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Adaptations to substance use disorder monitoring by physician health programs in response to COVID-19

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The medical community and its regulatory bodies have shifted from viewing a physician's substance use disorder (SUD) as a strictly disciplinary issue to recognizing it as a chronic medical condition requiring treatment and rehabilitation (The Sick Physician, 1973). Physician health programs (PHPs) have evolved over several decades to assist physicians suffering from SUD or other potentially impairing conditions to salvage their lives and careers, enabling them to continue providing unimpaired and even exceptional medical care to their patients (DuPont et al., 2009). Due to the PHPs' dual missions of protecting the public while supporting physicians in their recovery, recommendations for the treatment and monitoring of physicians have generally been more intensive and stringent than what is recommended for patients with SUD in the general population (FSPHP, 2019). Specifically, physicians with SUD are generally first referred for a comprehensive assessment with an expert who specializes in evaluating this population, then—if indicated—they are referred for intensive treatment at a residential center with an established track-record of successfully treating health care professionals. Following discharge, they undergo PHP monitoring (with random toxicology testing, collateral reports, and required participation in facilitated group meetings and mutual support groups) for approximately 5 years. This work is vitally important in combatting the growing physician shortage (The Complexities of Physician Supply and Demand, 2019) and safeguarding community investments in the education and training of physicians.

Still, the juxtaposition of physicians as both human and heroic has never been so starkly apparent as during the COVID-19 pandemic. This crisis introduced a critical challenge for PHPs in determining how best to support those working in health care (often amid conditions of extreme emotional stress, personal and professional loss, and physical exhaustion) to protect against rekindling their SUD or co-occurring conditions. The restrictions that social-distancing guidelines imposed and the need for medical staff to be available on the front lines in the battle against COVID-19 required significant revamping of the standard assessment, treatment, and monitoring procedures. Faced with operating in the context of a rapidly transmitted deadly virus, PHP leaders had to re-evaluate prior assumptions regarding the implementation and execution of various program components. Discussions among PHP leaders examined the fundamental question of how to balance the dynamic tension between exposing physicians to unnecessary risk of infection via monitoring requirements that support recovery (i.e., in-person clinical services, support meetings, and toxicology testing), and sustaining a healthy and safe workforce amid a health care crisis. Tuning our approaches to find this balance presented both challenges and opportunities. In response, PHPs implemented flexible and creative solutions across the United States and Canada.

Prior to the COVID-19 pandemic, most services for the general SUD treatment population were initiated with in-person or telephone-based assessment and triage to the appropriate level of care. Similarly, PHPs received referrals and performed initial intake assessments primarily by face-to-face meetings or, less often, by phone. Most PHPs then referred physician clients to independent forensic medical evaluators with significant experience/expertise in evaluating physicians with potentially

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impairing conditions. Though several options for evaluators were typically provided, the assessments historically occurred face-to-face, and sometimes required travel and/or overnight stays, depending on the complexity of the referral question and the location of the referred physician. Pandemic-related restrictions on travel and social distancing required modifications to this process. Consequently, evaluators quickly shifted to offering telehealth evaluation services using HIPAA-compliant videoconferencing software. This ensured that most physicians could be seen in a timely manner, which increased access to care. However, these evaluations had some noteworthy limitations. Namely, lack of opportunity for a physical exam that might identify signs of drug use and/or symptoms of withdrawal, increased difficulty obtaining specimens for toxicology testing, and decreased opportunity for clinical observation resulted in less thorough evaluations being performed.

PHPs typically offer multiple treatment center options based on the physician's diagnoses, ASAM Criteria (Mee-Lee, 2013), location, and other individualized needs of the referral. Whereas in the general SUD treatment population, cohort-specific referrals are often determined by age, gender, or primary substance of abuse, for PHP participants, the treatment program should have expertise treating physicians and a history of successful outcomes, along with a sufficient physician peer group within the patient cohort, to maximize treatment outcome. Because most of these centers employ a partial-hospitalization or residential level of care, concerns about COVID-19 transmission were exacerbated. However, we found that treatment centers were very responsive to safety concerns, and providers began separating new admissions from their residential communities for a period of quarantine, with daily symptom screening and negative virus testing required (once available) to join community programming. Programs implemented new restrictions on visitors, and most programs suspended "weekend passes," therapeutic leave options, and opportunities for "commuter" status to decrease risk of infection/transmission. Some programs temporarily switched to virtual group therapy and provided patients with access to virtual mutual support group meetings and Caduceus meetings. Many treatment providers also implemented videoconferencing options for patients receiving lower levels of care. When in-person programming continued/resumed, many programs introduced mask mandates to further reduce the likelihood of virus transmission while restoring the opportunity for intimate sharing that may occur more readily during in-person group interactions. These important modifications allowed physicians with SUD to continue accessing high-quality treatment throughout the pandemic.

PHPs made multiple adjustments to their monitoring processes in response to COVID-19 as well (Table 1). First, PHPs disseminated information regarding local and national resources for dealing with stress to PHP participants to increase opportunities for connection and support. PHPs shared information on accessing virtual/online mutual help group meetings, along with contact information for crisis hotlines and assistance for health care professionals who were struggling. Pre-COVID-19, monitoring of attendance at mutual support meetings (which typically require in-person attendance 3 times weekly) generally involved paper logs, app-based electronic logs, and/or using GPS data from the participant's cellular phone to confirm presence at the designated meeting location at appropriate times. However, to reduce risk, mutual support meetings shifted to virtual formats. Anecdotally, participants often reported that their mutual support group meeting attendance actually increased, as a result of both their need for additional support and the ease of accessing online meetings. Many PHPs also require participation at weekly or monthly face-to-face facilitated groups, with reports from facilitators documenting attendance. These groups also switched to group videoconferencing platforms, with several PHP group facilitators reporting improved attendance among participants after switching to the online format.

Finally, a crucial component of monitoring is random and for-cause toxicology testing on a range of specimens, including urine, breath, blood, hair, and nails. Typically, third party administrators facilitate daily (Monday through Friday) check-ins that determine when PHP participants are randomly selected to present for specimen donation at predetermined collection sites. The COVID-19 pandemic introduced a number of challenges to this process, as many physicians had decreased flexibility to leave work for testing due to increased clinical responsibilities and/or burdensome PPE requirements. Access to testing centers was also limited in some cases, and the PHPs and participants expressed legitimate concerns regarding the increased risk of exposure while visiting testing centers. Thus, many PHPs shifted from heavy reliance on urine testing to alternative methods such as in-home salivary testing, with testing supplies mailed directly to the participant and chain-of-custody for specimens verified by cellular phone video records. Programs offered breath alcohol testing as an alternative to urine testing for many participants, and the addition of testing methods that cover a lengthier window of detection (e.g., hair/nail testing and blood phosphatidylethanol [PEth] testing) allowed for reduction in urine testing frequency. For urine testing, many PHPs arranged for collection at non-walk-in sites. In addition, PHPs extended the window for providing a specimen (from the typical 6–10 h after notification of selection to up to 48 h). This allowed physicians to schedule their toxicology tests, reducing wait time in public areas and minimizing the need to leave their posts at work. Though these alternatives were important stop-gap measures in a time of crisis, and they opened up the possibility for flexibility in future monitoring, their sole use is not ideal. Some of the methods (e.g., salivary and hair testing) introduced an increased financial burden, and extended windows for providing a specimen may result in increased opportunity to "beat the system" if offered consistently.

As the pandemic wears on, the decreased availability and increased burden of in-person evaluation, treatment, and monitoring options that fully meet the needs of physicians with SUD remain a considerable

Table 1
Adaptations to PHP monitoring in the era of COVID-19.

PHP intake procedures

- Shift to videoconference or phone-based intake sessions

Comprehensive evaluations

- Option for evaluations via telehealth to avoid travel and adhere to social distancing guidelines

Treatment center safety measures

- Isolation/quarantine of new patients
- Daily symptom screening/COVID testing (when available)
- Limitations on visitors
- Restrictions on therapeutic passes or "commuter" status option
- Switch to virtual or videoconferencing-based group therapy and mutual support group meetings
- Mask mandates on treatment center campus
- Telehealth services for patients receiving lower levels of care

Ongoing interpersonal monitoring

- Dissemination of information regarding national and local resources for stress management and crisis intervention
- Increased "check-in" contacts by PHP staff
- Switch to virtual/videoconferencing-based facilitated monitoring group meetings

Mutual support group meeting attendance

- Provision of information regarding online and virtual meetings
- Requirement for attendance at in-person meetings suspended in favor of virtual meetings

Toxicology testing

- Transition from reliance on frequent urine testing to alternate methods
  - o At-home testing (e.g., salivary and breath testing with chain-of-custody verified through cellular phone video)
  - o Lab-based testing of specimens with longer window of detection (e.g., hair, nail, blood testing)
- Arrangements for urine testing by appointment rather than walk-in only
- Increased window for providing urine specimen from 6–10 h to up to 48 h

challenge. Some interim solutions during COVID-19 that have been less than ideal will need to be evaluated on a case-by-case basis to determine when in-person services are more appropriate. However, an informal listserv poll of PHP program directors indicated that the many modifications to PHP functioning during this crisis, including alternative options for toxicology testing and increased use of tele-monitoring services and virtual peer support, have not led to an apparent surge in relapses. No instances of patient harm resulting from relapses of monitored physicians during the pandemic have been reported.

Indeed, though the risk of relapse/return to use may seem greater due to temporary disconnections from in-person support meetings, therapy, and medical care, as well as the isolation of lockdowns, thus far PHPs have not observed increased relapses compared to similar time periods pre-COVID-19. Potential mitigating factors may include the physicians' feelings of obligation to meet the challenge of their professional role and a strong personal commitment to service in a time of crisis, along with the scrutiny of colleagues. Additionally, those under monitoring often have designated workplace monitors/liaisons who fulfill combined roles of providing both accountability and support. Rapid implementation of outreach and support by PHP staff and uninterrupted toxicology testing likely helped to prevent relapse or, if a temporary return to use did occur, prevented loss of control.

Lessons learned during the acute crisis phase of the pandemic are already resulting in enduring adaptations that appear to be improving the monitoring experience for participants without increasing risk to recovery or patient safety. For example, the expanded use of telehealth evaluation services has the potential to increase convenience and decrease cost for patients who are forthcoming in their presentation of an uncomplicated SUD. Telehealth services may also provide greater access to ongoing follow-up care with a trusted/preferred treatment provider following discharge. Options for virtual monitoring group participation and recommendations regarding participation in online meetings are likely to continue in the future. In addition, alternative toxicology testing options will likely continue to be considered on an individual basis. Thus, we believe this initial positive experience may provide momentum for continuing opportunities to increase efficiency in the management of SUDs among our physician colleagues, as well as patients with SUD in the general population. The future of SUD monitoring for health professionals will almost certainly be characterized by greater flexibility, choice, and shared decision-making between the PHP and physician participant, so long as recovery support, accountability, and patient safety are not compromised. We embrace this disruptive opportunity to recalibrate the system, evolve the way we collaborate with and support physicians with SUDs, and promote the scholarly investigation of emerging questions and practices. Future studies should examine the impact of these modifications on recovery outcomes to ensure that we continue to provide the best possible care.

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