Mississippi Professionals Health Program

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What is the Purpose of MPHP?

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

What is the Goal of the MPHP?

- To coordinate effective detection, evaluation, treatment, and aftercare monitoring of licensed professionals with issues of impairment, enabling their return to a healthy, safe and productive practice.
- Early intervention protects patients and saves the providers' careers

Benefits of MPHP

- Early detection of potentially impaired physicians
- Protects patients
- Saves physicians' careers
- Addresses problems in a clinical, proactive way
- Facilitates avoidance of disciplinary action, and expensive, complex legal battles

Physician Benefits

- Confidentiality
- Advocacy for malpractice insurance carriers, hospitals, and medical boards

Mississippi Needs Physicians!

- 5,185 Active Physicians in Mississippi
  - Ranked 50th of states
  - 175.6/100,000
  - Median USA active physicians = 255.8/100,000(785,326)

AMA Physician Masterfile (December 31, 2009)

MS Office-Based Physicians(OBP): Economic Impact

- 4,256 OBPs in Mississippi
- 5.7 jobs – created by each OBP
- $695,000 wages and benefits supported per OBP
- $5 billion total economic output in 2009

SNR Denton & The Lewin Group, Inc. January 2011

Unequivocal Success

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

(See References)

History of PHPs

- Formal efforts to deal with physician impairment existed as far back as 1958
- Drug addiction and alcoholism among doctors identified by FSMB as a disciplinary problem
- FSMB called for the development of a model program of probation and rehabilitation that could be adopted by individual state boards

History of PHPs, cont.

- 1974 AMA acknowledged physician impairment from alcoholism and drug dependence
- Developed model legislation offering therapeutic alternative to discipline
- Recognized alcoholism and addiction as illness

History of PHPs, contd.

- MPHP originally created by Ellis and Nina Moffitt and MSMA in 1978 and incorporated as a 501(c)3 charitable organization
- By 1980 all but 3 Medical Societies had had authorized or implemented impaired physician programs
- FSPHP created in 1990

Purpose

- Early detection, intervention, and long term, intensive management of impaired physicians
- Primary focus on impairment from substance use disorders

PHP Issues Addressed Nationally

- Substance use disorders-100%
- Psychiatric disorders-85%
- Disruptive behavior/Professional sexual misconduct-60%
- Acute or chronic diseases resulting in physical disability

Drugs of Abuse

- 49% - Alcohol
- 35% - Opioids
- 8% - Stimulants
- 5% - Sedatives
- 3% - Marijuana
- 2% - Other

- Alcohol Only – 37%
- Drugs Only - 27%
- Both - 31%

Co-Occurring Psychiatric Disorders

- 50% of MPHP Participants(37.4%)

MPHP Funding

- MSBML - 54%(50%)
- Participant Monitoring Fees – 30%(16%)
- Hospitals – 5%(9%)
- MSMA – 5% (plus in-kind contributions)
- Charitable Contributions

Supported by Medical Boards

- Early detection of impairment protects public health
- Prevention of future harm by long term, intensive management

Medical Board Characteristics

- Regulatory, legal entity
- Action can take months to years
- Constrained by due process
- Required to perform investigations, develop cases, provide notices, and conduct judicial hearings with allowance for appeals

PHP Characteristics

- Act rapidly, if needed, to recommend discontinuation of practice, formal evaluation and referral to treatment
- Compliance by physician allows mechanism for intervention without board action
- Free to act on reported symptoms and not constrained by due process
- Physicians often go to treatment the day of the referral, which protects the public

Necessity of Confidentiality

- Provides incentive for physicians to accept early intervention
- Goal is to foster physician recovery
- Goal is NOT to hide doctors from the board!

California Diversion Program

- Discontinuation in 2008 by the California Medical Board
- Firestorm of negative publicity led by charges of hiding "physicians on drugs" by a Citizen Advocacy Group

Limits to Confidentiality

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

Honest Disclosure

- **Honest Disclosure.** I understand my ethical and contractual obligation to honestly and completely answer any and all application questions regarding my recovery and participation with MPHP. Such questions may appear on application or reappointment materials with practice groups, ***hospital credentialing groups***, state licensing boards, malpractice carriers, etc. Deception or dishonesty in reporting reflects negatively on my recovery and MPHP in its role as my advocate. When in doubt, I will call MPHP for guidance. Infractions regarding dishonesty are viewed seriously and will result in a report to the Board of Medical Licensure and possible recommendations for further treatment, contract extension or loss of advocacy. ____Initials

Providers for Evaluations and Treatment

- Providers represent a very small group of facilities throughout the country
- All are experienced and know for excellence in treating impaired professionals
- All providers are approved by the MSBML
- Participants are provided with a list of approved providers for selection

Providers

- Being identified as an approved PHP treatment provider is considered prestigious
- Quality of care offered by providers is constantly improved as the providers compete for PHP referrals

Characteristics of MPHP

- Total abstinence from alcohol and/or drugs of abuse
- 5-year Recovery Contract Agreement(RCA) for substance use disorders
- RCA violations are viewed as predictors of relapse and are reported to MSBML

Recovery Contract Agreement

- Attendance at minimum of three 12-step meetings per week
- Attendance at weekly Caduceus Group meeting
- Random drug screens at various intervals
- Required compliance with psychiatric and/or therapeutic recommendations
- Monthly Self-Report to MPHP Case Manager

Monthly Self Report:

- Work status/environment
- 12-step meeting attendance logs
- Psychiatric care(medication, therapy)
- Attitude toward recovery
- Cravings or relapse(substances or behavior)
- Spouse/significant other concerns

Monthly Self-Report, cont.

- Other recovery related activities:
  1. Sponsor contact frequency
  2. Recovery related service work
  3. Daily spiritual activities(12 step work, prayer, meditation)
  4. Eating/Exercise/Fun

Relapse

- Definition: deterioration or regression after a period of recovery from an illness; recurrence.
- Relapse rates with Type 1 Diabetes, Hypertension and Asthma: 30-70%
- MPHP 5 year rate of single, level II relapse < 17%
- Addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

3 Levels of Relapse

- Level 1: "Behavior that might indicate mental relapse, without chemical use."
- Level 2: "Relapse with chemical use, outside the context of active practice."
- Level 3: "Relapse with chemical use, within the context of the licensee's active practice."

All level 2 and 3 relapses are reported to the Mississippi State Board of Medical Licensure

Patient Safety?

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

*McLellan, AT et al. 2001. Retrospective study of 904 physicians over 7.2 years

Conclusions

- PHPs are effective
- Addiction is highly treatable
- Recovering Doctors can practice safely
- Mississippi cannot afford to NOT rehabilitate its physicians

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