



Physician Health Program Guidelines

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Physician Health Program Guidelines

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Additional sections on physical health conditions, behavioral disorders, boundary disorders and physician health promotion have been identified for development for inclusion in later editions of these guidelines.

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Cautionary Statement

The FSPHP Physician Health Program Guidelines are a clinical tool intended solely for use by physician health programs for program development and enhancement. These guidelines reflect the consensus of existing physician health programs. These guidelines are evolutionary in nature and are intended to be modified based upon future research and experience.

These guidelines may not encompass all administrative structures and program options available to PHPs. Implementation of these guidelines may be impacted by applicable state legal, contractual, or regulatory requirements. The ability of any given State Physician Health Program to implement all guideline components may be limited. Guideline modifications by individual PHPs are anticipated and are appropriate when based upon sound clinical judgment and/or regional/ local legal considerations or systems issues.

The Federation of State Physician Health Programs expressly disclaim that application of these guidelines to any individual physician health program will result in optimal programmatic function. The Federation of State Physician Health Programs expressly disclaims any and all responsibility for application of the guidelines to any individual program.

Acknowledgments

These Guidelines have been developed by the FSPHP Guidelines Task Force which was formed during the annual FSPHP meeting in May 2002. Comments were solicited from FSPHP programs over a two year period resulting in significant modification and revisions of the document. The 2004 version of these guidelines was presented to all voting members of FSPHP member programs in March 2004 for review. The Guidelines were approved for adoption by 79% of FSPHP voting members. The section *Management of Other Psychiatric Disorders* and the revision of Appendix II were approved by 66% of FSPHP voting members.

Portions of these Guidelines have been modeled upon information contributed by many individuals and state physician health programs via the FSPHP e-group. In particular information contributed by Dr. Greg Skipper and Dr. Michael Gendel has been generously incorporated. The forums of the Citizens Advocacy Center on the Regulatory Management of Chemically Dependent Health Care Practitioners provided additional background information and a broad perspective on regulatory issues. Thoughtful review and endless revision by members of the FSPHP Guidelines Taskforce refined these guidelines over a two year period. Detailed review of the guideline draft and constructive commentary was contributed by many programs and used by the Taskforce to further strengthen the document.

The FSPHP wishes to thank the members of the Guidelines Taskforce. Special recognition is due Dr. Susan McCall, Dr. Gary Carr, Dr. Warren Pendergast and Mr. Terry Bedient for their tireless efforts on behalf of the Federation.

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General Guidelines for State Physician Health Programs

I) Purpose and Use of Guidelines

A) The following guidelines are applicable to State Physician Health Programs serving physicians and are applicable specifically to physicians. Many programs monitor other health professionals with health conditions which may compromise their ability to practice with reasonable skill and safety. All or part of these guidelines may be used for these populations if determined appropriate. Guidelines for management of specific conditions are separately delineated. These guidelines may not encompass all administrative structures and program options available to PHPs. Implementation of these guidelines may be impacted by applicable state legal, contractual, or regulatory requirements. The ability of any given State Physician Health Program to implement all guideline components may be limited by lack of resources. These unavoidable limitations should not deter State PHPs from working towards implementation of all applicable guidelines. Guideline modifications by individual PHPs are anticipated and are appropriate when based upon sound clinical judgment and/or regional/ local legal considerations or systems issues.

II) Physician Health Program (PHP) Purpose and Philosophy.

- A) Rehabilitation of physicians with potentially impairing health conditions is the primary function of PHPs.
- B) PHPs provide a non-disciplinary therapeutic program for health care practitioners with health conditions which may compromise their ability to practice with reasonable skill and safety.
- C) The scope of conditions which different PHPs address will vary. Comprehensive Programs are preferable, providing they have the expertise and resources to competently manage all areas in which they offer services.
- D) PHPs are dedicated to excellence in medical practice and will not compromise patient care by supporting licensees practicing medicine during a period of impairment. PHPs will strive to have a practitioner voluntarily remove themselves from practice when indicated and refrain from practice until found to be medically stable to resume practice. Any practitioner unable or unwilling to withdraw from practice during a period of potential impairment will be reported to the licensing authority for determination of fitness to practice.
- E) For non-board mandated participants, programs should provide confidential management. PHP participants should not be subject to investigation or disciplinary action by a licensing authority based solely upon a health diagnosis or affiliation with the PHP.
- F) Chemically dependent PHP participants should not be disciplined based solely upon violations related to their manner of obtaining substances for their personal use. Nothing in this guideline is intended to imply that participants in PHPs are not accountable to licensure agencies for behavior which otherwise violates the medical practice act or is injurious to patients.
- G) Non-board mandated PHP participants are granted full confidentiality and their treatment is not disclosed to the licensing authority if they maintain compliance and successfully complete the Physician Health Program. Participants remain fully accountable to licensure agencies for their professional practice during the period of their PHP participation.

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- H) PHPs should accept referrals from the licensing agency to monitor practitioners under Board mandate.
- I) PHPs must comply with CFR 42 for participants with substance use disorders and other confidentiality requirements as applicable.
- J) PHPs assist participants in avoiding discrimination by documenting their recovery/health stability and verifying that they are not impaired in their ability to practice medicine by reason of their health condition while it is in remission or appropriately controlled.
- K) PHPs should provide steadfast support / advocacy before state medical boards and other agencies to help prevent discrimination against recovering physicians. Support / advocacy should be based upon objective and verifiable measures of recovery through review of evaluation/treatment documentation and other indicators of recovery. Support / advocacy must be based on evidence that the participant's ability to practice medicine is not compromised by their health condition. Unconditional advocacy without regard to the quality of recovery or stability of health is detrimental to the credibility of the PHP and its participants.
- L) PHPs promote activities that support physician well-being. This may involve sponsoring, encouraging, and/or conducting educational programs and research to better understand the antecedents (stressors, rates of burnout, and other obstacles to physician well-being), presentation and optimal treatment of health conditions commonly affecting health professionals.

III) Administrative Considerations

- A) Multiple administrative structures are utilized by PHPs: These structures are not mutually exclusive and programs frequently meet criterion for several categories
 - 1) Board Authorized Or Board Managed Programs
 - (a) Contract with Board
 - (b) Formal Documented Agreement with Board
 - (c) Board operated with independent clinical oversight
 - (d) Board operated with full board oversight
 - 2) Medical Society Affiliated or Sponsored Programs
 - (a) Contract with Medical Society
 - (b) Formal Agreement of Understanding with Medical Society
 - (c) Medical Society Operated
 - 3) Independent Not for Profit Corporation Programs
 - (a) Contract with Medical Society and/or Board
 - (b) Formal Agreement of Understanding with Medical Society and /or Board
 - (c) Independent corporation contracting for services with multiple licensing authorities and serving multiple professions within the state
- B) PHPs require legal authority to operate which may be granted through formal agreement with the licensing agency or through legislative authority.
- C) To operate effectively programs must develop and maintain a positive relationship with the state licensing authority.

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- D) FSPHP members must have the support of organized medicine in their state through recognition of the State Medical Society/Association as specified in the FSPHP Constitution and Bylaws, Article III.
 - E) PHPs require independent confidential administrative and clinical oversight by a Board or Council whose members are experienced in addressing the health conditions commonly found in the population of monitored health professionals. No members of the PHP clinical oversight body (those having privity to the identity of program participants and involved in making clinical or case management decisions) should be engaged in the treatment of participants or have other conflicts of interest.
 - F) Board operated programs must provide for anonymity of voluntary program participants.
 - G) PHPs should be covered by malpractice insurance and/or equivalent (errors and omissions) risk management coverage.
 - H) PHPs must have access to legal counsel. Optimally PHPs will have qualified legal immunity for actions taken in good faith.
 - I) PHPs should not operate for the purpose of making a profit.
 - J) PHPs should be based within the state they serve.
 - K) PHPs will work collaboratively with other state programs when interstate monitoring or transfer is involved. The primary monitoring state will be the state in which client practices and/or lives (if not practicing). The primary monitoring state should provide quarterly reports to other states in which the physician holds an active license.
 - L) PHPs require qualified compensated staff in addition to any program volunteers.
 - M) PHPs require the oversight of a Medical Director committed to physician rehabilitation, with appropriate experience, training and skills, including expertise in addictions. Addiction certification through ASAM or ABPN is strongly encouraged. The Medical Director should work through the FSPHP and other appropriate organizations to stay abreast of developments in the field.
- IV) Functions of Physician Health Programs
- A) PHPs have mechanisms in place to accept and follow-up on reports of physicians with potentially impairing health conditions. PHPs accept self-referrals and referrals from others concerned about a physician's well-being.
 - 1) Assessment of the validity/eligibility of a referral is performed when a concern is first reported.
 - (a) Collateral information may be gathered to determine if an intervention is warranted.
 - 2) Intervention or initial contact is made for the purpose of having the professional complete an appropriate evaluation.
 - 3) Arrangements for evaluation and/or treatment are made as indicated.
 - 4) Aftercare monitoring and case management of potentially impairing health conditions is arranged after completion of primary/stabilizing treatment.

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- 5) Adjustment of treatment/aftercare/monitoring is undertaken based upon on-going evaluation of the monitored health condition.
 - 6) Relapse detection and management for participants with substance use disorders is on-going. Monitoring the stability of other health conditions and their impact on the physician's ability to practice medicine will be reviewed and documented on an on-going basis.
 - 7) Documentation of recovery/disease stability and the compatibility of the physician's health status with their ability to practice medicine will be used to advocate on for the physician. Advocacy is appropriate to assist the participant in maintaining an appropriate medical practice and avoiding discrimination. Advocacy provided by PHPs will be based upon objective information about the physician's health status.
- B) PHPs promote physician wellness and the treatment of all health conditions including substance use disorders and other addictions, mental and behavioral disorders, and physical illness.
- 1) Educational opportunities for health professionals and medical communities regarding the treatment of substance use disorders, mental and behavioral disorders, physical illness, and other addictions commonly affecting health professionals will be supported. Educational programs provided or sponsored by PHPs should include education about the disease model of substance use disorders.
 - (a) Targets for outreach and education activities include: students, professional associations, hospitals, medical groups, licensing authorities, legislators, employee assistance programs, mental health providers, family members, treatment providers, malpractice insurers, managed care plans, consumer groups, and the general public.
 - (b) Educational techniques may include: lectures, brochures, web sites, publications/articles, newsletters, display booths, on-site consultations, and inclusion of information on licensure and renewal applications and on malpractice insurance forms.
 - (c) Toll free phone lines may be utilized to encourage individuals to call for information and pre-recorded information may be offered as an option to support anonymity.
 - 2) Cultivation of relationships with state medical schools and residency programs to promote improved education of the next generation of physicians regarding the family illness of substance use disorders, mental and behavioral disorders, physical illness, and other addictions commonly affecting health professionals is encouraged.
 - 3) PHPs should foster relationships with their state's medical association, hospital staffs, and colleagues to promote education, identification of illness, appropriate referral, treatment and monitoring for the professionals they serve.
 - (a) Assisting medical staffs to develop effective bylaws and mechanisms that promote physician health and compliance with JCAHO MS 2.6 is encouraged.
 - 4) Through FSPHP membership individual PHPs support efforts to encourage advances in organized medicine's policies and approach to the broader issues of substance use disorders and mental illness in our society.

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- 5) Interactions with licensure authorities should communicate and reinforce the disease concept of addiction and educate about the availability of successful treatment options for all health conditions which may be used in place of disciplinary action.
- C) PHPs should support and participate in research in the field of substance use disorders and physician health.
 - 1) Data collection and research is encouraged for individual programs. Collaboration between programs and with the FSPHP is encouraged.
 - 2) Collection of standardized information is encouraged to facilitate comparing and pooling information from multiple state programs.
 - 3) Information routinely collected should include standardized information from intake, evaluation, treatment, and monitoring.
 - (a) At minimum information gathered includes referral source, patient demographics, diagnoses, treatment (type and duration), outline of the clinical course (disease exacerbations or chemical relapses), health status and compliance status at time of monitoring completion, i.e., successful completion, transfer, board referral, enrollment in continued voluntary monitoring, etc.
 - (b) For chemically dependent individuals, substance(s) of choice and detailed relapse information is recorded.
- V) Maintenance of Records
 - A) PHPs should maintain documentation on participants for a minimum of ten years after case closure unless otherwise required by law or records retention policies. Preferably records will be kept indefinitely.
 - B) Participant records should be stored under double lock such as in a locked file within a locked office except when in use.
 - C) Usual record contents may include: intake, assessment, evaluation, and treatment records; consents to release information; monitoring agreements and informed consent; toxicology and/or other laboratory reports, monitoring/compliance reports; workplace reports, group reports and therapist reports; consultations; self-reports; meeting attendance logs; medications logs; pertinent medical records; correspondence; progress notes and anecdotal information.
- VI) Quality Assurance Measures
 - A) Rates of successful completion, markers of program failures, suicides and substance related deaths, loss of licensure or leaving medical practice for impairment related reasons, and length of participant retention may be used to evaluate program effectiveness.
 - B) Detailed relapse statistics for chemically dependent individuals will facilitate an analysis of monitoring efficacy. Information should be recorded about the relapse (i.e. relapse severity, substance type, content/setting, temporal relationship to patient care, whether impairment was suspected, etc).
 - C) Program utilization may be reflected by referral numbers, enrollment numbers, non-enrollment numbers (ineligible, no diagnosis, refused services, etc), the frequency of consultation requests and the number of return customers along with the reason for program re-involvement (disease exacerbation/relapse, concern about a colleague, program volunteer, etc

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- D) Demographics of participants may be analyzed as a marker of program visibility among licensees (marketing effectiveness) and acceptability of the program to different groups (perceived bias). Demographics may also be useful in evaluating clinical trends, identifying high risk groups and other research.
- E) User friendliness may be measured through participant satisfaction surveys, satisfaction surveys from boards and professional organizations, number of participants requesting further program services after program completion and the number of complaints received.
- F) Budget and financial statements document fiscal responsibility and cost effectiveness.
- G) Personnel and staffing levels and documentation of staff continuing education activities reflect the quality of program management.
- H) Public relations activities may be documented through the publication of an annual report and by the number of other promotional activities completed.
- I) Documentation of cases requiring referral to the state licensing agency is a marker of responsible public safety considerations in the management of cases refractory to treatment.
- J) Any trends and emerging issues should be evaluated upon identification.
- K) The number of legal challenges a program receives may be a marker of clinical acumen, user-friendliness as well as the pathology of the population the program serves.
- L) Formal program evaluation through quality assurance reports, peer review activities or contracted evaluation may also be desirable.

VII) Funding of PHP Monitoring Programs

- A) Funding must be adequate to support all program services offered. Adequate resources to maintain competent case management and participant monitoring are critical. Funding must be available to support qualified professional staff, to provide on-going training and development and to sustain a professional work environment.
- B) Due diligence must be taken to avoid acceptance of funds from sources that could create a conflict of interest.
- C) Funding sources may include but are not limited to: licensing fees, participant fees and contributions from malpractice insurers, professional societies and associations, hospitals and other health care organizations, benefactors, endowments, and grants.
- D) Program participants are personally responsible for payment for their medical costs including required evaluations, primary treatment and aftercare/monitoring costs.
- E) Participant fees should be fair and equitable with full disclosure at intake.

Management of Substance Use Disorders (SUD)

- I) All physician health programs manage physicians with substance use disorders. To effectively manage this population, a baseline of required knowledge, skills and resources is necessary. The following characteristics and abilities are vital for all physician health programs to maintain.

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- A) High visibility in the medical community with a user friendly avenue to receive reports concerning physician health or behavior is necessary.
 - B) Ability or resources to gather relevant information about and determine the legitimacy of reports in a sensitive manner
 - C) Ability or resources to facilitate effective interventions.
 - D) Ability to make appropriate referrals for evaluation and treatment based on the participant's needs (not a preset list of providers). A choice of several appropriate evaluation/treatment options/programs should be offered participants whenever possible.
 - 1) Maintenance of current information on multiple resources available to accept referrals for evaluation (See Appendix 1)
 - 2) Maintenance of current information on multiple programs available to accept referrals for treatment (See Appendix 2)
 - E) Expertise to understand and incorporate recommendations from evaluation and treatment resources into aftercare plans.
 - F) Physician Health Programs must not have any conflict of interest or business association with programs utilized for referrals.
- II) Physician Health Programs provide aftercare and monitoring for physicians with substance use disorders in accord with the parameters outlined below. Deviations from these guidelines should be based on sound clinical judgment and clearly documented in the participant's chart.
- A) The minimum period of monitoring for substance dependence is 5 years which is consistent with the FSPHP Public Policy Statement on Length of Monitoring.
 - B) The minimum period of monitoring for substance abuse is 1 year and a maximum of 2 years assuming no additional concerns are raised during the monitoring period.
 - C) The minimum period of monitoring for diagnostic purposes is 1 year and a maximum of 2 years when there has been a significant incident involving drugs/alcohol, a SUD has not been diagnosed and abstinence is recommended.
 - D) Basic contractual components between state Physician Health Programs and participants, whether voluntary or mandated, should include the following components:
 - 1) Agreement for good faith participation.
 - 2) Agreement for abstinence and the requirement to immediately report any use of alcohol or mood altering chemicals.
 - 3) Agreement to not prescribe scheduled drugs for family members and a strong recommendation to refrain from treating their family members.

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- 4) Agreement to not manage one's own medical care, i.e.
 - (a) Participants will not diagnose or manage their own illnesses and will not self-prescribe or independently discontinue any medications.
 - (b) Participants will have a personal physician and provide a copy of the monitoring contract. A release of information between the state Physician Health Program and personal physician will be maintained.
 - (c) Participants must inform all treating physicians/dentists, etc of their diagnosis, their relationship with the state Physician Health Program and their duty to provide a release of information to communicate freely with the state Physician Health Program.
 - (d) Participants should take no medication until the state PHP is notified. In case of emergency, the PHP should be notified within 24 hours or when the participant is medically stabilized.
 - (e) Participants shall inform the PHP as soon as feasible in the case of medical or psychiatric hospitalizations.
 - (f) Guidance should be provided about the use of over the counter medication.
- 5) Agreement to attend self-help groups such as AA/NA. Those with strong objections should be responsible for providing recovery focused alternatives with appropriate availability and intensity.
- 6) Agreement to attend a facilitated weekly support group for recovering professionals or approved alternative when not available.
- 7) Agreement to maintain consent for ongoing communication with an approved workplace monitor/contact.
- 8) Agreement to abide by any specified workplace restrictions.
- 9) Agreement to maintain consent for the physician health program to speak with the participant's family/SO as needed.
- 10) Agreement to submit to biological specimen monitoring without question.
- 11) A statement of the confidentiality provided and the limitations of same.
- 12) Informed Consent
 - (a) A statement of actions which will follow a failure to comply with the monitoring contract or in the case of a relapse which may include withdrawal from practice, intensification of treatment, inpatient evaluation, additional treatment, or a report to the licensure board.
 - (b) A statement defining any requirements for reporting to the licensure board.
 - (c) A statement defining other reporting requirements.
 - (d) A statement that the monitoring contract may be extended at the discretion of the state physician health program if the at the end of the contract period clinical reevaluation indicates the need for additional monitoring
- 13) A statement of individuals who must agree in writing to contractual monitoring changes if applicable.

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- 14) Agreement that monitoring will be transferred to the appropriate state PHP or Licensure Board if the participant moves.
- 15) Agreement to faithfully follow up with designated treatment providers (individual therapists, family therapists, marriage therapists, psychiatrists, relapse prevention group) and/or others designated in the participant's contract.
 - (a) Agreement to maintain an active release of information to the state physician health program and necessary treatment providers.
 - (b) Agreement to comply with necessary medication regimen
 - (c) Monitored use of adjunct medications may be required.
- 16) Agreement to the release of information to the state licensure authority in the case of infeasible non-compliance (not capable of being annulled or voided or undone).
- 17) Optional contract components may include, but are not limited to, notification of the state PHP for:
 - (a) Travel outside monitoring area
 - (b) Change of address
 - (c) Change of employment
 - (d) Malpractice claims
 - (e) Arrests
 - (f) Work site and performance difficulties
- E) Return to Work requirements (if returning after medical leave)
 - 1) Completion of any indicated treatment with staff endorsement of readiness to resume practice
 - 2) Documentation that, to a reasonable degree of medical certainty, abstinence has been achieved
 - 3) Monitoring/aftercare program has been defined and is under implementation
 - 4) Workplace monitor/contact agrees to serve and understands expectations and responsibilities
 - 5) Any legal, licensing and credentialing requirements have been satisfied
 - 6) Agreement by all parties to any workplace modifications or practice restrictions
- F) Evaluation of recovery stability is ongoing for the duration of the monitoring period. Documentation of recovery is used as evidence that the participant's ability to practice medicine is not impaired by a substance use disorder. The following monitoring components provide evidence of recovery.
 - 1) Regular work site or other behavioral monitoring reports (at least quarterly) assess stability and reliability if appropriate for the individual being monitored. Work site monitoring is not designed to assess premorbid clinical skills or competence.
 - 2) Status reports from program consultants, therapists, psychiatrists or other providers as applicable

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- 3) Appropriate toxicology test results
 - 4) Work-site visits by the monitoring program as appropriate
 - 5) Compliance with all aspects of monitoring agreement
- G) Designing and Enforcing Practice Restrictions (when applicable)
- 1) Individually determined based upon return to work criteria
 - 2) Workplace settings should be carefully evaluated for support of and/or risk to recovery at the time of return to work
 - 3) When appropriate, work site monitor provides regular reports of compliance
 - (a) release for communication must remain valid at all times
 - 4) Examples where PHP imposed limitations may be appropriate
 - (a) Inability to obtain adequate workplace monitoring may limit the settings in which a licensee may engage in patient care
 - (b) Limitation of hours may be imposed to avoid overwork
 - (c) Restriction of access to mood altering substances is frequently indicated
 - (d) Voluntary withdrawal from practice pending evaluation and/or treatment is usually indicated.
 - (i) if concerns of impairment arise
 - (ii) when inappropriate toxicology results are received.
- H) Criteria for Work site or other Monitors
- 1) Regular on-going contact with the licensee
 - 2) Avoid conflicts of interest: The monitored individual should not have supervisory authority over the worksite monitor.
 - 3) The role of the work site monitor should be to evaluate the individual's performance, NOT their illness; otherwise this blurs boundaries and creates dual relationships. By providing general performance information (punctuality, professional demeanor to patients and staff, record keeping), work site monitors may identify behavioral changes, which may indicate relapse behavior.
 - 4) Monitor ideally will have knowledge of the symptoms and signs of relapse
 - 5) Monitor will provide routine reports, in no case less often than quarterly, to the state PHP and when required to other assigned oversight authority
 - 6) Monitor agrees to immediately report any concern to state PHP
- I) Toxicology Testing
- 1) Urine drug screens are routinely employed

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- (a) Random schedule
 - (b) Frequency as determined clinically appropriate and in accord with program standards (Reference: Crosby RD, Carlson GA, Specker SM. *Simulation of Drug Use and Urine Screening Patterns*, J Addict D. Vol.22(3) 2003: 89-98.)
 - (c) Chain of Custody will be utilized on all specimens
 - (d) Witnessed collection is the gold standard: deviation from this collection protocol for a specimen must be approved by the PHP (dry room collection is acceptable only when witnessed collection is not possible)
- 2) A forensic laboratory facility qualified to perform and confirm a state of the art healthcare testing profile must be used
- (a) Adulteration testing must include at a minimum specific gravity and creatinine and other tests for adulterants as recommended by the laboratory
 - (b) All positive screening results must be confirmed prior to reporting
 - (i) Alcohol positive results should be reflexed to test for glucose and yeast
 - (c) Level of detection testing rather than using predetermined cut-off should be employed in analysis and reporting
 - (d) Clinical toxicologist must be available for consultation in test interpretation
- 3) Toxicology test panels need to be as comprehensive and as sensitive as possible. Commonly abused pharmaceuticals must be tested for on a routine basis. Commonly marketed drug panels such as "NIDA-5" and "CSAT-7" are not adequate for testing in this population.
- (a) All positive urine drug screens must be reviewed by the Medical Director
 - (b) The Medical Director must have the training and expertise to correctly interpret the test results. MRO training or certification is encouraged.
- 4) Additional forensically sound testing and monitoring methodologies may be employed as indicated
- III) Guidelines for addressing relapse behavior and chemical relapse
- A) A relapse protocol must be developed which is acceptable to the PHP and the licensing authority in each state
 - B) Each relapse should be evaluated clinically with a graduated response tailoring treatment intensification to relapse severity
 - C) State PHPs must respond immediately to any toxicology confirmed positive for drugs of abuse. Depending on circumstances, an immediate withdrawal from practice pending further evaluation may be indicated.
 - D) A mechanism for an independent review and/or second opinion beyond the PHP Medical Director must be available if there is dispute regarding the recommendations for intensification of treatment

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- E) Immediate reporting to the licensing authority is required in certain cases
 - 1) Impairment is identified and the practitioner refuses to cease practice
 - 2) Treatment recommendations have been rejected
 - 3) The participant is determined to be refractory to treatment following multiple treatment episodes
 - 4) The participant is under Board Order requiring reporting
 - 5) If otherwise required per relapse protocol (See III A).

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Management of Other Psychiatric Disorders

- I) Physician health programs should provide services to physicians with psychiatric disorders. Physician health programs should be structured to manage this population. The FSPHP supports the development of mental health services in all programs. While not all psychiatric disorders reach a level of severity to warrant monitoring, many cases will benefit from the coordination of care provided by a PHP. Cases of psychiatric illness which have caused workplace concern or have been refractory to initial stabilization are especially appropriate for PHP referral. To effectively manage this population, a baseline of required knowledge, skills and resources is necessary. The PHP must have a psychiatrist available on staff or otherwise formally affiliated with the PHP in order to provide the necessary expertise to conduct various aspects of PHP work with psychiatric disorders (other than substance related disorders). Such expertise is necessary during the initial evaluation, in the understanding and implementation of treatment recommendations, and in the clinical monitoring of the psychiatric disorder. The following characteristics and abilities are vital for all physician health programs providing mental health services.
 - A) Conducts outreach and educational activities to all physicians which serves to educate the medical community regarding this physician health concern, explains the role of the state PHP, educates potential referents, and encourages self-referral. .
 - B) Ability to effectively interface with existing medical staff resources such as Wellness Committees.
 - C) Ability to accept and triage self-referrals in addition to the ability or resources to facilitate effective interventions when indicated
 - 1) Ability to guide referent in crisis intervention with immediate referral to the appropriate level of care.
 - D) High visibility in the medical community with a user friendly avenue to receive reports concerning physician health or behavior is necessary.
 - E) Ability or resources to gather relevant information about and determine the legitimacy of reports in a sensitive manner
 - F) Ability to make appropriate referrals for evaluation and treatment based on the participant's needs. A choice of several appropriate evaluation/treatment options/programs should be offered participants whenever possible. Alternatively, if appropriately staffed and structured, the PHP may perform the evaluation.
 - 1) Physician Health Programs should consider cultural competence and other specialized needs when making referrals
 - G) Maintenance of current information on multiple resources available to accept referrals for evaluation and treatment (See Appendix 1 & 2)
 - H) Physician Health Programs must not have any conflict of interest or business association with providers/programs utilized for referrals.
- II) Physician Health Programs must be capable of flexibility in designing individualized aftercare and monitoring services for physicians with psychiatric disorders.

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- A) A typical period of monitoring for psychiatric disorders is 1-5 years; however the length of monitoring should be based upon the condition being monitored and assessment of the physician participant. The length of monitoring agreements should be individualized with consideration given to the following factors:
- 1) Type and natural history of the psychiatric disorder
 - (a) Severity of symptoms and level of impairment at presentation
 - (b) Prior history including compliance with treatment
 - (c) Responsiveness to treatment, stabilization of symptoms and sequelae, and projected timeframe for realization of maximum treatment and/or monitoring benefit
 - 2) Presence or absence of comorbid conditions
 - 3) Participant's level of Insight into their condition and their motivation for treatment
 - 4) Quality of environmental and social supports
 - 5) Relative risk for workplace impairment and the participants insight into and reaction to periods of impairment
- B) Specific aftercare components should incorporate recommendations from evaluation and treatment resources. The PHP must have needed latitude in individual cases to modify treatment provider recommendations based upon additional information and consideration of available resources.
- 1) Ongoing treatment will normally require follow-up with a treating psychiatrist and frequently with additional mental health providers
 - (a) Consents for release of information between providers and the PHP must be maintained.
 - (b) Ongoing treatment providers and monitors must understand their responsibility to immediately notify the PHP in the case of significant changes in the status of the participant and whenever a program participant's ability to practice with reasonable skill and safety is in question.
 - (c) The PHP must ensure ongoing treatment providers have all necessary information from which to formulate and implement a therapeutic treatment relationship.
 - (d) The PHP should facilitate coordination of care between the participant's community providers throughout the treatment process.
 - 2) Evaluation of mental/emotional stability is ongoing for the duration of the monitoring period. Confidentiality of therapy should be protected while at the same time documentation of psychiatric stability must be obtained as evidence that the participant's ability to practice medicine is not impaired by a psychiatric disorder. Clinical monitoring of the client is an essential activity. Components of clinical monitoring may include:
 - (a) A qualified psychiatrist who is a PHP staff member or consultant should regularly assess the client in a face to face context. Forensic psychiatric experience is encouraged in this role.

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- (b) The PHP may assign a monitoring psychiatrist who will independently evaluate the participant and consult with the treatment providers and provide an opinion on psychiatric stability omitting details of therapy content. Outside PHP consultants must be familiar with the documentation and reporting needs of the PHP. Such consultant(s) also must be familiar with the importance of timely documentation of compliance with treatment.
 - (c) An alternative to a) & b) above is direct reporting to the PHP from ongoing treatment providers. Status reports from therapists, psychiatrists or other mental health providers should specifically exclude content of psychotherapy sessions unless the therapist considers it vital to case management in which case the therapist should discuss the report with their patient in advance.
 - (d) Reports from therapists and psychiatrists should include, but are not limited to:
 - (i) A statement documenting attendance and productivity of sessions
 - (ii) Recommendations for any changes in treatment
 - (iii) Any medication changes
 - (iv) A statement of stability to practice medicine, need for medical leave or recommendation for re-evaluation
- 3) If appropriate resources are available, support group participation may be appropriate.
- 4) Abstinence from alcohol and other drugs of abuse should be incorporated when clinically indicated
- (a) Recreational drugs of abuse are contraindicated during the contract period
 - (b) Treatment providers should be made aware of all PHP prescription drug requirements
 - (c) Abstinence is indicated in all cases of comorbid substance use disorder (utilize guidelines for treatment of SUD)
 - (d) Alcohol use may be contraindicated during stabilization of a mood disorder or other psychiatric condition when mood-altering chemicals are likely to jeopardize stability as well as to impair judgment regarding proper use of prescribed medications, regular sleep patterns, diet management, etc.
 - (e) Abstinence is indicated if there is a history of alcohol use exacerbating the psychiatric disorders or interfering with the efficacy of prescribed medications.
 - (f) When abstinence is a treatment requirement toxicology testing should be utilized as detailed in the section on Substance Use Disorders
- C) Generic contractual components between state Physician Health Programs and participants, whether voluntary or mandated, should include the following components:
- 1) Agreement for good faith participation.
 - 2) Agreement specifying limitations on recreational use of or abstinence from use of alcohol or mood altering chemicals...
 - 3) Agreement to not prescribe scheduled drugs for family members and a strong recommendation to refrain from treating family members.
 - 4) Agreement to not manage one's own medical care and to comply with necessary medication regimen.
 - (a) Participants will not diagnose or manage their own illnesses and will not self-prescribe or independently discontinue any medications.

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- (b) As directed by the PHP, participants must inform appropriate treating physicians of their diagnosis, their relationship with the state Physician Health Program and their duty to provide a release of information to communicate freely with the state Physician Health Program.
 - (c) Psychotropic medication changes must be reported to the PHP in a timely fashion
 - (i) Participants may be required to provide documentation of medication refills and attestation statement of appropriate use if there has been a history of medication non-compliance or failure to stabilize their condition
 - (ii) Monitored use of medications or testing for therapeutic medication levels may be required.
 - (iii) Participants should be required to inform the PHP as soon as feasible (generally within 24 hr.) if a potentially addictive medication is required if there is a history of substance related disorder or significant vulnerability to developing a substance related disorder, and whenever urine toxicology testing has been implemented,
 - (d) Participants shall inform the PHP as soon as feasible in the case of medical or psychiatric hospitalizations
- 5) Agreement to maintain consent for ongoing communication with an approved workplace monitor/contact, if indicated.
 - 6) Agreement to abide by any specified workplace restrictions.
 - 7) Agreement to maintain consent for the physician health program to speak with the participant's family/SO as needed.
 - 8) Agreement to submit to biological specimen monitoring without question if requested by the PHP
 - 9) Informed Consent
 - (a) A statement of the confidentiality provided and the limitations of same.
 - (i) A statement defining any requirements for reporting to the licensure board.
 - (ii) A statement defining other reporting requirements.
 - (b) A statement of actions which will follow a failure to comply with the monitoring contract or evidence of impairment which may include, but is not limited to, withdrawal from practice, intensification of treatment, inpatient evaluation, additional treatment, and/or a report to the licensure board.
 - (c) A statement that the monitoring contract may be extended at the discretion of the state physician health program if, at the end of the contract period, clinical reevaluation indicates the need for additional monitoring
 - 10) Agreement that monitoring will be transferred to the appropriate state PHP or Licensure Board if the participant moves while monitoring is still indicated.

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- 11) Agreement to faithfully follow up with designated treatment providers (individual therapists, family therapists, marriage therapists, psychiatrists) and/or others designated in the participant's contract.
 - (a) Agreement to maintain an active release of information to the state physician health program and necessary treatment providers.
 - 12) The monitoring agreement should make clear the conditions under which anonymity can be broken, if any.
 - (a) Agreement that the state licensure agency will be notified in the event that the PHP determines that a participant's practice of medicine may pose a risk to patients and he/she refuses to refrain from practice or otherwise follow PHP directives for remediation as recommended.
 - 13) Optional contract components may include, but are not limited to, notification of the state PHP for:
 - (a) Travel outside monitoring area
 - (b) Change of address
 - (c) Change of employment
 - (d) Malpractice claims
 - (e) Arrests
 - (f) Work site and performance difficulties
- D) Return to Work Considerations, Practice Restrictions and Workplace Monitors
- 1) When indicated these components should be employed as outlined in the section on Substance Use Disorders
- III) Guidelines for addressing recurrent episodes of psychiatric disorders
- A) Each recurrence should be evaluated clinically tailoring further treatment or treatment modification to symptom etiology and severity
 - 1) State PHPs must respond immediately to concerns of possible impairment which could place patients at risk. Depending on circumstances, an immediate withdrawal from practice pending further evaluation may be indicated.
 - 2) Consideration should be given to implementing diagnostic monitoring with a requirement for abstinence to rule out a covert substance use disorder or exacerbation of the condition by substance use
 - B) A mechanism for an independent review and/or second opinion beyond the PHP Medical Director must be available if there is dispute regarding the recommendations for treatment
 - C) Immediate reporting to the licensing authority is required in certain cases
 - 1) Impairment is identified and the practitioner refuses to cease practice
 - 2) Evaluation or treatment recommendations have been rejected

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- 3) The participant is under Board Order requiring reporting
- 4) At any time there is a threat to the public safety refractory to immediate intervention efforts.

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Appendix 1: Evaluations

I) Types of Evaluations

A) Fitness for Practice Evaluations: Forensic Evaluation

- 1) Comprehensive evaluation which normally requires several days with repeated interviews and testing sessions
- 2) Determines if a health condition exist which impairs or is likely to impair normal professional performance.
- 3) Determines a working diagnosis
- 4) Evaluates Performance Issues
 - (a) Is the physician capable of practicing medicine?
 - (b) Is further evaluation of professional skill or competency required or is remedial training required?
 - (c) Is continuing work detrimental to the health, safety, morale or well being
 - (i) Of the physician?
 - (ii) Of others?
 - (d) Are there functional limitations?
 - (e) Does the individual have the ability to comply with relevant laws, regulations, procedures and codes of conduct?
- 5) Under what conditions is the practitioner appropriate to resume medical practice?
- 6) Makes treatment or monitoring recommendations

B) Clinical Evaluation: Establishing Treatment

- 1) May be the initial step in the development of a treatment relationship
- 2) May be appropriate in cases where workplace impairment is not an issue and there is no evidence of denial
- 3) Determines the diagnosis
- 4) Makes treatment/monitoring recommendations

C) Clinical and/or Forensic Re-evaluation

- 1) Evaluation is to determine if modification and/or Intensification of treatment is appropriate
- 2) This evaluation may be suitable during exacerbations of pre-existing conditions (substance use disorder relapse, depressive or manic episode, behavioral disturbance, multiple sclerosis, etc)

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- (a) The presence of new conditions and status of prior diagnoses are assessed

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- 3) Recommendations for treatment should specify the type and intensity of treatment required and provide information about a selection of competent providers
 - (a) If treatment is recommended, and such treatment is available from the evaluator, the participant shall always be offered the option to seek treatment from another provider acceptable to the PHP to avoid potential conflict of interest.
 - (b) In some cases, especially when the participant is in strong disagreement with the recommendation for treatment, it may be appropriate for the evaluating facility to encourage re-evaluation or require treatment elsewhere.
- II) Characteristics of Evaluation Providers Appropriate for PHP Referrals
- A) The evaluator must possess the knowledge, experience, staff, and referral resources necessary to fully evaluate the condition(s) of impairment in question
 - B) Adhere to all applicable confidentiality regulations
 - C) There should be no actual or perceived conflicts of interest between the evaluator and the referent or patient.
 - 1) No secondary gain should accrue to the evaluator dependent on evaluation findings/outcome.
 - 2) An evaluator should not be in a treatment relationship with the professional being evaluated.
 - 3) If the evaluation is mandated, the evaluator should not be affiliated with the entity requiring the evaluation.
 - D) The evaluator must keep the PHP fully advised throughout the evaluation process. The evaluator will:
 - 1) Apprise PHP of evaluation dates.
 - 2) Apprise PHP, family, and other appropriate sources of the participant's safe arrival.
 - 3) Execute any required PHP forms at the time of arrival or as soon as practical.
 - 4) Notify the PHP immediately regarding AMA departures, or other significant occurrences.
 - 5) Advise PHP of evaluation findings and recommendations before advising patient of recommendations.
 - 6) Notify PHP before participant's discharge.

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- 7) Provide timely documentation including a brief typewritten summary of findings and recommendations by 2nd business day following completion of the evaluation. A comprehensive typewritten evaluation should follow within 14 days. Specific documentation of information supporting diagnostic and placement (level of treatment) criteria is especially helpful.
- E) Have resources available and be prepared to conduct a secondary intervention at the time diagnoses and recommendations are discussed. Involve the state PHP with a secondary intervention as indicated/needed.
- F) Have immediate access to medical and psychiatric hospitalization if needed.
- G) Arrange for timely intake and admission.
- H) Fully disclose costs prior to admission.
- I) Evaluate All Causes of Impairment
 - 1) Mental illness
 - 2) Chemical dependency and other addictions
 - 3) Dual diagnosis
 - 4) Behavioral problems including: sexual harassment, disruptive behaviors, abusive behaviors, criminal conduct
 - 5) Physical Illness including: neurological disorders and geriatric decline
- J) Employ standardized psychological tests and questionnaires during the evaluation process
- K) Conduct comprehensive and discrete collateral interviews of colleagues and significant others to develop an unbiased picture of all circumstances, behavior and functioning
 - 1) Carefully identify and interview collateral contacts for evaluation.
 - 2) Report an incomplete evaluation if the patient refuses to provide a release of information for necessary collateral interviews.
 - 3) Evaluators must consider whether collateral sources may have an agenda outside the interest of the patient and balance this information accordingly.
 - 4) Unless contraindicated collateral contacts should include: the person initiating report; representatives of the hospital/office work environment; colleagues; family members including spouse/significant other; health care providers; and others as identified.
 - 5) Reports on collateral sources of information but avoids associating any specific information with its source.
- L) Make Rehabilitation/Treatment Recommendations
 - 1) State clearly if treatment or other intervention is needed
 - 2) Identify if workplace modifications or accommodations are required
 - 3) Identify if a change of specialty, employer or career should be explored
 - 4) Detail any monitoring requirements

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- M) If the patient disagrees with diagnosis (based of DSM-IV criteria) or treatment recommendations, the evaluator should encourage a second opinion regarding diagnosis/recommendations. The second opinion should be obtained at a PHP approved evaluation facility.

III) Criteria for Multidisciplinary Assessment

- A) This type of evaluation is recommended whenever cognitive distortions are suspected; e.g. chemical dependency, bi-polar disorder, organic brain syndromes and behavioral disturbances.
- B) Maintain qualified staff and referral resources to provide a multi-disciplinary evaluation which should include:
 - 1) Standardized testing using validated instruments
 - (a) Psychological: personality testing, cognitive screening, and other screening instruments for depression, anxiety, etc...
 - (b) Substance Use Disorder Screening
 - 2) Psychiatric Evaluation must be completed and supplemental psychological testing performed as indicated
 - (a) Cognitive and neuro-psychiatric assessment
 - 3) Psychosocial Assessment
 - 4) Medical Assessment
 - (a) Physical Examination
 - (i) Referral/treatment as indicated
 - (b) Laboratory Examination
 - (i) Chain of custody comprehensive toxicology testing
 - (ii) Screening blood tests
 - a At minimum should include: CBC, electrolytes, LFTs, communicable disease battery, and thyroid function tests
 - b other tests as indicated
 - 5) Addiction Medicine Assessment
 - (a) Chemical Use History
 - (b) Family assessment
 - (c) Spiritual Assessment
 - (d) Inclusion in peer recovery group when available
 - 6) Examinations by other specialists as indicated

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- 7) Collateral interviews
 - 8) Records review
- IV) Criteria for Independent Evaluator
- A) Unbiased and Objective
 - B) Well respected in medical community
 - C) Appropriate credentials
 - D) Broad clinical experience in evaluating and monitoring in the hospital environment
 - E) Understands addiction as well as other mental and physical illness
 - F) Working knowledge of medical staff/hospital administration dynamics
 - G) Understands legal, liability and forensic issues
 - H) Cooperative attitude toward referent
 - I) Willing to share clinical findings with referent and appropriate workplace contacts

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Appendix 2: Treatment Programs

- I) Characteristics of Treatment Programs which are appropriate for PHP referrals
 - A) Characteristic defined in Appendix 1 are also appropriate for treatment facilities and are hereby incorporated by reference.
 - B) Ability of PHP to visit site and referred patients
 - C) Business office must be capable of and willing to work with insurance providers and should have avenues available to assist with payment plans for the indigent physician
 - D) A peer professional patient population and a staff accustomed to treating this population is highly desirable
 - E) Programs and practitioners should make appropriate referrals when faced with a patient who has an illness/issue that is outside of the practitioner's area of expertise.
 - F) Staff to patient ratio should be conducive to each patient receiving individualized attention.
 - G) Must keep state PHP informed throughout the treatment process through calls from the therapists involved as well as written reports. Type and frequency of contact may be arranged with the state PHP but in all cases should occur no less than monthly.
 - H) A strong family program is desired. The family/SO should be kept apprised throughout the treatment process
 - I) Immediately report to the state PHP threats to leave AMA, AMA discharges, therapeutic discharges, any other irregular discharge or transfer, hospitalization, positive urine drug screen, non-compliance, significant change in treatment protocol, significant family or workplace issues, or other unusual occurrences.
 - J) Must have the medical, psychiatric, and addictions staff necessary to fully address all health issues, obvious and otherwise. Specifically, the staff must be vigilant in screening for, identifying and diagnosing covert co-occurring addictions and co-morbid psychiatric illnesses and address these concurrently with the presenting illness. This includes appropriate resources to assess and manage concurrent chronic pain diagnoses (in-house, consultative, and/or referral capacity).
 - K) A multi-disciplinary team approach should be used and include psychological, psychiatric and medical stabilization.
- L) Funding for Treatment Programs
 - 1) Participants are responsible for all payment for required treatment
 - 2) Fees should be fair and equitable.
 - 3) Full fees must be disclosed up front.

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- 4) A flexible payment plan should be available for the varied income levels of participants, but the patient should make some financial investment into the treatment process.
- M) Length of stay must be clinically driven and justified
- N) Complete and appropriate records must be maintained to fully defend diagnoses, treatment, and recommendations.
- O) Discharge planning and coordination: Before discussing with patient, provide the state PHP with verbal notification of discharge planning and again prior to actual discharge. Documentation including a brief typewritten summary of final diagnoses, recommendations for return to work, and aftercare recommendations shall be transmitted electronically by 2nd business day following discharge, with a comprehensive typewritten evaluation following no later than 14 days.
- P) Discharge summary must be adequate to:
 - 1) Document diagnostic criteria and the basis for aftercare recommendations.
 - 2) Show that patient needs were addressed.
 - 3) Show that appropriate treatment was provided.
 - 4) Show that criteria for discharge were met.
 - 5) Justify return to work/fitness to practice recommendations.
 - 6) Identify all Axis I - V diagnosis (with elaboration on co-morbid illnesses present) and define aftercare recommendations.
 - 7) Define any special needs that treatment providers feel would be advantageous to include in an aftercare contract with the state PHP.
 - 8) Return to work/fitness to practice assessment prior to discharge
 - 9) Extended treatment options when indicated.
- II) Substance Use Disorder Treatment Programs also require the following
 - A) Programs must use an abstinence-based model (appropriate psychoactive medication as prescribed). In rare cases that are refractory to abstinence-based treatment, alternative evidence-based approaches should be considered.
 - B) When a 12-step model is utilized for substance use disorders, appropriate therapeutic alternatives (acceptable to the PHP) should be made available to participants with religious or philosophical objections. If an appropriate alternative is not available at the initial facility, then the physician shall be responsible for working with the facility and the PHP to identify an alternative of appropriate intensity.
 - C) A strong family program is considered mandatory. Family program component should focus on disease education, family dynamics, and supportive communities for family members. Family/SO needs must be accessed early in the process and participation with family/SO programs and individual therapy encouraged.
 - D) Treatment services must include:
 - 1) Intervention and denial reduction
 - 2) Detoxification

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- 3) Ongoing assessment and treatment of patient needs to occur throughout treatment with referral for additional specialty evaluation and treatment as appropriate
 - (a) Eating disorders
 - (b) Gambling addiction
 - (c) Sexual compulsivity/Addiction
 - (d) Psychiatric Illness
 - (e) Cognitive Impairment
 - (f) Medical illness
 - (g) Chronic pain
 - (h) Other
- 4) Family treatment
- 5) Group and individual therapy
- 6) Educational programs
- 7) Mutual support experience (e.g. AA/NA/etc.) and appropriate alternatives when indicated
- 8) Development of continuing care plan and sober support system
 - (a) Indicate any patient/family needs for ongoing therapy
- 9) Relapse prevention training
- 10) Return to work/fitness to practice assessment prior to discharge
- 11) Extended treatment options when indicated.