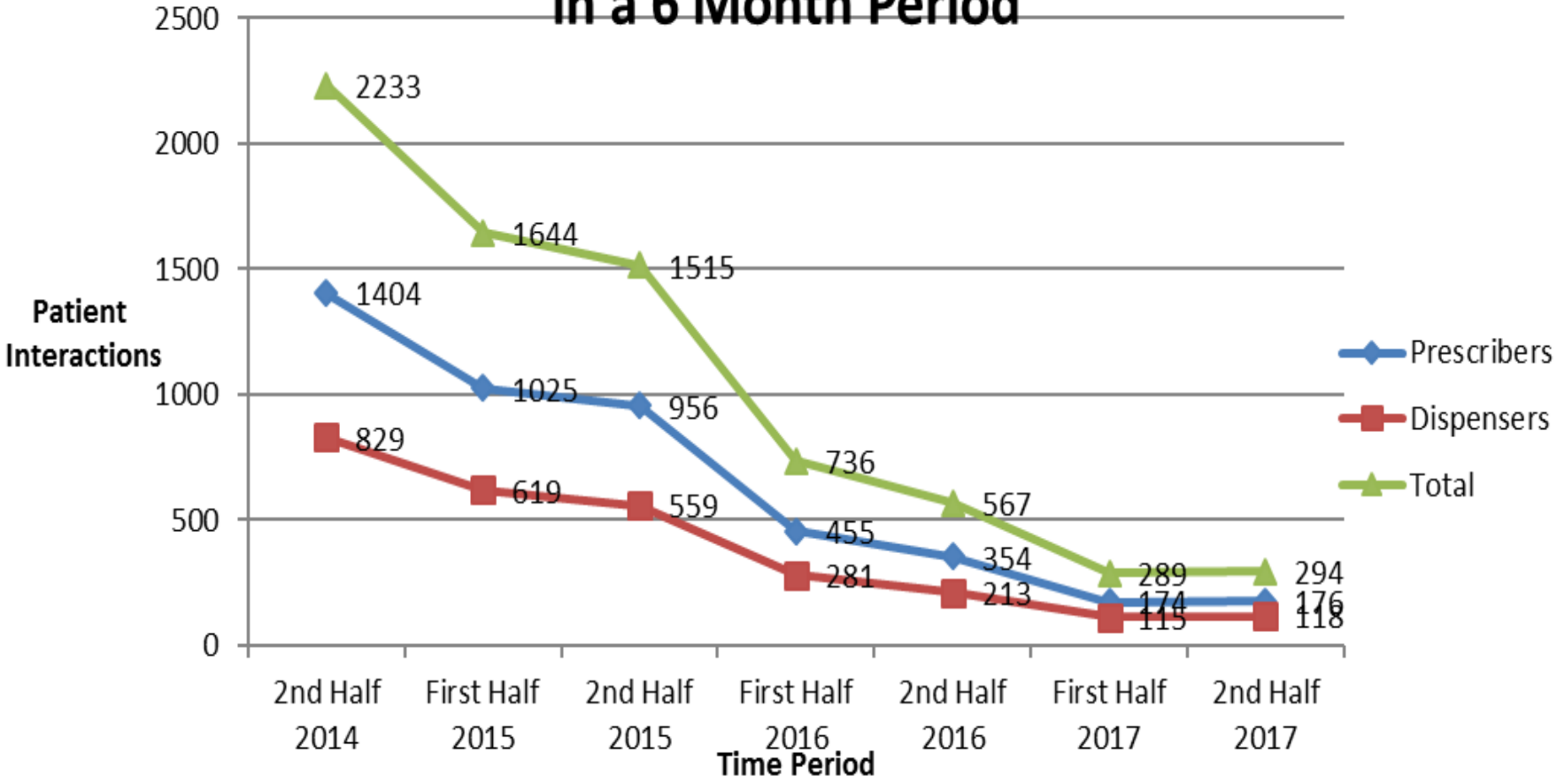
Patients Obtaining CS Prescriptions from 8+ Prescribers and 5+ Dispensers in a 6 Month Period



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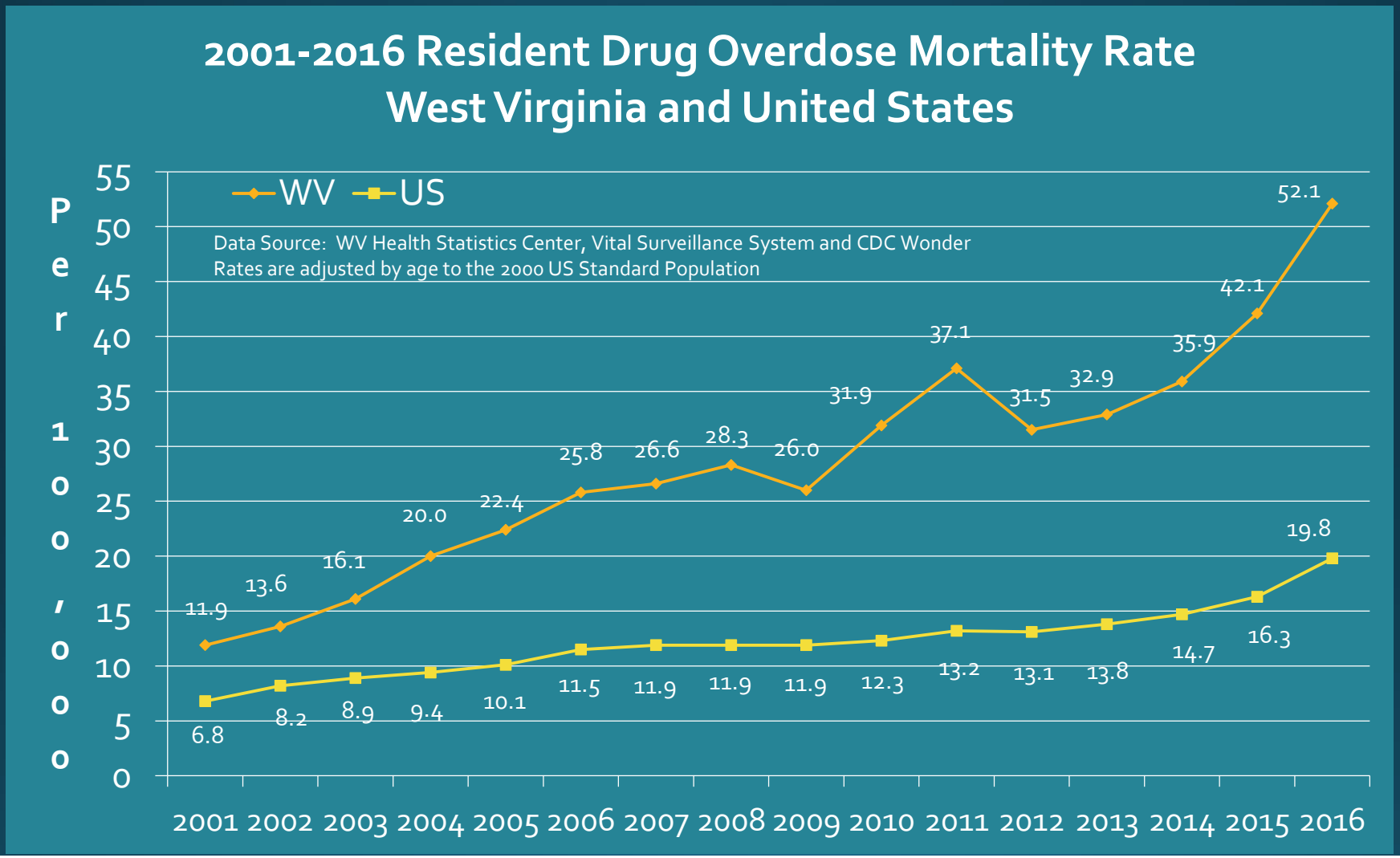
WV versus US



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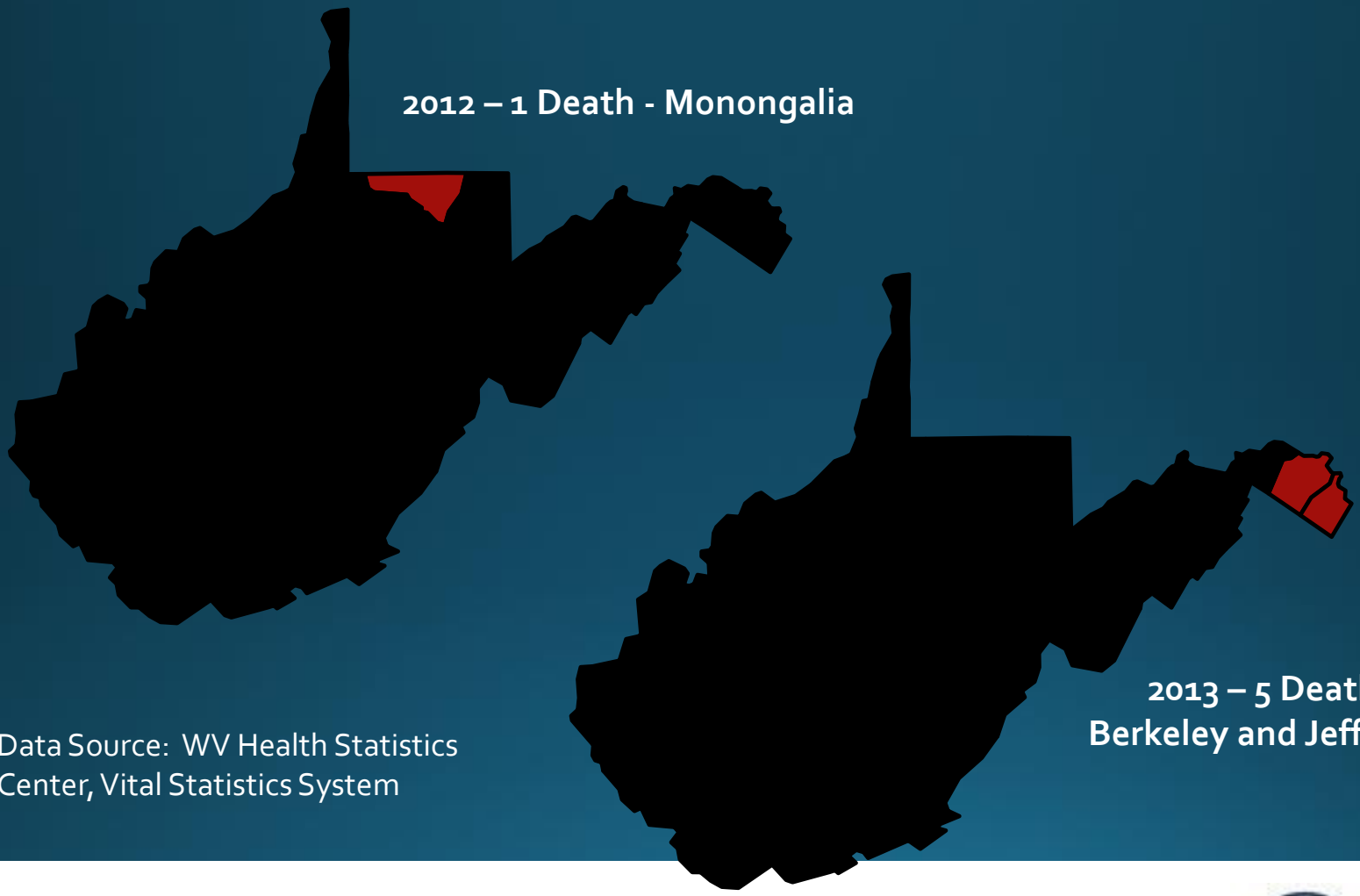
Polypharmacy – Co-use Heroin and Fentanyl



Data Source: WV Health Statistics Center, Vital Statistics System

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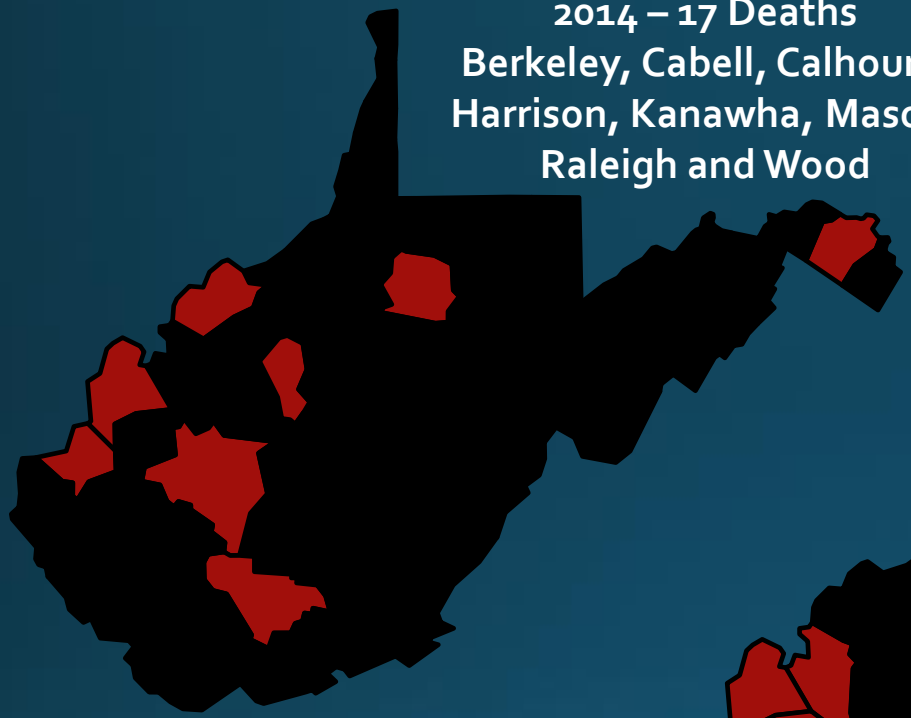
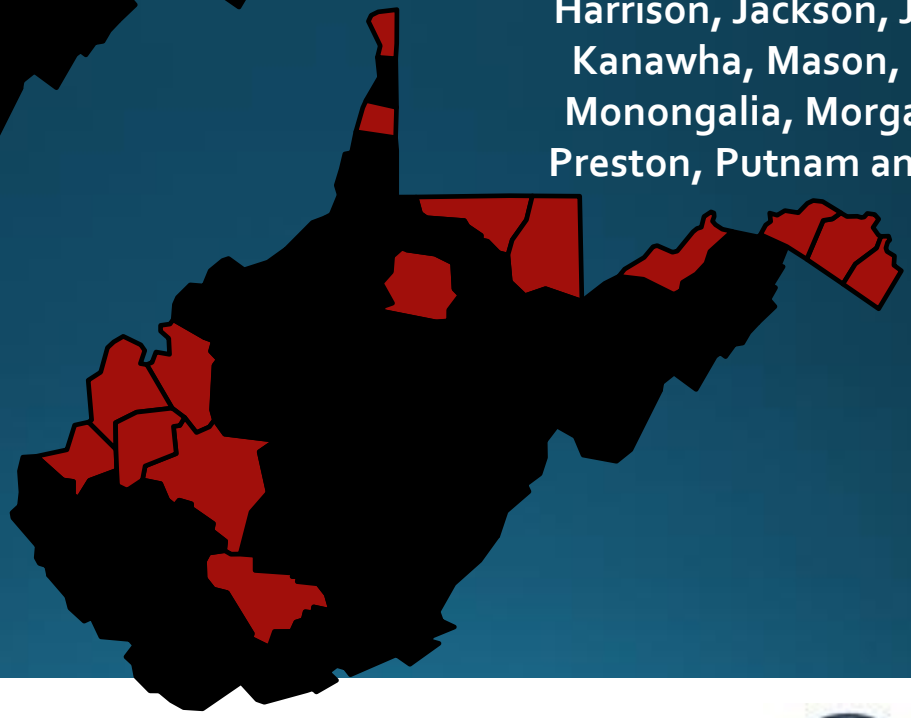
Polypharmacy – Co-use Heroin and Fentanyl

2014 – 17 Deaths
Berkeley, Cabell, Calhoun , Harrison, Kanawha, Mason, Raleigh and Wood



2015 – 64 Deaths
Berkeley, Cabell, Hancock, Harrison, Jackson, Jefferson, Kanawha, Mason, Mineral, Monongalia, Morgan, Ohio, Preston, Putnam and Raleigh



Data Source: WV Health Statistics Center, Vital Statistics System
2016 preliminary data

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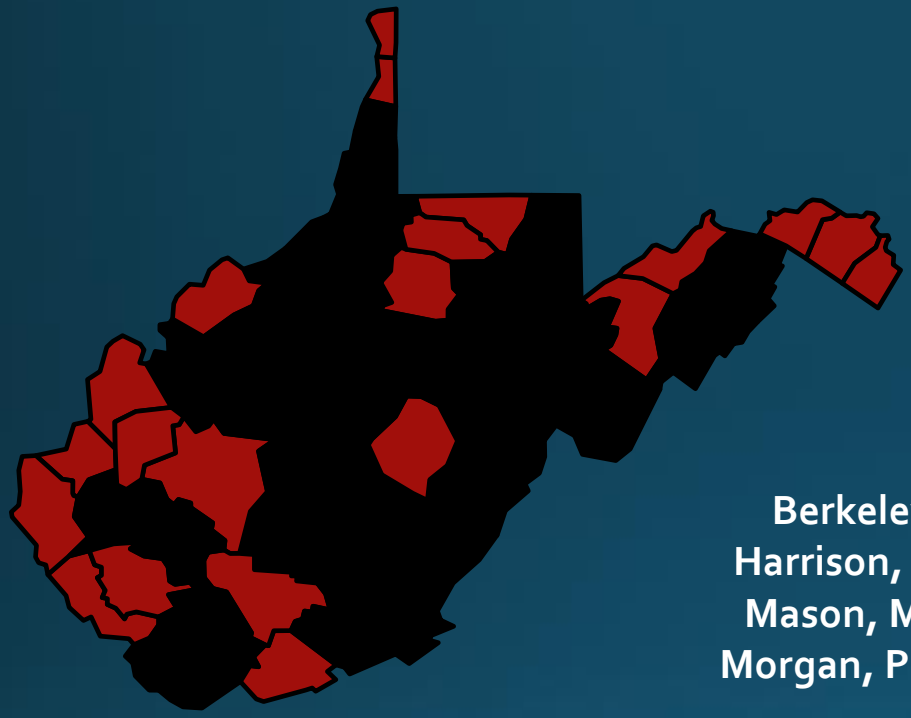
Polypharmacy – Co-use Heroin and Fentanyl



2016 – 136 Deaths
Berkeley, Brooke, Cabell, Grant, Hancock, Harrison, Jefferson, Kanawha, Logan, Marion, Mason, Mercer, Mineral, Mingo, Monongalia, Morgan, Putnam, Raleigh, Wayne, Webster and Wood

Data Source: WV Health Statistics Center, Vital Statistics System
2016 preliminary data

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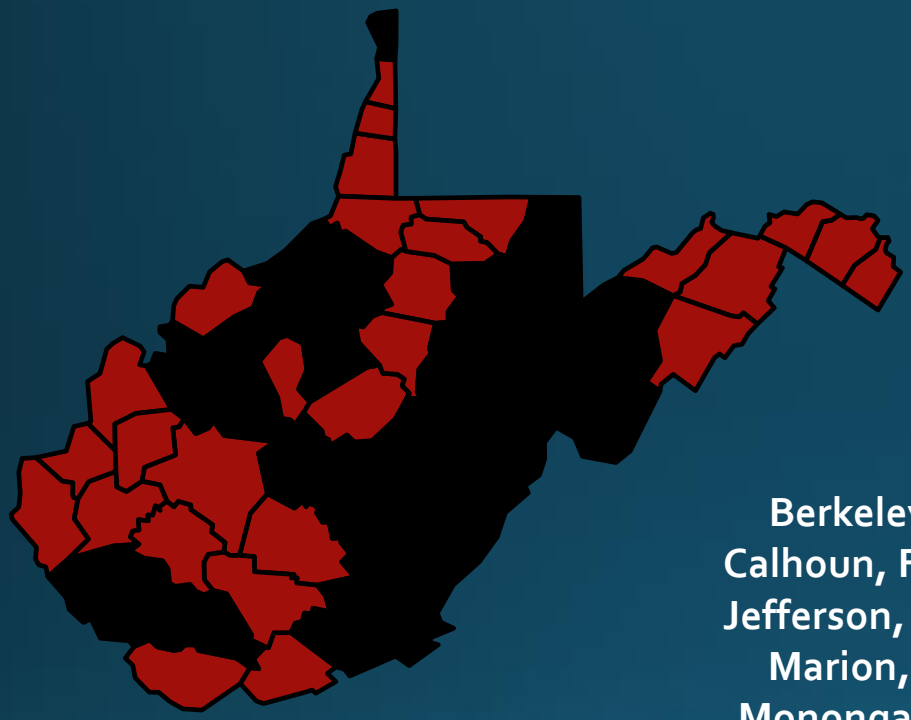
Polypharmacy – Co-use Heroin and Fentanyl



2017 – 220 Deaths
Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Fayette, Hampshire, Hardy, Harrison, Jefferson, Kanawha, Lewis, Lincoln, McDowell, Marion, Marshall, Mason, Mercer, Mineral, Monongalia, Morgan, Ohio, Putnam, Raleigh, Wayne, Wetzel and Wood

Data Source: WV Health Statistics Center, Vital Statistics System
2016 preliminary data

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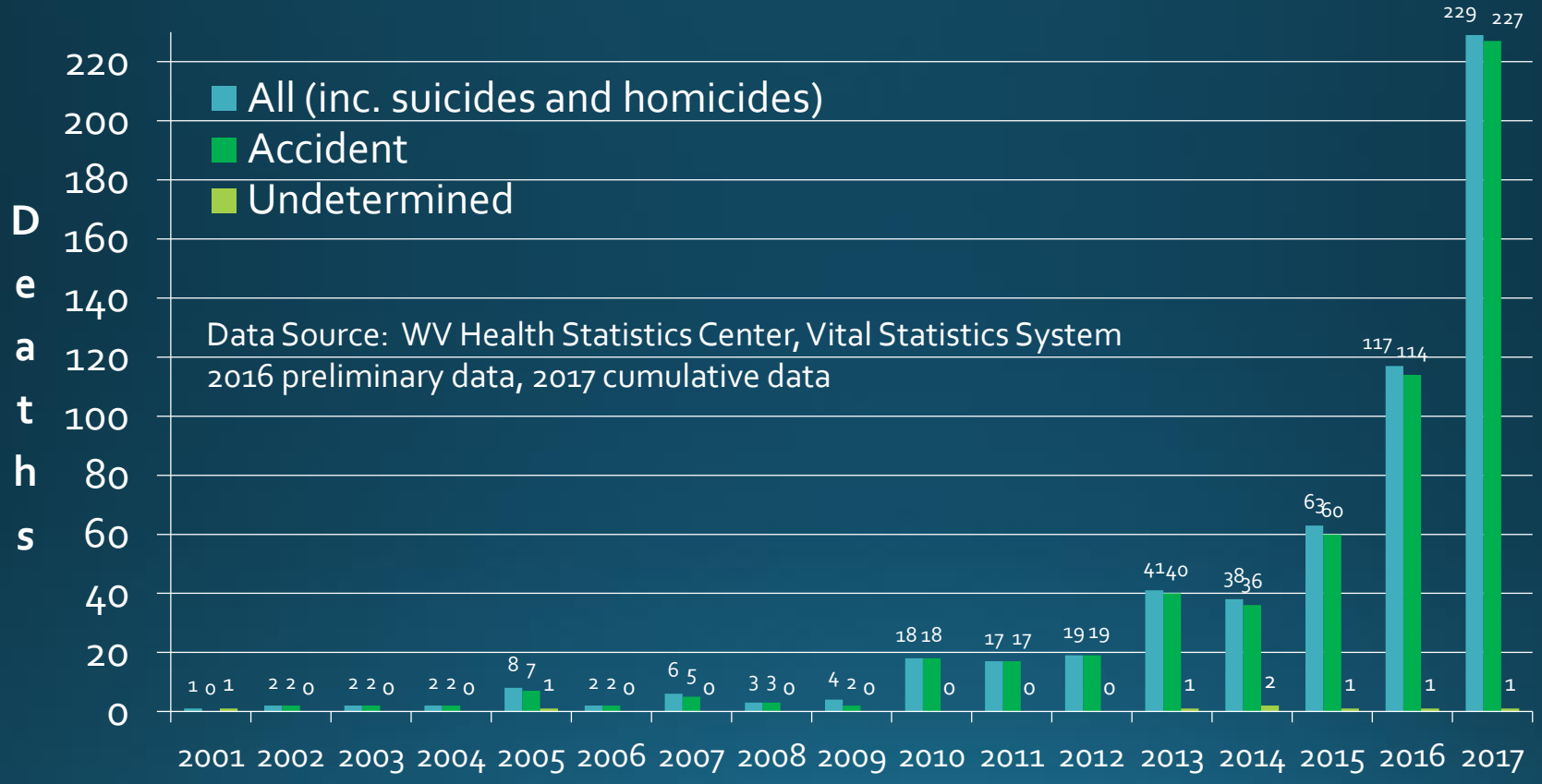
STIMULANTS

Amphetamine- or Methamphetamine-Related Overdose Deaths by Year & Manner



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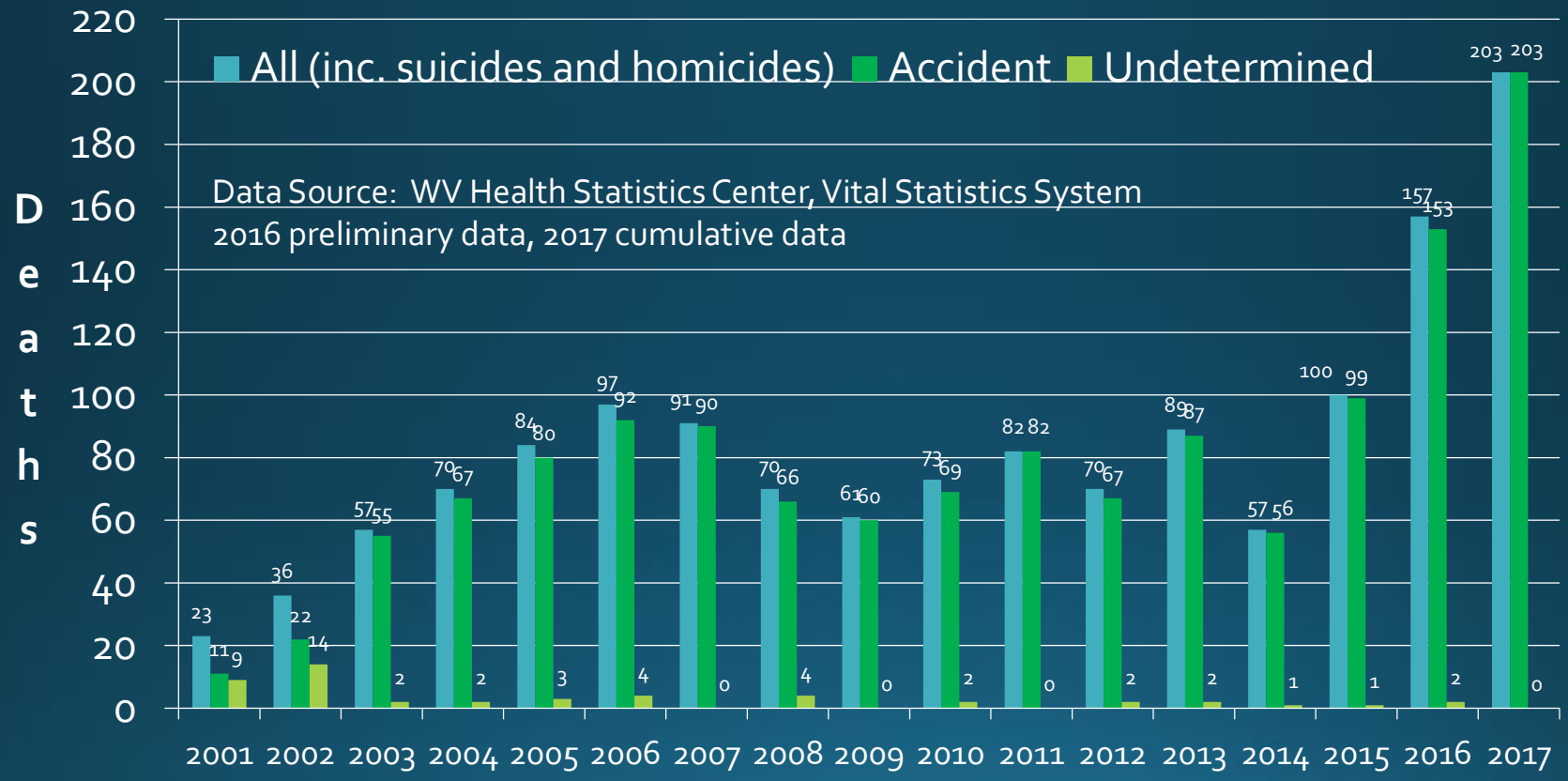
STIMULANTS

WV Cocaine-Related Overdose Deaths by Year & Manner



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Summary of HIDTA Seizure Data

Total Seizures 2010-2016

- **Heroin 38,586.3 Kg**
- **Stimulants Combined 596,998.7 Kg**
- **Cocaine 469,144.6 Kg**
- **Methamphetamine 127,854.1 Kg**

15.5 Kg of Stimulants Seized for every 1.0 Kg of Heroin

SIMILARITIES

OPIOIDS

- HIGHLY ADDICTIVE
- VULERABLE POPULATIONS
- PROFITABLE INTERESTS
- SHIFT NECESSARY TO FIX

DIFFERENCES

- NEW
- ACCELERATING

NICOTINE

- HIGHLY ADDICTIVE
- VULNERABLE POPULATIONS
- PROFITABLE INTERESTS
- SHIFT NECESSARY TO FIX

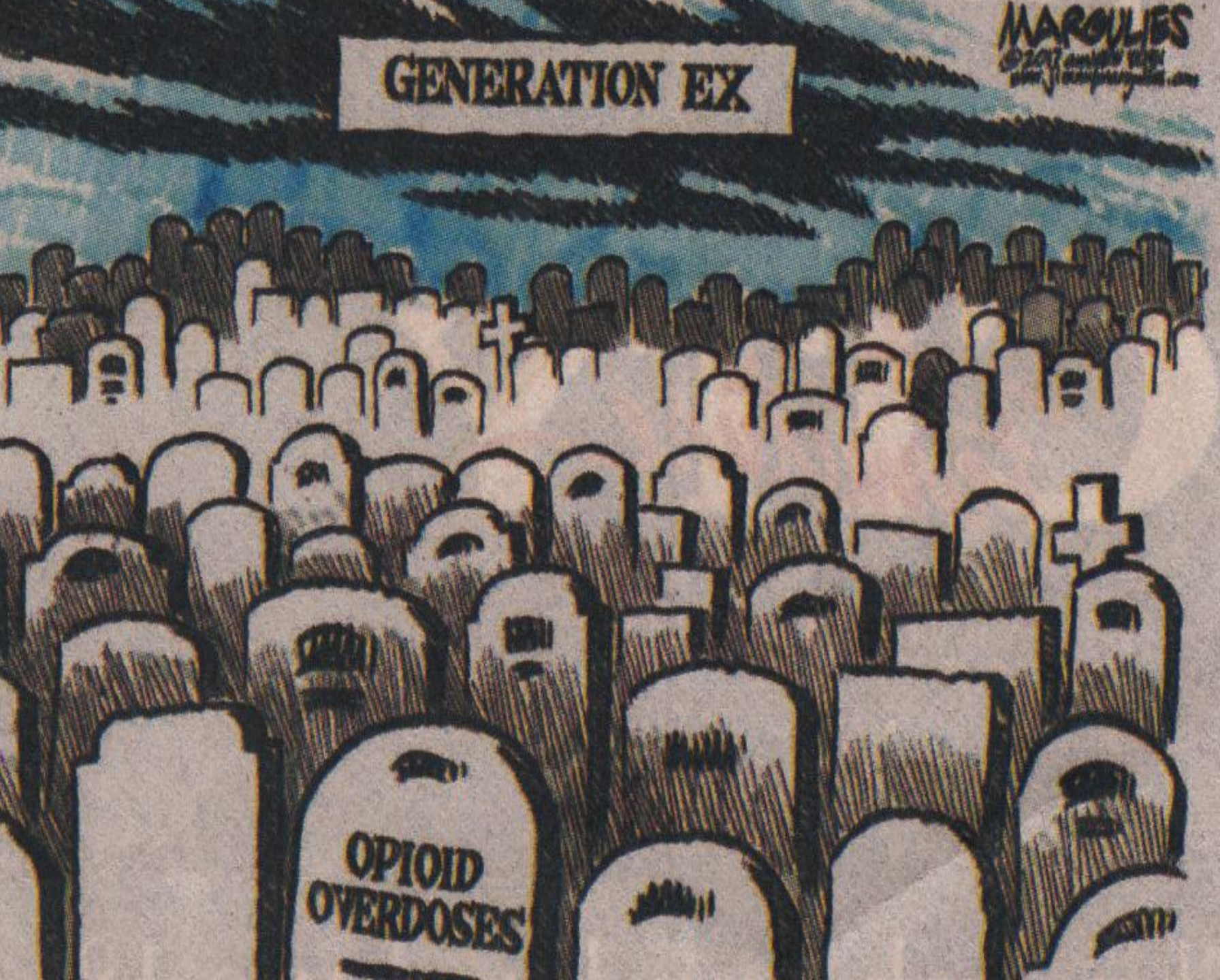
DIFFERENCES

- OLD
- DECREASING

Addiction

There is No One "Gateway" Drug

- Alcohol, tobacco and marijuana are three gateway drugs for adolescents
- Subsequent opioid use
- Drug prevention must not be drug by drug
- It is about any and all drug use by youth


GENERATION EX
MARGULIES
OPIOID
OVERDOSES

Addiction is the Problem

- Prescription Opioids
- Heroin
- Amphetamines
- Inhalants
- Cocaine
- Benzodiazepines
- Marijuana

Addiction is the Problem

- Mood Altering Substances
- Work
- Television
- Shopping
- Gaming
- Internet
- iPhone
- Facebook
- Gambling
- Food
- Sex
- Our own opinion, thoughts, feelings & beliefs

*HOLE

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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

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OBJECTIVES

- Burnout & Resilience
- Opioids & Doctors
- Good News
- PHP Model of Chronic Disease Management

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Overview Physician Health Programs (PHPs)

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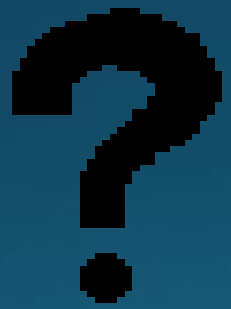
What is a Physicians Health Program



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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.

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.

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

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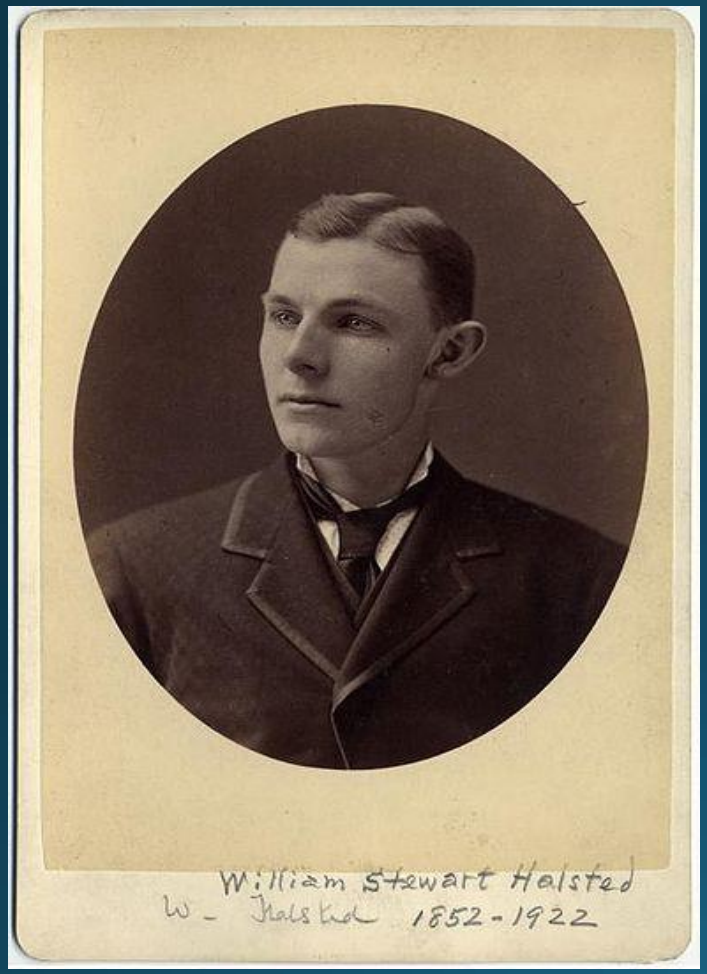
Impaired Physician



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Addiction & Mental Illness are NON-DISCRIMINATORY & POTENTIALLY IMPAIRING

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Incidence of Physician Impairment

- "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.

AMA Physicians Health Program Act
(WVSMA Resolution 2017)

- 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

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RELATIONSHIPS

PHP Model

Licensure Board (alternative)

Collaboration
Communication
Accountability
Transparency

PARTICIPANT

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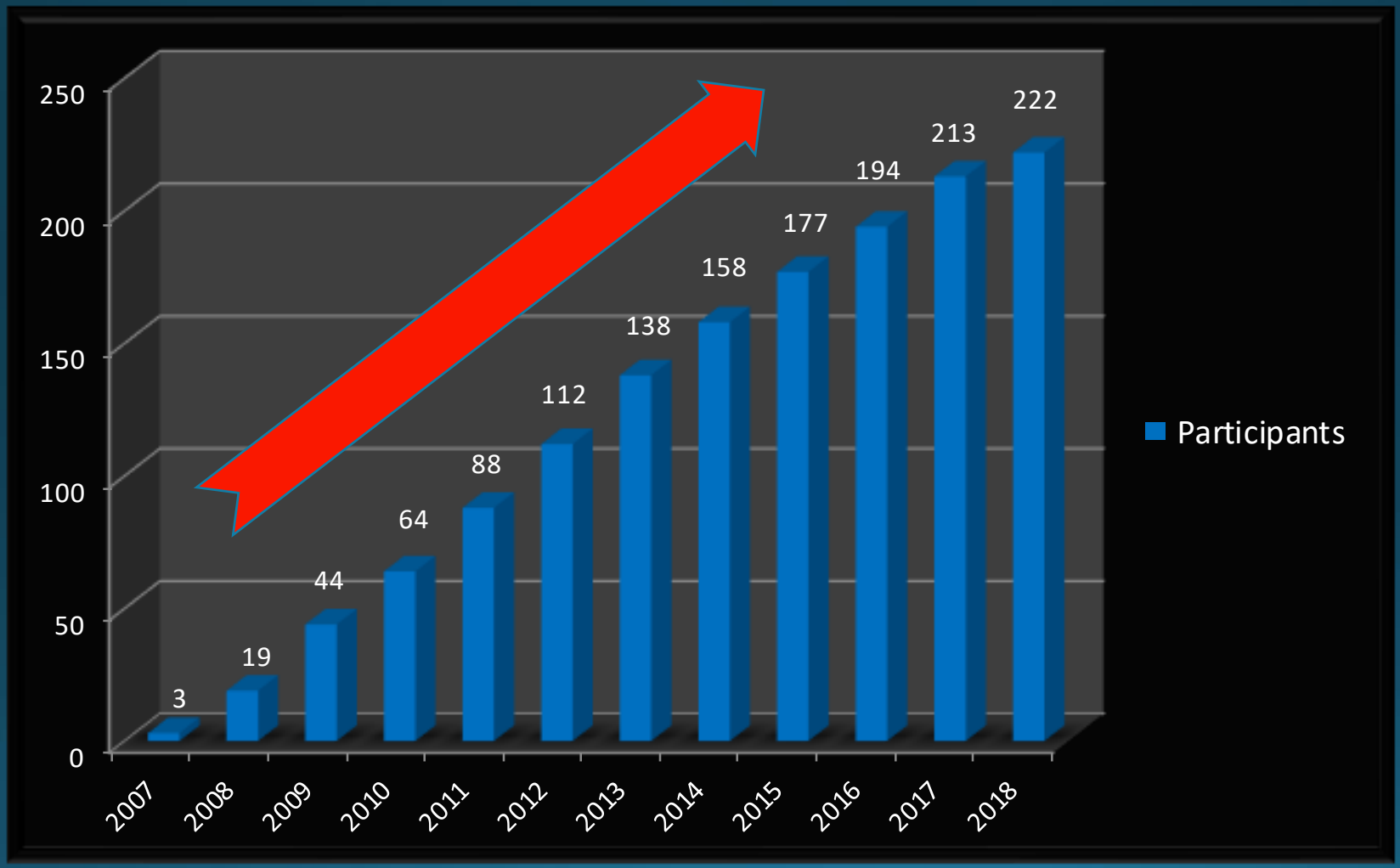
WVMPHP Program Volume



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%

2017 NSDUH Report Illicit <30 days
30.5 Million Adults (11.2%) =1 in 9 Americans!!

- Marijuana – 26 million (9.6%)
- Prescription Drugs – 6 million (2.2%)
- Prescription Pain Relievers –3.2 million (1.2%)
- Cocaine – 2.2 million (0.8%)
- Hallucinogens – 1.4 million (0.5%)
- Inhalants - 0.6 million (0.2%)
- Methamphetamines – 0.8 million (0.3%)
- Heroin - 0.5 million (0.2 %)

PHP/ RECOVERY GOALS

- Early detection
- Thorough assessment & evaluation
- Abstinence based treatment
- Long-term monitoring/support
- Documentation (abstinence, compliance, etc.)

Balancing Act

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PHP and Board Balance

PHP		Licensing Board
Confidentiality	⟷	Public protection
Illness	⟷	Impairment
Treatment	⟷	Sanctions

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EFFECTIVE SYSTEM OF THE PHP & BOARDS

- 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.

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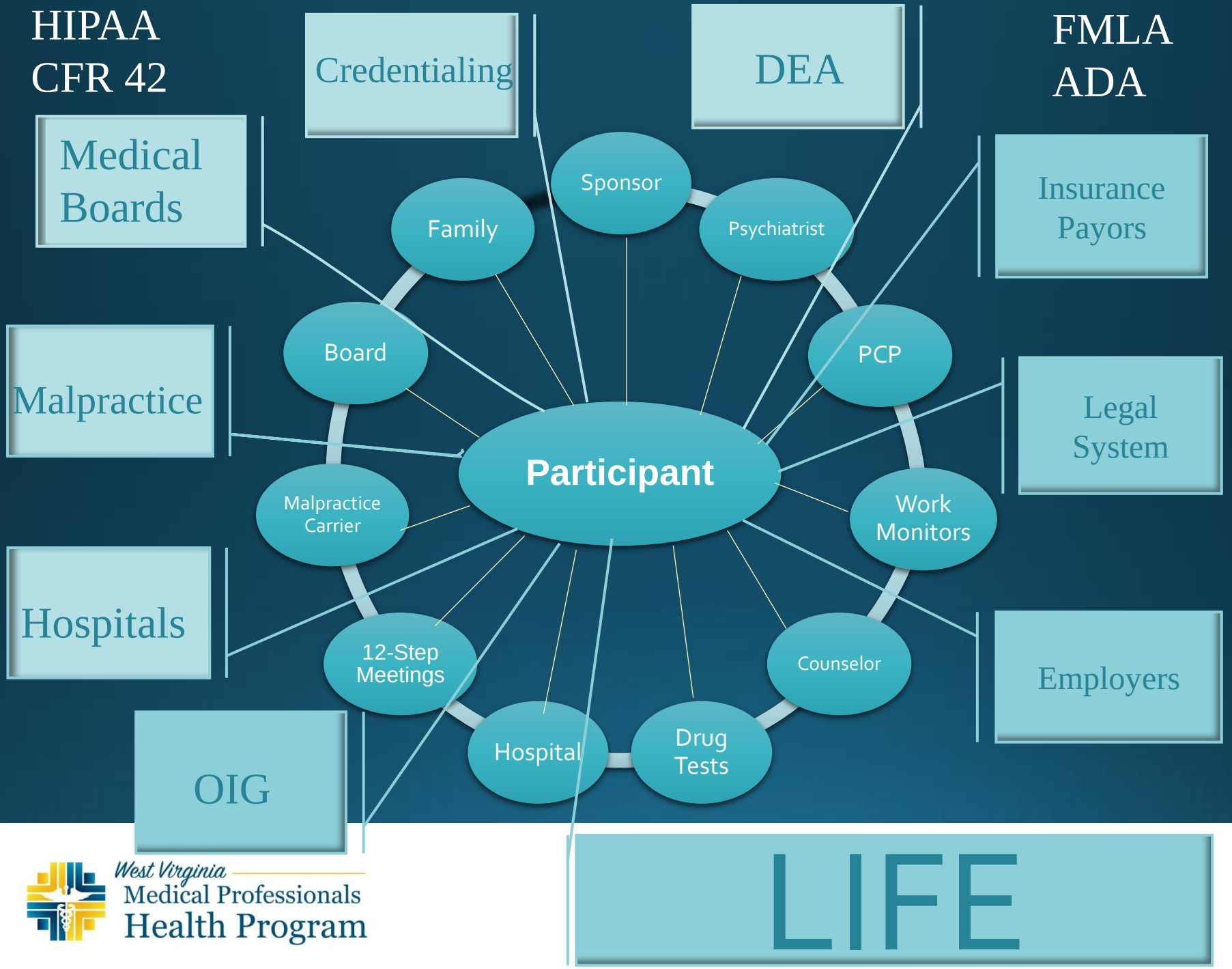

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The RIGHT Question

"Why NOT?"

vs

"HOW to?"

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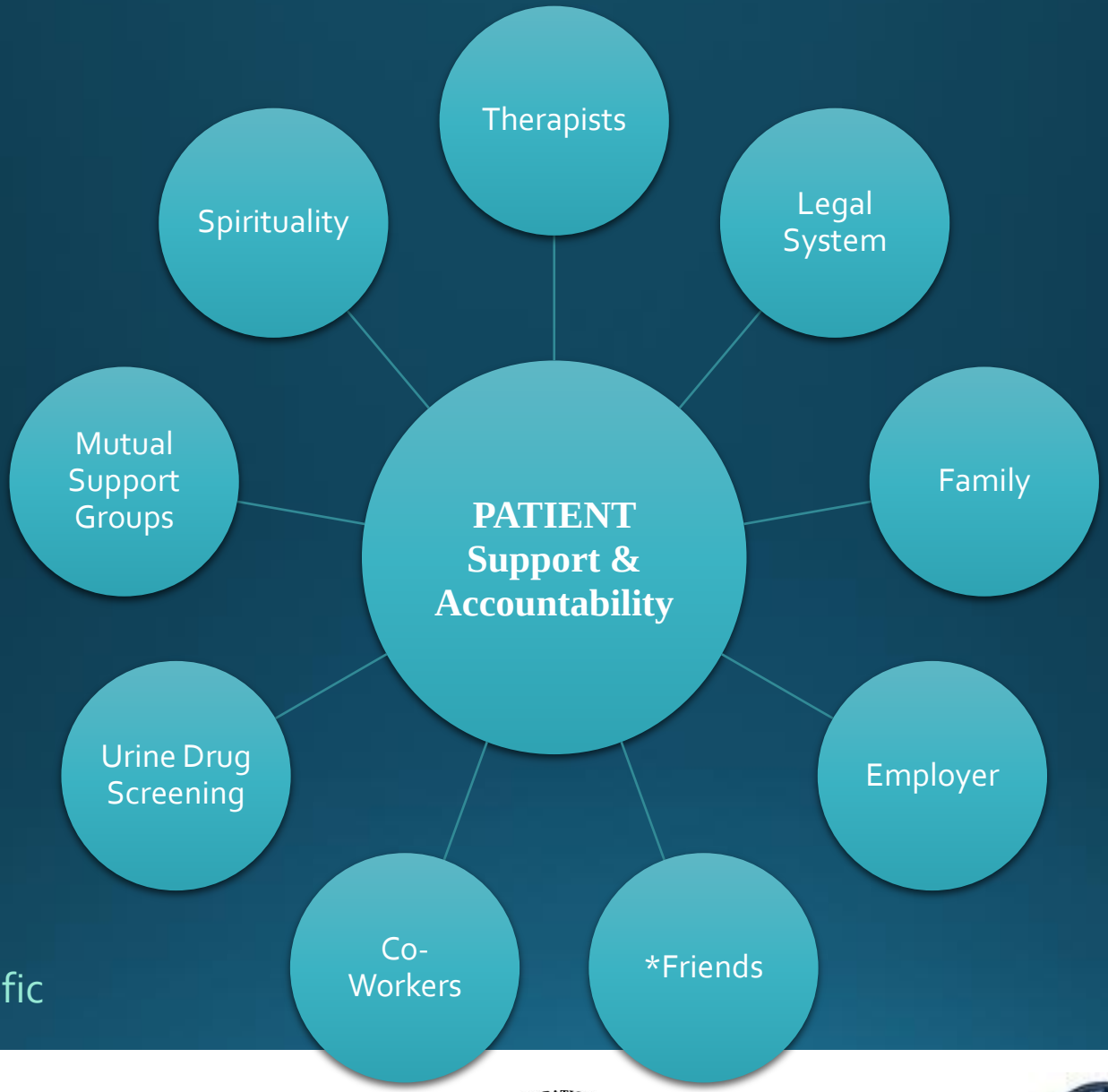

*Cohort specific

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Professional Recovery Research Highlights

Author	Method	Number of MD's	Follow-up (months)	Outcome
Vogtsberger, 1984	Literature review	16 programs	--	27-92%
Shore, 1987	Record review	24	96	96%
Galanter, Talbott, 1990	Questionnaire Self report	100	33	100%
Hoyt, 1990	Self report Questionnaire	100	66	76%
Smith, Smith, 1991	Record review	120	4-6	85%
Gallagos, Talbott, 1992	Continuing care Self report	100	20	77%
Reading, 1992	Survey	80	24	84%

Blueprint PHP Study

A National Survey of Physician Health Programs 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

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Blueprint Phase I

- 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

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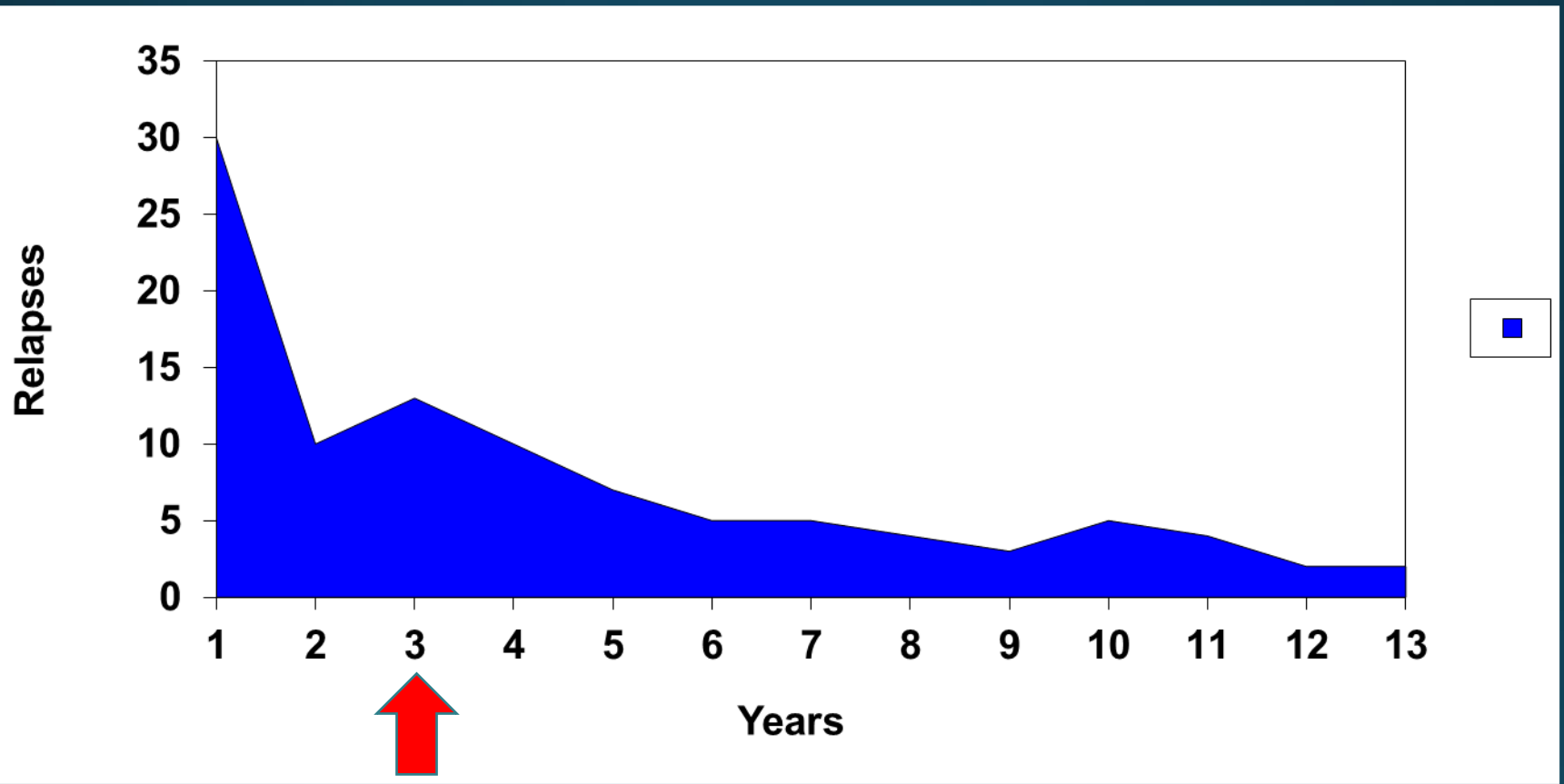
Blueprint Phase II
Five Year Outcome Study

- 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



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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

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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 (2016)

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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

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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

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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.

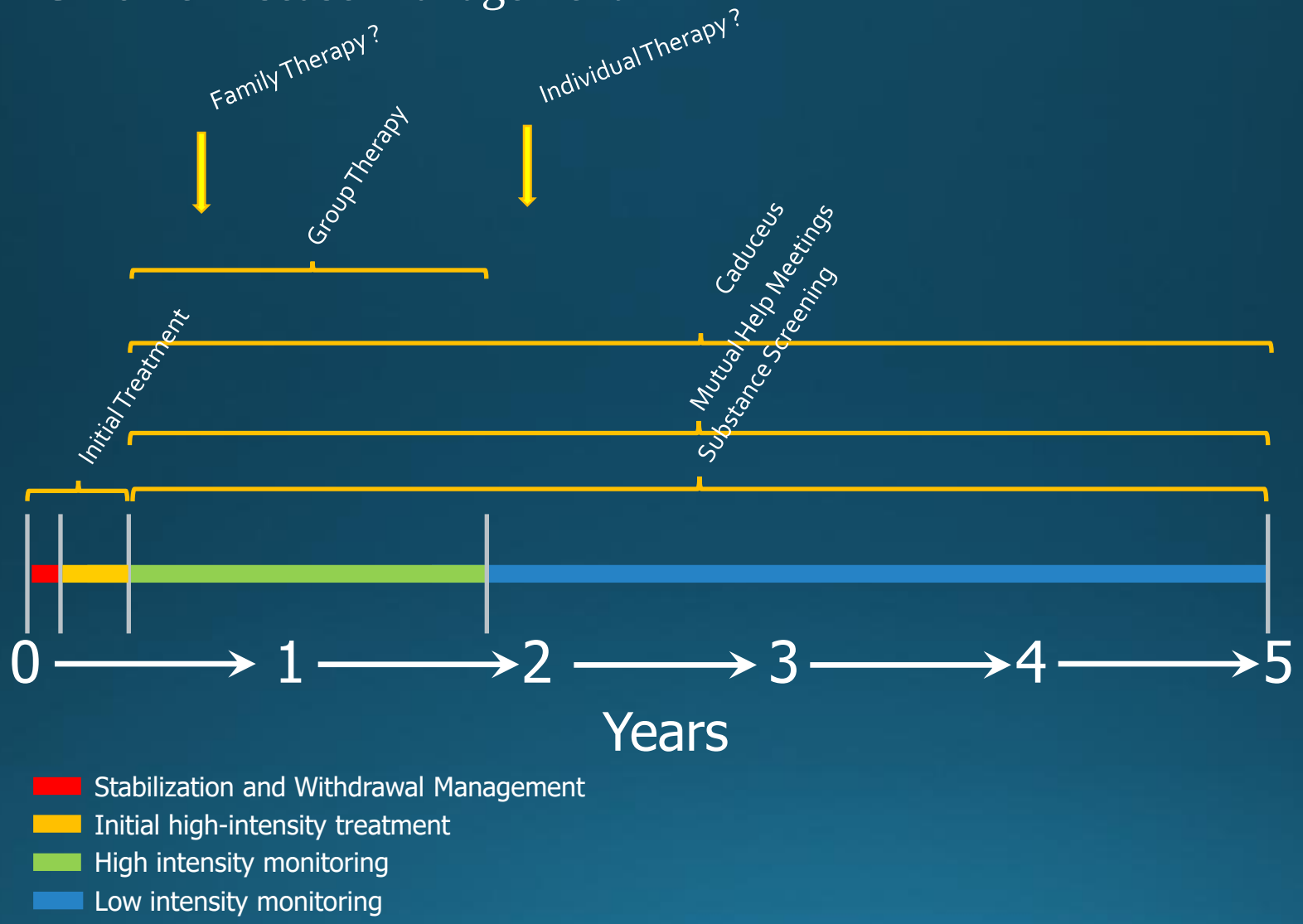
Brooks et al, When Doctors Struggle Current Stressors and Evaluation Recommendations for Physician Contemplating Suicide, Archives of Suicide Research, DOI, Jan 2018

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.

Timeline: Physician Treatment

Chronic Disease Management



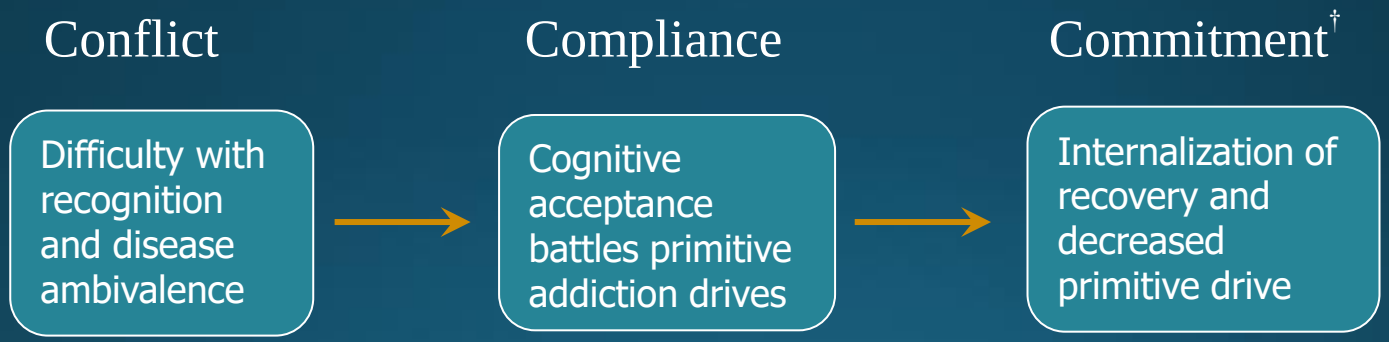
Philosophy of PHP Care Management

Relapse = Do more

- Relapse is seen as a part of the illness.
- 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:



† Earley, P. H. (2017). RecoveryMind training : A Neuroscientific Approach to Treating Addiction. Central Recovery Press.

Central Elements of PHP Monitoring

- Data collection using a distributed and protected database.
- An assigned Case Manager works with individual participants remotely (primarily though 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.

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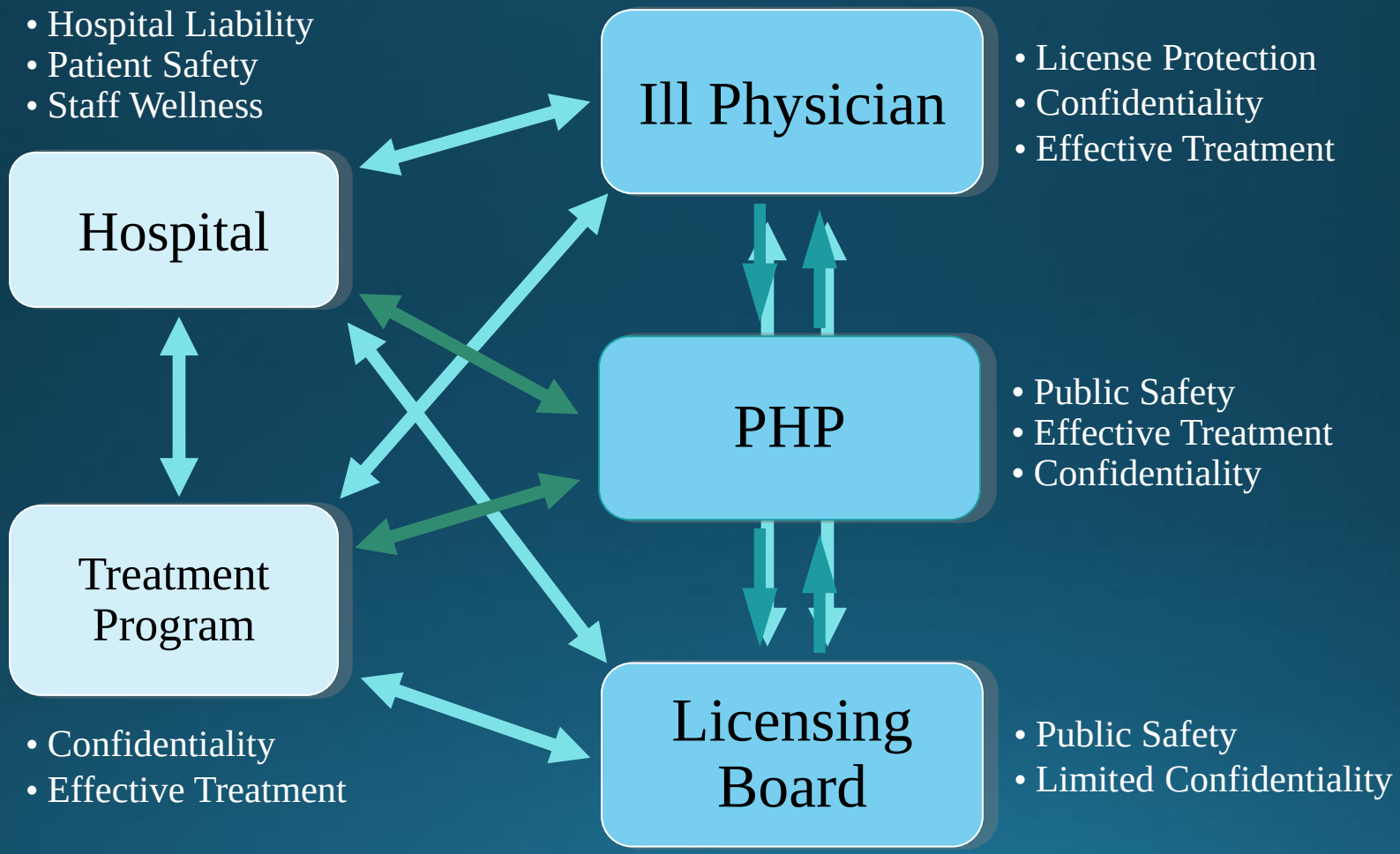
Stakeholders in Physician Health



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?

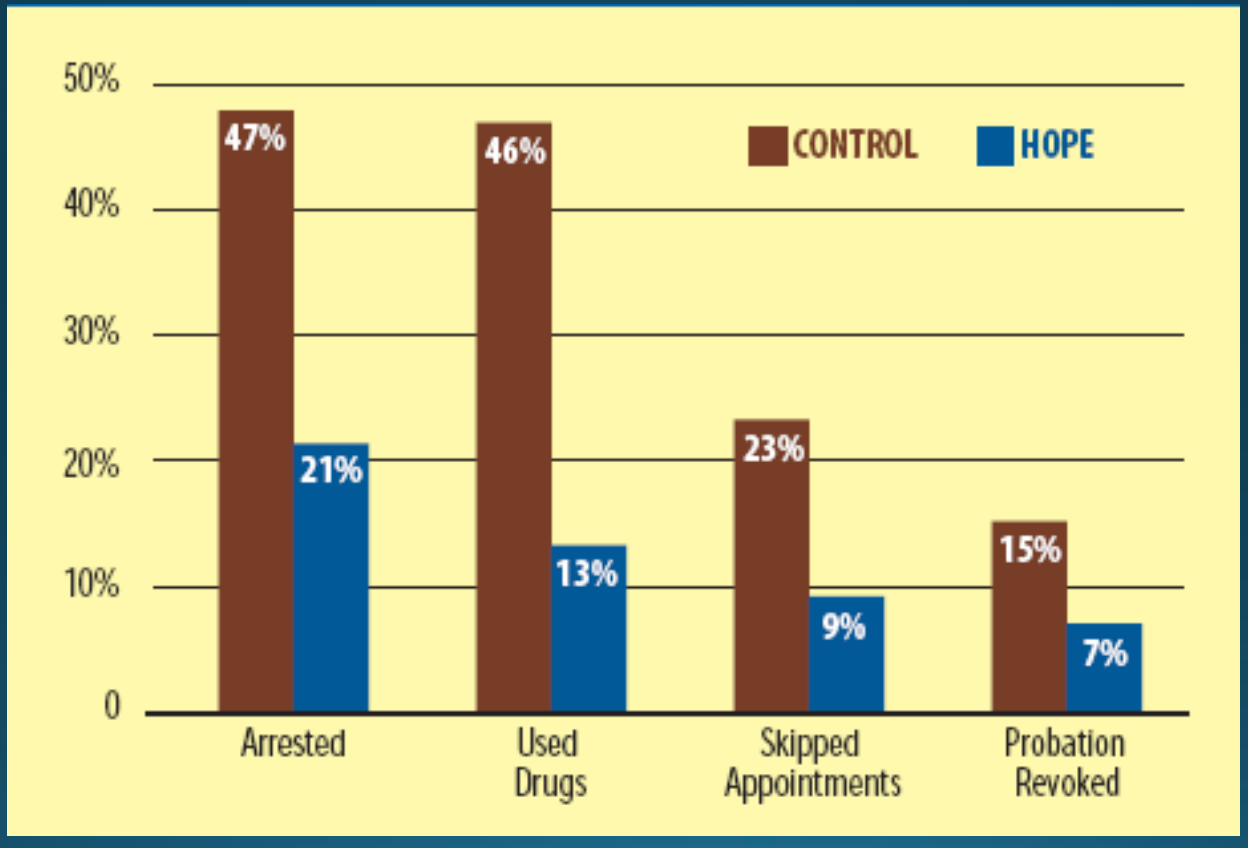
- Critics of generalizing from the PHP experience often argue that physicians are an unrepresentative patient population.
- "Doctors are not representative of anything in the 'real world' of addiction!"

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.



Cost

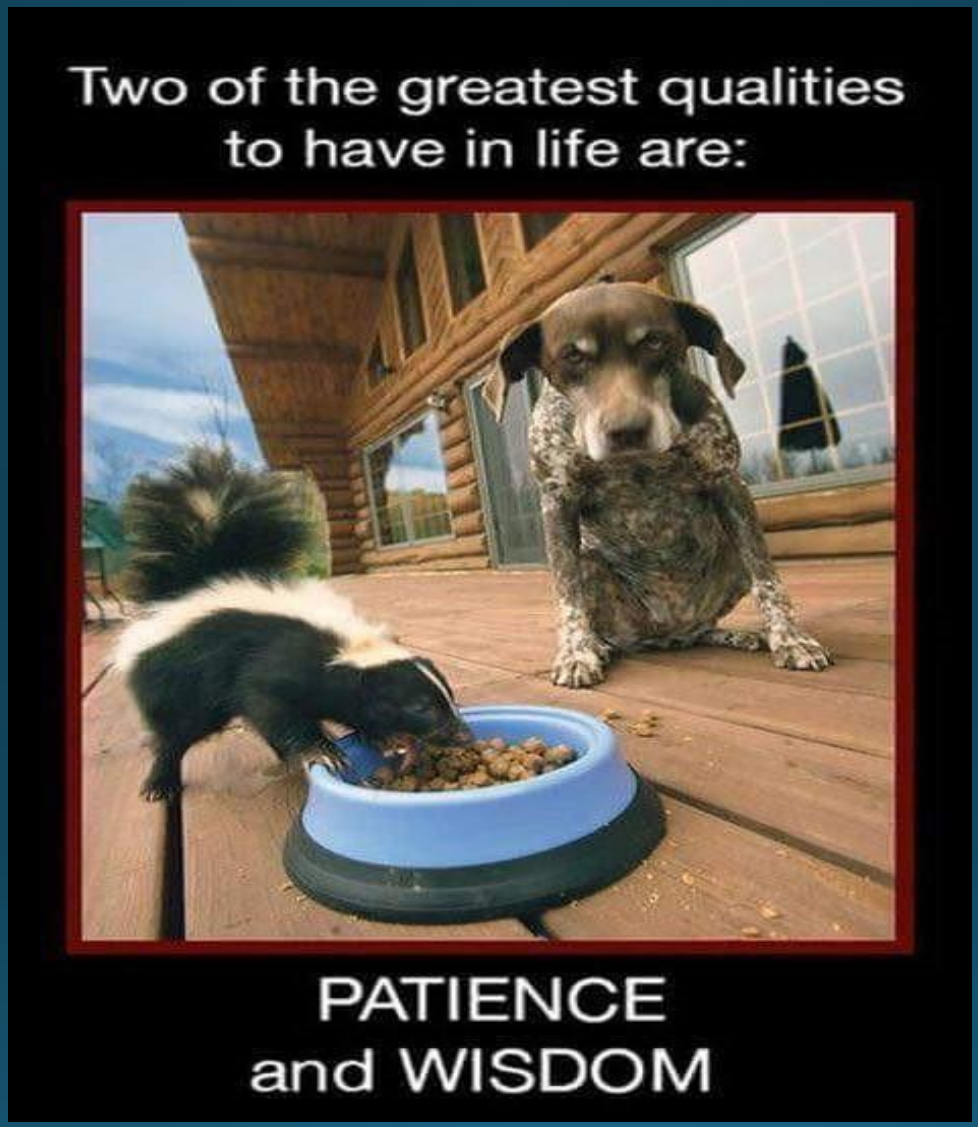
- The financial burden for the monitoring part of some PHP programs is approximately the same as the cost of trade name Suboxone plus a monthly physician visit for to a physician to obtain that prescription.
- This estimate does not take into account the cost of drug screening as buprenorphine maintenance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

OBJECTIVES

- Burnout & Resilience
- Opioids & Doctors
- Good News
- PHP Model of Chronic Disease Management
- Lessons Learned

Lessons Learned

- 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 and support with the participant.
- Long-term recovery (5-years or more) is the expected outcome.



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2019 Appalachian Addiction Conference

October 16 – 19, 2019
Morgantown, WV

www.wvmphp.org

THANKS TO EACH AND EVERY ONE OF YOU …..

FOR WHO YOU ARE AND FOR WHAT YOU DO ! !

Brad

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