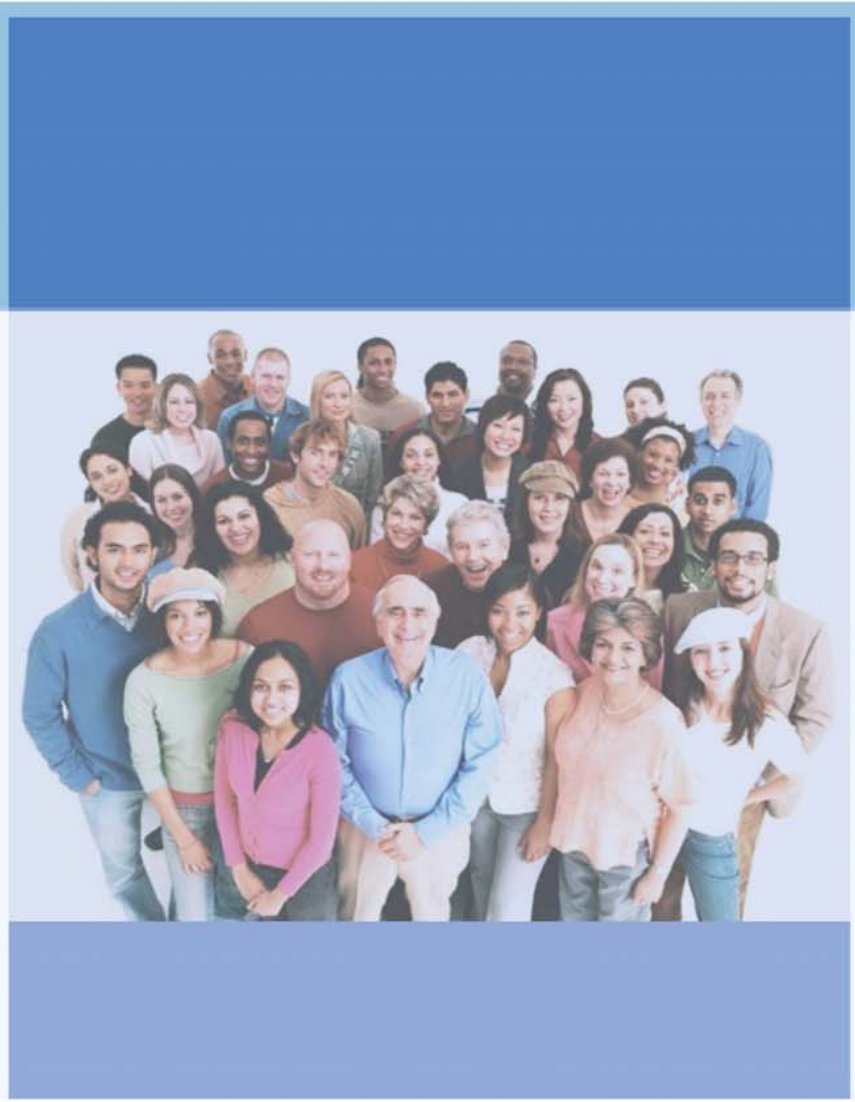
RECOVERY FROM ADDICTION

Physician Health Programs: Applying the chronic disease model with care, continuity and contingency



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October 18, 2010 - October 22, 2010
Banff, Alberta

Alberta family wellness initiative

Norlien Foundation

"Mind you, only one doctor out of ten recommends it."

Addiction in physicians

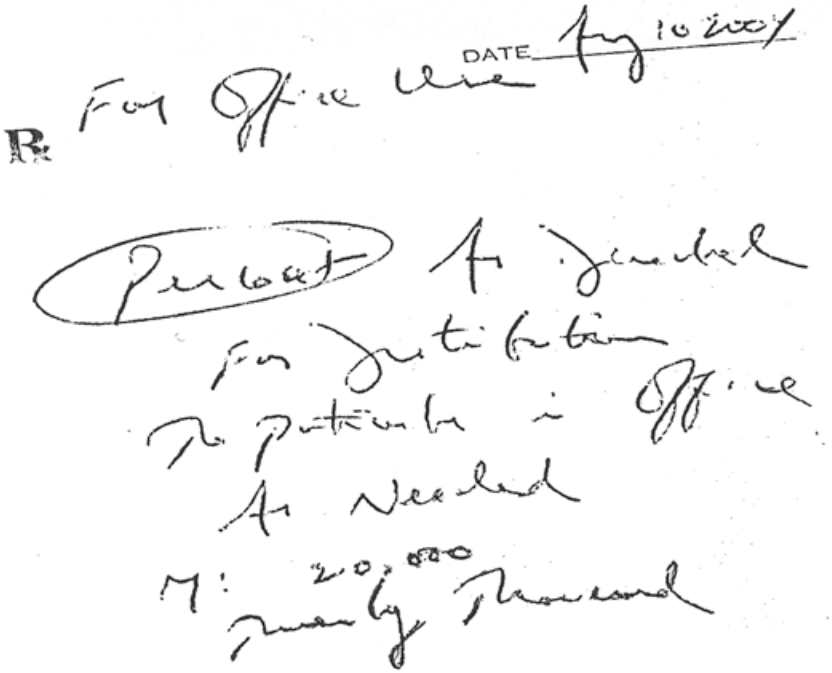
Substance abuse/dependence:

Lifetime prevalence: 8 %

- Self report responses
  - Hughes PH, Brandenburg N., Prevalence of Substance Use Among US Physicians. JAMA 1992;267:2333-8

Annual incidence: 1/2 to 1%

PERCOCET
"For distribution to patients in the office as needed."
M: 20,000



Preferred substances (OMA PHP data)

- Alcohol 60%
- Opioids (pharmaceutical) 35%
- Benzodiazepines and other 5%

Physician Health Programs

- Emerged from informal, volunteer efforts of colleagues caring for colleagues in the 1970's and 1980's; now formalized throughout North America
- Based upon the collegial and professional responsibility to all physicians whose safety to practice medicine may be adversely impacted by any psychological, physical or social problems, including addiction

The shared goals of PHPs

- Encouraging physicians to seek and receive assistance before health issues impact and/or impair practice
- Accountability to the profession and to the regulator when there is risk to the public or with impairment
- Preserving healthy professional and personal lives for physicians and their families
- Positively impacting patient care

PFSP

Watch for any pattern or cluster of these observable behaviors:

- Unexpected professional behavior
- Decreased performance
- Diverting drugs
- Increased irritability
- Charting irregularities
- Missing in action
- Unusual orders from pharmacy
- Dilated or constricted pupils
- Nodding off during a case
- Slurred speech
- Dangerous to leave alone on case
- Pocketing drugs
- Isolating or withdrawing from peers
- Often late
- Mood alterations (unexplained anger)
- Overreacting to criticism
- Wearing long sleeves all the time
- Frequent home crises
- Frequent bathroom breaks
- Forgetful, unpredictable
- Taking frequent extra calls
- Tremors, shakes
- Increasing difficulty with peers, supervisors and/or authority

Dare to care for a colleague.
Dare to care for yourself.
1.877.767.4637

ALBERTA MEDICAL ASSOCIATION | Physician and Family Support Program

We would like to acknowledge the resources provided by the Wearing Masks Program and by All Anesthesia Coalition for the Prevention of Substance Abuse in Anesthesia. For more information contact: Allanesthesia.com

live better

ALBERTA MEDICAL ASSOCIATION | Physician and Family Support Program

The shared approach to addiction in physicians: chronic disease model (cdm)

- Tradition of the chronic disease model
  - Care
    - Multidisciplinary, Case management
  - Continuity
    - Abstinence , “In this for the long run”
- Recognizing the safety sensitive nature of medical practice
  - Contingency
    - Occupational health principles applied

“If you have seen one PHP, you have seen one PHP” - Two “Made in Canada” models

Alberta

- Services provided to medical students, residents and physicians and their immediate families
- Core components:
  - TF telephone assistance for assessment, referral and support
  - Case coordination services
    - Only for physician spectrum
  - Health promotion and education

Ontario

- Services provided to medical students, residents, physicians and their immediate families, other health professional
- Core components:
  - Intake assessment / support
  - Referral for treatment
  - Case management, monitoring and advocacy
  - Health promotion / education

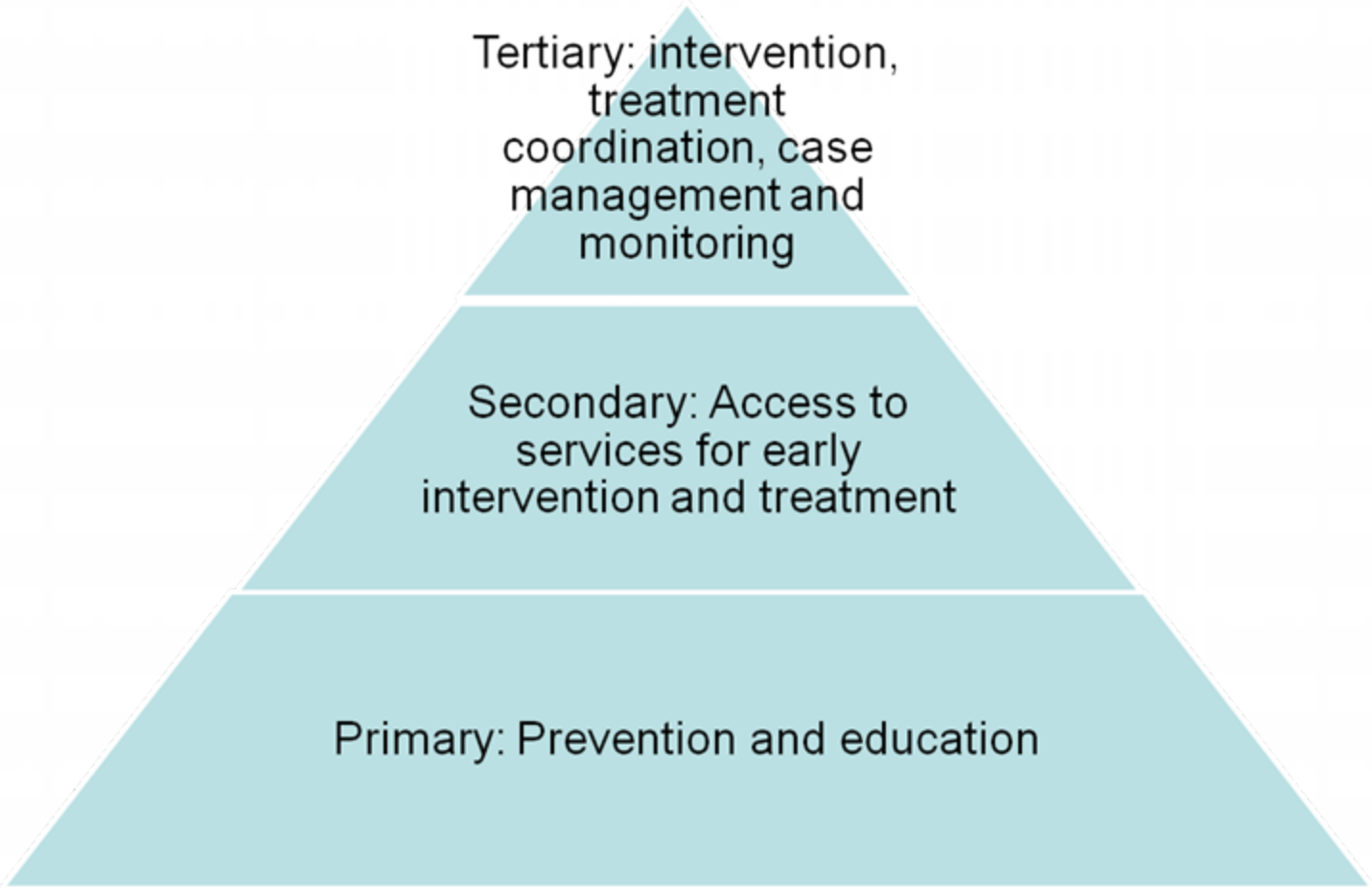
Alberta

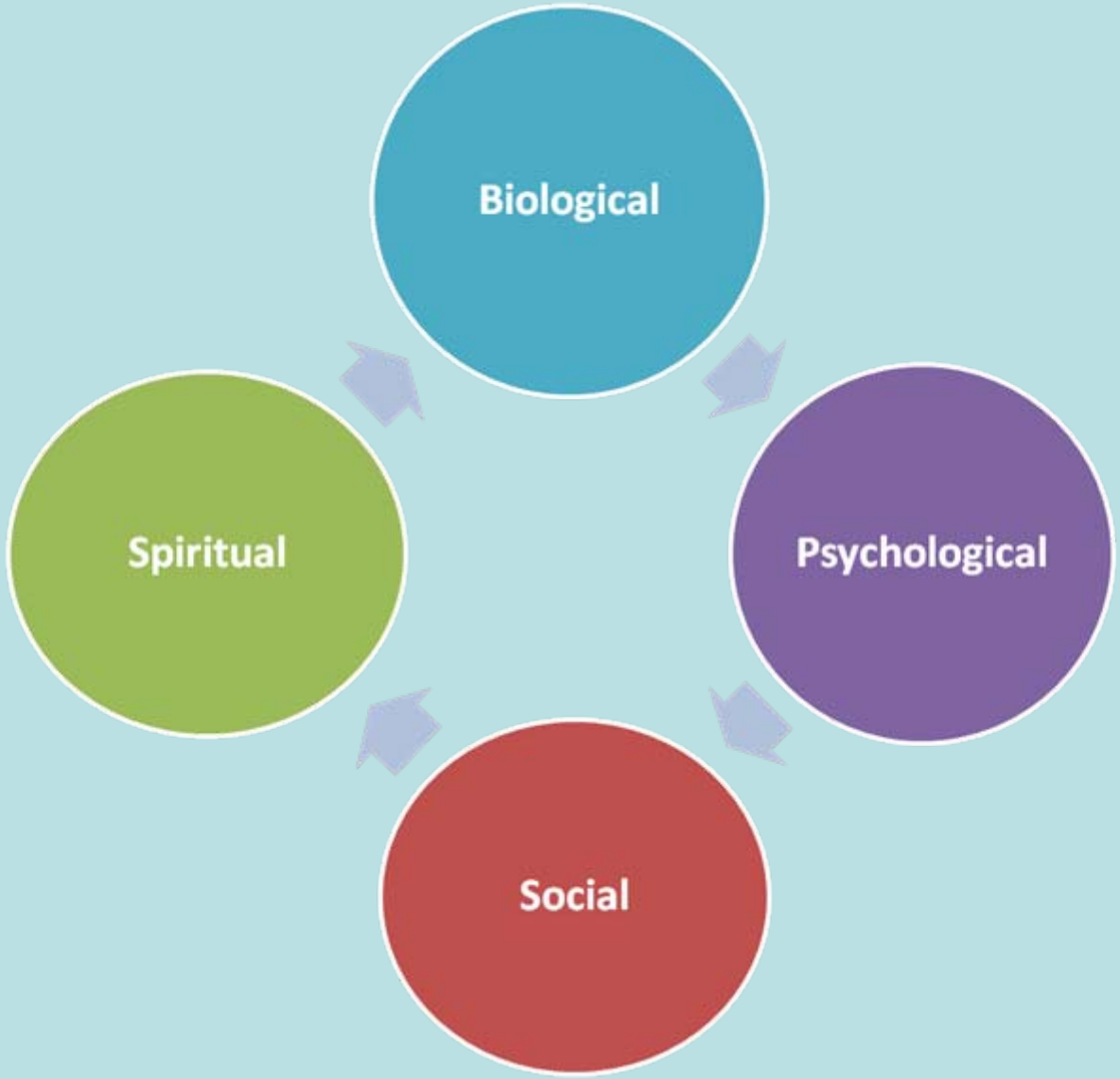
- Currently biologic monitoring program is not a part of case coordination services
  - Active liaison with the service provided by the regulator

Ontario

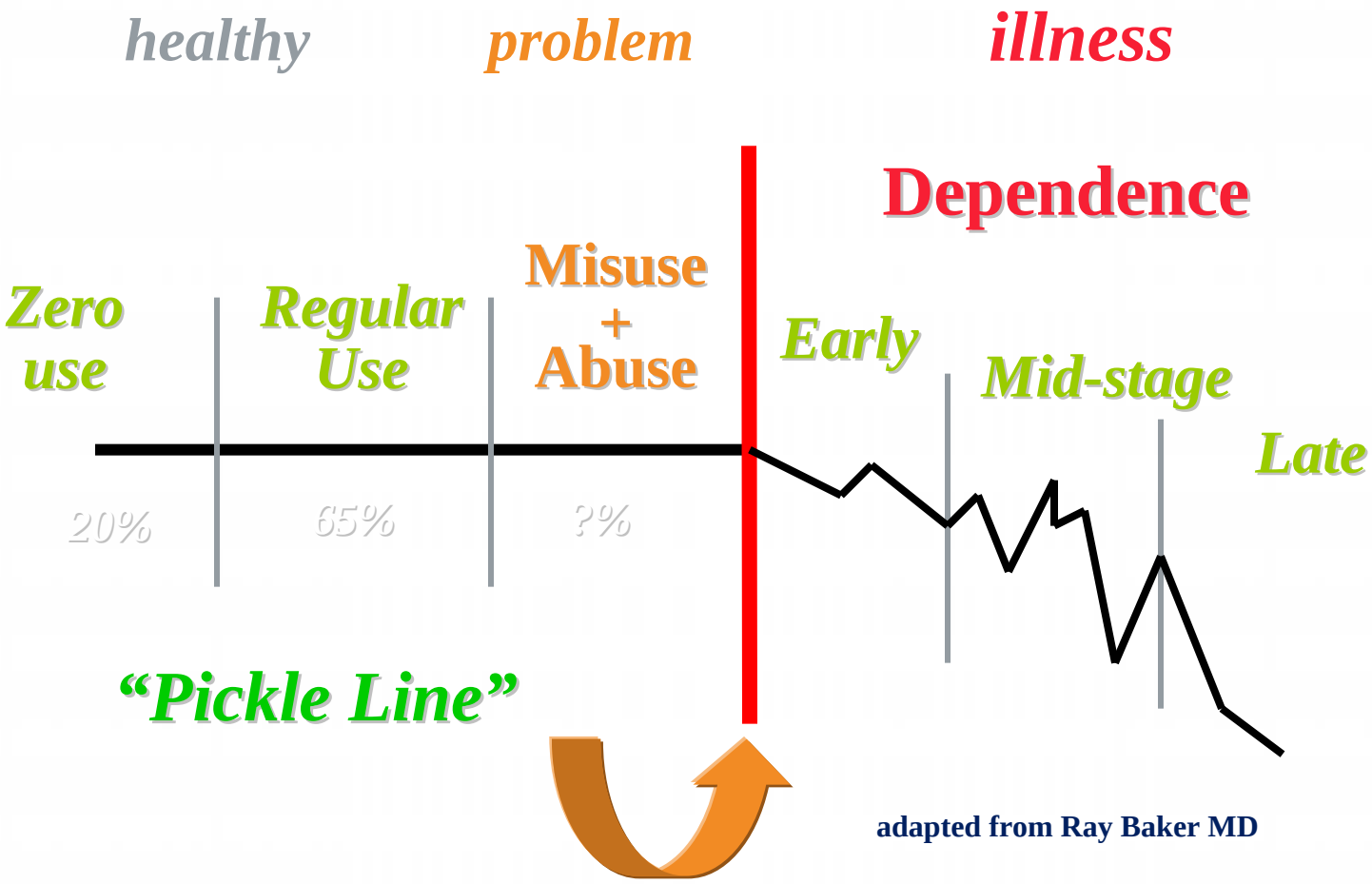
- Biologic monitoring
  - Random urinalysis
  - Hair testing
  - Breath testing

Physician Health Programs



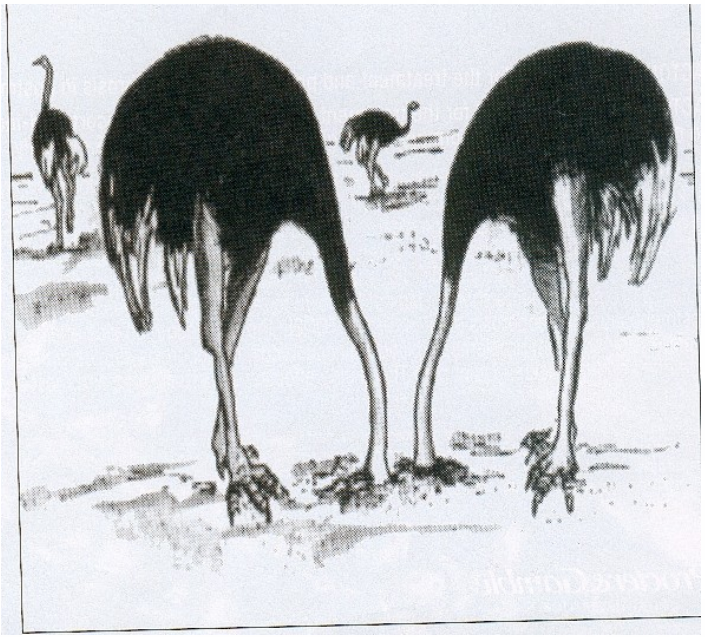

Biological
Psychological
Social
Spiritual

Spectrum of Substance Use Disorders



adapted from Ray Baker MD

Barriers for physicians seeking and receiving assistance



"Sometimes it's not so much seeing the light as feeling the heat."

Case Identification

- Education regarding nature of addiction in health professional
- Education regarding recognition of signs and how to intervene
- Support for colleagues on a case by case basis

Important considerations for intervention and treatment

- Patient safety
- Prompt response and resource availability
- Medical stabilization/withdrawal management
- Support, including family support
- Suicide risk
- Work responsibilities covered
- Reporting obligations - accountability

Management of Substance Abuse

- Assessment
- Trial of abstinence
- Education regarding low-risk substance use
- Supportive counselling, treatment of concurrent disorders
- Monitor adherence to chosen protocol
- Reassess if needed

Treatment of Substance Dependent Doctors

- Detoxification
- Usually residential program (4-6 weeks)
- Aftercare (one – two years)
- Total abstinence approach – Chronic Disease Model
- Psycho education
- Relapse prevention skills
- Healthy lifestyle counseling

Treatment of Substance Dependent Doctors

- Mutual support programs (12 Step)
- Peer support groups
- Identification and treatment of co-morbid disorders
- Family program and support
- Pharmacotherapy
- Agonist Therapy?
  - ***Opioid dependent doctors seldom require methadone or buprenorphine***.

PHP Monitoring of SD Recovery

- Rigorous – no attrition
- Contractual
- Clinically focused
- Biological (substance use disorders)
  - Random urine testing
  - Hair analysis
- Behavioral / treatment compliance reports
- Face to face with PHP monitor / case manager
- Return to work considerations and planning
- Workplace monitors
- Contingencies for non-compliance

PHP Case Management

- Receive reports from all monitoring components,
- Review toxicology reports
- Co-ordinate and facilitate communication
- Liaise and advocate with workplace
- Resource identification as needed
- Prompt response to relapse to substance or behaviors
- Annual review with participant
- Case conferences as needed
- Progress and advocacy reports for third parties
- Identify and respond to family and other concerns

Comparing CDM principles and addiction treatment in physicians

CDM principles

- Responsibility for the entire population group
- Case finding /screening

PHP

- A discrete population
- Safety sensitive occupation
- Multiple possibilities:
  - Self
  - Family
  - Colleagues with in the workplace or as treatment providers
  - Regulator
  - Callers to PHP screened for SUDs and addictions regularly

PHP

- **Risk assessment begins with first call**
  - Substance misuse/abuse vs. dependence, presence of possible concurrent disorders
- **Need for direct intervention**
  - Lower threshold for immediate assessment and treatment than the general public
- **Assessment and treatment**
  - Frequently at residential treatment centers first
    - Expertise with health professionals
    - Multidisciplinary care
    - Medical and psychiatric care
    - Family support

CDM principles

- **Stratify by risk and provide care in least intrusive setting**
- **Treatment in the community before more complex acute services**

CDM

- Primary care provider runs the show

PHP

- PHP runs the show
  - Occupational health principles applied
  - Case management/coordination
    - Clinical focus
    - Monitoring for health and recovery
    - Response to behavior and substance
  - Accountability
    - By clear agreement/contract
    - Contingency is clear
    - Patient safety

PHP

- Recognize the importance of the relationship between the PHP team and participant
  - Transparency of expectations and processes
  - Personal responsibility emphasized
  - ABSTINENCE

CDM

- Involve patients in their own care

CDM

- Support with education and on-going follow-up

PHP

- Continuity is important
  - Agreements and contracts post: initial treatment = 5 years for substance dependence
  - Community based, on going treatment for addiction and concurrent disorders
- Education
  - Relapse prevention
  - 12 step groups
  - Health professional groups

PHP

- PHP teams are multidisciplinary
- Following initial treatment, PHPs able to support all treatment providers with:
  - Perspective
    - “Painting the picture”
    - A different advocacy than that of a treatment provider
  - Strong support for health and recovery
    - Monitoring(including biological) results
    - Compliance
  - Insure additional referrals, resources are available when required

CDM

- Multidisciplinary team
- Supports family physicians, specialists and other services

PHP

- Preserve the confidentiality of the physician – physician patient relationship as much as possible
- Coordinate care
- Liaison and facilitation communication
  - Family
  - Treatment providers
  - Workplace
  - Regulator as necessary

CDM

- Integrate care across organizational boundaries

Applying occupational health principles

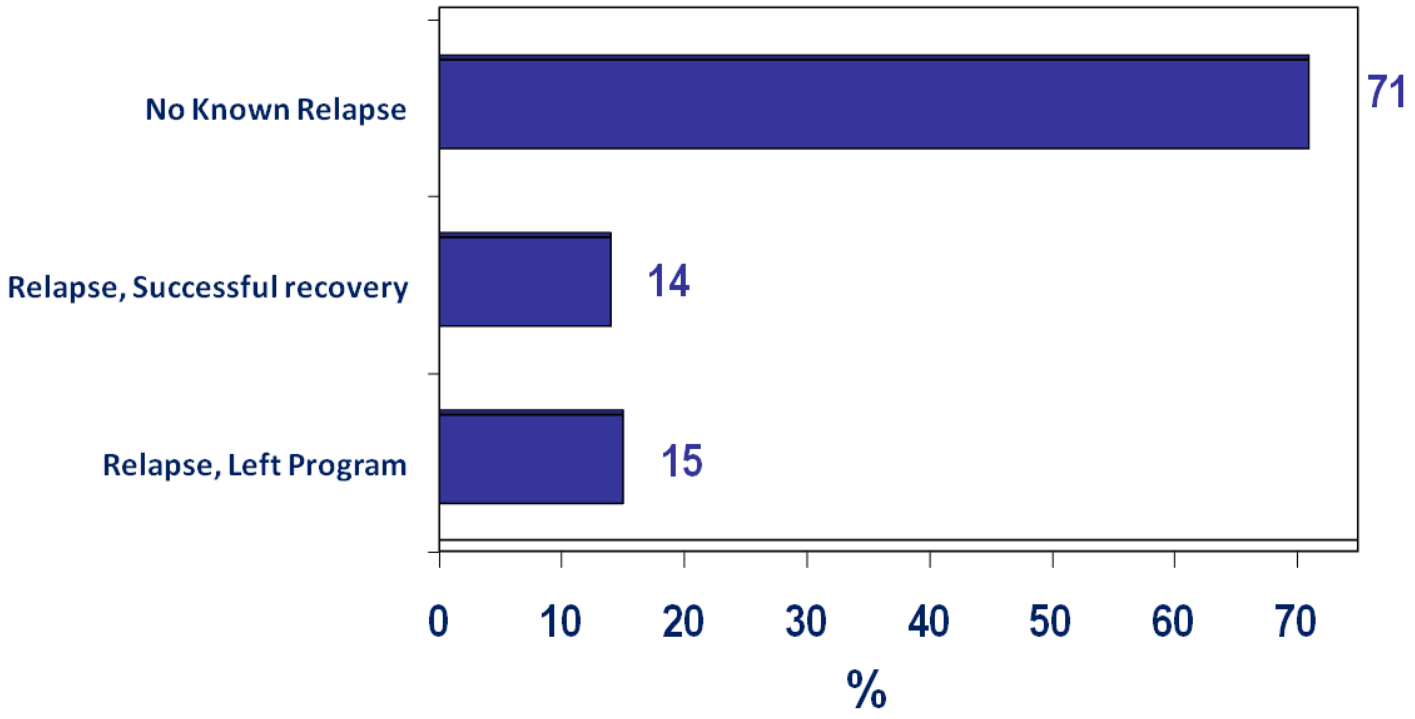
- Always aware of the safety sensitive nature of a medical occupation
  - Fiduciary responsibility
  - Accommodations in the work and workplace considered
- PHPs do not function as treatment providers for participants
- Participate in return to work planning with the participant and the workplace
- Monitor for health and recovery

CDM: Performance measures help guide care

- "It appears that the care and management of addicted physicians, as coordinated through these PHPs, may be qualitatively and quantitatively different from the care available to the lay public."
  - DuPont, McLellan et al J Substance Abuse Treatment 37 (2009)

OMA PHP Relapses - 5 Year Program
First 100 monitored participants

Brewster, Kaufmann et al; BMJ Nov 2008



“Blueprint” Study

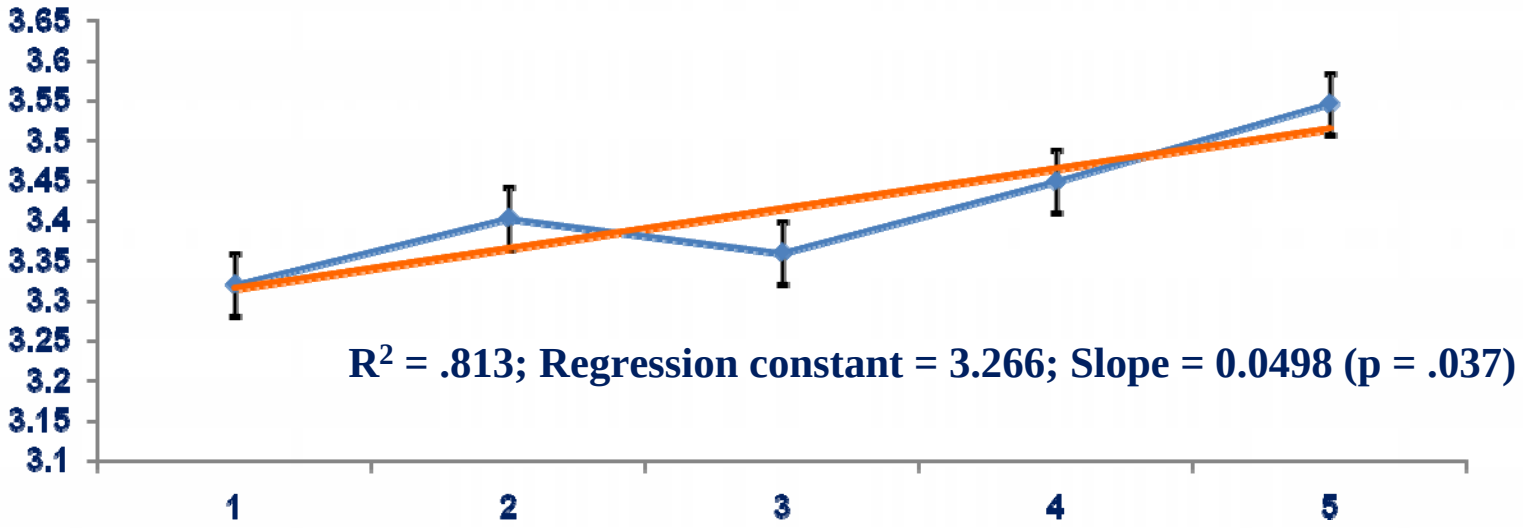
McLellan et.al., BMJ, Nov. 2008

- 16 American PHPs retrospective longitudinal study
- 904 consecutive MDs with SUDs, 647 monitored
- 81% never relapsed over five years
- 79% licensed and working after five years
- 11% revoked
- 3.5% retired
- 3.5% died
- 3% status unknown

Relapse risk (Washington State PHP)
(Domino, et. al. JAMA, Mar 23, 2005)

- Relapse rate: 25% (74 of 292 cases between 1991-2001)
- Increased relapse risk if:
  - Concurrent psychiatric disorder
  - Family history of substance use disorder
  - Previous relapse
  - Combinations of these adds to cumulative risk
- No increased relapse risk:
  - Drug of choice
    - Including major opioid as long as above factors absent
  - Specialty
  - Gender

LIFE SATISFACTION* BY PROGRAM YEAR - OMA PHP



R^2 = .813; Regression constant = 3.266; Slope = 0.0498 (p = .037)

*** Mean of 14-items: 4-Very satisfied; 3-Satisfied; 2-Dissatisfied; 1-Very dissatisfied**

PFSP Program Evaluation 2008: Did PFSP make a difference for participants in case coordination?

90% of responding participants reported that the problem that had caused them to access the program had improved (46% responded)

- Overall wellness full 76% partial 14%
- Job effectiveness full 71% partial 14%
- Relationships with others full 71% partial24%

Overall life satisfaction

- Beginning of case coordination 3.7/10
- Conclusion of last interaction 8.1/10