

WPHP Report: Setting the Record Straight, Part 3



WASHINGTON
**Medical
Commission**
Licensing. Accountability. Leadership.

Chris Bundy, MD, MPH
Executive Medical Director,
Washington Physicians Health Program

Introduction

In this, the final installment in this series, we continue our journey toward a deeper understanding of what your physician health program is, what it does and why. As previously mentioned, part of WPHP's mission is to inform and educate the medical community about physician health and impairment. In so doing, we facilitate informed decision-making and demonstrate accountability to those we serve. One of the areas of our work that is often misunderstood is the evaluation and treatment process, particularly with respect to concerns related to substance use. In what follows, I will address some of the common questions and nuances about the evaluation and treatment process as well as the outcomes that support our model.

Does WPHP provide treatment?

No. WPHP provides case management and referral for evaluation and treatment based on an initial assessment conducted by our clinical staff. This assessment includes an extensive biopsychosocial history, toxicology testing and cognitive screening. In addition, we engage in a detailed review of the concerns that led to the WPHP referral and the health professional's understanding of those circumstances. We then integrate all the available data into a clinical formulation that serves as the basis for next steps. Often, we identify illness or distress but no evidence of impairment or risk of impairment. In such cases we can offer support, referral for treatment and other resources without the need for ongoing monitoring. However, if we believe the individual is impaired (unable to practice with reasonable skill and safety due to a health condition) or at significant risk for impairment we may recommend a comprehensive diagnostic evaluation (CDE) at a center with special expertise in the assessment of physicians and other safety sensitive workers. Independent third-party evaluation and treatment helps ensure an objective and accurate appraisal of the individual's health and safety to practice.

How does WPHP select evaluation and treatment centers?

WPHP approves the evaluation and treatment centers that provide CDEs and multidisciplinary treatment based on criteria set forth in the Federation of State Physician Health Program Guidelines (1), the Federation of State Medical Boards Policy on Physician Impairment (2) and our Department of Health contract. It is well known that physicians and other health professionals require specialized evaluation and treatment services

tailored to the unique manifestations of illness, response to treatment, and professional re-entry characteristics of this population (3). It is critical that these programs have substantial experience and expertise in the evaluation and treatment of health professionals, specific programming unique to their needs and, in treatment settings, a cohort of health professional peers. In addition, these programs must have the developed expertise to evaluate a health professional's fitness for practice and provide return to practice plans that are informed by a thorough understanding of the professional's health condition and job-specific work demands.

How accessible is this specialized care?

Unfortunately, there are a limited number of programs across the country that meet our rigorous approval criteria, and none are currently located in Washington. In addition, the higher level of treatment intensity and duration required to facilitate an expedient and safe return to practice may not be adequately covered by health insurance, thus increasing the self-pay burden to physicians. This is almost always a source of distress for our participants. It is therefore not surprising that participants often lobby for local treatment from providers of their choosing covered by their health insurance. However, experience has shown that compromising the quality of evaluation and treatment in the interest of cost, convenience or participant preference can result in poor or even devastating personal and professional outcomes while also undermining the credibility of WPHP advocacy upon which our participants rely. While relapse or recurrence may be expected in the recovery process, health care employers, credentialing entities and the public are, understandably, less tolerant of such in physicians and other health professionals. It is therefore imperative that WPHP follow established guidelines that are designed to promote the best outcomes for physicians and the public.

When our peers get sick, they deserve the best care and opportunity for rehabilitation and return to work available. WPHP tirelessly advocates with payors and providers to mitigate out of pocket care expenses for our participants. In addition, we provide need-based scholarships, funded from charitable donations, to assist with evaluation and treatment expenses. Through these efforts, we have been very successful in helping our participants overcome financial barriers to appropriate care.

How does WPHP protect against bias in the evaluation process?

Conflict of interest in the evaluation process has typically centered on two concerns. The first is a misguided idea that PHPs somehow receive financial benefit from the evaluation and treatment centers they use. As stated in Part 1 of this series, WPHP has strict conflict of interest policies that prohibit us from accepting any material benefit from an organization or entity with a business interest in WPHP. We strongly believe that, in no case, should there be a financial or business interest between a PHP and approved evaluation or treatment providers.

The second concern involves the idea that conflict of interest is inherent when evaluators also serve as treatment providers. This situation is neither unique nor discouraged in the orthodoxy of the medical profession, where it is customary to provide both diagnostic and treatment services. That said, because of the potential professional implications involved in these evaluations, WPHP takes several measures to mitigate actual or perceived conflicts. WPHP informs participants when evaluators also provide treatment, provides participants with a choice of several approved evaluators, advises participants that they may inform their evaluator that they intend to pursue treatment elsewhere if treatment is recommended and directs evaluators to recuse themselves from offering treatment if the participant raises concerns about conflict of interest.

What outcomes can a doctor or PA expect by participating in the program?

WPHP assesses program performance and develops program improvements through systematic collection and analysis of clinical data and participant surveys. Numerous quality, satisfaction and outcome variables are measured and compared to internal and external benchmarks.

More than 90% of WPHP participants are working in their field at program completion with 87% having their medical license in good standing without restriction and 75% reporting benefit from WPHP advocacy. Among substance use disorder (SUD) participants, 80% have no relapse to active use during the 5-year monitoring period and, among those that relapse, two-thirds have a single brief episode. These outcomes are typical of PHPs (4), have been stable over time (5) and are unrivaled in the field of addiction medicine. It is more challenging to define and categorize relapse or recurrence for non-substance related conditions, so we don't have systematic data on these outcomes. However, our experience and research (6) suggest outcomes are comparable to those achieved by our SUD participants.

96% of participants rate their overall health as good or higher at program completion with two-thirds of that group rating their health as very good or excellent. WPHP participants consistently experience less than half the

rate of burnout reported in national samples with only 15% reporting significant symptoms of burnout in 2019. At program completion, 80% report improved personal relationships and better work-life balance that they attribute directly to program participation. In short, the benefits of program participation extend beyond management of the impairing health condition. For a more detailed review of these benefits please see our WPHP 2019 Annual Report.

Program participants report high levels of satisfaction. Over the past four years, 60-80% participants have rated their overall program satisfaction at six points or higher on a seven-point Likert scale. We have received similar satisfaction ratings from Chief Medical Officers and Graduate Medical Education Program Directors. At program completion, 80% of participants rate the program as "extremely useful" or "lifesaving" on anonymous exit surveys and 95% report being treated with courtesy, respect and professionalism by WPHP staff.

Finally, and perhaps most importantly; suicide appears to be rare among WPHP participants. Over the past 10 years, there have been three WPHP program participants who died from suicide. Due to incomplete data and low base rate issues in studying suicide, we can't know for sure whether the relative risk for suicide among WPHP program participants is higher or lower than non-participant health professionals in Washington. However, we do know that WPHP participants have risk factors for suicide that place them at the highest levels of risk among an already high-risk group (physicians are 1.5-3.5 times more likely to die by suicide than the general population). Although physician suicide statistics for Washington are not known, suicide rates among physicians nationally allow us to estimate that at least 100 physician suicides likely occurred in our state during the past decade. This means that the vast majority of physician suicides (known and unknown) in Washington occurred outside of our program. That so few suicides have occurred among WPHP participants, who are arguably among the highest risk for suicide among physicians and PA's in Washington, suggests that involvement in WPHP may be protective against suicide, especially considering that we intervene on the very factors that most contribute to elevated risk. I have personally had dozens of participants tell me that WPHP saved their life and that they had been on the brink of suicide or made a suicide attempt prior to coming into our program. I often wonder how many deaths from suicide might have been prevented had the physician or PA found WPHP first.

Conclusion

It is my sincere hope that this series has shed light on the work we do and how it benefits our colleagues, patients and the profession. Threading the needle of rehabilitation and advocacy for our participants while protecting public safety is a complex and often daunting endeavor. The

WPHP Report

challenges and rewards of this work fuel the passion and commitment required so that our participants may flourish. I will unapologetically confess that I am most certainly biased. As a former WPHP participant myself, I offer my own testimonial as to the merits of this program, an unequivocal endorsement that is rooted in personal experience. And while I have tried to focus on clear and accurate data in describing our program so that readers might arrive at their own conclusions, it is difficult to interpret the words of this series without the benefit of context. In the end, it is our participants and alumni themselves who provide that context – it is their voices and stories that bring hope and meaning to the information that this series has provided. To hear from them, learn more about our program and stay up to date on issues in physician health, please visit us at our recently updated [website](#) and/or follow us on [Facebook](#) and [LinkedIn](#). We look forward to continuing this journey with you!

References

1. Federation of State Physician Health Programs, Physician Health Program Guidelines, 2019. Accessed 2/4/2020 at <https://www.fsphp.org/resources>
2. Federation of State Medical Boards, Policy on Physician Impairment, 2011. Accessed 2/4/2020 at <https://www.fsmb.org/siteassets/advocacy/policies/physician-impairment.pdf>.
3. Earley, P. "Physicians Health Programs and Addiction among Physicians." Chap. 49 In American Society of Addiction Medicine, Principles of Addiction Medicine, edited by S Miller, D Fiellin, R Rosenthal and R Saitz, 671-92. Philadelphia: Wolters Kluwer, 2019.
4. McLellan, AT, Skipper, GE, Campbell, M, and R.L., D. "Five Year Outcomes in a Cohort Study of Physicians Treated for Substance Use Disorders in the United States." *BMJ* 337 (2008): 1-6.
5. Domino, K, Hornbein, TF, Polissar, NL, Renner, G, Johnson, J, Alberti, S, and Hanks, L. "Risk Factors for Relapse in Health Care Professionals with Substance Use Disorders." *JAMA* 293, no. 12 (2005): 1453-60.
6. Knight, JR, Sanchez, LT, Sherritt L, Bresnahan, L, Fromson, JA. "Outcomes of a Monitoring Program for Physicians with Mental and Behavioral Health Problems." *Journal of Psychiatric Practice* 13, no. 1 (2007): 25-32.

Billing hepatitis C medications for Apple Health clients

From [Health Care Authority](#)

All hepatitis C (HCV) medications are paid for by the Apple Health (Medicaid) fee-for-service (FFS) program. Mavyret does not require prior authorization (PA). All other HCV medications require PA. For coverage criteria please see the [Antivirals - Hepatitis C Treatment policy](#).

To bill FFS for an HCV medication prescribed to a client enrolled in an Apple Health Managed Care Plan, include a "2" in the Claim Segment, Prior Authorization Type Code (461-EU) field. All FFS rules apply, including authorization requirements.

If a pharmacy claim for an HCV medication is billed to an Apple Health Managed Care Plan, you will receive the following rejection message:

Apple Health Managed Care Plan	Message Line 1	Message Line 2
Amerigroup	Product Service ID Carve-Out Bill Medicaid Fee for Service.	Excluded NDC, Bill WA FFS BIN 610706 Plan Exclusion
Community Health Plan	Product/services not covered	Bill HCA FFS- Call 800-562-3022
Coordinated Care	Bill to Health Care Authority	Contact HCA at 800-562-3022. Plan Exclusion.
Molina	831 Bill Medicaid FFS	Plan Exclusion bill to Provider One
United Health	Bill Fee For Service	

For questions, please [e-mail us](#).