

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



Welcome to the 23rd edition, Volume 2 of *Physician Health News*. We hope you will find this an informative forum for all aspects of physician health and well-being. *Physician Health News* is the official newsletter of the Federation of State Physician Health Programs (FSPHP) and is published by the FSPHP.

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The FSPHP is a national organization providing an exchange of information among state physician health programs (PHPs) to develop common objectives, goals, and standards. If you're not a member yet, please consider joining. State, Associate, International, Individual, and Organizational membership categories are available. We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive FSPHP. For more information on each of the membership categories, including new categories for organizational and individual members, please see our website or contact Julie Robarge.

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PRESIDENT'S MESSAGE

FSPHP Strong: "Onward and Forward"

P. Bradley Hall, MD

As I reflect on our most recent annual meeting and where we have been as an organization, where we are, and where we are headed, all I can say is "WOW." Per routine, the highlight of the year for me was the annual education conference and business meeting this past April. Attendance continues to grow, as does the relevant



P. Bradley Hall, MD

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content of physician health programs, physician health, and beyond. I could feel the energy and passion radiating throughout the conference as we reconnected and recharged. I thank you all for your participation in and contributions to the FSPHP and the success of our annual conference.

Accolades to Linda Bresnahan, Executive Director; Julie Robarge, Association Management Specialist; the Program Planning Committee, co-chaired by Martha Brown, MD, and Doris Gundersen, MD; and the Board of Directors, committees, and our membership for a job well done!

In June, I had the honor of speaking to the Organization of State Medical Association Presidents (OSMAP) on the topic of physician health, physician health programs, and the AMA. This organization represented past, present, and future state medical association presidents. The value of a strong triumvirate relationship with state medical associations, physician health programs, and licensure boards partnering to enhance the health and well-being of the population we serve is so important to our work. This tripartite relationship is exemplified at a national level with the FSPHP, FSMB, and the AMA. It extends to many other organizations at a national and state level as well. The presentation reviewed the history of PHPs, the AMA, the FSMB, and most important, the multitude of FSPHP current collaboratives and initiatives. The response from the audience, during and afterward, demonstrated a true desire to enhance state medical association relationships to the benefit of their own membership. It is my hope that those in attendance carried the message home.

In July, I attended the National Academy of Medicine's meeting, "Establishing Clinician Well-Being as a National Priority: Meeting 1." This public meeting was held for the purpose of providing an opportunity for the public and invited experts to provide feedback on the direction of the recently established "action collaborative" of which the FSPHP is supportive and involved. The desire is to provide a venue grounded in evidence-based knowledge to (1) assess and understand underlying causes of clinician burnout and suicide and (2) advance solutions that reverse the trends in clinician stress, burnout, and suicide. In early July, the Action Collaborative released a discussion paper entitled "Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care." This collaborative is represented by approximately 30 inaugural sponsors and a multitude of other organizations with nearly 300 in attendance at the July meeting in Washington, DC. Again, to be present in an atmosphere of energetic and passionate attendees

reminded me of our annual meeting and my colleagues of the FSPHP. As result, participation further confirmed and inspired my involvement with the FSPHP in achieving its mission and goals. This inspiration is exemplified by the work of the board member workgroups as outlined in the Spring 2017 Newsletter.

The FSPHP launched its inaugural fundraising campaign in the spring of this year. Nearly 500 solicitations have been sent out, with initial responses being positive. With 100 percent participation of the board in 2016 and the additional launch of the campaign in 2017, we are hopeful that success is on the horizon. The workgroup and funding development committee will continue to follow through with the well-developed plan.

Under the guidance of the ACE workgroup of board members, we will continue in the development and implementation of an FSPHP-endorsed review process. This is in follow-up of our performance enhancement review (PER) guidelines of PHPs. This will provide a mechanism to measure and enhance the quality of each PHP's work. One objective of the workgroup includes updating the FSPHP Guidelines via the ACE Committee, which will be critically important in the FSPHP-endorsed PER process. The board is also reviewing the opportunity to engage a qualified consultant to assist, expedite, and follow through in achieving our goal at the highest of standards for which the FSPHP has always operated. The FSPHP board is intent on updating our membership on the status of the PER process and a Treatment Center Review Process as part of our annual meeting in the Spring of 2018.

The FSPHP board met for our annual board retreat in Chicago. The primary goal was to review the workgroup plans, provide any appropriate updates, and continue the involvement of the FSPHP committees. The board recognizes the incredible value of your work on these committees in achieving the workgroup goals, which ultimately enhance our ability to achieve the mission of the FSPHP: "To support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care." This will further allow us to connect with our vision of "A society of highly effective PHPs advancing the health of the medical community and the patients they serve." The updated strategic work plans of the FSPHP will be shared with members in our next issue.

Since becoming a part of the FSPHP, my hope for the organization has continued to develop and grow as a result of the established track record of perseverance and associated successes we can look back on today. "Hope" has transformed into "faith" that in the future, the FSPHP will continue to be successful even if the specifics are not clear. Whatever the future will bring, it is good. Upon this writing, I continue to personally reflect

on where we have been, where we are, and where we are headed. And again, all I can say is "WOW."

Onward and forward,
Your president and servant,
P. Bradley Hall, MD ■

MESSAGE FROM THE EXECUTIVE DIRECTOR

**Linda Bresnahan, MS,
Executive Director**

I hope you all enjoyed the summer months and that your summer included time off with family, well-being, and enjoyment. A few pieces of FSPHP news for you follow.



Linda Bresnahan, MS

First FSPHP Annual Campaign

This year, 2017, marked the first-ever FSPHP inaugural fundraising campaign and silent auction. FSPHP and our fund committee members would like to thank the numerous generous donors. We have so far raised over \$15,740, with the silent auction raising \$8,880 and our annual drive raising \$6860. We are grateful for this ongoing support. Board members, FSPHP members, and others invested in physician health have made contributions with a few matching PHP donations. This growing support will further our strategic goals to develop a Performance Enhancement Review Program and a Treatment Center Review Program and increase member services and support, while furthering our research and education goals, too. To donate online, you may click here www.fsphp.org/donate.

2017 Inaugural Annual Appeal Donors

Advocates (\$1,000–\$2,499)

Chris Bundy, MD
Scott Hambleton, MD
Washington Physicians Health Program

Caregivers (\$500–\$999)

Dr. and Mrs. David Goldberg
P. Bradley Hall, MD
Ohio Physician Health Program
Doris Gundersen, MD

Friends (\$1–\$499)

Michael Baron, MD	Jonathan Lee, MD
Kirk Bower, MD	Kelley Long
Kathleen Boyd, MSW, LICSW	William Mathews, MD
Linda Bresnahan, MS	Charles Meredith, MD
Gary Carr, MD	Lisa Merlo, PhD, MPE
John Colaluca, MD	Warren Pendergast, MD
Sarah Early, PsyD	Jon Shapiro, MD
Angela Graham, MPA	Amy Tardy, PhD
Lynn Hanks, MD	Heather Wilson, MSW, CFRE

A Special Thank You to Our Silent Auction Winners

Candace Backer, LCSW	Teresa Jackson, MD
Chris Bundy, MD	Robin McCown
Sally Garhart, MD	Charles Meredith, MD
Doris Gundersen, MD	Linda Rodriguez, LCSW-C
Marlene Hall	Martin Rusinowitz, MD
Scott Hambleton, MD	Kristin Wallace

Institute for the Advancement of Behavioral Healthcare

The FSPHP has been invited to be an Event Supporter of the Institute for the Advancement of Behavioral Healthcare ("Institute") and the National Rx Drug Abuse & Heroin Summit. The relationship among the Institute, Summit, and the FSPHP recognizes our support of their effort at no cost to FSPHP and provides FSPHP with an opportunity to share news of the work of PHPs at the conference.

Institute for the Advancement of Behavioral Healthcare:
www.iadvancebehavioralhealthcare.com

National RX Summit, April 2018:
<https://vendome.swoogo.com/2017-Rx-Summit>

FSPHP Annual Meeting 2018, Wednesday, April 25–Saturday, April 28, 2018, Embassy Suites, Charlotte, NC

Your Program Planning committee has been confirming plans for the launch of the 2018 annual meeting. The program theme will focus on best practices for physician health, with emphasis on enhancing and optimizing the PHP model. The call for abstracts has been released and is available online at www.fsphp.org/event/fsphp-annual-education-conference-business-meeting-2018. The PPC is interested in increasing facilitated panel presentations with more PHP involvement presenting and comparing PHP methods and examples.

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Message from the Executive Director*continued from page 3***2017 American Conference on Physician Health**

The first American Conference on Physician Health is a collaboration of Mayo, Stanford, and the AMA to occur every other year in America (on the off years of the International Conference on Physician Health, which occurs on the odd years). This meeting will occur October 12–13, 2017, at the Palace Hotel, San Francisco, California, www.ama-assn.org/events/2017-american-conference-physician-health. If you plan to attend, or have a presentation on their agenda, please share news of your presentation with our members on the Yahoo! groups. Dr. Gundersen and Dr. Bundy are both presenting posters.

Poster Sessions: https://med.stanford.edu/content/dam/sm/CME/documents/brochures/2017/ACPH-Presentations_abstracts-Rev7-25-17.pdf

Detailed Conference website: <https://med.stanford.edu/cme/courses/2017/ACPH17/ACPH17.html.html>

FSPHP Board of Directors

Your FSPHP Board of Directors met at the AMA Headquarters, September 14–September 15, 2017. The board members updated the FSPHP strategic plans and reviewed committee reports. More will be shared on these updated plans in our next issue. Michael Tutty, PhD, provided an update of the mission and initiatives within the Professional Satisfaction and Practice Sustainability Division of the AMA.

Discussion with American Board of Obstetrics and Gynecology

Dr. Susan Ramin, the Associate Executive Director for the Maintenance of Certification at the American Board of Obstetrics & Gynecology, reached out to FSPHP to seek feedback on their health questions on the MOC application and on their process for reviewing disclosures of PHP involvement. We appreciated the opportunity to provide feedback, and we look forward to more collaboration on their questions and process. We applaud their efforts to lessen barriers for physicians who are involved in a PHP.

FSPHP Presence

- SAMHSA-COPE Medical Education Summit in La Quinta, California, *Chris Bundy, MD*
- Organization of Staff Medical Association Presidents (OSMAP) in Chicago, Illinois, June 2017, *P. Bradley Hall, MD*
- AMA Annual Meeting, June 9–12, 2017: *Warren Pendergast, MD*, attended as our FSPHP Observer.

- National Academy of Medicine, July 14, Washington, DC: *P. Bradley Hall, MD*, and *Warren Pendergast, MD*, attended for FSPHP.
- International Health Facility Diversion Association (IHFDA), September 30, 2018, Daniel Perlin, MD, <https://ihfda.org/about>

FSPHP Regional Meetings

A very special thank you to the FSPHP members who volunteer to host regional meetings. Thanks also to those state PHPs who have generously funded the FSPHP regional meetings. These regional meetings are rich in content and in member opportunities to network. Set aside your regional meeting date, and perhaps consider cross-pollinating to other region meetings.

- **FSPHP Western Region Members Meeting**
Occured on August 24, 2017, 5:00 p.m. at Hilton, San Francisco Union Square. Occurred after the CPPPH/CSAM Workshop, Stories, and Strategies to Engage Providers and Address Burnout. Thank you to our FSPHP member Karen Miotto, MD, for coordinating the meeting with the FSPHP Western Region Directors, Dr. Chris Bundy and Michael Ramirez. Karen Miotto, MD: kmiotto@mednet.ucla.edu
- **FSPHP Northeast Region Member Meeting**
Friday, November, 3, 2017, Physicians' Health Program, 777 East Park Drive, Harrisburg, PA 17105-8820
Contact: Kendra Parry, MS, CADC, CIP, CCSM, Director, Physicians' Health Program: kparry@pamedsoc.org
- **FSPHP Southeast Region Member Meeting**
Due to the hurricane in Florida this past month, the September Southeast Region Meeting was postponed.
- **FSPHP Central Region Member Meeting**
Occured on September 21–22, 2017. Thank you to Amy Van Maanen, LBSW and the Iowa Physician Health Program for hosting the Central Region meeting. Stay tuned for a summary of this meeting in our next issue. Amy Van Maanen, LBSW, Iowa Physician Health Program: amy.vanmaanen@iowa.gov

Membership Renewal

Membership for 2018 renewal opens on October 1, 2017. Encourage new staff, colleagues, board members, committee members, and those treating your PHP participants to join! New members who join by October 1 receive three free months of membership.

Thank you for everything you contribute as members of the FSPHP to our mission. Your dedication to the work you do is reassuring and inspiring. It is my pleasure to serve the FSPHP as your executive director.

Linda Bresnahan ■

FSPHP AND FSMB SURVEY REGARDING PHYSICIAN REFERRAL TO PHPS

Mark Staz, MA, Director, Continuing Professional Development, FSMB and Linda Bresnahan, MS, Executive Director, FSPHP

Physician Health Programs (PHPs) and state medical boards are committed to physician wellness and reducing physician burnout. In support of these efforts, the Federation of State Physician Health Programs (FSPHP) has partnered with the Federation of State Medical Boards (FSMB) to help gather valuable information regarding PHP referrals.

Soon, you will receive a short survey asking you to supply information regarding the number of PHP referrals in your state in 2016 and in other years since your program's inception. The FSMB will then examine these data in relation to health questions on state licensing board applications. The FSMB wants *to assess if there is a variation in the voluntary utilization of a PHP for prevention and supportive substance use and mental health needs of physicians based on the different state licensing board application requirements for disclosure of a health history.*

Background

In an effort to promote physician wellness and increase patient safety, the FSMB created a Workgroup in 2016 on Physician Wellness and Burnout, chaired by Arthur S. Hengerer, MD. The workgroup has been tasked with considering the issues of physician wellness and burnout from a regulatory perspective, identifying key patient safety issues, and determining ways in which state medical boards can better support physician wellness. As with many FSMB committees and workgroups, most appointees are either staff or board members of state medical boards. The Workgroup also includes representation



Mark Staz, MA



Linda Bresnahan, MS

from subject matter experts in physician wellness, psychiatry, and from the PHP community through FSPHP's immediate past-president Dr. Doris Gundersen.

As a result of these discussions, the Workgroup is focusing on developing best practices for phrasing questions on licensure applications that address leave from medical practice, mental illness, substance use disorders, and other potentially impairing conditions. Many state medical boards feel that these questions are essential to equip them with the necessary information to effectively assess risk for patient harm and make informed licensure decisions. However, recent research suggests that the inclusion of such questions might act as a barrier to seeking necessary mental health/addiction treatment among some physicians experiencing symptoms of burnout or other conditions. Part of the Workgroup's task will therefore involve clarifying the distinction between illness and impairment and emphasizing that a physician who suffers from an illness is not the same as one who is impaired in a way that is meaningful in the context of his or her ability to safely provide care to patients.

The FSMB Workgroup is compiling a report, including recommendations, to be finalized in early 2018. The FSMB values the FSPHP's involvement throughout this process and appreciates its commitment to this area of mutual concern. State medical boards' duty to protect the public includes a responsibility to ensure physician wellness, and the FSMB is eager to continue working with the FSPHP on these important goals. For all of you, this article might be of some interest: <http://jaapl.org/content/36/3/369>

The survey is endorsed by the FSPHP Research Committee, and state PHP participation is greatly appreciated. ■

FEELING THE BURN: PHYSICIAN BURNOUT IN AMERICA

Kurt Mosley, VP of Strategic Alliances, Merritt Hawkins and Staff Care Companies of AMN Healthcare



Kurt Mosley

There is an old adage that one human year is equal to seven dog years since dogs age quicker than we do. The same can be said about healthcare in America over the last five years—it seems we have packed 20 years' worth of changes into just three or four actual years. Our physicians have dealt with more changes in that short time period than they have since

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Feeling the Burn: Physician Burnout in America

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the implementation of Medicare and Medicaid in 1965. As a result of the ever-expanding amount of changes, burnout has become more common among physicians than any other group of U.S. workers.

A recent survey conducted by Merritt Hawkins on behalf of the Physicians Foundation asked the question: "To what extent do you have feelings of professional burnout in your medical career?" Nearly half of the physicians responding said they had either frequent or constant feelings of burnout. On the flip side of the question, only about 11 percent indicated they had no such feelings of burnout. According to survey data, physician specialists at the front line of care seem more prone to burnout. Almost 50 percent of the physician specialists stated they had feelings of professional burnout "often or always."

The key to reducing physician burnout is establishing the root causes. Suggested contributing factors are:

- Government and industry regulations
- Nonclinical paperwork
- Lack of time available for patients
- Uncertainty of the future of medicine
- Confidence in career choice

According to the survey, regulatory and paperwork burdens were the most cited factors causing physician dissatisfaction. The fact that physicians report low professional satisfaction due to regulatory and paperwork burdens makes sense as healthcare is the most highly regulated profession in the United States. The Patient Protection and Affordable Health Care Bill passed in 2010 is over 2,500 pages in length. The new MACRA law is over 900 pages. The enactment of the Medicare and Medicaid Bill of 1965 was just over 400 pages in length.

The second most frustrating factor cited in the survey was erosion of clinical autonomy. When asked what factors they find most satisfying about medical practice, physicians cited patient relationships (73.8 percent) as number one. The erosion of clinical autonomy and lack of face time with patients go hand in hand. The growing number of government regulations and third-party interventions creates an even bigger roadblock for physicians to achieving their goal of developing patient relationships.

We must look at the burdens we are placing on today's doctors and let them do what they do best. We must support them in their efforts to take care of the healthcare population in the way they see fit. Our doctors spend anywhere from 12 to 16 years training for their profession, but the way they practice is often directed

and guided by a person who may have fewer than six months of experience in the healthcare industry. It is time to recognize and correct the issues that cause career dissatisfaction and burnout for doctors so they can focus on the health and well-being of their patients. ■

PHP 2.0: WPHP PILOT PROGRAM TO ADDRESS BURNOUT AND ENHANCE RESILIENCE IN HEALTH

Chris Bundy, MD, MPH, Medical Director, Washington Physicians Health Program; Laura Moss, MD, Associate Medical Director, Washington Physicians Health Program; and Charles Meredith, MD, Emeritus Medical Director, Washington Physicians Health Program



Chris Bundy, MD, MPH

Synopsis

The Washington Physicians Health Program (WPHP) presented the results of a two-year pilot program to promote physician wellness. Rationale for developing the program, program elements, implementation hurdles, outcomes, and lessons learned were discussed.



Laura Moss, MD

Intervention and prevention of physician burnout were the rationale for developing the Wellness Program. The program targeted individuals and organizations. Interventions targeting individuals consisted of Mindfulness-Based Stress Reduction (MBSR) workshops and five-week seminars based on Jon Kabat-Zinn's MBSR model for health professionals. Courses were offered to licensees and their spouses. WPHP contracted with Mindfulness Northwest (MNW) to deliver course content and manage registrations, while WPHP developed marketing and promotion through existing stakeholder networks. Interventions targeting organizations included education and outreach presentations on the causes and consequences of burnout and the relationship between burnout and negative health outcomes in physicians. WPHP provided consultation to physician well-being committees and curated relationships among stake-



Charles Meredith, MD

holder organizations to address the diverse drivers of physician distress and burnout.

Costs of the program were primarily related to staff full-time equivalent employees (FTEEs) to design, implement, and manage the program. This was absorbed by existing FTEEs and therefore difficult to directly measure. We estimated the cost to range from \$3,700–\$74,000 depending on the accounting methodology. Overall, the individual intervention (MBSR) was delivered to 265 professionals/spouses through 12 five-week series and two workshops over the two-year period.

Outcomes were measured pre- and post-intervention for a convenience sample of 42 consecutive enrollees in the five-week series. Improvements in Cognitive and Affective Mindfulness Scale-Revised (10.5 percent), Perceived Stress Scale (–20.6 percent), and Maslach Burnout Inventory (Emotional Exhaustion –6.4 percent, Depersonalization –14.7 percent, Efficacy 7.8 percent) were reported by participants at program completion.

Declining registration over time has been the most significant challenge to the program. Early robust registration, likely representing pent-up demand, declined over time despite aggressive ongoing promotion efforts. Time and travel barriers, competing demands for physician time, and lack of the perceived benefit of wellness-based interventions were identified as barriers to physician participation. WPHP and MNW will be developing a teleconferencing modality for program delivery to reduce the time and travel barriers for participation of physicians from across the state going forward. Making CME credit available to participants may increase physician incentive to participate as well. ■

REDUCING PHYSICIAN SUICIDE IN THE WORKPLACE: PRACTICAL STEPS TOWARD ORGANIZATION-BASED PREVENTION

Elizabeth Brooks, PhD, Doris C. Gundersen, MD, and Michael H. Gendel, MD



Elizabeth Brooks,
PhD



Doris C. Gundersen,
MD



Michael H. Gendel,
MD

Background

Physicians commit suicide at a rate higher than that of the general public. While most doctors agree that they have an ethical obligation to intervene when they believe a colleague is impaired, many do not recognize the warning signs, are uncomfortable referring a colleague to care, and do not know how to appropriately intervene. The Colorado Physician Health Program developed an educational module for the American Medical Association's (AMA) Steps Forward website, Preventing Physician Distress and Suicide. The module aims to raise awareness about physician suicide and encourage organizations to make proactive changes to address this critical issue in the workplace.

Drawing on *Steps Forward*, the current presentation discussed these practical suggestions.

Overview

Four key strategies are instrumental in helping organizations address the problem of physician suicide: (1) Talk about the risks and warning signs for physician suicide. (2) Standardize the concept of care-seeking within the organization. (3) Make it easy to find help. (4) Create a support system for physicians within the organization.

The easily digestible module content includes downloadable tools, such as talking points for confronting physicians about suspected ideation; links to videos such as *Struggling in Silence*, *Physician Depression and Suicide*; and links to further resources and information. A review of the module will better prepare viewers to recognize organizational barriers and implement supports that encourage care-seeking. The *Steps Forward* module on suicide is freely accessible online (www.stepsforward.org/modules/preventing-physician-suicide) and available for CME credit.

Conclusions

Targeting workplace-based change is necessary and appropriate because organizations are uniquely positioned to reach out to and influence doctors who need assistance or those who suspect their colleagues need care. Upon review of the module, learners will know practical, low-cost steps to take that may reduce the incidence of suicide in physician populations. ■

GOING TO SUMMIT: REACHING YOUR PEAK OF FUNDRAISING!

Lessons from the Colorado Physician Health Program

Sarah Early, PsyD, Executive Director of CPHP, and Amanda Parry, MPA, Director of Public Affairs of CPHP, with contributions by Angela Graham, MPA, Donor Relations Manager of CPHP (unable to attend Annual Meeting)

Sarah Early, PsyD, and Amanda Parry, MPA, of the Colorado Physician Health Program (CPHP) guided session attendees through a fundraising training focusing on foundational strategy and specific tools that work well for a physician health program (PHP). The audience answered several polled fundraising questions. Some responses included: 28 percent had no fundraising program, 50 percent of respondents solicited to individuals within their state, 60 percent of PHPs asked hospitals to support their efforts, only 16 percent engaged in fundraising events, and 52 percent received grant funding.

Community constituent relationships, donor development, and public image are all vital foundational elements to successful fundraising. The fundraising history was shared; the *Spirit of Medicine* (SOM) Campaign began in 1994, starting with personal contacts and a few hospital solicitations. In 2004, CPHP hired a Donor Relations Manager to run the campaign, a step she recalled as *crucial* to the success of fundraising for CPHP. In the 2015–2016 fiscal year, the SOM incorporated two large direct-mail solicitations to hospitals, individuals, organizations, and other community constituents along with regular correspondence with donors, awards for large donor-organizations, and a thank-a-thon. With much enthusiasm, CPHP surpassed its peak in 2016, with a \$258,400 final amount raised!

Three essential tools presented were a development plan, a case for support, and a donor database. CPHP utilized their development plan to set actionable steps (3–5 each year was the recommendation) toward which the staff and Board of Directors could stay



Sarah Early, PsyD



Amanda Parry, MPA

accountable throughout the year. Second, a case-for-support document was developed and printed for utilization during donor and community constituent meetings. This pamphlet includes essential elements of why the program is important: impacts, costs associated, needs, current utilization, and so forth.

Next, the importance of a donor database was highlighted. A fundraising program does not need to be complex or costly, but simply robust with its donor information. It is essential to make your donors feel valued (because they are), and the more information you can retain on each constituent, the better off your relationships with each donor will be, and the more fruitful your campaign will be.

The presenters strongly emphasized that the last “tool” in fundraising is the role and buy-in from a PHP’s Board of Directors. Tips were also given on how to involve these leaders when they may not be keen on fundraising. For instance, engage Board Directors in thanking donors, versus asking. Teaching Board Directors that fundraising is truly about making connections, building relationships, and believing in the mission makes the concept much less daunting. Talking about your program’s function and demonstrating an impact your PHP made should be easily within a Board Director’s repertoire. The strong active support of a Board of Directors in a PHP’s fundraising efforts will be vital to the campaign’s success. ■

ANALYSIS OF THE EFFECTIVENESS OF EMPLOYEE ASSISTANCE PROGRAMS: THE CASE OF THE QPHP

Denis Chênevert, PhD, Professor, Director of the Healthcare Management Hub, Department of Human Resources Management, HEC Montréal; and Marie-Claude Tremblay, MBA, Human Resources Management Consultant



Denis Chênevert, PhD

The Québec Physicians’ Health Program (QPHP) celebrated its twenty-fifth anniversary in 2015.

Last year, it helped almost 1,400 physicians—twice as many as ten years ago. This essential service not only prevents human tragedies, it also contributes to controlling costs in the health and social services network. A number of employee assistance programs (EAPs) like

the QPHP have emerged over the past decades. The upsurge in job burnout has resulted in rising costs for insurers, which are passed on to organizations in the form of higher insurance premiums. To mitigate this problem, these organizations have sought to provide workplace health and wellness programs, which include EAPs, using external suppliers. Despite the fact that there appears to be consensus on the importance of such programs, there is not always evidence to back it up. In fact, barely 1 percent of organizations make thorough assessments of the return on investment (ROI) of their EAP. Given that fact, it is important to identify the existing data on the effectiveness of EAPs. The notion of effectiveness is multidimensional and takes on its full meaning in the concept of stakeholders. In that regard, effectiveness can be considered in terms of the following dimensions: economic/accounting, social/political, client/patient, and individual/employee. When this logic is applied to the specific context of Québec's health and social services sector, it becomes more complex, and even more so when applied to physicians. As they are not salaried employees in the institutions where they work, physicians cannot benefit from the EAPs available to other employees. In most cases, they must find help on their own and pay for it themselves. However, studies suggest that they are more vulnerable to burnout and suicide than the general public. To assist these physicians, whose needs for psychological support are growing, the QPHP developed services specifically adapted to this clientele. External services provided by peers are necessary to reduce the considerable stigmatization inherent to this group of independent professionals. The goal of this report, therefore, is to explore the effectiveness of EAPs in North America in order to identify possible avenues that will enable the QPHP to reposition itself.

It is recommended that the QPHP examine its role within the diverse workplace wellness and productivity strategies of the various health institutions. Given that physicians work in an environment in which the principal characteristics are controlled by the management of these institutions, it would make sense to better harmonize the complementary services offered by the QPHP.

It is recommended that the QPHP examine what data could be gathered and analyzed to develop a more in-depth examination of needs and the QPHP's impact on the health and productivity of care staff. This could include the following:

- Analysis of the level of satisfaction of services offered
- Analysis of the work climate within some care teams
- Analysis of the profitability of services offered using the ROI technique
- Communication of the results of analyses performed to the various stakeholders
- Establishment of an action plan with performance indicators
- Establishment of a balanced scorecard ■

HEALTHCARE PROFESSIONALS AND SEXUAL BOUNDARY VIOLATIONS: PROBLEMS AND SOLUTIONS

Tracy R. Zemansky, PhD, CSAT-S

Key Conclusions

The more knowledge and understanding PHPs have about physician boundary crossings, boundary violations, and sexual misconduct, the better prepared they can be to use best practices to assist physicians with education, early intervention, assessment, and effective treatment.

Increasing media attention on the most egregious cases of sexual misconduct can be seen as a mandate for a more proactive, interventional approach to these issues. While not all PHPs work specifically with boundary violations, the mandate to promote physician wellness implies a duty to assist, even if by simply giving information on where to find additional help. As with substance addiction, secrecy and shame only fuel the basic problem. Confidential early intervention and treatment are more important than ever.

The nature of physician education and training may increase the risk of boundary violations/sexual misconduct, particularly for individuals with certain personal characteristics, personality styles, interpersonal skills, and life histories. Increasing demands on physicians—including higher workloads and the rapidly changing medical profession—also increase risks. Higher stress



Tracy R. Zemansky,
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Healthcare Professionals and Sexual Boundary Violations: Problems and Solutions

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and “burnout” are other indicators of potential boundary difficulties.

It is possible to identify characteristics and personality styles of physicians who are vulnerable to boundary violations and risk sexual misconduct. It is also possible to identify typical behavioral/emotional patterns and other “warning signs” that lead to misconduct/boundary violations. Understanding these vulnerabilities can help those involved with physician wellness to intervene *before* serious problems or patient harm occurs. Recognizing the “slippery slope” from relatively benign boundary crossings to overt sexual misconduct can also help address problematic patterns prior to any impact on patient safety.

Standard Precautions for healthy professional boundaries must be taught and implemented in all medical settings, much like Universal Precautions for infection are used with all patients, regardless of diagnosis. While practical application of some Standard Precautions may vary slightly depending on practice locale (i.e., rural versus urban) and/or medical specialty (i.e., emergency medicine versus psychiatry), most precautions are highly recommended in all settings for prevention of known and unknown sources of boundary problems.

Best Practices for early identification, intervention, multidisciplinary assessment and treatment are available and can help Wellness Committees and PHPs structure effective Return to Work Plans, Practice Guidelines, and effective Monitoring Agreements for physicians with Boundary Violations/Sexual Misconduct allegations, convictions, or histories.

We do not have to wait until a problem occurs; bringing this difficult topic into the open is a critical first step in helping physicians understand and maintain healthy professional boundaries. ■

MONITORING OF PHP PARTICIPANTS: BEST PRACTICES TO HELP AVOID DIFFICULTIES

**Martha Brown, MD;
Penelope Ziegler, MD; and
Thomas Crabb, Esq.**



Martha Brown, MD

This presentation provided an overview of some of the operational and legal issues Professionals Resource Network (PRN) has encountered as the operator of the Florida Impaired Practitioners Program for over 30 years.

PRN has developed a list of approved evaluators in various disciplines around the state as well as out-of-state evaluators and evaluation programs. Professionals wishing to become PRN-approved must submit an application and credentials for review. Approved evaluators must attend a PRN Evaluator Training Workshop prior to beginning evaluations and yearly thereafter. Evaluator training includes the components of a forensic evaluation of a professional, such as a face-to-face interview, review of records, toxicology, collateral contacts, and other testing if indicated, as well as the required format for the written evaluation report, including an opinion on the practitioner’s current safety to practice.



Penelope Ziegler, MD



Thomas Crabb, Esq.

PRN maintains a list of approved intensive treatment programs for substance use disorders and co-occurring disorders. These include hospital-based medically managed withdrawal programs, residential treatment, partial hospital treatment, and intensive outpatient treatment programs. PRN assists program referrals and participants in locating appropriate treatment programs.

Monitoring contract development begins when an evaluation is completed if monitoring is recommended. Efforts are made to have the contract signed during or immediately following treatment and must be signed prior to return to practice. Monitoring agreements should be tailored to each specific case.

PRN has developed and facilitated monitoring groups throughout the state for participants with a Substance Use Disorder and/or mental health issue. Weekly groups are run by an approved PRN facilitator, who is required to attend annual training by PRN. Facilitators help detect problems or potential problems participants may be having.

Protecting participant confidentiality is of utmost importance to PRN. Knowing the “rules of the game” to which your program is subject is paramount, recognizing that those rules often change. PRN is subject to the federal confidentiality of substance use disorder regulations (42 C.F.R. Part 2), state laws specific to the Florida Impaired Practitioner Program, and additional obligations under PRN’s primary contract with the Florida Department of Health. A comprehensive understanding of the nest of legal and contractual obligations regarding these issues should be a primary goal of any physician health program.

Program expectations should be expressed to participants as clearly as possible, and as early and often as possible, to improve the performance of the program and minimize legal risk. Having an articulated policy for the resolution of grievances is advantageous. Many programmatic issues can be easily resolved when they are identified and addressed early in the course of the program participation.

The presentation concluded with the recognition that physician health programs, including PRN, are subject to an increasing level of litigation risk. Multiple levels of protection are optimal to help mitigate that risk, including potential statutory and sovereign immunity under state law (which may require seeking state law changes to increase immunity protections), comprehensive insurance covering program operations, and ensuring adequate program funding and reserves. ■

THE AGING PHYSICIAN: PRACTICAL SOLUTIONS FOR A SENSITIVE ISSUE

David E.J. Bazzo, MD, Clinical Professor of Family Medicine, UC San Diego, School of Medicine, Director, Fitness for Duty, PACE

The national healthcare community has embarked on a nuanced discussion about aging as a risk factor for poor performance among physicians. The percentage of physicians practicing later into life continues to



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increase. While there are a number of risk factors that may affect a physician’s clinical competence not related to age (lack of ABMS board certification, out-of-scope practice, isolated practice, poor performance in medical school, etc.), one cannot escape the inherent changes that occur with aging (memory decrement, diminished hearing and visual acuity, decreased fine motor skill, illness). Studies suggest a net negative impact on clinical performance with increasing years.

Ageism is reprehensible; however, given the important responsibilities of our profession, it is equally irresponsible to ignore the decrements in physical and cognitive function that are attendant upon the passage of time for most of us. Medicine’s social contract with society dictates that we have a responsibility to assure competence, promote the public good, and be transparent and accountable. Senior physicians should be allowed to remain in practice as long as patient safety and quality care are not compromised.

Licensing, maintenance of certification, and institutional privileging attend to the ACGME/ABMS Core Competencies (Practice-based Learning and Improvement, Patient Care and Procedural Skills, Systems-based Practice, Medical Knowledge, Interpersonal and Communication Skills, and Professionalism), but they do not require assessment of health. The basic tenets of a “screening examination” necessitate that no symptoms or findings are present that would lead immediately to a diagnostic or “for cause” evaluation. Consequently, a senior physician screen would attempt to elucidate potential health or cognitive issues, through a screening process, that would lead to a diagnostic evaluation if present.

A spectrum of approaches to screening has been put into practice, ranging from the expensive and aggressive to the cursory. The American Medical Association, as well as other groups, has recommended further study and possible development of guidelines for “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians.” The California Public Protection and Physician Health, Inc. organization has developed a white paper looking at the legal issues, professional issues, and safety issues surrounding this topic and has developed a sample policy for review.

The UC San Diego Physician Assessment and Clinical Education (PACE) Program (a national leader in physician competency assessment) has developed an aging physician screening assessment based on the latest scientific evidence and best practices currently available. The screen consists of a cognitive evaluation utilizing the MicroCog™ and Montreal Cognitive Assessment (MoCA®), a health evaluation (history, physical, vision,

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The Aging Physician: Practical Solutions for a Sensitive Issue

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hearing, substance use, and mental health screen), and questionnaire to assess other factors that impact a physician's ability to safely practice. Dexterity testing is administered for physicians performing procedures.

The results of a pilot study for this screening battery revealed potential findings that may impact a physician's ability, particularly in the cognitive domain, to practice safely that were previously unknown. Additionally, the MOCA® may not have the sensitivity of the MicroCog™ in screening for cognitive deficits in physicians. Participants in the pilot study generally viewed the screening process as favorable.

Current data from physicians participating in the PACE Aging Physician Assessment (PAPA) revealed that one physician of the 27 evaluated to date was identified to have significant cognitive decline. ■

WHAT'S AGE GOT TO DO WITH IT? INSIGHTS ON THE AGING PHYSICIAN CONTROVERSY FROM WPHP'S COGNITIVE SCREENING PROGRAM

Chris Bundy, MD, MPH, and
Laura Moss, MD

The issue of cognitive decline among late-career physicians is intensely controversial. While intellectual capacity declines over the life span and advancing age is the greatest risk factor for neurocognitive disorders, there is wide variation among individuals. This variation raises the question of whether and when physicians should be proactively evaluated for cognitive decline and requires consideration of cognitive impairment not being unique to older physicians. For example, physicians referred for disciplinary or competency evaluations consistently demonstrate deficits in neurocognitive functioning regardless of age. From 2012 to 2014, 5–7 percent of clients referred to WPHP had impairing levels of cognitive dysfunction that were unrelated to age and at least half were unsuspected at time of referral. Learning objectives included reviewing the rationale



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MPH



Laura Moss, MD

for the WPHP cognitive screening pilot, describing the WPHP findings, and facilitating an informed discussion about cognitive screening in physicians.

Goals for the WPHP cognitive screening pilot:

1. Assess the value of routine cognitive screening for WPHP initial referrals using the Montreal Cognitive Assessment (MoCA) and a cutoff score of 27 or greater for passing. The validated passing cutoff score for the general population is 26 or greater and for individuals who did not complete high school, it is 25 or greater.
2. Assess the frequency and severity of abnormal screens, the frequency of abnormal screens for clients aged 60 or younger, the illnesses and referral questions associated with abnormal MoCAs, and the proportion of clients found to be unfit for duty with subsequent neurocognitive testing.

Findings:

1. During a six-month time frame, 14/61 (23 percent) of new WPHP referrals had an abnormal MoCA.
2. Fifty percent of abnormal MoCA screens were found in clients aged 60 or younger.

Reasons for referral included:

1. Only 2/14 clients with abnormal MoCA screens were referred due to concerns about cognitive dysfunction and both were referred for additional neurocognitive testing. One was found fit for duty and the other diagnosed with a dementing illness.
2. Other referral reasons included poor work performance (n=2), mental health/behavioral (n=5), co-occurring mental health and substance use (n=1), substance use disorder (n=3), and other (n=1).

Limitations of the pilot included assessment of small numbers of clients over a brief period of time. The MoCA is not a particularly sensitive tool, it is not validated for highly educated people or for people with English as a second language, and there is no data looking at using the cutoff score we selected.

In summary, WPHP's pilot data found cognitive dysfunction in 23 percent of new referrals, 50 percent of abnormal scores were found in clients aged 60 or younger, and that referral reason was not predictive of cognitive dysfunction. These findings support previous research findings and suggest that screening doctors for possible cognitive dysfunction should not be based solely on age. ■

TREATMENT LENGTH OF STAY FOR THE ADDICTED PHYSICIAN: "LET'S DISCUSS"

Daniel Angres, MD, and Paul Earley, MD

The amount of time that an addicted physician should minimally spend in a treatment program is a controversial topic. There are those who believe that a standard 30-day experience (or even shorter) is enough and those who advocate for 90 days (or more) and those who fall somewhere in between. This presentation is intended to extend this discussion at a time when there is an increasing need for data-driven evidence toward what constitutes the best outcomes.

Dr. Angres described his experience with treating addicted physicians in Chicago beginning in the 1980s. He spoke of his working directly with Dr. Doug Talbott and adapting his four-month treatment model, which included a month of residential on the front end. The adaptation Dr. Angres described included shortening or even suspending the front-end residential component (depending on clinical need), emphasizing the partial hospital program combined with independent living, and having a transitional phase prior to return to work. Additional factors were thought to be essential in a program treating this population, including a physician leader along with seasoned staff who had a track record in treating this population, a strong 12-step focus, attention to family and co-morbidity, and enough physician patients in the program so a peer-oriented therapeutic community could be established.

Over time, the length of stay (LOS) in the Chicago program averaged between six to seven weeks. This was less than the more common minimum three-month programs that we have seen throughout the country. Peer-reviewed outcomes from this shorter LOS were published in *Healing the Healer: The Addicted Physician* in 1998, including comparisons to Dr. Talbott's program in Atlanta utilizing the longer four-month model. The outcomes that demonstrated 80 percent abstinence rates over several years were comparable for both programs.

The landmark PHP studies done by DuPont and his team were also referenced and members of that team



Daniel Angres, MD



Paul Earley, MD

worked with Dr. Angres in going back over that data to determine what role, if any, LOS had with those excellent outcomes. When the physicians in that study were divided into five LOS groups, there appeared to be a relatively equal distribution of relapses spanning the shorter to longer stays.

However, it was mentioned that longer LOS seemed to favor fewer positive urines when the data was divided between several states that had differing LOS expectations. In other words, it was not completely clear how the LOS may have contributed to these outcomes. Some of the questions that were generated around these findings included the role of PHPs in these outcomes, including their ability to effectively treatment match as well as monitor physicians following treatment.

Dr. Earley described the factors that favor a longer LOS, including the safety-sensitive issues with this population and multiple consequences that can occur as a result of a relapse, including a diminished confidence in this treatment-monitoring process from hospitals and boards. There was also a recognition of some of the resistances unique to physicians and the added stress factors facing physicians today that might necessitate a longer stay.

There was an overall recognition from the speakers, that seemed to be shared by the audience in polls taken during that talk, that both treatment providers and PHPs need to be more open and flexible regarding LOS at a time when the voices challenging our overall model are stronger than ever. ■

PHYSICIAN MENTAL HEALTH: PREVENTING SUICIDE AND BUILDING RESILIENCE

Christine Moutier, MD, Chief Medical Officer, American Foundation for Suicide Prevention



Christine Moutier, MD

Physician suicide rates are higher than those of the general population, and an unprecedented number of physicians are experiencing burnout, depression, and other forms of distress. Trainees and physicians, in addition to contending with obvious contributors like stress and sleep deprivation, often work in settings that discourage help-seeking. A convergence

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Physician Mental Health: Preventing Suicide and Building Resilience

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of individual and cultural factors, along with access to lethal means and a greater knowledge of lethality of various means than the general population, combine with institutional and self-stigma, likely leading to the high rate of suicide. The ramifications of unattended distress affect not just physicians themselves, but also can jeopardize patient safety and the healthcare industry as a whole.

Physicians commonly cloak or rationalize feelings of anxiety, agitation, and shame, loath to draw attention to self-perceived weakness. Barriers to help-seeking within the medical community include uncertainty about whether treatment would help, concerns about confidentiality, and time constraints. In addition, there is widespread fear of discrimination, particularly related to one's own mental health.

Various national initiatives have recently begun to address the issue of physician well-being. The combination of education, stigma reduction, and policy change is critical to address the problem of physician distress and suicide risk. Even within populations who recognize the need for mental health help-seeking, those currently in distress are less likely to reach out for help; therefore, it is crucial to foster an environment in which leaders and peers play an active role in noticing the warning signs of distress and supporting individuals to get help when needed.

Several components are common to successful suicide prevention and well-being programs. These include educational efforts that destigmatize mental health problems and policy changes that make help-seeking feasible and confidential. Screening programs that incorporate anonymity allow those in even the greatest distress and at the highest suicide risk to communicate with trustworthy help. Successful efforts additionally include safe and accessible avenues for individuals to address changes in well-being, ideally long before crisis, and confidential and timely follow-up with a mental health professional without fear of punitive consequences.

With data clearly demonstrating the problem and evidence-based avenues for addressing physician health, it is now time to address the manner in which physician mental health is queried on hospital privileging and medical licensing forms. Hospital and medical boards are encouraged to put the focus on competence and impairment rather than illness and treatment, as outlined in the Americans with Disabilities Act. Just as with

physical health, a past history of a psychiatric condition is not relevant if it does not affect a physician's current ability to practice. One recommended way of phrasing would be, "Do you currently suffer from any health condition (physical or mental health) that compromises you from practicing safely or competently?" A strong and valid option is to leave out any questions specific to mental health, keeping questions focused on any health-related impairment. Several states' medical boards have taken this enlightened step, some replacing the mental health inquiries with strong statements highlighting the importance of optimizing mental health for all physicians.

An environment that is conducive to help-seeking is crucial in preserving physicians' mental health. Healthcare institutions on local and national levels have a responsibility to address culture and make policy changes that effectively support the cultivation of mental health and resilience as a critical part of safe practice. ■

THE RECENT EMERGENCE OF TWO NEW LEVELS OF COACHING INTERVENTION IN PHYSICIAN HEALTH

Joe Siegler, MD, and
Tom Dolan, PhD

*FSPHP Annual Conference,
April 2017*

In Fort Worth, Drs. Joe Siegler and Tom Dolan presented their ideas on how coaching can fill a gap in levels of care available to physicians in need of behavioral and addiction intervention, as well as success in recovery sustained over time. The speakers emphasized that coaching is compatible with all current existing levels of care available to physicians enrolled in PHPs: whether inpatient, residential, or outpatient. They clarified that coaching can be utilized *concurrently* while physicians are enrolled in PHPs or *independently* (without PHP involvement) for those already established in recovery or presenting at a higher level of performance.



Joe Siegler, MD



Tom Dolan, PhD

Dr. Siegler's model¹ for raising physician performance focuses on three types of physicians who may benefit from coaching. He focused on Level 3 "complex" underperformers with multiple issues (e.g., addiction and workplace issues) and Level 2 "single issue" physicians (e.g., anger issues). Level 1 coachees are already higher performers who wish to perform even better (e.g., on-boarding in a new position, or experiencing mild burnout).

During the past decades, the ever-enlarging capacity of coaching to handle a growing number of issues can be of enormous support to a physician in a PHP, frequently working to enter and sustain recovery while achieving a long list of assorted goals. The speakers attributed the place of coaching "at the table" by its ability to focus simultaneously on a comprehensive set of competency areas, such as leadership, professionalism, personal issues, and habits—among other goals.

Another vital set of coaching practices that foster greater success in outcomes includes application of a successful *triad of communication*: *respect* granted consistently to all three levels of presenting physicians; *effective collaboration* by the PHP, coach, organizational stakeholders, and the established multidisciplinary team; and *unified expectations* communicated by all team members to the coachee.

The speakers discussed effective ways of locating a coach and evaluated positive recent research findings regarding the effectiveness of coaching for individuals and organizations.

Drs. Siegler and Dolan closed with a discussion of the need for coaching in healthcare now more than ever before. They pointed to the transition throughout healthcare, where there are higher expectations for physicians due to cultural changes requiring more team behaviors and greater productivity, as well as enhanced patient and workplace safety. The PHP's multidisciplinary team's expansion to include coaching levels of care is a commonsense provision of services fortifying behavioral and addictions recovery as well as skill sets in multiple competency areas—to raise performance while facing an emerging high risk of both behavioral and addictions relapse over time.

It is vital for the physician coachee, their family, their workplace, and for the safety of their patients and community that *criteria-based* interventions are made for all three levels of physicians presenting to PHPs. It is imperative that these physicians not only engage in recovery, but that they also meet their goals and sustain them over time. Coaching as two additional—

concurrent or independent—levels of care possessing a highly comprehensive toolkit can magnify success for physicians and those who depend on them. ■

Reference

¹Siegler, J. (2016, May/June). Raising Physician Performance with Coaching. *Healthcare Executive*, 31(3), 88, 90–91.

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BURNOUT AWARENESS AND WELLNESS PROMOTION AMONG PHYSICIAN EDUCATORS

Lisa J. Merlo, PhD, MPE



Lisa J. Merlo, PhD, MPE

Many medical students and residents lament the lack of physician role models who appear satisfied with their job responsibilities and work-life balance. Indeed, burnout and distress affect the majority of practicing physicians at some point. Even before earning their MD or DO degree, many medical students report questioning whether they really want to become a doctor. Psychological distress is prevalent among medical students, and rates of depression increase significantly among residents within the first three months of their internship year. Thus, faculty and administrators who work closely with medical trainees (e.g., Residency Program Directors, Course/Clerkship Directors, Small Group Leaders, and Student Deans) are frequently expected to deal with significant mental health issues (e.g., burnout, depression, anxiety, substance use disorders) among their trainees.

Unfortunately, few medical educators specialize in psychiatry or have adequate training to address these issues in the students and residents they supervise. This creates an additional burden for these faculty members, who often feel unprepared and ill-equipped to manage this growing aspect of medical education. Trainees may not receive the best guidance regarding how best to address their psychological distress, resulting in delayed care and increased likelihood of a negative outcome. In addition, the educators' lack of knowledge and experience can lead to feelings

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Burnout Awareness and Wellness Promotion among Physician Educators

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of insecurity, ineffectiveness, and frustration as they struggle to help the trainees, with resulting decreases in their own well-being.

To further explore this phenomenon, we conducted an anonymous survey of 27 medical school faculty (65 percent female) who work closely with first- and second-year medical students. Faculty averaged 10 years' teaching experience (range = 1–32 years), with 69 percent working full-time. They generally reported feeling they were a positive role model for trainees (93 percent reported feeling at least "moderately" successful in this regard), and noted that they drew on their personal experiences to provide guidance to trainees. They noted academic problems and work–life imbalance as the student problems they faced most often, but reported feeling least prepared to assist students with substance use disorders. The faculty reported that student depression/suicidality and academic problems caused the faculty the most personal stress. Lack of time to devote to struggling students and lack of expertise to address student problems were identified as driving their concerns. When asked about resources to improve confidence in their ability to help students, the faculty indicated that access to a mental health consultant would be most beneficial, followed by participation in Balint-type groups. Other ideas included increased education regarding available resources for students, meetings/discussions with more experienced faculty, and more protected time to devote to students.

When asked about their own experience of burnout, 26 percent of faculty indicated "moderate" burnout, with emotional exhaustion the most common symptom. However, none of the faculty indicated factors related to teaching or mentoring as driving their experience of burnout. In conclusion, responsibilities related to student guidance/mentoring may contribute to distress among physician-educators. Providing adequate training and time to serve in this role may benefit students and educators alike. ■

AGING PHYSICIANS: WHEN IS IT TIME TO HANG UP THE SPURS?

Billy Stout, MD; Lyle R. Kelsey, MBA, CAE, CMBE Oklahoma State Board of Medical Licensure and Supervision; Robert Westcott, MD, Oklahoma Health Professionals Program; Dillon Welindt, BS, Wales Behavioral Assessment; and Betsy White Williams, PhD, MPH, Professional Renewal Center® University of Kansas School of Medicine

Introduction

Over 30 percent of physicians licensed in the United States are older than 60.¹ Physicians aged 55 to 64 account for 26 percent of the active workforce, while those 65 to 75 account for 11 percent.² This increase in age of practicing physicians comes at a time with increased demand for physician services and insufficient supply to meet those needs.

While there is a literature that demonstrates that medical expertise requires experience abilities like novel/abstract problem solving (fluid intelligence), processing speed, episodic memory, retrieval, sensory processing, and manual dexterity decrease with age. Alterations in hearing, vision, sleep and circadian rhythm are included in those changes. Studies looking at the relationship between physician age and performance demonstrate an inverse relationship.³



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With age comes heterogeneity. Age alone is not a sufficient predictor of cognitive performance in surgeons.⁴ Health concerns are an important consideration in addition to aging.⁵ The aging physician workforce poses many challenges, including the need to acknowledge contributions of older practitioners while ensuring that those with performance issues are appropriately identified, assessed, rehabilitated, and/or encouraged to retire. The identification of best practices to address the complex issue of aging physicians is important for physician health programs (PHPs), state medical boards, and the public.

Survey data collected from PHPs suggest a consistent increase in cases related to aging physicians presenting to PHPs. Key referral words associated with these cases include “performance,” “medical care,” “memory,” and “cognition.” In dealing with these cases, the majority of PHPs (90 percent) begin with an interview. Eighty percent of PHPs report requesting neuropsychological testing, while fewer than 10 percent refer to clinical competency assessment programs.

Oklahoma’s state medical board Rule: 435:10-7-5 addresses the need to determine continued competency of a physician and surgeon with the criteria for review, including those who are 75 years of age and those who have recently had significant illnesses/medical events that could affect their ability to practice medicine. Physicians meeting these criteria can be required to submit to physical, psychological, or psychiatric examination and evaluation of clinical competence by the board or its designee or be required to appear for an interview. Data from 2016 and 2017 suggest a low rate of complaints in physicians over 75.

Data from 117 clients (mean age 51) referred for fitness for duty evaluations secondary to issues of professionalism/poor interpersonal and communication skills indicate significantly poorer health relative to published data on practicing physicians.⁶ The most frequent medical conditions in the evaluated group are hypertension, sleep apnea, obesity, hyperlipidemia, and pain.

Neuropsychological performance evaluated in the context of overall health indicates that as health declines, neuropsychological performance declines. Those with poorer overall health performed significantly worse than those in good health.

Aging physicians will continue to present challenges for PHPs and regulators. Mandatory age-related screening does not account for the heterogeneity associated with age or the many factors contributing to underperformance across the life span. Health is an under-identified threat to performance across the career span.

Increased emphasis on health and wellness as direct challenges to performance quality in the medical workforce must be addressed across the life span.

Acknowledgements

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OCCUPATIONAL HEALTH MONITORING AGREEMENTS: OPTIMIZING THE EFFECTIVENESS OF PROFESSIONAL COACHING FOR PHYSICIANS

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The Occupational Health Monitoring Agreement (OHMA) is a tool that combines coaching for physicians with workplace monitoring. Professional coaching is a valuable tool that can be used by healthcare organizations to help physicians who display problematic workplace behavior, such as anger management problems or poor interpersonal skills. State Physician Health Programs often encounter physicians who display these kinds of problems, but who do not have a mental health problem requiring treatment and monitoring. The use of monitoring by PHPs has numerous benefits in addition to ensuring adherence with a plan, including engaging the workplace and ensuring their support. In this workshop, we discussed our experience implementing OHMA in Massachusetts over the past two years.

Physicians who participate in OHMA are first assessed by Physician Health Services to rule out substance use and behavioral health problems. Depending on the personal motivation of the client, he or she is either given referrals to coaching to pursue on their own or they are offered the OHMA. The benefits of the OHMA



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are that the workplace is more involved in determining the goals of coaching, and they are also kept up to date of the progress someone is making in coaching.

An important distinction between the OHMA and other PHP monitoring agreements is that non-compliance does not result in a report to a licensing board. Instead, progress reports occur at six and ten months via conference call involving the coach, the workplace leadership and monitors, and the PHP monitor.

In order to demonstrate our thought process for determining the right intervention for the clients we evaluated, we presented several cases. The first involved a decision about whether to refer to coaching with no follow-up versus OHMA. Factors that would lead us to recommend OHMA included an impression on our part that there might not be adherence otherwise, as well as situations where workplace dynamics seemed to be a bigger problem and our client was possibly being scapegoated.

Workplace involvement via a formal agreement could help address the larger workplace issues.

We then presented several cases where there was a clearer mental health issue, and the decision involved OHMA versus referral to psychotherapy versus Behavioral Health Monitoring Agreement. Often these cases involved clients who had been referred several times previously, but did not follow through with recommendations. If a client did not have mental health issues necessitating a behavioral health monitoring agreement, but there were personality traits impacting their ability to work well with others, psychotherapy could be more helpful than coaching.

In the first two years of OHMA, there have been both successes and failures; however, it has been useful to have an additional tool in our toolbox to help physicians. It is our hope that this intervention will be used by more healthcare organizations in Massachusetts and that we will be able to help more physicians. ■

PHPS AND PROFESSIONAL SEXUAL MISCONDUCT: PITFALLS AND PEARLS

Scott Hambleton, MD, FASAM;
Doris Gundersen, MD;
Michael Ramirez, MS; and
Martha Brown, MD

The presentation was moderated by Scott Hambleton, MD, Medical Director of the Mississippi Physician Health Program, using a panel discussion format. Case studies were utilized to illustrate the experience and approach of three PHPs that provide services to this population of physicians. A primary objective of the presentation was to help clarify the role of PHP involvement with these cases, in an effort to improve successful management of them.

The three PHPS included: Colorado Physician Health Program, represented by Doris Gundersen, MD; Montana Professional Assistance Program, Inc., represented by Mike Ramirez, MS; and Florida Professionals Resource Network, represented by Martha Brown, MD.

The role of PHPs in coordinating the intervention, treatment, monitoring, and safe return to work for physicians engaged in professional sexual misconduct is variable. A slight majority of PHPs do not provide advocacy or monitoring for this population of physicians, for a variety of reasons.

Additionally, there has been recent negative publicity focused on medical boards and regulatory agencies that permit physicians to practice medicine after engaging in these behaviors.

PHP involvement in these cases is often quite challenging and potentially exposes the entire cohort of physicians who are monitored by the PHP to increased risk.



Scott Hambleton, MD,
FASAM



Doris C. Gundersen,
MD



Michael Ramirez, MS



Martha Brown, MD

The consensus of the panelists and the overwhelming consensus of the audience are that PHPs should be involved in these cases, provided that they have support of key shareholders and staff that are competent to effectively manage these complex cases. The panelists agreed that, in many cases, physicians engaged in these boundary violations can be effectively rehabilitated and stressed the importance of adhering to reporting requirements of regulatory agencies and the necessity of relying on facilities with expertise in the evaluation and treatment of these individuals. ■

APPROACHING SUBSTANCE USE DISORDERS AND PSYCHIATRIC DISORDERS WITH AGING PHYSICIANS

Chip Abernathy, MA, LPC

Physicians have similar rates of substance use disorders and other psychiatric disorders as the general population, with some differences in types of disorders that are more and less common among physicians. Approaching an aging physician who is in a state of declining health due to a substance use disorder or other type of psychiatric disorder presents certain challenges. To better understand how to help these doctors and their families, it is good to know signs and symptoms, how to best communicate with an aging physician about recognition of a problem, and what needs to occur as a result.

Approaching older physicians about addiction or mental health issues has both similarities and differences as compared with approaching older nonphysicians. Differences include their medical training, resistance to assuming the role of patient, fear of disciplinary action, and practice coverage concerns. Similarities include denial, life experience associated with aging, and stigma associated with these disorders. It is wise to keep in mind some practical guidelines for speaking with older adults in general about healthcare matters: Try not to rush; avoid interrupting; use active listening; ensure understanding; demonstrate empathy; be straightforward and compassionate; give them time to react; and provide opportunities to continue conversation in follow-up appointments or calls.



Chip Abernathy, MA,
LPC

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Approaching Substance Use Disorders and Psychiatric Disorders with Aging Physicians

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Educational approaches aimed at identification of a substance use disorder or a psychiatric disorder and what to do about those can lead to physicians getting help sooner. These approaches need to emphasize that: There are indicators of a possible problem with addiction or psychiatric illness that can be recognized, and when they are present, action needs to be taken. Referring an ill physician for assessment is needed when signs of illness are present; also, to whom to refer them for assessment needs to be made clear. Seeking help or encouraging a colleague to seek help before illness turns to impairment is far better than putting it off. Also emphasize that the state PHP is available for assistance and include how to contact them.

So, what to do? Make efforts to increase awareness of indicators of substance use disorders and psychiatric disorders in the medical workplace. Encourage utilizing online resources to confidentially self-screen for substance use disorders (AUDIT for alcohol, DAST for other drugs) and mental health disorders (PHQ-9 for depression, GAD-7 for anxiety). If indicated, encourage the physician to seek help before the problem gets worse, even possibly becoming a problem at work.

Addiction and other psychiatric disorders are deadly diseases that can be successfully treated. With the rapidly growing older adult population, rates of substance use disorders and mental health disorders are expected to rise. It is highly likely that this trend will follow among aging physicians. Being prepared for how to best approach this situation and taking the right actions will help both the physicians and those in their lives, including family, friends, patients, and colleagues. ■

MEDICAL STUDENT SPIRITUALITY AND SUBSTANCE USE

Lisa Merlo, PhD

Research documents high levels of substance use by medical students, but little is known regarding risk factors for problematic use. This study examined the association between spirituality and substance use among medical students in the State of Florida. As part of a larger study, students (n = 868, 57 percent



Lisa J. Merlo, PhD,
MPE

female) were invited to complete an anonymous online survey. Of those, 196 students (22.6 percent) described their spirituality as “none” (“non-spiritual” group), 269 (31.0 percent) described themselves as believing in a Higher Power and/or as “spiritual” (“spiritual” group), 161 (18.5 percent) described participating informally in prayer, meditation, reading spiritual materials, and so forth (“informal-practice” group), and 242 (27.9 percent) reported regular attendance at a place of worship (“formal-practice” group). A linear relation was observed between level of spirituality and substance use. Specifically, 59 percent of non-spiritual students, 40 percent of spiritual students, 28 percent of informal-practice students, and 23 percent of formal-practice students reported a history of tobacco use ($\chi^2 = 21.64, p < .001$). With regard to alcohol, 51 percent of non-spiritual students, 45 percent of spiritual students, 44 percent of informal-practice students, and 24 percent of formal-practice students reported “often or usually” binge drinking after exams ($\chi^2 = 37.50, p < .001$). There was a significant difference between groups on the average number of standard drinks consumed within the past 7 days ($F = 5.36, p = .001$), on a typical drinking day ($F = 9.13, p < .001$), and on the highest drinking day ($F = 13.65, p < .001$), with students in the formal-practice group reporting significantly lower levels than the other groups. About 31 percent of respondents across all four groups reported increasing their alcohol consumption since beginning medical school. Further, 15 percent of non-spiritual students believe they have had a drinking problem, compared to 13 percent of spiritual students, 13 percent of informal-practice students, and only 8 percent of formal-practice students, though these results did not reach statistical significance ($\chi^2 = 5.4, ns$). Lifetime history of marijuana use was reported by 61 percent of non-spiritual students, 54 percent of spiritual students, 45 percent of informal-practice students, and 28 percent of formal-practice students ($\chi^2 = 54.34, p < .001$). Similarly, marijuana use *during medical school* was reported by 34.4 percent of non-spiritual students, 28 percent of spiritual students, 19 percent of informal-practice students, and only 10 percent of formal-practice students ($\chi^2 = 63.57, p < .001$). In conclusion, increased spirituality appears to be associated with decreased risk for substance use during medical school, suggesting that more attention should be paid to this characteristic when assessing student risk for substance-related disorders or impairment. ■

DISABILITY INSURANCE AS A TOOL TO RESTORE PHYSICIAN WELLNESS FROM BURNOUT AND MENTAL ILLNESS

Mark Selzer, JD

Today's practice of medicine is totally different and has substantially changed from a business perspective when compared to that of even 10 or 20 years ago. Many physicians explain and complain that they are now working much harder to make the same or less money than they were years ago. They have been literally practicing under a "microscope" and in a "glass house." They have become the perpetual target by less-than-optimal treatment results. They have become a victim in business buyouts, mergers, and acquisitions. They are often required to see greater amounts of patients in less time. Charting and record keeping have drastically changed. It has become more difficult to develop the traditional patient-physician relationships and to instill trust and confidence in patients relative to a physician's treatment and care. All of these factors have caused what appears to be a significant increase in not only a physician's overall professional dissatisfaction, but also in physician burnout and related medical conditions. The traditionally honored profession of medicine is no longer so honored.



Mark Selzer, JD

The assessment, treatment, and monitoring of impaired physicians is a complex endeavor that is often made even more complicated by competing legal demands. Although many physicians carry disability insurance that is designed to cover them in the event they cannot practice their specialty, changes in the insurance marketplace have made it increasingly difficult to "prove" disability. At the same time, medical licensing boards are placing requirements that are more stringent on impaired physicians looking to preserve or restore their license to practice, with PHPs caught in the middle of protecting the public, protecting a participant's license, and assisting impaired physicians in monitoring appropriate treatment.

Physicians who are suffering from burnout, mental illness, and/or addiction can use their disability insurance as a tool in their own treatment and to help restore their health. When suffering from burnout, physicians may experience a myriad of health problems, cognitive difficulties, insomnia, depression, anxiety, substance use

disorders, fatigue, difficulty with personal relationships, and disruptive and performance-related issues at work.

These conditions, when suffered by a physician, become even more magnified at work because they will not only affect themselves and their colleagues, but most important, they also may impact their patients. It is often important and necessary for physicians to step away from work and focus on taking care of themselves when suffering from burnout and stress. Disability insurance, for physicians, often provides total disability coverage for the inability to perform the material and substantial duties of one's own specialty and residual/partial disability coverage is often provided when one must reduce their duties or the amount of time working.

Physicians must be familiar with their policies, whether they are group policies through their employment or individual policies that they have purchased themselves. Many do not understand what their disability insurance policies obligate them to satisfy contractually in order to obtain the benefits necessary to restore their health. Once physicians become ill, it is important to understand how they can use their disability insurance to focus on treatment and recovery to improve their health and restore their wellness and return to work, whether that is on a full- or part-time basis, or even in another specialty. ■

A PHP'S IMPACT ON CLIENTS' PROFESSIONAL, PERSONAL, AND INTERPERSONAL BEHAVIORS

Elizabeth Brooks, PhD, Assistant Professor, University of Colorado Anschutz—Colorado School of Public Health Principal Researcher, Colorado Physician Health Program



Elizabeth Brooks, PhD

Background

Physician Health Programs (PHPs) work to maintain and restore the health of doctors. Although services vary by organization, PHPs often provide evaluation, monitoring, and treatment referrals. *The purpose of this study was to understand how participants' involvement with a PHP impacted their personal, interpersonal, and professional functioning.*

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A PHP's Impact on Clients' Professional, Personal, and Interpersonal Behaviors

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Design

Between December 2016 and April 2017, recently discharged participants (n=77) completed an online exit survey as a regular part of program services. The survey took approximately eight minutes to complete and recorded participants' beliefs about how the program impacted their functioning in three domains (personal, interpersonal, and professional). Responses were analyzed using simple descriptive statistics.

Results

Respondents presented to the program for a variety of reasons (e.g., stress, depression, family issues, substance use); length of participation ranged from evaluation-only to five or more years of monitoring. Clients' personal functioning showed the greatest improvement among the three domains. On average, 52 percent of respondents endorsed improvement in their personal life (individual item range: 23–73 percent); 49 percent endorsed improvement in their interpersonal life (individual item range: 38–56 percent), and 38 percent endorsed improvement in their professional life (individual item range: 8–56 percent). Improvements in coping and mood were most frequently endorsed by respondents. Most respondents (79 percent) believed they were better off after participating in the program.

Discussion

Overall, PHP participation shows a positive impact on physician functioning as evidenced by increases in each of the survey domains. Outcomes may have been influenced by the clients' reasons for presenting and length of time in the program. As additional program participants complete the survey, we will examine differences between these, and other, client characteristics. A copy of this tool is freely available and may be obtained by contacting Dr. Elizabeth Brooks, Elizabeth.brooks@ucdenver.edu. ■

FSPHP E-GROUPS— PLEASE JOIN!

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

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

Visit <https://www.fsphp.org/resource/fsphp-e-group-guidelines> for guidelines on the use of the e-groups.

For any questions concerning the two e-groups, please call Julie Robarge or Linda Bresnahan at FSPHP (p) (978) 347-0600, or email jrobarge@fsphp.org or lbresnahan@fsphp.org.

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

fsphpmembers@yahoo.com

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

statePHP@yahoo.com

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



FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS SAVE THE DATE

Wednesday, April 25 to Saturday, April 28, 2018

FSPHP ANNUAL EDUCATION CONFERENCE AND BUSINESS MEETING

Physician and Professional Health: Enhancing an Effective Model

Will Coincide with FSMB Conference Location

Highlights

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

Topic Areas

- PHP Best Practices
- Drug and Alcohol Testing Methods/ Current Approaches in Toxicology
- Best Practices for Monitoring
- Current Legal Issues Affecting Privacy of Health Information for Physicians
- Legal, Ethical, and Risk-Management Strategies for PHPs
- Improvement to Outreach, Referral to Treatment, and Assessment and Monitoring of Health Professionals



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Be sure to use group code **FSP** to get the discounted room rate of \$189
Deadline for special group rate is midnight, April 6, 2018.

TUESDAY

Board of Directors Meeting

WEDNESDAY

Registration/Exhibitors Open
Luncheon
General Sessions
Committee Meetings
Welcome Dinner and Silent Auction

THURSDAY

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

FRIDAY

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

SATURDAY

FSPHP/FSMB Joint Session

Further Details to Come. . .

2017 FSPHP ANNUAL MEETING







NEW MEMBERS RECEIVE THREE FREE MONTHS WHEN JOINING ON OCTOBER 1!

Visit www.fsphp.org/membership/classes-membership to consider your eligibility to join FSPHP.

FSPHP MEMBER BENEFITS

The FSPHP mission is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

Members of the FSPHP join a community of Physician Health Program professionals across North America, including some international members dedicated to the health of physicians and healthcare professionals.

- FSPHP members have access to exclusive networking, resources, collaboration opportunities, and education tailored to the needs of Physician Health Program staff and initiatives.
- Access resources that will provide examples of experience and guidelines for your work, inspire new ideas, provide creative solutions, and give you the tools needed to excel in the field.
- Contribute to FSPHP's tradition of collaboration. Connect, network, and exchange ideas, resources, success stories, and lessons learned with your experienced and expert colleagues around the country.
- Participate in unique and specific training that is relevant to your mission. Learn from and with your peers through annual and regional meetings, newsletters, and our member email group covering all areas of physician and healthcare professional health topics.
- Gain the knowledge to assist you in your job through opportunities like the FSPHP Annual Conference and regional meetings. All FSPHP members receive a discount on FSPHP education programs. <http://www.fsphp.org/event/annualeducation-conference-business-meeting-2018>
- Connect with other FSPHP members who can help you answer the questions you face. Visit the FSPHP Yahoo! Groups and post your questions online or look up contact information in the online directory for FSPHP members you met at an annual conference.
- Learn about FSPHP Policies and Guidelines and share with your board, committees, staff, healthcare organizations, and stakeholders in your state.
- Post documents to the FSPHP discussion forum relating to standards, regulations, and other newsworthy items, including sample forms and templates.
- Keep up with the latest issues that affect physician or professional health programs.
- Gain personal and professional growth, as well as a broader view of the depth and vision for the organization, by taking on a leadership role, chairing a committee, or serving on the board of directors. The vision and dedication of FSPHP volunteer leaders are our biggest asset.
- Find new employment opportunities or advertise one through the FSPHP Job Center, your one-stop shop for careers in physician or professional health programs.
- Connect with a seasoned professional who will help you navigate the physician health and/or professional health program profession.

PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS NATIONAL MEETINGS

FSPHP ANNUAL MEETINGS

2018 FSPHP Education Conference and Business Meeting
April 25–28, 2018
Embassy Suites by Hilton
Concord, NC

2019 FSPHP Education Conference and Business Meeting
April 24–27, 2019
Worthington Renaissance Forth Worth Hotel
Ft. Worth, TX

FSPHP REGIONAL MEETINGS

FSPHP Northeast Region Member Meeting
November 3, 2017
Physician's Health Program
Harrisburg, PA

FSMB ANNUAL MEETINGS

2018—106th Annual Meeting
April 26–28, 2018
Sheraton Le Méridien Charlotte Complex
Charlotte, NC

2019—107th Annual Meeting
April 25–27, 2019
Omni Fort Worth Hotel
Fort Worth, TX

2017 AMERICAN CONFERENCE ON PHYSICIAN HEALTH (ACPH)

Hosted by the Stanford University School of Medicine
in collaboration with the American Medical Association
and the Mayo Clinic

October 12–13, 2017
The Palace Hotel
2 New Montgomery Street
San Francisco, CA

2018 INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH

Hosted by the AMA, BMA, and CMA
October 11–13, 2018
Fairmont Royal York
100 Front Street West
Toronto, ON

2019 AMERICAN CONFERENCE ON PHYSICIAN HEALTH (ACPH)

Hosted by the American Medical Association in collab-
oration with the Stanford University School of Medicine
and the Mayo Clinic.

September 12–14, 2019
Sheraton Charlotte Hotel
Charlotte, NC

AMERICAN ACADEMY OF ADDICTION PSYCHIATRY ANNUAL MEETING AND SYMPOSIUM

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

December 6–9, 2018
Hyatt Regency Coconut Point Resort and Spa
Bonita Springs, FL

December 5–8, 2019
Rancho Bernardo Inn
San Diego, CA

AMA HOUSE OF DELEGATES ANNUAL MEETING

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

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

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

AMA HOUSE OF DELEGATES INTERIM MEETING

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

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

November 16–19, 2019
Manchester Grand Hyatt
San Diego, CA

November 14–17, 2020
Manchester Grand Hyatt
San Diego, CA

AMERICAN PSYCHIATRIC ASSOCIATION ANNUAL MEETING

May 5–9, 2018
New York, NY

May 18–22, 2019
San Francisco, CA

AMERICAN SOCIETY OF ADDICTION MEDICINE**ASAM 49th Annual Conference**

April 12–15, 2018
Hilton San Diego Bayfront
San Diego, CA

ASAM 50th Annual Conference

April 4–7, 2019
Hilton, Orlando
Orlando, FL

ASAM 51st Annual Conference

April 2–5, 2020
Gaylord Rockies Resort and Conference Center
Denver, CO

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS (IDAA) ANNUAL MEETING

2018—Reno, NV

2019—Knoxville, TN

2020—Spokane, WA

NATIONAL ORGANIZATION OF ALTERNATIVE PROGRAMS

2018 Annual Education Conference
March 26–29, 2018
Omni Royal Orleans Hotel
New Orleans, LA

**Physician Health and Other Related Organizations
National Meetings**

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**AMERICAN BOARD OF MEDICAL SPECIALTIES
ANNUAL CONFERENCE**

September 25–27, 2017
The Westin Michigan Avenue Chicago
Chicago, IL

**NATIONAL ASSOCIATION OF MEDICAL STAFF
SERVICES**

**NAMSS 41st Educational Conference and
Exhibition**

October 21–25, 2017
The Broadmoor
Colorado Springs, CO

**NAMSS 42nd Educational Conference and
Exhibition**

September 29–October 3, 2018
Long Beach Convention Center
Long Beach, CA

**NAMSS 43rd Educational Conference and
Exhibition**

October 19–October 23, 2019
Philadelphia Marriott Downtown
Philadelphia, PA

**AMERICAN ACADEMY OF PSYCHIATRY
AND THE LAW**

48th Annual Meeting

October 26–29, 2017
Hyatt Regency
Denver, CO

49th Annual Meeting

October 25–28, 2018
Marriott
Austin, TX

**FSPHP WOULD LIKE
TO THANK OUR 2017
CONFERENCE EXHIBITORS
FOR THEIR SUPPORT TO
THE MISSION OF FSPHP**

DIAMOND

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CeDAR/University of Colorado Hospital
First Lab
UF Health Florida Recovery Center

PLATINUM

Bradford Health Services
Laboratory Corporation of America Holdings
Pavillon
Pine Grove Behavioral Health
Positive Sobriety Institute, A Rivermend Health
Family Program
Providence Living Treatment Center

GOLD

Affinity eHealth
Casa Palmera
Elmhurst Professionals Program
Hazelden Betty Ford Foundation
Ridgeview Institute
Sante Center for Healing
Sovereign Health Group
The Farley Center at Williamsburg Place
UC San Diego PACE Program
Vanderbilt Comprehensive Assessment Program

SILVER

Arrowhead Lodge
Acumen Assessments/Acumen Institute
Beauterre Recovery Institute
BoardPrep Recovery Center
Cirque Lodge
Clarity Professional Evaluation Center
Fellowship Hall
International Doctors of AA
Lifeguard
MARR, Inc.
Marworth Treatment Center
Palmetto Addiction Recovery Center
Promises Professionals Treatment Program
Recovery Trek, LLC
Soberlink, Inc.
Talbot Recovery
The Ranch

ADVERTISING AVAILABLE IN OUR SPRING 2018 ISSUE!

Submit your advertisements by January 2018!

INFORMATION AND SPECIFICATIONS

Dear prospective *Physician Health News* advertisers:

We would like to invite you and your organization to advertise your services in the future editions of *Physician Health News*. *Physician Health News* is mailed to all state programs and state licensing boards. The newsletter is also distributed widely at the FSPHP Annual Meeting. The newsletter includes articles and notices of interest to the physician health community and planning information for the upcoming physician health meetings and conferences, including FSPHP meetings.

We offer ad design and proofreading services for an additional fee. For your convenience, full advertisement specifications and PDF instructions can also be provided upon request. We hope you will consider taking advantage of this opportunity to advertise your facility, services, and contact information.

Become part of a great resource for state PHP professionals. The spring issue each year offers an advertising section.

We look forward to working with you in future editions.

FSPHP Publication Committee

Sarah Early, PsyD (CO)

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SPECIFICATIONS

Ad Size

3.125" w x 2.25" h

Guidelines for PDF Ads

Black and White Only

Ads should be submitted as grayscale. They will be printed in black ink only. As a convenience, we are able to turn your ad into grayscale if necessary.

Border

You do not need to include a border with your ad. We will frame your advertisement with a .5-point border during newsletter production.

Font

To reduce registration problems, type should be no smaller than 9 point. Fonts must be embedded and TrueType fonts should be avoided.

Screens

150 line screens are preferred for halftones. Halftone minimum screen tone value is 10%.

File Guidelines

All submissions should be Acrobat PDF files and should be sent at the exact size specified herein. Native files or other file formats will not be accepted.

Guidelines for Word Files

Supply MS Word document and high-resolution logos and graphics (if applicable). Maximum two passes for ad approval.

Submission

Remember to label your file with your company name (i.e., CompanyX.pdf or CompanyX.doc). This will assist us in identifying your ad. Please also double check that your ad contains the most up-to-date information.

PLEASE CONSIDER A SUBMISSION IN FUTURE ISSUES!

QUESTIONS?

Please contact Linda Bresnahan at lbresnahan@fspHP.org

FSPHP
668 Main St., Suite 8, #295
Wilmington, MA 01887

PHYSICIAN HEALTH NEWS

The FSPHP produces a newsletter twice a year in March/April and again in August/September that is sent to all state programs, medical societies, and licensing boards. The FSPHP requests articles (500 words or fewer) and other related information be submitted for inclusion in the FSPHP Newsletter.

SUBMISSIONS FOR NEWSLETTER

By **January 30** for the spring issue

By **May 31** for the summer issue—*the summer issue is typically reserved for content related to our FSPHP annual meeting.*

This newsletter is intended to help members stay abreast of local, state, and national activities in the area of physician health. Please consider a submission to help keep all states informed of your program's activity and progress in the field of physician health.

Please send submissions by email to lbresnahan@fsphp.org.

Items that you may want to consider include:

- Important updates regarding your state program

- A description of initiatives or projects that have been successful, such as monitoring program changes, support group offerings, outreach and/or education programs, and so forth.
- Notices regarding upcoming program changes, staff changes
- References to new articles in the field
- New research findings
- Letters and opinion pieces
- Physician health conference postings and job postings

Please limit articles to 500 words or fewer and other submissions to 200 words or fewer.

WE WANT YOUR INPUT!

The FSPHP Board of Directors is very interested in your ideas and suggestions, and we welcome agenda items you would like to bring before the board. But it is important to be organized in our approach in order to make sure ideas are fully explored and vetted. The board established a policy that members are asked to submit written requests for consideration directly to regional directors. You may also write directly to FSPHP Executive Director Linda Bresnahan at lbresnahan@fsphp.org. This will ensure an organized chain of communication between you and your representatives. Thank you for your assistance!