PRN: A Comprehensive Approach to Impaired Physicians and Healthcare Providers


14th Annual Cardiovascular Conference
World Golf Village
Friday April 12, 2013

- Clinical Associate Physician for Professionals Resource Network (PRN) and former Assistant Medical Director
- Medical Director for the Intervention Project for Nurses (IPN)
- Director at Large for the American Society of Addiction Medicine’s Board of Directors
- American Board of Addiction Medicine Certified
- On Board of Directors for the Brain Health Foundation (not for profit brain research organization developed for the Jacksonville Psychiatric Society)
- Private Addiction Medicine and Psychiatry Practice since 1984
- One of the 3 Principle Investigators for the Phase 2 and 3 Clinical Trials for the FDA approval of Suboxone

Disclosures

Speaker & Consultant for: Reckitt Benckiser and Alkermes
Learning Objectives

Gain an understanding about:

- The challenges that physicians and other health professionals face that put them at risk for addiction(s) and mental health problems.
- The types of impairment in a professional’s ability to work safely.
- Specific data about monitored professionals.
- The mission and purpose of PRN.
- What the resources are that PRN provides to assure the ability to safely return to work.
- How monitoring is accomplished.
- How to report or self-report when impairment exists.
Physicians & healthcare providers are held to a higher standard.

When impaired, they can present challenges to those who provide care and monitoring.
The challenges of dealing with the impaired healthcare provider
The Professionals Resource Network

Administered by The Florida Medical Foundation which is a Non-for-profit branch of The Florida Medical Association, Inc. established in 1874
The Professionals Resource Network Mission:

- To protect the public in the state of Florida by assuring the health and safety of practitioners and the integrity of the medical professions.

- To provide advocacy for health practitioners.
Professionals Resource Network

“Broad Brush” approach

Professionals Task
- Resource Orientated
- Network Group

Family Network
- Special Projects
- Litigation Network
- Stress Network

Infectious Disease Network
- Chemical Dependency Network
- Psychiatric Network
- DOH Evaluation
- Sexual Disorder & Offender Network
- Monitoring
- Data Management
- Regulatory Liaison Services
3% behavior problems
4% boundary problems
55% chemical dependency
10% concurrent
12% dual diagnosis (psych and CD)
12% psychiatric
4% other (cognitive, physical/medical etc.)

* (as of April 1, 2013)
1.5% of All Florida’s Private Practice Physicians are in PRN

605 Active Physicians in PRN at this time *

605 Physicians (MD/DO) Monitored

0 1 2 3 4 5 6 7 8 9 10

* (as of April 1, 2013)
Physicians Monitored by Profession

- Anesthesiologists 7%
- Family Practice 9%
- Emergency Medicine 3%
- Psychiatrists 4%
- Surgeons 8%
- Internal Medicine 6%
- Pediatricians 3%
- OB/GYN 2%
By profession:

- 56% of the total population monitored by PRN are doctorate level professionals.
- 44% of the total population monitored by PRN are non-doctorate level professionals.
By profession (doctoral):

- 58% of the doctorate level professions (other than MD/DOs) monitored by PRN include Veterinarians, Dentists, Podiatrists, Psychologists, Chiropractors, etc.. They are not otherwise specified in this lecture.

- 42% of the doctorate level professions are physicians (MDs or DOs).
PRN’s Physician addiction outcome study - 92% drug free after 5 years!

- 24 randomly selected physicians (23 males and 1 female)
- 10 medical subspecialties represented
- Age range 30 to 63 years old
- 37.5% with history of IV drug use
- Recovery supported by: frequent drug screens, counselor reports, addictionist or psychiatrist evaluations, AA/NA attendance and return to work
- Most studies report 30 to 60% success at 6 months
Types of impairment addressed:

- Chemical Dependency or Abuse
- Psychiatric disorders that are potentially impairing
- Sexual boundary violators
- Medical and infection diseases that can result in impairment
- Disruptive physicians
The Disruptive Physician

(More recently added category of monitoring at PRN)
The physician profile:

Gabbard & Menninger – 1988

- Family heroes that have fragile egos
- Choose nurturing mates, yet shun partner’s efforts to nurture
- Work is tied to self esteem
- Able to attain esteem from approval without the threats associated with intimacy
The physician profile:

Valient, et. al.

- Physicians are more apt to have suffered an emotionally impoverished childhood.
- They attract a nurturing mate to override physician’s fragile ego.
- Family Hero: Valued for Accomplishments.
- Develop into perfectionistic workaholics (good for career – bad for relationships).
Physician in a vicious cycle:

- Physicians become workaholics to compensate for their perceived impoverishment
- Feel guilt about prolonged time from home
- Spouse becomes frustrated, angry and critical
- Emotions are expressed negatively
- Self esteem boosted by approval at work
- More time spent at work = more guilt
Family delays gratification:

It will get better & we’ll be a family when:

- He gets through medical school
- Residency is over
- He passes the Boards
- He becomes a partner
- The new physician comes
- He retires
Intrusions into the physician’s intimacy:

- Please don’t call me at work
- Will you be home for dinner?
- Night call
- Pager
- Cell phone
- Fatigue
- Managed care (stress in medicine)
Differences in communication:

- Women identify and share feeling better
- Her delusion: “He will learn to share.”
- Men: expect their emotional needs to be identified and met without communication
- Mate: can’t identify and fulfill needs (not mind readers) = frustration, guilt
- Quiet despair for years until crisis comes
Spouse experiences a loss of identity:

- Mrs. “Dr. Wonderful”
- Sacrifices for sake of family - She becomes both mother and father to the children
- Financially dependent on physician
- Job considered menial compared to the physician’s “life and death” decisions
- Family is second class to medical career
Marriage is jeopardized:

- Diverging activity and interests
- Spouse competes with high achieving MD/DO perfect mother, wife, professional
- Living with M Deity Syndrome (grandiosity of physician)
- Loss of identity: Becomes helpless, resentful, angry and depressed
The consequences - marital and family dysfunction.
Mix in addiction:

- Secrets, guilt and shame
- Loss of interest in family activities
- Social isolation
- Physician becomes less available emotionally
- Shirks responsibilities
- Physician acts out in other areas in life
“I don’t know. I may be man’s best friend, but I’m my own worst enemy.”
Response of spouse:

- **Roles of caretaker and support are exaggerated**
- **She feels responsible**
- **Covers up and makes excuses**
- **Organizes his chaos**
- **Takes over his responsibilities**
- **Frustration, exhaustion, guilt, fear and anger**
Communication problems increase:

- Both are in too much pain to discuss, much less understand each other’s feelings
- Over-controlled hostility
- Both running on empty
- Extramarital affairs
  - Addict – due to poor judgment
  - Spouse – vulnerable to another relationship
The relationship continues to deteriorate

“OF COURSE I DRINK A LOT. IF YOU WERE MARRIED TO YOU, YOU’D DRINK A LOT, TOO.”
Other consequences of addiction:

- Impaired judgment
- “Personality” changes
- Injury to self
- Decreased productivity
- Absenteeism
- Loss of employment
- Violent behaviors
- Medical problems
The consequences of addiction: errors in judgment
The consequences of addiction changes in “personality”
There is a relationship between workplace violence, domestic violence and child abuse and use of psychoactive substances.
The consequences of addiction - medical problems

- Icterus
- Cyanosis
- Gynaecomastia (in men)
- Scanty hair Testicular atrophy
- Splenomegaly
- Scratch marks pigmentation
- Palmar erythema Xanthomata Dupuytren's contracture
- Clubbing
- Oedema

Medical conditions and signs associated with addiction.
The consequences of addiction:

- Licensing Board action (probation, restrictions, reprimands, fines etc.)
- Legal sanctions
- Patient harm
- Malpractice suits
The consequences of addiction: harm to patient
The consequences of addiction: medical malpractice suits

Jury awards $3.5 million to man who says doctor operated drunk
The consequences of addiction:

- Prison
- Accidental death
- Suicide
The consequences of addiction: prison
The consequences of addiction: accidental overdose
The consequences of addiction: accidental overdose

Doctor’s death laid to painkilling drug

By Sandy Strickland
Staff writer

A young Jacksonville physician, who family members say was fatigued from a hectic work schedule and suffering from excruciating headaches, died accidentally after injecting a painkiller, officials announced yesterday.

The body of Dr. James “Rip” Corwin III was found 2½ months ago in the doctors’ lounge at St. Luke’s Hospital. He was to attend his brother’s wedding that afternoon.

Tests have determined that sufentanil, a synthetic opiate used as an anesthetic, was in Corwin’s body, said Dr. Bonifacio Floro, assistant Duval County medical examiner.

Corwin, a general surgeon, was in practice with his father, Dr. James Corwin II, a former Duval County School Board chairman.

Corwin was 33 and had been a football standout at Fletcher High School, where he played center and was captain of the team.

For several days before his death,

(See DUVAL, Page A-4)
The consequences of addiction:
The path to suicide
The consequences of addiction: The path to suicide
The consequences of addiction: Suicide
Suicide

ALCOHOL ABUSE   Family-of-Origin

14%   26%

Control Group   Suicide Group

(JAMA, May 1987, Vol. 257)
Suicide

DRUG PROBLEM EVER

Control Group  

Suicide Group

(JAMA, May 1987, Vol. 257)
Suicide

SELF PRESCRIPTION

22%  56%

Control Group  Suicide Group

(JAMA, May 1987, Vol. 257)
“You’re a doctor 24 hours a day - You can’t escape.”

“I don’t want my 13 month old son to grow up to be a doctor.”
“It wasn’t like he did it all the time - It wasn’t like every day - It was more for escape - like to sleep you know.”

“He could stop at anytime - He wanted to. And he would too.”
Debra Paul

Died at Age 27
Select populations monitored (as of 8/20/07):

- MD's: 482
- DO's: 56
- Pharmacists: 145
- Dentists: 52
- Psychologists: 13
- Massage therapists: 90

Legend:
- MD's
- DO's
- Pharmacists
- Dentists
- Psychologists
- Massage therapists
Anesthesiologists are disproportionately represented (as of April 1, 2013).

Physicians (MD/DO)

- Anesthesia: 7%
- All other physician specialties: 93%

All other specialties
Non MD/DO Professions studied:

< 1% Excluded
Gender comparison:
All Professions (as of April 1, 2013)

- Male: 71% (29 individuals)
- Female: 29%
Marital status percentage:
for PRN Participants

- Married: Doctorate 56, Pharmacist 55, Non-Doctorate 45
- Separated: Doctorate 7, Pharmacist 2, Non-Doctorate 5
- Divorced: Doctorate 22, Pharmacist 22, Non-Doctorate 24
- Widowed: Doctorate 1, Pharmacist 0, Non-Doctorate 0
- Never Married: Doctorate 14, Pharmacist 21, Non-Doctorate 26
Referral source percentage:
for PRN Participants

- Doctorate
- Pharmacist
- Non-Doctorate

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<th>Source</th>
<th>Doctorate</th>
<th>Pharmacist</th>
<th>Non-Doctorate</th>
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</table>
Smoking history percentage: for PRN Participants

- Doctorate
- Pharmacist
- Non-Doctorate

Current:
- Doctorate: 33%
- Pharmacist: 34%
- Non-Doctorate: 50%

Past:
- Doctorate: 35%
- Pharmacist: 26%
- Non-Doctorate: 28%

Never:
- Doctorate: 32%
- Pharmacist: 40%
- Non-Doctorate: 22%
THE FOLLOWING PROFESSIONS GROUPED TOGETHER HAVE A POPULATION OF LESS THAN 3%

PROF: Dietician/Nutritionist, Occupational Therapy, Acupuncturist, Clinical Lab Personnel, Clinical Social Workers, Dental Hygienist, Massage Therapy, Nursing Home Administrators, Optometrist, Opticianary, Physical Therapy, Speech-Language Pathology & Audiology, Hearing Aid Specialists, Medical Physicists, Electrolysis, Athletic Training

ACTIVE LICENSE as of 6/30/2004: 278,421
PRN RERRAL as of 6/30/2007: 1,072
% IN PRN: <1%

PRN vulnerable population:
Primary drug of choice:
Percentages For PRN Participants

Doctorate
Pharmacist
Non-Doctorate

<table>
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<tr>
<th>Drug</th>
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<td>2</td>
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<td>Opioids</td>
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<td>20</td>
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<td>Sed/Hypn</td>
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<tr>
<td>Stimulants</td>
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</tbody>
</table>
Average age of first use:
Percentage for PRN Participants

- **Alcohol**
  - Doctorate: 16
  - Pharmacist: 17
  - Non-Doctorate: 15

- **Cocaine**
  - Doctorate: 27
  - Pharmacist: 27
  - Non-Doctorate: 32

- **Marijuana**
  - Doctorate: 20
  - Pharmacist: 13
  - Non-Doctorate: 19

- **Opioids**
  - Doctorate: 32
  - Pharmacist: 27
  - Non-Doctorate: 26

- **Sed/Hypn**
  - Doctorate: 27
  - Pharmacist: 27
  - Non-Doctorate: 30

- **Stimulants**
  - Doctorate: 24
  - Pharmacist: 25
  - Non-Doctorate: 21
Motivations for seeking treatment: Percentages for PRN Participants

- Personal Problems: Doctorate 62%, Pharmacist 58%, Non-Doctorate 62%
- Family Problems: Doctorate 54%, Pharmacist 51%, Non-Doctorate 46%
- Occupational Problems: Doctorate 48%, Pharmacist 58%, Non-Doctorate 47%
- Mandatory Referral: Doctorate 34%, Pharmacist 36%, Non-Doctorate 37%
- Benevolent Coercion: Doctorate 40%, Pharmacist 39%, Non-Doctorate 19%
History of chemical dependency in Family of Origin

- **Mother**: 26 Doctorate, 12 Pharmacist, 20 Non-Doctorate
- **Father**: 31 Doctorate, 26 Pharmacist, 45 Non-Doctorate
- **Sister**: 13 Doctorate, 11 Pharmacist, 24 Non-Doctorate
- **Brother**: 24 Doctorate, 24 Pharmacist, 24 Non-Doctorate
Each specialty has unique risks:

- D.O.’s at sex boundary risk with close contact during manipulation
- Anesthesiologists have a plethora of drug choices “under their nose”
- Dentists who use Nitrous Oxide at risk for offending sexual boundaries
- Psychiatrists at risk for inappropriate relationships
Pharmacist's temptation:

“So... how do you like working as a pharmacist?”
Dentists who use nitrous oxide at risk for offending sexual boundaries

Dental case prompts emotional testimony

Cape dentist accused of sexual misconduct

By LEE MELSEK
News-Press staff writer

A teen-aged former dental assistant tearfully described to a state hearing examiner Thursday how she claims Cape Coral dentist Steven Schwartz molested her after placing her under the influence of nitrous oxide.

Jimerson’s complaint to Florida’s Agency for Health Care Administration, which regulates state medical professionals, triggered Thursday’s hearing in Fort Myers before state hearing officer David Maloney. Maloney will make a recommendation to the Florida Board of Dentistry by April as to whether Schwartz vio-
Obligation to report impairment:

- Practice Acts in many states provide possible discipline for failing to report.
- Can provide immunity from civil liability.
Impaired practitioner legislation provides:

- In some cases, a therapeutic alternative to the disciplinary process.
- In other cases, therapeutic intervention and treatment concurrent with disciplinary proceedings.
Impaired practitioner legislation provides:

- Recognition that illness and recovery can be mitigating factors in Licensing Board action.
- An opportunity for a licensee to reenter practice after satisfactorily completing appropriate treatment and demonstrating progress with recovery.
Impaired practitioner legislation provides:

- Increased incentive for self reporting.
- Early intervention.
- Increased incentive for entry into treatment.
Reporting to impaired practitioner program Vs. Licensing Board:

- Physicians Recovery Network: Confidential and provides for treatment along with advocacy.
- Licensing Boards: Information becomes public and is disciplinary.
Intervention and evaluation:

- Interrupts the addiction process.

- Intervention can be done by telephone, at home or in the place of practice.

- The practitioner is confronted with verified reports of behavior and events that are indicative of impairment.
Intervention and evaluation:

- Removes from threat of harm by either Voluntary Withdraw from Practice or (sometimes an Emergency Suspension or Restriction of Practice Order is necessary).

- Evaluation is arranged through a Board Approved Evaluator/Treatment Provider.
Evaluation for addiction in the health professions:

- **History**
- **Physical signs**
- **Co-morbid medical conditions**
- **Laboratory signs**
- **Behavioral signs**
- **Collateral information**
- **Observed chain of custody urine specimen**
At my physical exam today, the doctor asked how many drinks I have a day.

What did you tell him?

Of course.

Two.

Do you think he believed you?
Addiction, disruptive or just “letting off a little steam”?
History of impaired functioning at work

"Oh, nothing serious. I just cut myself shaving."
Identification of the addict:
Physical signs

- Icterus
- Cyanosis
- Gynaecomastia (in men)
- Scanty hair
- Testicular atrophy
- Splenomegaly
- Scratch marks
- Pigmentation
- Palmar erythema
- Xanthomata
- Dupuytren's contracture
- Clubbing
- Oedema

- Spider naevi
- Hepatomegaly
- Purpura
- Ascites
- Distended veins
- Tattoos
- Flapping tremor
- Leuconychia
- Koilonychia
- Paronychia

- Oedema
Identification of the addict: don’t forget to look for nasal septum changes

225 Nasal vestibulitis with squamous epithelium replacing the mucosa. A deviation of the septum has predisposed to a chronic vestibulitis. Digital irritation, or the use of cocaine which may also lead on to a septal perforation may underlie this problem. Despite the increased use of cocaine gross septal damage in cocaine sniffers is not very common.
Look for IV tracts
Look for IV tracts in “unusual” places also.
Identification of the addict - consider laboratory signs

**A5-4 Iron-deficiency anemia.** In severe iron deficiency, the red blood cells are smaller than normal (microcytosis), and their central area of pallor is expanded (hypochromia) so that the cells appear to have only a thin rim of hemoglobin.

**A5-2 Megaloblastic anemia.** Oval macrocytes, well filled with hemoglobin, are admixed with lesser numbers of small tear-drop-shaped red blood cells. Note also hyper-segmented granulocyte.
Consider associated medical conditions: (i.e. Esophagitis)
Get an observed urine collection

DRUG-TESTING COMES TO THE FARM....

BUT I COULDN'T! NOT WITH YOU HERE!!
The threat of license issues facilitates compliance with evaluation and treatment.
Treatment options include:

- No treatment (if no impairment exists).
- Outpatient.
- Intensive Outpatient (IOP).
- Partial Hospitalization (PHP).
- Extended Residential.
- Inpatient Residential.
- Some combination of the above.
Treatment dynamics:

- Addict receives significant treatment
- Learns new behaviors
- Works on family of origin issues
- Understands interpersonal psychodynamics at a deeper level
- Practices directness and recovery behaviors
- Wants to try it out – AT HOME !!!
- The relationship is severely challenged!
Is that 2 steps forward and 1 step back or 2 steps back and 1 forward?

"GUESS WHO MY BARTENDER DECIDED CAUSES ALL THE TROUBLE IN THIS FAMILY?"
Response of significant other:

- Don’t talk that psychobable
- Can’t blame your family and childhood
- Does not understand this “foreign language”
- Don’t tell me to go to Al-Anon
- You’re the one with the problem
- I don’t have time
- You owe me!
Spouse at home:

- Experiences relief and frustration
- Handles all the family’s affairs:
  - Bills
  - Child care
  - House, cars, yard work etc.
- Addict off at “summer camp”
- Dealing with family shame
What to tell people?

- Stage I  keep it a secret
- Stage II  tell a few trusted people
- Stage III  evangelist: tell everyone
  martyr: tell everyone

Stage depends on level of denial verses acceptance of the disease
Family work during treatment:

- Family therapy assessment of addict
- Phone sessions with mate
- Conference calls with addict and mate
- Family visits
- Therapeutic leave of absence
- Work while in treatment sets the stage for returning home (especially mate’s work)
The “good looking” co-dependent:

- I’m not angry – I love him
- What can I do to help him?
- Tries to make it easy for addict - makes sure everything is OK
- May look good, but very hard to confront
- Emotionally frozen but may have intermittent angry explosions
The “Do nothing” mate:

- I don’t have a problem – addict does
- Angry, blaming and controlling - Continues same emotional state as before
- Becomes the victimized martyr
- Suspicious and mistrusting:
  “He was selfish when he was using and he is selfish now”
Spouse begins recovery:

- Begins to detach and takes things less personally
- Starts to accept the disease
- Looks at co-dependency issues
- Introduction to Al-Anon and contacting sponsor
- Gets individual therapy
- Attends family sessions
- Therapeutic Leave important in identifying triggers
Impaired professional monitoring:

- Contract with The Professionals Resource Network or appropriate program.
- Weekly facilitated monitoring groups throughout the state.
- Random Urine Drug Screens.
- Psychotherapy (if indicated).
- Other monitoring based on the case.
Contract with The Physicians Recovery Network:

- Typically 5 years duration.
- License long for Bipolar Affective Disorder Type 1.
- May have option for early release in 1-2 years if diagnosis is abuse or if long term sobriety that can not be documented.
Contract with The Physicians Recovery Network:

- Chemical Dependency (CD) - Doctoral and non-doctoral versions.
- Psychiatric Contract.
- Dual Diagnosis or Concurrent illness Contract.
- Special Procedures Contract (HIV).
- Behavioral Contract (Disruptive physicians).
- Sexual Boundary Violation Contract.
Facilitated groups:

- Run by a professional counselor.
- Meets weekly.
- Attended by local PRN participants.
- AA/NA/SMART Recovery attendance.
Family component offers therapy groups and statewide networking

**KUDZU** By Doug Marlette

MY SERMON TOPIC TODAY IS:

"ADAM AND EVE..."
Family financial help is available
Through The FMA Alliance to PRN component

"Cain and Abel..."

"The original dysfunctional family."
Toxicology monitoring system:

- Participant calls between 5 AM and 1 PM daily on week days.

- Advised to “drop” a urine on random basis depending on the assigned schedule.

- Participant must submit specimen at designated sight before lab closing at end of the work day.
Toxicology monitoring system:

- If away from the designated site but still in Florida, and advised to “drop”, then must call PRN Coordinator at the lab and arrange a new designated site for that day.

- If out of state, then call as usual. If advised to “drop” a specimen, then must call PRN Coordinator at the lab and reschedule, then fax proof of travel to PRN.
Toxicology monitoring system:

- The population you are dealing with is a consideration when selecting the panel (i.e. Anesthesiologists get tested for Fentanyl and Soma users get tested for meprobamate on a quarterly basis).
- Developing a frequency schedule
- Handling of positive results.
- Low creatinine and low specific gravity.
Urine drug screening:

**Frequency**

A. 0-6 months under contract - Weekly

B. 6 months. - 2 years under contract – Bi-Monthly

C. 2 years. - 4 years. under contract - Monthly

D. 4 years. - 5 years. under contract – Random (not to be called less than monthly)

E. Anesthesia & Related Professions – Fentanyl Quarterly in addition to above
Urine drug screening:

High Risk Population Definitions

- **Confirmed Relapse** - After/during appropriate treatment, contract begins again and UDS frequency starts over beginning with Frequency A for 6 months…etc…

- **Confirmed Multiple Relapses** (After two years recovery each time) - Contract begins again and participant is placed in Frequency A indefinitely with annual reviews.
High risk population - Does not take advise of facilitator
Urine drug screening:  
High Risk Population Definitions

- **Minimal Compliance** - Contract does not start over, but participant returns to Frequency A until 6 months of adequate compliance.

- **Regulatory/Probation Cases (CD Related)** - Frequency never goes beyond Frequency B until regulatory action is satisfactorily completed.
Urine drug screening:
High Risk Population Definitions

Low Creatinine/Low Specific Gravity (“Dilute or Abnormal report”) - After results are received:

- Within 24 hours confirmed observed drop - if repeat Low Creatinine or Low Specific Gravity, the participant will be sent for an evaluation.
- The evaluation results determine the frequency of UDS calls.
- Each case will be evaluated on an individual basis.
Urine drug screening:
High Risk Population Definitions

Suspected Relapse (Behavioral) - The PRN office will call additional UDS at the Clinical staff’s discretion until the issue of possible relapse is resolved.
Urine drug screening:

High Risk Population Definitions

Positive UDS - Relapse Not Confirmed - Rx not coordinated through PRN, but eventually authorized - Reviewed by PRN staff and UDS Frequency decided based upon individual case. As above and not authorized by Local Medical Doctor

a) evaluation

b) frequency determined on individual basis.
MRO Handling of positive urine:

- Legitimate prescriptions for Marinol, opiates, benzodiazepines and stimulants.
Primary reintegration:
Safe to practice

- Practice Parameters?
- Change in Practice Plan?
- Change in Practice Setting?
Primary reintegration:

Not safe to practice

- Time frame
- Monitoring while not in practice
- Re-evaluation before return to practice
- Employment while not in practice
- Disability
Competency evaluation:

- Neuropsychological Testing
- Skills Assessment (CARES @ University of Florida)
Steps to advocacy:

- Evaluation and intervention.
- Treatment.
- Monitoring - facilitated groups, Random Urine Drug Screens, Psychotherapy (if indicated) and other monitoring based on the nature of the case.
- Advocacy (to Licensing Boards, Hospitals, Insurance Companies etc..)
Advocacy:

- Is based on being in compliance with the Physicians Recovery Network Contract.

- Medical Director or Associate Physicians for Physicians Recovery Network appear at the Board or Council meeting as a consultant (per statute.)
Thank you for listening


Questions?