# Healthcare Provider Burnout and Substance Use Disorder

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RCORP-TA
RURAL COMMUNITIES OPIOID RESPONSE PROGRAM - TECHNICAL ASSISTANCE

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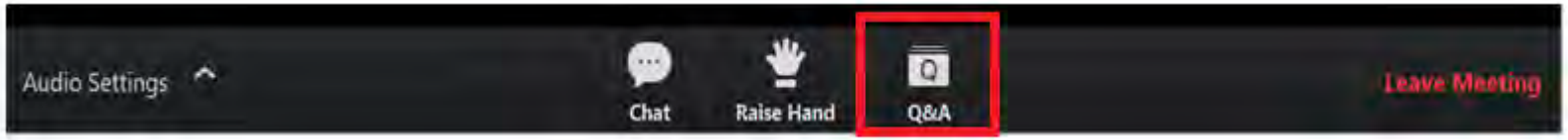


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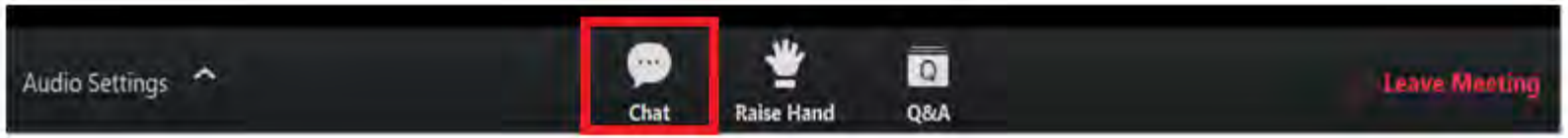

# Exploring the Potential of Rehabilitating Healthcare Providers Prosecuted for Substance Use Disorder

*Texas A&M University Health Science Center*

**T3: (Triad) Grant Project Team**

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# Acknowledgements

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**Data Analysis; and Scott Horel, Data Coding Specialist and Analyst, A&M School of Public Health**

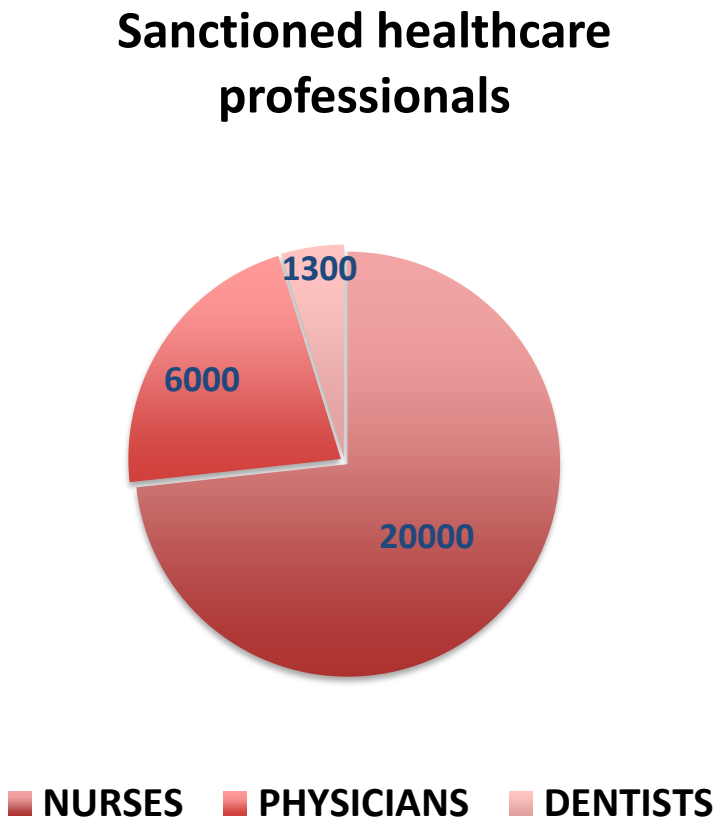
# Objectives for RCORP Webinar session

1. Understand the scope of illegal SUD in the medical community and its association with a loss of professional license through State Licensing Boards.
2. Identify how the application of a “Just Culture” might address the problem of SUD within the healthcare profession.
3. Discuss and explore how peer-to-peer support programs might address the problem of SUD for affected HC providers.

# Background

**Currently, over 57,000 healthcare providers have been sanctioned and excluded from participating under Centers for Medicare & Medicaid Services (CMS) healthcare practice because of unlawful behavior, including narcotics violations & SUD**

**At the same time, the U.S. suffers from a national shortage of healthcare providers, especially in primary care, nursing, medicine, and dentistry services for impoverished communities and rural regions.**



# Background cont.

- **It is well recognized that the health care profession involves demanding work with "day-in and day-out" physical as well as emotional stress, causing loss of enthusiasm and often burnout.**
- **A number of factors have been found to be associated with burnout. Some are personal, such as advancing age, one's educational level, and physical and emotional resiliency.**
- **Other factors include organizational characteristics such as assignments, burdensome and routinely intense work or caseloads, (lack of) available resources, support and lack of understanding from persons in authority, and undue expectations by persons in authority.**
- **An individual experiencing burnout may resort to compensating or seeking relief through substances that relieve stress, such as alcohol and drugs.**

# Statement of the Problem Re: Providers Excluded Due to SUD

- We know that healthcare providers also develop problems with SUD, including opioids.
- Health care provider burnout leads to vulnerability and susceptibility to development of SUD or relapse from prior SUD.
- Many providers develop other chronic health disorders concurrent with SUD.
- SUD is frequently associated with loss of one's professional license—a serious, usually permanent, loss of status and ability to work.

# What is “Provider Burnout”?

***Among many suggested definitions….***

**Definition #1:** “Burnout” is a response to some event or work pressure that interposes itself between you and the ability to be compassionate or care about your profession.

**Definition #2**: Provider “burnout” is a widespread phenomenon characterized by a reduction in energy that manifests in emotional exhaustion, lack of motivation, and feelings of frustration and may lead to reduction in ability to engage in one’s licensed profession, such as nursing, medicine, or dentistry.

# METHODS

A mixed methods (i.e., qualitative and quantitative) study is proposed to examine providers (nurses, physicians, and dentists) who end up in trouble with licensing boards or the legal system due to SUD.

Our goal is to examine precipitating factors and circumstances that enabled or encourage deviation from legal and professional standards of conduct.

Today we will be reporting on our work to date analyzing:

- National Practitioner's Data Bank—analyzed using SAS.
- Office of Inspector General's (OIG) list of Excluded Individuals and Entities—analyzed using STATA.

# Model/Schema

**Healthcare Provider Chronic Burnout/Stress**

**Development of SUD as a Coping Mechanism**

**Addiction → Legal Problems → Loss of License**

# Theoretical Model, (1985)

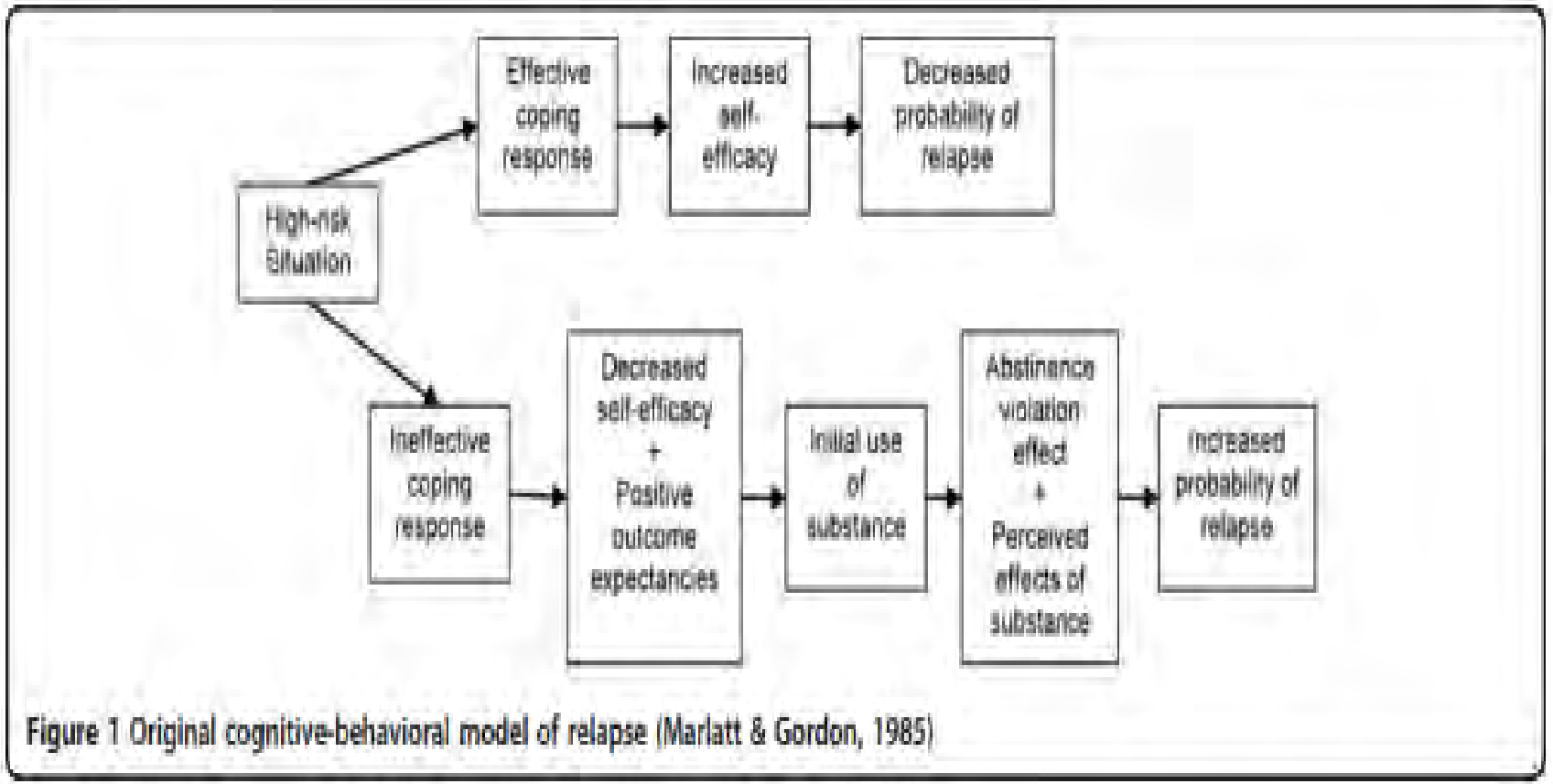
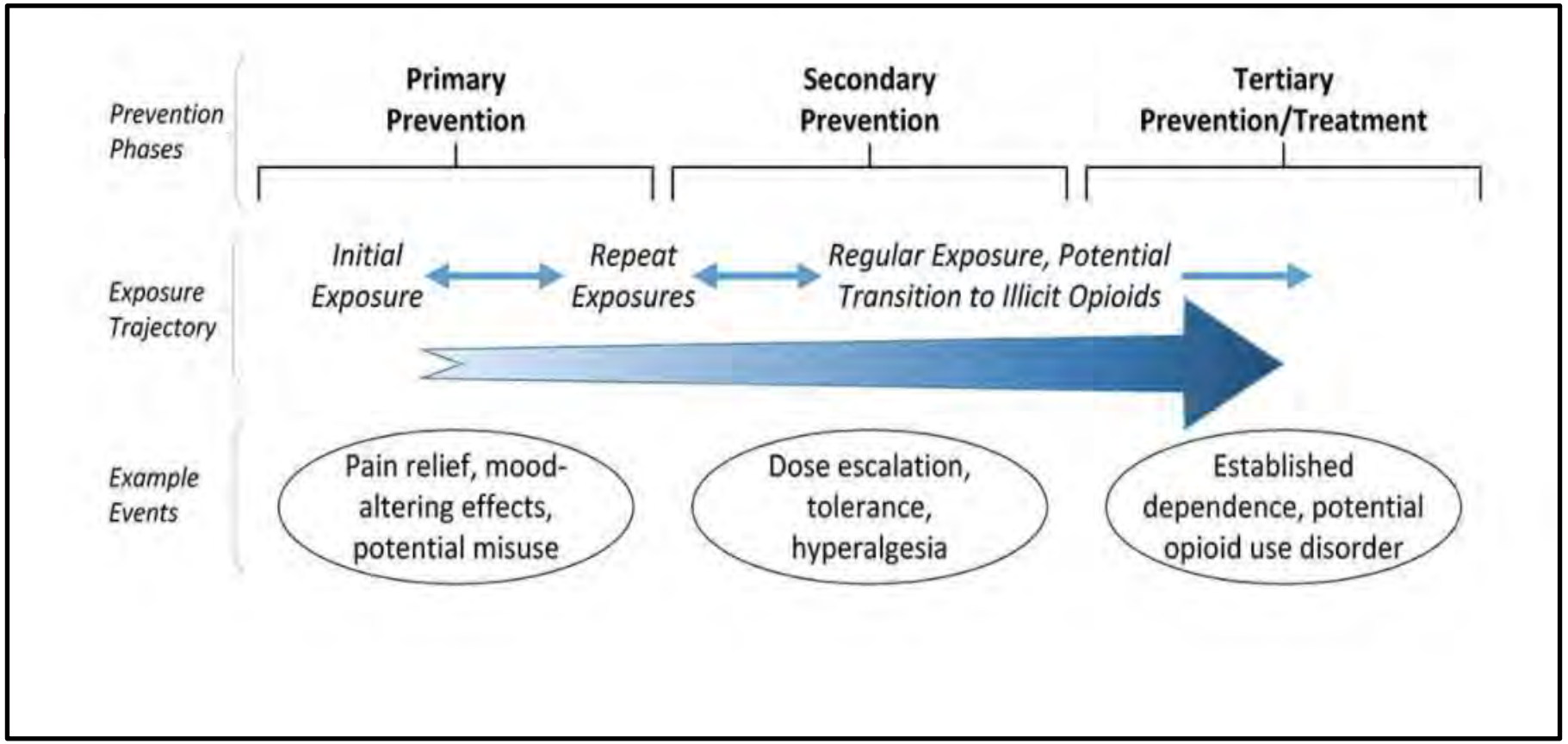



Figure 1 Original cognitive-behavioral model of relapse (Marlatt & Gordon, 1985)

# More




A theoretical framework and nomenclature to characterize the iatrogenic contribution of therapeutic opioid exposure to opioid induced hyperalgesia, physical dependence, and opioid use disorder

Gillian A. Beauchamp, Lewis S. Nelson, Jeanmarie Perrone & Michael S. Lyons

https://doi-org.srv-proxy2.library.tamu.edu/10.1080/00952990.2020.1778713

PUBLISHED ONLINE:
08 September 2020

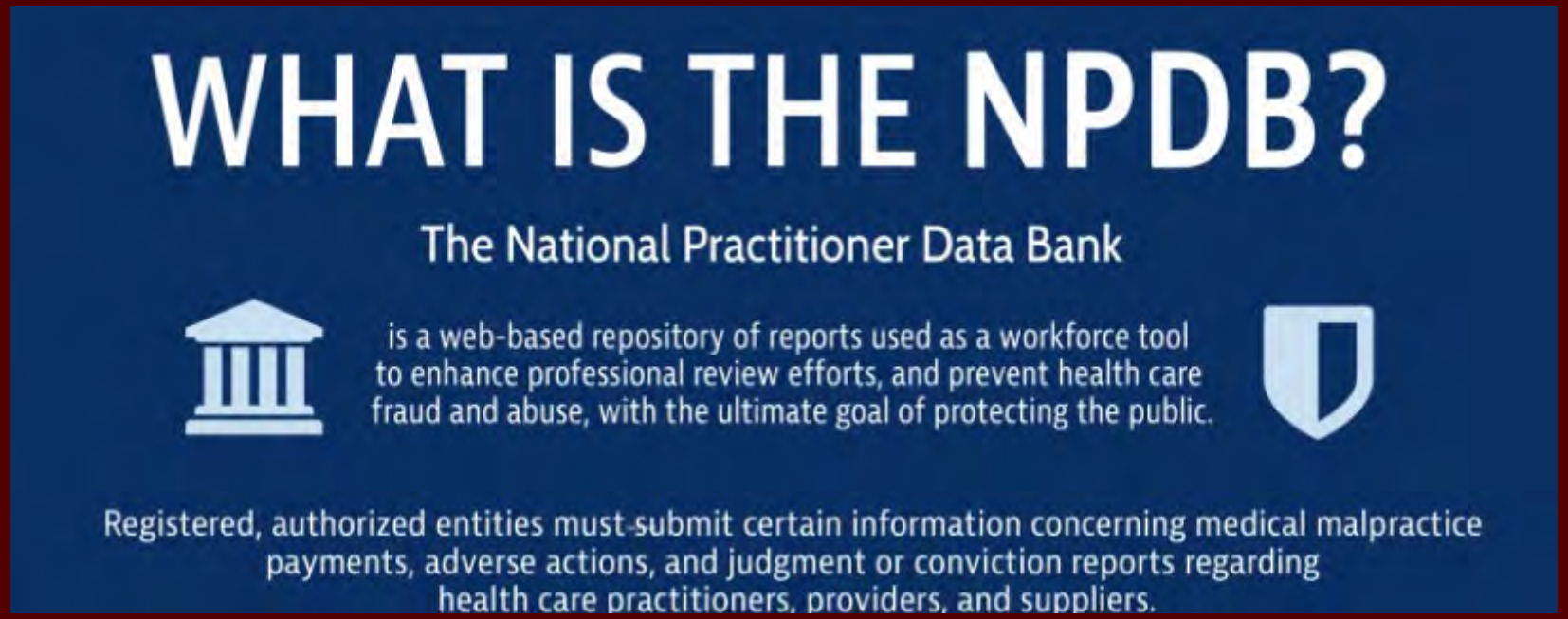
# Initial Exploratory Analysis

- **NPDB Data**: Preliminary analysis reveals **85,234** nurses, physicians, and dentists reported for drug use problems.

- **OIG Data**: **≥ 57,000** providers sanctioned by CMS for "fraud and abuse". CMS sanctions include providers barred due to illegal drug use. Of these, **2,136** are identified as having been barred specifically due to illegal drug use or Alcohol Use Disorder.
- Another **24,086** were barred at the state level due to licensing actions, (drugs), or Peer Review Proceedings.

# The view from 30,000 ft.

# FINDINGS FROM NPDB



# National Practitioner's Data Bank

**NPDB is a publicly available data file with information on:**

1. **Adverse action (safety & standard of care violation) reports,**
2. **Medical malpractice payment reports received by the NPDB on health care practitioners, and**
3. **Information from Medicare and Medicaid exclusion actions relation to violations of the law.**

**We analyzed data from 1990-2020 using *StataSE* 15.**

# Approach

**30,000 ft.**

**OVERVIEW**

- **Nurses**
- **MDs/DOs**
- **Dentists**

**Pulled SUD-related reports from the NPDB for Nurses, MDs/Dos, and Dentists:**

- **Alcohol or Other Substance Abuse**
- **Narcotics Violation**
- **Drug Screening Violation**
- **Felony Conviction Re: Controlled Substances Violation**
- **Conviction Re: Controlled Substances**
- **Violation of Drug-Free Workplace Act**
- **Unable to Pactice Safely by Reason of ETOH or Other SUD**
- **Narcotics Violation or Other Violation of Drug Statutes**
- **Diversion of Controlled Substance**

# Table 1: All Nurses Reported to the NPDB for Adverse Actions, by Specialty, 1990–2019

| Practitioner's Field of License in Nursing | Total Reported to NPDB | Total Reported for SUD by Nsg. Field | Percent of Total for Specialty Reported for SUD |
|---|---|---|---|
| Registered Nurse | 272,467 | 46,677 | 17.13% |
| Nurse Anesthetist | 2,697 | 187 | 6.48% |
| Nurse Midwife | 1,530 | 6 | 0.39% |
| Nurse Practitioner | 6,131 | 316 | 4.90% |
| Doctor of Nursing Practice* | 5 | 0 | 0% |
| Advanced Nurse Practitioner, APRN** | 6 | 2 | 25% |
| Clinical Nurse Specialist | 86 | 3 | 3.37% |
| Total | 282,922 | 47,191 | 17% |

* Began Reporting in 2010

** Reported 03/02-09-02

## Table 2: All Nurses Reported for SUD-Related Offenses by Age Group, NPDB 1990–2020

| Age-Group in Years | Total in Age Group | Number of SUD Reports, by Age | Percent reported for SUD by Age |
|---|---|---|---|
| 20-29 | 29,306 | 6,332 | 22% |
| 30-39 | 105,599 | 23,194 | 22% |
| 40-49 | 121,423 | 24,205 | 20% |
| 50-59 | 87,093 | 12,463 | 14% |
| 60-69 | 30,288 | 2,636 | 9% |
| 70-79 | 3,075 | 108 | 4% |
| 80-89 | 388 | 77 | 20% |
| | | | |
| Total | 377,200 | 69,017 | |

# Next, We Examined MDs & DOs

- **Between 1990–2019, there were 521,807 MDs or DOs reported.**

- **Next, we pulled all of the reports for the following:**

  - **Alcohol or Other Substance Abuse**
  - **Narcotics Violation**
  - **Drug Screening Violation**
  - **Felony Conviction Re: Controlled Substances Violation**
  - **Conviction Re: Controlled Substances**
  - **Violation of Drug-Free Workplace Act**
  - **Unable to Practice Safely by Reason of ETOH or Other SUD**
  - **Narcotics Violation or Other Violation of Drug Statutes**
  - **Diversion of Controlled Substance**

# All MDs/DOs Reported to the NPDB for Adverse Actions, 09/01/1990–12/31/2019

**Table 3: MDs/DOs Reported to the NPDB for Adverse Actions: 1990–2019**

| Practitioner's Field of License | Total Reported to NPDB | Total Reported for SUD | Percent Reported for SUD |
|---|---|---|---|
| MD | 479,824 | 11,645 | 2.4% |
| MD Resident | 3,374 | 202 | 5.7% |
| DO | 37,997 | 1699 | 4.3% |
| DO-Resident | 612 | 42 | 6.4% |
| Total | 521,807 | 13,588 | 2.6% |

# All MDs/DOs Reported for SUD-Related Offenses by Age Group, NPDB 1990–2019

**Table 4: MDs/DOs Reported to the NPDB SUD, by Age 1990–2019**

| Age-Group in Years | Total in Age Group | Number by Age and SUD | Percent reported for SUD by Age |
|---|---|---|---|
| 20-29 | 29,306 | 92 | 22% |
| 30-39 | 105,599 | 2,184 | 22% |
| 40-49 | 121,423 | 4,351 | 20% |
| 50-59 | 87,093 | 3,628 | 14% |
| 60-69 | 30,288 | 2,164 | 9% |
| 70-79 | 3,075 | 729 | 4% |
| 80-89 | 388 | 152 | 20% |
| | | | |
| Total | 377,200 | 13,300 | |

## Table 5: All Dentists Reported to the NPDB for Adverse Actions, by Specialty, 09/01/1990-12/31/2019

| Practitioner's Field of License | Total Reported to NPDB | Total Reported for SUD | Percent Reported for SUD |
|---|---|---|---|
| Dentist | 93,841 | 2,597 | 2.7% |
| Dental Resident | 162 | 2 | 1.2% |
| Total | 94,003 | 2,599 | |

# Table 6: All Dentists Reported for SUD-Related Offenses by Age Group, NPDB 1990-2020

| Age-Group in Years | Total in Age Group | Total by Age and SUD | Percent reported for SUD by Age |
|---|---|---|---|
| 20-29 | 2,072 | 27 | 1% |
| 30-39 | 19,648 | 514 | 3% |
| 40-49 | 27,456 | 884 | 3% |
| 50-59 | 24,364 | 708 | 3% |
| 60-69 | 14,981 | 358 | 2% |
| 70-79 | 4,328 | 77 | 2% |
| 80-89 | 617 | 16 | 3% |
| | | | |
| Total | 93,466 | 2,584 | |

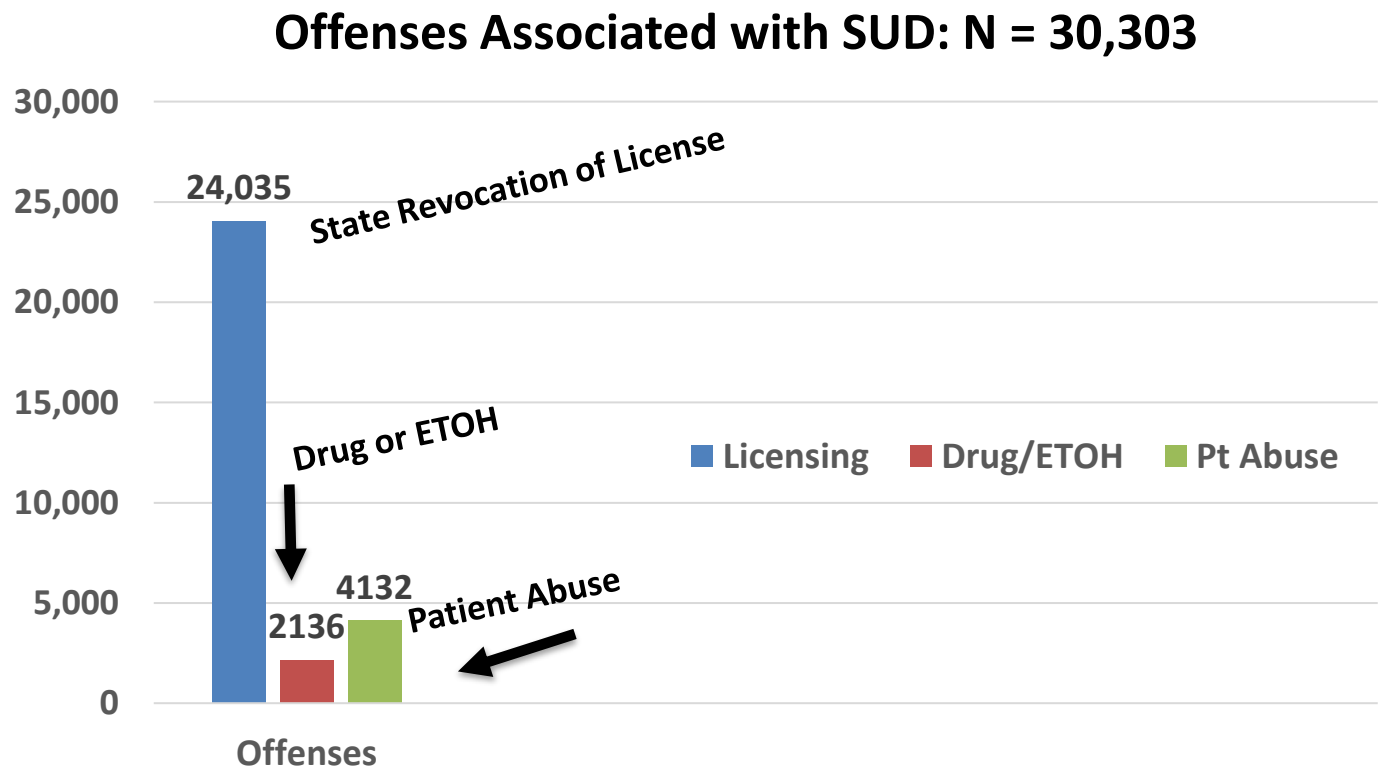
# OIG Data

- **Large data Set**
- **Messy with regional variance in coding**
- **Difficult to parse—time intensive**
- **Contains complete listing of person with addresses, county, names of businesses**

# Example of Coding Challenges

| | | | |
|---|---|---|---|
| ANESTHESIOLOGY | 163 | 0.43 | 0.46 |
| ANESTHETIST | 1 | 0.00 | 0.46 |
| CARDIOLOGY | 49 | 0.13 | 0.59 |
| DENTAL HYGIENIST | 34 | 0.09 | 0.68 |
| DENTAL PRACTICE | 57 | 0.15 | 0.83 |
| DENTIST | 1,190 | 3.14 | 3.97 |
| DERMATOLOGY | 36 | 0.10 | 4.07 |
| ENDOCRINOLOGY | 11 | 0.03 | 4.10 |
| FAMILY PRACTICE | 537 | 1.42 | 5.52 |
| GASTROENTEROLOGY | 19 | 0.05 | 5.57 |
| GENERAL PRACTICE | 991 | 2.62 | 8.18 |
| GENERAL PRACTICE/FP | 1,778 | 4.69 | 12.87 |
| GENETICS | 3 | 0.01 | 12.88 |
| GERONTOLOGY | 2 | 0.01 | 12.89 |
| GOV'T INSUR RECIPIEN | 1 | 0.00 | 12.89 |
| GRANTEE | 1 | 0.00 | 12.89 |
| GS 1-12 | 1 | 0.00 | 12.89 |
| GYN/OBS | 204 | 0.54 | 13.43 |
| INTERNAL MEDICINE | 628 | 1.66 | 15.09 |
| NEPHROLOGY | 15 | 0.04 | 15.13 |
| NEUROLOGY | 79 | 0.21 | 15.34 |
| NURSE PRACTITIONER | 27 | 0.07 | 15.41 |
| NURSE/NURSES AIDE | 28,639 | 75.58 | 90.99 |
| NURSING FIRM | 20 | 0.05 | 91.04 |
| ONCOLOGY | 28 | 0.07 | 91.11 |
| OPHTHALMOLOGY | 61 | 0.16 | 91.27 |
| ORTHOPEDICS | 55 | 0.15 | 91.42 |
| OSTEOPATHY | 346 | 0.91 | 92.33 |
| OTORHINOLARYNGOLOGY | 31 | 0.08 | 92.41 |
| PAIN MANAGEMENT | 83 | 0.22 | 92.63 |

# Office of the Inspector General (OIG)



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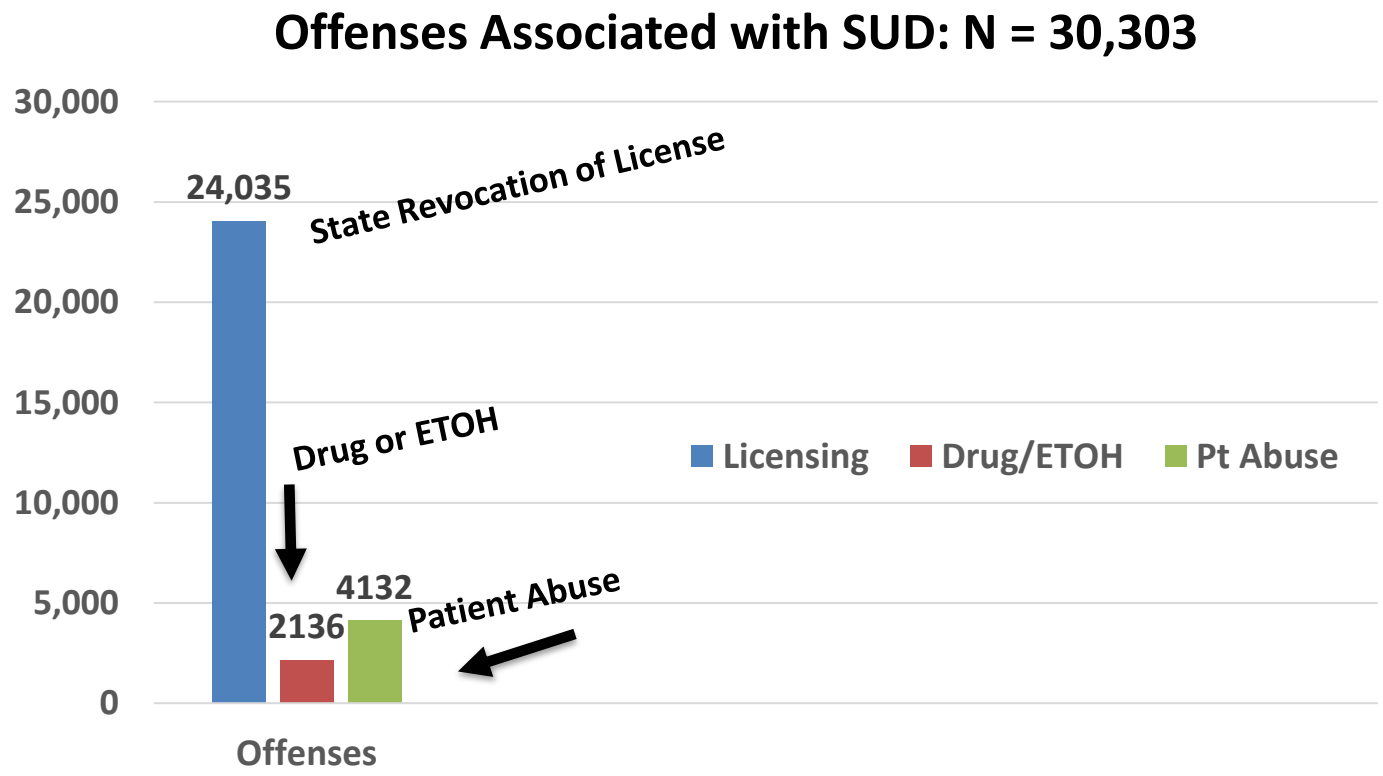

# How does *Just Culture* Apply?

- **Recovery-Oriented Systems of Care (ROSCs)** are a form of *Just Culture* for anyone, including professionals, who find themselves with SUD as a coping mechanism.

- ***ROSCs*** should incorporate trauma-informed care into recovery systems, recognizing that occupational burnout is a form of long-term trauma.

# *Just Culture* & Recovery-Oriented Systems of Care (ROSCs)

- ***ROSCs*** **provide comprehensive services to individuals who have experienced trauma or occupational burnout.**
- **Recovery should be person-centered and person-directed towards long-term recovery.**
- **Integrating trauma-informed approaches into recovery-oriented systems of care is a natural coupling of two complementary and critical care modalities.**

# Research Plan Going Forward

1. **Review of Existing Literature**
   a. Just Culture
   b. Recovery Oriented Systems of Care, (ROSCs)
   c. Peer-to-Peer Recovery for Health Care Professionals

2. **Qualitative Plan: Description**
   a. Focus Groups & Focused Interviews

3. **Quantitative Plan: Description**
   a. Surveys of State Licensing Boards
   b. Surveys of professional organizations
   c. Surveys of professional health care providers prosecuted for substance use disorder

# NEXT STEPS

- Refine and continue this momentum to…
  - Reduce the provider associated stigma of SUD, including opioid use disorder (OUD), nationally.
  - Strengthen and expand SUD/OUD prevention, treatment, and recovery service delivery nationally with the input of experts.

# Addiction in Health Professionals and Diversion from Discipline

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# Disclosures
## (through Michael M. Miller MD Consulting LLC)

- AmmonLabs
- JBS International
- Advancing a Healthier Wisconsin (AHW) Endowment
- Aware Healthcare, Inc.
- Waypoint Health Innovations, LLC
- UW WorldMeds
- Alkermes

# Substance Use Issues Among Health Care Professionals

- Using Addictive Substances
- Using Addictive Substances at Workplace
- Using Addictive Substances While On Duty
- Being Arrested Related to Substance Use
- Diverting Controlled Substances From Workplace
- Trafficking Controlled Substances
- Having Addiction

# Substance Use Issues Among Health Care Professionals

In each of these scenarios, the question is:

- Is this individual “bad” or “sick”?
- Are the person’s actions indicative of unprofessional conduct?
- Are the person’s actions indicative of a behavioral health condition?
- Do the licensee’s actions warrant professional discipline?
- Do the licensee’s actions warrant referral for clinical evaluation?



# Professional Discipline

- Restriction of Privileges
- Suspension or Expulsion From Medical Staff
- Licensure Body Reprimand
- Licensure Limitations
- Suspension of Professional License
- Revocation of Professional License

# Alternative to Discipline ("Diversion Programs")

- Statewide Physician Health Programs
- State-based programs for other health professional licensees

- Different organizational models (governance/operations)
  - Operated by a professional society (state medical association)
  - Operated by the state licensure body (exec. branch department)
  - Operated by an independent, for-profit business (contracted EAP provider- a commercial provider of Employee Assistance Program services)
  - Operated by a free-standing non-profit foundation (multiple stakeholders)



# Alternative to Discipline ("Diversion Programs")

- Statewide Physician Health Programs
- State-based programs for other health professional licensees

- Different business models (funding streams)
  - Participant fees (admission fee, monthly case management fees)
  - Licensure surcharge
  - Contributions from professional societies (medical, dental, nursing, pharmacy, etc.)
  - Grants from professional liability insurance carriers (Med Mal)
  - Grants from hospitals/health systems
  - Donations (philanthropy)
  - Professional fee-for-service (if the program offers ongoing recovery groups/therapy)
  - Operated by the state licensure body (exec. branch department)



# Professionals Health Programs
## Physician Health
## Dentist/Nursing/Pharmacist et al. Health

- They don’t diagnose, but they refer for diagnostic evaluation.
- They don’t treat, but they require that the licensee go to treatment.
- They MONITOR:
  - Treatment Monitoring
  - Laboratory Monitoring
  - Workplace Monitoring
- They do case management and establish documentation of continuous abstinence/remission.
- They may refer to Professional Discipline.



# Professionals Health Programs
## Physician Health
## Dentist/Nursing/Pharmacist et al. Health

- They receive complaints/statements of concern.
  - Spouses
  - Colleagues
  - Administrators
  - Medical Staff Leaders
  - Community members (patients, pastors)
  - Individuals (licensees)
- They investigate.
- They do interventions.
  - Volunteer Intervenors Corps

# Typical Monitoring Regimens

- Five-year duration (for nurses, sometimes two years)
- 48 random urine drug tests per year in Year 1 (and often Year 2)
- Frequency

# Professionals Health Programs
## Physician Health
## Dentist/Nursing/Pharmacist et al. Health

Three Functions/Charges/Missions of Professionals Health Programs

1. Monitoring/Case Management
2. Education About Professionals' Health
3. Advocacy for Participants

# Conditions Addressed by Professionals Health Programs

Addiction

Mental Disorders

Disruptive/Abusive Behavior

Boundary Violations

Burnout

Wellness

Disease Prevention/Health Promotion

# Contingency Management

Petry, NM. (2011) Contingency management: what it is and why psychiatrists should want to use it. Psychiatrist. May; 35(5): 161–163. doi: 10.1192/pb.bp.110.031831

- Contingency management is a highly effective treatment for substance use and related disorders.
- Contingency management refers to a type of behavioral therapy in which individuals are ‘reinforced’, or rewarded, for evidence of positive behavioral change.
- Dependent variable: attendance, medication adherence, (-) UDT results
- The reinforcers typically consist of vouchers exchangeable for retail goods and services or the opportunity to win prizes.



# Contingency Management

Petry, NM. (2011) Contingency management: what it is and why psychiatrists should want to use it. Psychiatrist. May; 35(5): 161–163. doi: 10.1192/pb.bp.110.031831

- Contingency management interventions are based on principles of basic behavioral analysis. A behavior that is reinforced in close temporal proximity to its occurrence will increase in frequency.

*[NOTE: Swift reward or punishment as a consequence of behavior is a key component of Drug Court programs. The highest success rates in outcome studies of addiction treatment are PHPs and Drug Courts!]*



# Contingency Management

In Professionals Health Programs, the reward for attendance and negative urine drug test results is the ability to continue in the diversion program, continue to practice under monitoring, and avoid referral for discipline.

In Professionals Health Programs, the bottom-line contingency isn't a reward but a punishment:

- If you violate the terms of your Participation Contract, you can be referred to your licensure board, discharged from the PHP, or both



# Chronic Disease Management in the Treatment of Addiction

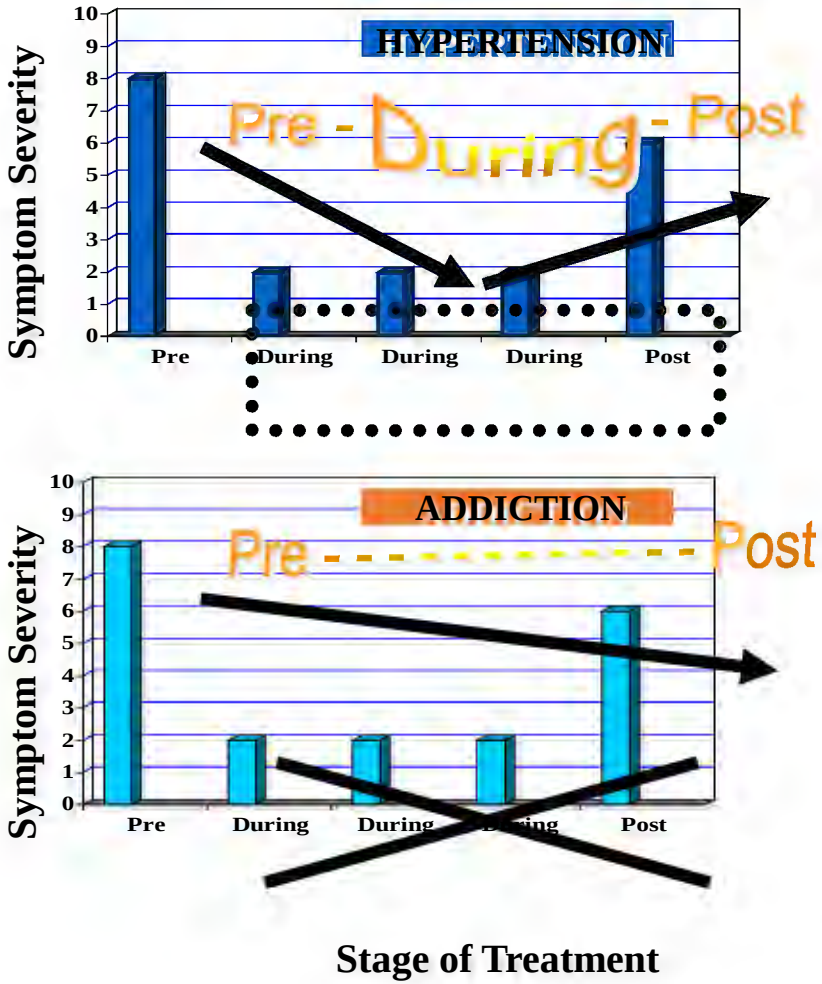
**What are the treatment goals for chronic disease management?**

- Decrease frequency of relapses
- Decrease severity of relapses
- Increase duration of remission
- Optimize level of function during remissions

# Addiction as a Chronic Disease

- You don’t cure it, you manage it.
- You remain with the patient and available to them.
- You act like a doctor!
- *After* the phase of active treatment, when the condition is stabilized and the patient is in remission, you *continue* your relationship:  MAINTENANCE ‘well-patient’ visits, to MONITOR their status of remission.

# Evaluation of A Hypothetical Treatment




***Just Like Hypertension, Addiction Is A Chronic Disease That Requires Continued Care***

***Source: McLellan, AT, Addiction 97:249-252, 2002.***

***Moral of the story: keep the treatment condition in place; don't withdraw the treatment condition!***

# Benefits of Chronic Disease Management: *Keeping "The Treatment Condition" in Place*

- Early detection of relapse
- Detection of risk factors for relapse
- Facilitate re-engagement with active efforts
  - Therapy for addiction
  - Self-help
  - Re-institution of pharmacotherapy?
  - Referral for co-occurring conditions (mental health issues that can set patient up to return to use)



# Chronic Disease Management

Why don't all patients with addiction receive the treatment that physicians with addiction receive?

- Comprehensive evaluation (addiction, MH, physical illness)
- Intensive treatment initially (Intensive Outpatient [IOP], Partial Hospitalization [PHP], Residential Treatment Center [RTC]
- Treatment continues for the duration of the monitoring contract
  - Keep seeing your addiction clinician
  - Often use IOP as stepdown after RTC
  - Weekly recovery groups and 1:1 with counselor for 1–2 years
  - Quarterly visits with addiction medicine physician for 5 years
  - Lab monitoring for all 5 years, with decreasing frequency



# Benefits of Professionals Health Programs

- People who have incidents at work that are related to an underlying health condition are treated at patients and not as “bad people.”
- Treatment, rehabilitation, recovery, and return to work happen.
  - 75% of physicians in PHPs have zero relapses.
  - Of those with relapses, 75% have no further relapses before d/c from PHP.
- The workforce is replenished.
- The workforce is enriched (persons in recovery are healthier and can be unique assets within their practice environment and community).
  - Helping to intervene/support other health professionals in same circumstance
  - Contributing to education about physician illness/recovery and success
  - Some health systems/employers preferentially recruit monitored physicians!



# Benefits of Professionals Health Programs

- “Diversion from Discipline” programs can work for persons with criminal histories (controlled substances law violations, fraud convictions, sexual abuse convictions), but, in general, licensure boards will not allow persons to avoid discipline in such cases.
- If you have been “bad” as well as “sick,” unprofessional conduct takes precedence.

# Benefits of Professionals Health Programs

- They can be involved with an individual before a clinical condition is present.
- Services to address “professional burnout.”
- Disease Prevention/Health Promotion for doctors and nurses!
- They can offer education/support for affected family members.
- They can allow participation in their programming (including monitoring) by trainees (residents with licenses, medical students and other health professional students without licenses).



# Thank you!

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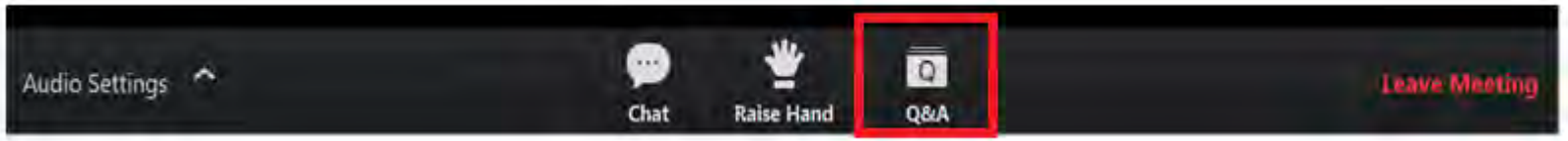
# Submitting Questions and Comments

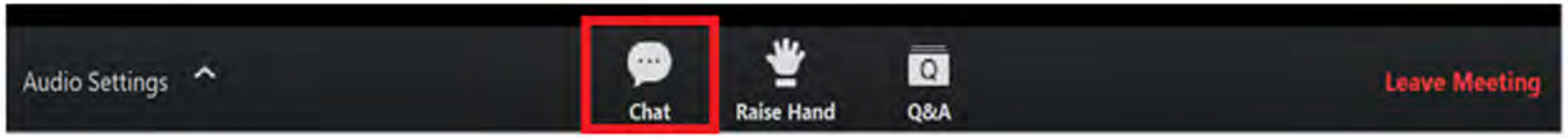
Submit questions by using the Q&A feature.

To open your Q&A window, click on the Q&A icon on the bottom center of your Zoom window.



# Webinar Evaluation Survey

- Please take 2-3 minutes to fill out the webinar evaluation survey.
- To locate the survey link, check the chat box located at the bottom of your Zoom window.




- Click the link to open the evaluation in your internet browser.

*Your feedback provides important information to JBS TA that helps future RCORP webinars!*

*Thank you!*

# Thank you

The purpose of RCORP is to support treatment for and prevention of substance use disorder, including opioid use disorder, in rural counties at the highest risk for substance use disorder.

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RCORP-TA

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