Physician Health Programs: The Gold Standard for Management of Patients with Addictive Disorders

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North Mississippi Medical Center
12th Annual Best Outcomes Conference
Pickwick Landing State Park
August 27-29, 2015
I have no disclosure of conflicts of interest
Objectives

- Discuss epidemiology of addiction.
- Describe addiction as a brain disease.
- Describe the function of the Mississippi Professionals Health Program and the success of physician health programs in managing physicians with addictive disorders.
Addiction Facts

- Lifetime prevalence: 10-12%
- 31 million Americans and <12% receive treatment. (SAMHSA, 2013 NSDUH)
- 40-60% of people relapse after drug and alcohol treatment. (NIDA)
- 80% relapse rate with opioid dependence. (NIDA)
Addiction Facts, contd.

- Causes 20% of all deaths per year
- Costs in excess of $600 Billion per year
- 1/3 of all hospital in-patient costs are addiction related
  (SAMHSA, 2013 NSDUH; Ries, et al., 2014)
- 25% of primary care patient visits
  (Jones et al., Am. Fam. Physician, 2003)
WHEN SHOULD YOU START TREATMENT???
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Melanoma
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HOMELESS
No Family or Support
Health Problems
Could use Some Compassion
Really Need The Help.
Rats
Self-administer
Heroin
Rats
Self-administer Cocaine
Sagittal Plane View of Brain:

- Human
- Rat

Virtually Identical Reward Circuit
“Lizard Brain”
Opioid binding sites (green dots)

Reward Pathway (orange)
Opioid Prescriptions Dispensed per Year (Oxycodone and Hydrocodone)
43,982 Deaths (All O.D. Deaths)

CDC, Web-based Injury Statistics Query and Reporting System (2014)
Patients with mental health and substance abuse co-morbidities are more likely to receive chronic opioid therapy than patients who lack these risk factors. (Edlund MJ, et al., 2010)
What is high risk opioid therapy?
Risk stratification?
Concomitant use with other controlled substances?
Tapering strategies?
Use of other modalities?
“No substantial evidence for maintenance of pain relief over longer periods of time, or significant evidence for improved physical function.” (Franklin, 2014)
“Particularly striking to the panel was the realization that evidence is insufficient for every clinical decision that a provider needs to make about the use of opioids for chronic pain...”

(Reuben et al., 2015)
What is a “Distressed Physician”???
Challenges of Practicing Medicine

- Reimbursement hassles
- Electronic medical records
- Prior authorization
- Maintenance of certification
- Scope of practice
- The prescription drug crisis!!!
Culture of Medicine

- “Suck it up and get it done!”
- Resilience is not taught, it is expected
- Asking for help is stigmatized and not praised
- Psychiatric issues are not considered “real” illnesses
Characteristics of Medical Work

- Long hours
- Intense involvement
- Emotionally charged interactions
- Requirement for complex decision making
- Ambiguous and frustrating solutions/outcomes
- Requirement for constant “giving” (e.g., time, knowledge, empathy)
- Breeding ground for distress
Distressed Physician: Outcomes

- Healthy coping skills: resolution of problem
- Unhealthy coping skills: potential harm to patients
  1. Substance abuse/addiction
  2. Anxiety, depression, burnout
  3. Suicide
  4. Professional boundary violations/misconduct
  5. Disruptive behavior
  6. Impairment
Burnout: Syndrome Triad

1. Emotional Exhaustion (feelings of emotional overextension and fatigue)
2. Depersonalization (negative, cynical attitudes and feelings about patients; dehumanized perception of others)
3. Reduced Sense of Personal Accomplishment

*Maslach Burnout Inventory: Manual, 3rd Edition*
Emotional Exhaustion

- I feel emotionally drained from my work.
- I feel fatigued when I get up in the morning.
- Working with people all day is really a strain for me.

Higher rating associated with burnout
Depersonalization

- I feel I treat some patients as if they were impersonal objects
- I've become more callous towards people since I took this job
- I don't really care what happens to some patients

Higher rating associated with burnout
Personal Accomplishment

- I deal very effectively with the problems of my patients
- I feel I'm positively influencing other people's lives through my work
- I feel exhilarated after working closely with my patients

Lower rating associated with burnout
Burnout Triad: Reported by Physicians

- 46-80% report moderate levels of emotional exhaustion
- Up to 93% report moderate to high levels of depersonalization
- Up to 79% report low to moderate levels of personal achievement

(S. Chopra et al, JAMA, 2004)
Effects of Burnout

- Highly statistically significant association between burnout and alcohol abuse or dependence.
- Highly statistically significant association between burnout and suicidal ideation.
- We know that burnout and depression often go hand in hand.
- We know that alcohol abuse has a strong association with medical errors.

(Shanafelt, et al., 2014)
Physician Addiction

- ≈ 12% (8%-13%) lifetime prevalence
- Physician illicit drug use < general population
- Physician alcohol abuse > general population (14-15%)
- Physician benzodiazepines & opiates use > > general population
  (Ries, et al., 2014; Oreskovich et al., 2012)
What is MPHP?

- 501 (c) 3 non-profit, charitable organization incorporated in 1978
- Subsidiary of the Mississippi State Medical Association
- Empowered by a Memorandum of Understanding with the Mississippi State Board of Medical Licensure
What is the Purpose of MPHP?

To provide a confidential, non-punitive alternative to disciplinary sanctions for licensees who may be suffering from potentially impairing conditions or illnesses.
Purpose, cont’d

- Early detection, intervention, and long term, intensive management of physicians with potentially impairing conditions
- Primary focus on potential impairment from substance use disorders
- End result: facilitation of a return to healthy, safe and productive medical practices
Formal efforts to deal with physician impairment existed as far back as 1958.

Drug addiction and alcoholism among doctors identified by FSMB as a disciplinary problem.
History of PHPs, cont.

- 1974 AMA acknowledged physician impairment from alcoholism and drug dependence
- Developed model legislation offering therapeutic alternative to discipline
- Recognized alcoholism and addiction as illness
MPHP originally created by Ellis and Nina Moffitt and MSMA in 1978 and incorporated as a 501(c)3 charitable organization.

By 1980 all but 3 Medical Societies had authorized or implemented impaired physician programs.

FSPHP created in 1990.
MPHP Monitoring

- MPHC evaluation
- Blood/urine drug screens
- Work place monitoring
- Recovery support group attendance
- MPHP Case Manager: check-ins/ visits
- Medication monitor
- QR to MSBML
- Level II and III relapse reported within 24 hours
Is the approach different than patients in the general population?
Recommenations for Persons in Safety Sensitive Occupations

Safety-sensitive workers are those who have a responsibility to the public. The extent of the effect on the public comes from two factors:

1. The size of the population safety-sensitive workers affect and the depth of the effect from potential impairment, and
2. The amount of public trust that is implied in that worker's occupation.

Both these factors place a burden on treatment, its efficacy, and the importance of that patient's recovery for overall public welfare. These two factors color decisions that are made regarding the type, intensity, and setting of treatment provided to this special population.

It is important to note that aggressive treatment and continued monitoring does more than assure the safety of the public at large. The consistent and sustained care of one individual helps his or her entire cohort. For example, if a police officer suffers an addiction relapse that has the slightest possibility of an adverse effect on public safety, his peers, the leadership of the police force, officials in the government jurisdiction served by the police force, and public opinion may reactively punish subsequent officers who develop a substance use disorder. "Guilt by association" is not an altogether inappropriate term for such realities. In contrast, the compulsory and consistent management of a given individual's recovery status pays off to others in his or her cohort; success of treatment and recovery for the one can have a positive "halo effect" for the many in that individual's occupational or professional cohort.

2. Safety-sensitive workers do best when offered cohort-specific treatment, which facilitates adequate self-disclosure and the subsequent repair of the damage produced by past substance-related behaviors. Once they develop a substance use disorder, many safety-sensitive workers compromise their job efficiency and (although less often than sensationalist journalism might suggest) at times create public harm. When it happens to someone in the general public, harm from substance misuse or addiction usually has a limited effect size. In the safety-sensitive worker, however, the depth and breadth of the potential damage to the public and the environment can be much larger. Addiction in a nuclear plant manager has an effect size that is greater than in a retail worker, for example. Most individuals in safety-sensitive positions take their oath of duty to heart: the breach of this commitment engenders shame. Safety-sensitive workers need to disclose, accept responsibility, normalize, and
Safety-Sensitive Workers’ Key Qualities

- All have responsibility to the public.
- Cohort-specific treatment facilitates self-disclosure and honest self-appraisal.
- Health care professionals (HCPs) may have direct access to addictive substances.
- HCPs may have difficulty adopting the role of a patient.

(ASAM Criteria, 3rd Ed.)
During the initial diagnostic portion of the treatment experience, safety sensitive workers should discontinue work.

Abstinence and recovery should first be solidly established.

(ASAM Criteria, 3rd Ed.)
Acute or chronic opioid use is not recommended for patients who perform safety-sensitive jobs.

These jobs include operating motor vehicles... other modes of transportation... sharps work (eg, knives, box cutters, needles)... and tasks involving high levels of cognitive function and judgment.

(Hegmann et al., 2014)
Contingency Management: The “Stick”

- MSBML
  - Executive Director
  - Full Medical Board: Hearing/action/order/public record

- Practicing medicine is much more difficult with Medical Board orders/restrictions
  - Loss of Specialty Board certification
  - Malpractice coverage
Contingency Management: The “Carrot”

- MPHP Confidentiality/anonymity:
  - PHPs referrals: exponentially increase when confidentiality is respected by Medical Boards
  - Decreases stigma of treatable conditions (addiction)
    - Promotes early intervention (days-to-weeks)
    - Promotes physician health
  - Contingent on full cooperation/compliance
  - Avoids costly legal battles
  - Protects the public
Without Confidentiality...

- Licensees more likely to “fight” the process
- Intervention is delayed: months-to-years instead of days-to-weeks
- Addiction is stigmatized: treatment is discouraged
- Addiction is enabled
- *Increased* risk of public harm
Limits to Confidentiality

- Defined in the *Memorandum of Understanding* (MOU) with the MSBML
- Anonymous cases are reported to the MSBML as a number, and not by name
- All relapses are reported to the MSBML
- The MSBML is the final authority and is not bound by any recommendations by the MPHP
California Diversion Program

- Discontinuation in 2008 by the California Medical Board
- Firestorm of negative publicity led by charges of hiding “physicians on drugs” by a Citizen Advocacy Group
Unequivocal Success of PHPs

- 5-year abstinence rates: 78%-84%
- Return to work rates: 96%
- Virtually no risk of harm to patients treated by participating physicians
- 45 States and District of Columbia have PHPs

(Domino et al. 2005; McLellan et al. 2008)
Patient Safety?

- Project Blueprint: One (1) Report of Patient Harm (Overprescribing)  
  (McLellan, AT et al. 2008)
- Consistent with another study of 259 physicians monitored over 11 years that failed to document even one case of patient harm.  
  (Domino, 2005)
Benefits of MPHP

- Early detection of physicians with potentially impairing, treatable conditions
- Protects patients
- Facilitates avoidance of disciplinary action, and expensive, complex legal battles
- Protects Mississippi physician workforce
Thank You!
REFERENCES


MSProfessionalsHealth.org


REFERENCES


Substance Abuse and Mental Health Services(SAMHSA), 2013 National Survey on Drug Use and Health(NSDUH).

REFERENCES

