Speaker 1 (00:00:05):

All right, we're going to go ahead and get started. Again, thank you all for being here with us. Let me know if you're having any trouble hearing me or if I'm way too loud. I'm Gore Agarwal. I'm a psychiatrist and serve as our chief Wellness executive at Northwestern Medicine, and I'm joined with our wonderful panelists. So you'll get to meet in a moment and then they'll be sharing their innovations and interventions here with us shortly. As Emma said, we want to start off with just a couple of poll questions to get a little sense of who's here in the audience, and I think it'll spur a couple of conversations, a couple of key points that we want to get across today and highlight. So give you a second to use your laptops or your phones to log in or you can text as well. Alright, so we'll start with the first question. Which description best describes how you spend most of your time training clinician in a healthcare system or group practice clinician in solo private practice or in a leadership administrative role? Alright, that gives us a good sense of who's in the room and how some of the thoughts we had today may be useful to you.

Speaker 1 (00:01:31):

How often do you feel burned out from work?

Speaker 1 (00:01:51):

So the reason we wanted to ask this is certainly the talk today is about thinking about how to improve the mental health care for our healthcare workers. But as is often the case with healthcare workers, we want to be thinking not just about all the people we serve and care about of course, but ourselves, and we need this just as much as the fact that we'll be providing and delivering care for our healthcare workers. What I'm seeing in our work, and I think what you're seeing around the country is mental healthcare workers themselves are very, very burned out. I think, again, it's not to take away from our I C U colleagues or infectious disease colleagues or ED colleagues, but when people have talked about the front lines of the last few years, I don't think we get included in that group. But as I'm preaching to the choir, as you all know, we've been a part of that, and perhaps more importantly, we're going to be the front lines of this for years to come. And why wellness matters, of course is for lots of reasons. I think it's morally right, but it's also important from the delivery of cares. It is hard to care for others if we are struggling as well. Please.

Speaker 2 (00:03:02):

Sorry, are your speakers on? It's a little bit hard

Speaker 1 (00:03:04):

To hear you. Sorry. Is that better? Is that better? Sorry about that. Thank you for letting me know. Yeah, I was just saying that the mental health of mental health care workers has been challenged. And when I talk to my colleagues, there's a lot of reasons for that. There's a lot of pros of telehealth, but my colleagues have said after the newness wore off, it's a little bit different. They don't sometimes feel as connected with patients virtually. That's not true for everyone. But I was surprised to hear that given that when I first talked to folks in the first six months, nine months, they're like, this has actually been fantastic. Some of that newness seems to be wearing off. And I think the other thing we hear a lot is for many, for the past several years, people have said, listen, when I talk to folks, I don't actually know how to help them. Particularly when I talk to healthcare workers, I don't know how to tell 'em it's going to be okay. I don't know how to tell 'em it's going to get better. And that sort of helpless feeling is one of the core things of burnout when we think about reduced professional efficacy. And so I think it's very

important to remember, yes, we are today going to be talking about how do we improve mental health care for healthcare workers, but I don't want us to lose sight of that includes us as well.

Speaker 1 (00:04:24):

And I think our last question, if you clinically treat healthcare professionals, what is your experience over the past six months, seeing more, seeing less, or about the same?

Speaker 1 (00:04:37):

I don't know why I'm surprised that's sort of what the data says, but I'm still actually surprised. So everyone is seeing more. Okay, that's validating in some ways. It's good that people are seeking care, but it also suggests that there has been damage done. And certainly that's the whole point of this initiative is to make sure that if people are seeking care, how can we make sure that they have high quality care that's accessible to them? Thank you all for doing that with us today. It goes to the idea of why I said I'm surprised, but I really shouldn't be surprised. If you look at some of this work that was presented throughout the pandemic, part of the reason it's important to understand phases is so that you can prepare and plan for what the future holds or what you think the future may hold.

Speaker 1 (00:05:27):

And as you know, we are moving towards reconstruction. That's sort of the phase we are in disaster. But what I tell our leadership is that the quality of the rebuild, the quality of the reconstruction is going to be directly related to the quality of recovery. And if we don't focus in on recovery, don't be surprised if you're rebuild and reconstruction doesn't go as well as you think it should. And for us, the quality of recovery is directly related to are we able to help our workforce recover, whether that's through mental, healthcare, formal services or other services. But it is notorious that we skip, recover, go right to rebuild, and that we have unfortunately learned the lessons of the consequences of doing so. And so that's really important. And obviously Dr. Morganstein spoke to this throughout the pandemic and really warned us that the frontline of this recovery phase is us, is that the psychological impact is going to dwarf the biological impact for years to come, both in duration and in size. For us, that is the unmet need and the purpose of this initiative that we are here to talk about today is to make sure that we are prepared for this footprint that's coming towards us.

Speaker 1 (00:06:57):

And for us, we wanted to be really focused on what phase we could add value on as mental health care workers. So if we think about the occupational health model, it's really important that we spend a lot of time in primary prevention, which is how can we help people before they become stressed, distressed, and diseased? And for us, we're really heartened by the work of the A a, the National Academy of Medicine, the a many places are working on this primary prevention model of how can we make healthcare work better for everyone? How can we fix the system itself? And that's fantastic. So we didn't want to add more to that bucket. We wanted to really hone in on the next two buckets, which is secondary prevention. How do we help people that are under stress or distress recover quickly so they do not progress to disease in the first place?

Speaker 1 (00:07:52):

And the top triangle, how do we make sure that we have available resources and the conditions set for those that have progressed to disease to make sure that they can get healthy again as quickly as possible and with high quality healthcare. So our buckets are focusing in on secondary prevention and

tertiary prevention. And that's what you'll hear about from our panelists today is their role in addressing those parts of the occupational health triangle. And again, if we think about where are the needs, the needs are varied from a distressed perspective. There's of course the burnout, the moral injury from a mental health perspective, mental illness perspective, depression, chemical dependency, P T S D, suicidal ideation, anxiety, sleep disturbances. We're seeing all of these in our healthcare workforce and we want to really make sure that we provide those resources to help recover. And that's really what Frontline Connect been about is that's what we have been funded from the Brave of Heart Fund to think about and to create resources.

Speaker 1 (00:09:02):

And those of you are with us last year, we began this journey last year right here at the A foundation where we met, where we convened an expert round table with lots of various stakeholders to share what the healthcare workforce is going through, what the healthcare workforce needs, and what have been the barriers to date to help meet those needs. We continued after the annual meeting to meet with leaders, stakeholders from around the country, did a lot of deep dive interviews, and then we said, we are at risk of doing what everyone does is we put together a toolkit that goes to die in a desk somewhere. And we don't want to do that. And we don't want to talk about the problem. We don't want to just share the problem. We don't want to admire the problem. We want to give people the resources to actually tactically, strategically move the bottle, move the, what's the word I'm move the needle towards implementation.

Speaker 1 (00:10:04):

And that's what we really said. How can we do that? What are the ways, what we know from change management and implementation science that actually moves the needle? And what we know is positive peer pressure is useful. And so what we also know is that if we can convince people that this isn't theoretical, but that it's being done now, so you can't tell me it can't be done, it's already being done. That is incredibly helpful to overcome some of the resistance to change. And so that's where we decided, hey, let's get people that are doing wonderful things. Let's elevate their innovations and show people what is possible. Let's connect people with those leaders so that they can share how they did it. So I'm a coach as well. And so what and how questions are really important to me, not just the why's, the where's how, and what needs to happen is a great accelerator of change.

Speaker 1 (00:10:59):

And so we wanted to add to that value. And so we are connected to lots of leaders. Some of 'em are with us here today that will sort of share how we thought about this. And we started to record video case vignettes to create a toolkit short, I can't watch videos for a long time either 10, 15 minutes high yield. How did you do this? What are the things people should be thinking about if they want to stand up this intervention? What are the resources you need? What are barriers you encountered that we can help learn from so that other people can have maybe even a smoother ride than you had towards implementation? And so if you go to our website currently, this is what you'll see, you'll see a lot of our videos that are up. They give you a brief snippet of what the video's about, what the intervention or innovation is about, what need you might see that aligns with the need that you're seeing in your institutions that you can say, Hey, you know what?

Speaker 1 (00:11:58):

That is something that I've heard from our workforce, maybe I should look into that. And if you look on the blue ribbon, it sort of gives you a sense of the types of issues that we are trying to overcome with certain innovations. So if we're thinking about stigma, we're thinking about licensure and credentialing, suicide preventions, internal EAPs, external EAPs, physician health programs, peer supports manager trainings, the viral workplace mental health data point right now that's sort of like the social determinants of health, which is your zip code matters more than your genetic code. The workplace mental health data point is your manager matters more than your therapist, your manager and your leader matters more than as much as your spouse when it comes to your mental health. And so that's something that sort of gets people going, wow, we've got to really make sure that if these people matter that much to mental health, let's make sure and train our managers and leaders as the first line of defense and the first line of, Hey, something's not quite right, can we get you help?

Speaker 1 (00:13:01):

How do we do clinician training? So I've spent the last 12 years taking care of impaired healthcare workers and then certainly as a coach, that's what I do too in terms of wellness and burnout. And what I've learned is that there's a lot of unique features to taking care of healthcare workers. And if we just send every mental healthcare worker out there, sometimes they might miss it. And sometimes we only get one chance with our healthcare workers like, all right, fine, I'll go see somebody. And then it's a negative experience. You might lose that person to seeking care. And so how can we make sure that people have the appropriate skills and knowledge to provide the highest quality care to our healthcare workers? And then thinking about employee resource groups, creating mental health employee resource groups where people can begin to decrease that stigma, increase vulnerability, and share best practices.

Speaker 1 (00:13:55):

So these are some of the types of things you'll see in our videos, and we certainly hope you find them valuable. We've tried to create partnerships with the Dr. Lorna Breen's Heroes Foundation, the American Hospital Association, the H R S A and the Schwartz Center, to help with dissemination of this toolkit and certainly also to connect us with leaders. And we're grateful for everyone's support. And with that, certainly we recognize, I'm sure we have missed people out there. And so if you have a program or you're aware of a program that you're like, Hey, you know what? You should really talk to these folks. We encourage you to use this QR code and reach out to us. We still have room for additional innovations. And we'd be very excited to highlight other people's work. With that, I will turn it over to Dr. Moodier.

Speaker 3 (00:14:44):

Thank you for being with us.

Speaker 4 (00:14:46):

Awesome. Thank you so much, G. And it's wonderful to be here with you and my esteemed colleagues. I'm going to focus my comments to really just say that I come at a national scope of suicide prevention at A F S P as the Chief medical officer based on my own lived experience as a medical student, and then losses of physician colleagues 13 in total at U C S D over a period of 15 years and was doing many the things of academic medicine. But my secret mission was about suicide prevention and the mental health of our developing trainees and colleagues across the continuum. Now that I have the luxury in a way of focusing on suicide prevention and what does the science tell us? And the work at the American

Foundation for Suicide Prevention is growing in leaps and bounds because the public is hungry for it and ready for it.

Speaker 4 (00:15:41):

So we come at it through a scientific approach, but using the public health model, and I'll just tell you very briefly about A F S P before getting into the program that I want to highlight and was asked to highlight for this session. So A F SS P is the leading private funder of all suicide and suicide prevention research globally. Our current investment is about $35 million, and those are the $24 donations of millions of Americans who walk and are out of the darkness walks. So again, it's an exciting time where the readiness and the hunger and the public's understanding that science matters and we can't just go about doing things that feel good, but we have to be based in the evidence. We also are one of the leading voices on the hill and at every state level for suicide prevention and mental health. And we do come at suicide prevention through a very broad lens.

Speaker 4 (00:16:36):

As I mentioned, the public health model means that social determinants of mental health and suicide risk all matter. So our advocacy efforts are very much in partnership with groups like the A P A, both APAs and NAMI and Mental Health America, others. We produce prevention education programs. And what I want you to walk away with knowing is that at the primary prevention level of all of this healthcare worker, mental health and wellbeing support at the primary prevention level is education. And it has to be universal education for every citizen, but certainly for those who are in special positions to take care of one another. And so if you are looking for a suicide prevention education program, don't feel like you have to make that up from scratch to train your clinicians, your families in patient care, et cetera, A F S P. That's what we do at the national office.

Speaker 4 (00:17:35):

And then we trickle them out through our arms and legs, who are our chapters, 74 chapters across all 50 states. So we are eager to partner with any health system, with any organization really. I'm going to highlight the interactive screening program in just a moment, so I'll skip over that. We also have a very longstanding and robust dedicated effort to suicide loss, bereavement and healing. And so that's a large part of what we do through our chapter network and our programs. And I've mentioned that our chapters who are primarily volunteer driven. So our mission is to save lives and bring hope to those affected by suicide. We do use a public health framework as mentioned. These are just some of our many, many incredible partners. These are longstanding years long partnerships, and you'll see that I've circled the ones that are outside of the healthcare or certainly mental health space to just show you that the public health approach is starting to catch on in terms of we need a Netflix, we need the industry leader of veterinary medicine to trickle down suicide prevention to their members of veterinarians who also have very high suicide rates, it turns out, et cetera, et cetera.

Speaker 4 (00:18:46):

So it is an exciting time in many ways. I've felt like oddly and ironically in a way that healthcare systems and as an industry that we've had our own hangups, for lack of a better word, to really kind of progress and leap forward like so many other industries are doing when it comes to mental health advancements and suicide prevention. It's an odd sort of disconnect. So I'll just highlight very briefly that the interactive screening program was the program that I found when I was on the U C S D academic medicine side, struggling to start a suicide prevention program for our health workers, physicians, trainees, medical

students, pharmacists, nurses. And what is unique about I S P is that the user, the end user, has the choice to remain utterly anonymous as they fill out the questionnaire and then interact with a counselor. And that anonymity and the encrypted sort of web-based platform that we host is I think, and not just that, but the dynamic nature of the interchange between users and the counselors.

Speaker 4 (00:19:54):

These program counselors are trained by us and use motivational interviewing techniques so that the needle can be moved from fear and stigma and what will happen to my career if I speak up, if I seek help to a readiness to seek help. So I will close my comments there. And just one more thing. When it comes to loss and healing, we as a group of people are not immune to suicide loss and other type of grief and bereavement experiences. If you are a leader of an organization after a suicide occurs, there's a very key important moment we call postvention, where your leadership and that crisis team, the actions matter and the way that you communicate about the death and about the support that's available, and helping the to walk through a period of healthy grieving while mitigating risk for suicide contagion. It is tricky business. And again, no one wants to make that up as you go along. You're in crisis mode already, and it's not something that any of us, even me in my role do every day. And so we've taken the best practices and customized them into these toolkits for after a suicide. So again, please just know that they're available freely downloadable on AFP's website and I'll stop there, turn it over to Dr. Dj. Okay.

Speaker 5 (00:21:31):

I'm a talker, so I have to make sure I don't overdo it. Okay. So my name is Dr. Natalia je. I am honored and grateful to have the opportunity to speak on behalf of the Dr. Lorna Breen Heroes Foundation. I am actually an internal medicine physician, not a psychiatrist who is working as a locum tenant hospitalist at different healthcare systems throughout the us. But I wanted to come here to familiarize everyone here with our focus of the organization, which is to advance solutions that will improve the wellbeing of the healthcare workforce, as well as eliminate some of the persistent wellbeing and mental health barriers and challenges that a lot of our healthcare workers are facing now. So this is a picture of Dr. Lorna Breen, who is the inspiration for this foundation. I don't know if you see the resemblance, but I feel like I look like her a bit.

Speaker 5 (00:22:30):

A lot of her, we have a lot of similarities, but unfortunately I never had the opportunity to meet her. Both of us are New York City physicians, we're outgoing, we have a supportive and loving family. But in 2020 I was there just as her during the height of the Covid 19 pandemic, the struggle of dealing with the day-to-day stressors of just being a practicing clinician as well as someone who other colleagues go to for assistance and help. It became too much by getting close to her family. I learned that she confided in them that she felt that she would be ostracized at work if she acknowledged how bad she needed help. And someone found out. And shortly after on April 26th, 2020, she died by suicide. Her story leaked in the New York Times, and her sister, Jennifer Feist and her brother-in-law, Corey Feist, who are the co-founders of this foundation, realized that their tragedy was similar among a lot of loved ones of healthcare workers. So they made it their mission and vision to reduce the burnout that a lot of us healthcare workers have to endure. So

Speaker 5 (00:23:46):

Lemme just click this. Okay, so I wanted to illustrate because a lot of times burnout and depression, anxiety, excuse me, substance use disorders, these words are used interchangeably, but they're actually

two different entities. Burnout is organizational syndrome and occupational syndrome and depression, anxiety, substance use disorder. That's actual a medical diagnoses. However, underneath these are our target areas of how we can try to address these two drivers of how our healthcare workforce is deteriorating in terms of wellbeing. But at the center core of how we can advance these solutions and make sustainable change is leadership and culture. And that's where all of us, not just you, not just me, all of us can come together and address that. So through that, we have advocacy. And through the wonderful community of the foundation and senators such as Tim Kane, Senator Tim Kane of Virginia, we were able to pass the bipartisan act of the Dr. Lorna Breen Heroes Care, excuse me, the Dr. Lorna Breen Healthcare Provider Protection Act, where we have funding, which is a first of its kind act where we have programming and research and true studies to help spearhead this movement, which it is. But before we get there, there's systemic barriers to mental healthcare that we need to address.

Speaker 5 (00:25:24):

The Medscape survey that was out earlier this year, the Physician Burnout and Depression report of 2023, I don't know if you can see the first three statements that were mentioned deals with stigma and barriers. And you see that between 40 to 50% of clinicians are saying they fear that the medical board of their employer will find out that they worry that people will think less of them. So our foundation have tried to truly work on these barriers, these institutionalized aspects of barriers. So in order to do that, I want you to remember three things that we can do. It's audit, it's change, and communicate. There's a lot of things on this slide, but I wanted to just point out we can audit what we use for our licensure applications, what we use for our peer reforms that include sometimes invasive mental health questionnaires that have nothing to do with our ability to actually be providers and care for our patients and each other.

Speaker 5 (00:26:37):

Also, once you find that if there is these intrusive questionnaires or language change it, we each have the ability to do so. And at our organization, our foundation, we have a toolkit that gives you sample emails, sample templates and letters that we can do both from a organizational level as well as on a state level. And then lastly, communicate. In medicine, we feel, especially clinicians, if you didn't chart it, it didn't happen. So you could do all that you can to change, but if you don't effectively communicate that with your team, it goes unheard and people don't actually see that change. So those are the three things I hope to be able to discuss more with you today. Okay. And I'm going to take it over to my colleague, Ms. Linda Rehan. Sorry.

Speaker 6 (00:27:37):

Hi, good morning. I'm Linda Bresnahan. I'm with the Federation of State Physician Health Programs. My background is with the Massachusetts Medical Society's Physician Health Program. I want to thank Emma and Sherry and Dr. G for having me here to tell you a little bit more about physician health programs. I really admire what this Frontline Connect is doing, bringing these mental health resources to healthcare professionals. And if there's one thing I can leave you with here during my five minutes and maybe during discussion after, is to understand what your physician health program is, every state has one of these to maybe partner with that physician health program to help bring it to the next level where we as a national organization are always working to help improve what the physician health programs do enhance the confidentiality of how they provide their services. So I want to tell you a little bit about that and encourage you maybe to take some action to get to know your state physician health program deeper than maybe you already do, and or work with that state physician health program

especially where at the beginning we learned a little bit about your role providing care to healthcare professionals and also as leaders in your field.

Speaker 6 (00:28:50):

So I don't have any conflicts. And so a little bit about what a physician health program is, these characteristics of the hallmark of what a physician health program is. Physician health programs were created. The mission of a physician health program was created back in the seventies, the American Medical Association and the Federation of State Medical Boards called upon state medical societies at a time where they felt physician wellbeing was at risk. Sounds familiar. And they were concerned about physician suicide, and they called upon their state medical societies and said, we need a resource other than referring these physicians to state medical boards, which was the only alternative at the time where physicians can come forward to voluntarily and have a confidential therapeutic alternative to discipline. So at that time, these committees got formed in all the state medical societies. Really by the early nineties, all throughout the eighties, almost every state medical society had a Committee of impaired physicians is what it was called at the time, where someone could get referred if there was concern of mental health or substance use.

Speaker 6 (00:30:01):

This is still how a physician health program works, but they evolved into their own organizations that are resourced. So volunteer committee members provided peer support to those that got referred. So for concerns of impairment, and this is for concerns of mental health or substance use, a physician health program is not a state medical board. There's a lot of confusion about that. I hope we can talk about any confusions you have about it during the interactive part of this session. So physician health programs are relied upon by their state medical boards. So a certain portion of those that are referred to the physician health program are known to their medical board. So somehow whether it was an unfortunate question on the license application that required them to disclose a health condition or whether their impairment led them to be known to the medical board, get referred maybe for diversion or maybe for some impairment that presented itself at work, they might get known to their medical board.

Speaker 6 (00:31:00):

And then the medical board relies on the state physician health program to monitor those physicians. So for example, when I was at the Massachusetts Physician Health Program, a third of those involved in the physician health program we're also known to the state medical Board. And we had to let the state medical board know on a reoccurring basis that they were compliant with our program. But two thirds of those involved in the physician health program or who had contacted the physician health program for guidance were not known to the state medical board. And that's true for many state physician health programs.

Speaker 6 (00:31:35):

So why might you lean on your state physician health program for support, experience and expertise much like yourselves? The physician health programs have over 30 years of experience treating healthcare professionals. So there are certain benefits to leaning on their expertise and support. A couple examples of that would be the peer support that's provided by a physician health program. So I can give you a few examples. I know in Massachusetts there's a peer support group meeting that meets regularly at the Mass Medical Society that any physician in the state can go to confidentially for any concerns about their wellbeing. So if they're concerned about stress or burnout, they can go to this peer

support group meeting and meet as one example of something innovative a physician health program is doing. And that experience and peer support can really be helpful. A few other examples that are evolving with physician health programs is what Dr.

Speaker 6 (00:32:34):

Moer referred to the interactive screening program. So it started in Tennessee, at least five or six of my state physician health program members have partnered with the American Foundation of Suicide Prevention and implemented the interactive screening program in collaboration with their state medical society. So this means on the website of the Physician Health Program and the State Medical Society, a physician can look into resources, come across the interactive screening program and confidentially take this screening instrument and then be connected if they're identified at risk with resources in that state for confidential support and mental health. Other reasons to lean on the physician health program, important reasons is their confidentiality structure. So physician health programs have a number of different confidentiality protections to them, and it does vary from state to state. And again, I asked you at the beginning to partner with the state physician health program so you could hear a little bit about the confidentiality mechanisms that exist and we still need to improve them.

Speaker 6 (00:33:39):

And I'm working with the American Medical Association's Advocacy Center, Daniel Blaney Cohn, to help strengthen legislation for all state physician health programs. So some state physician health programs have the gold standard of confidentiality, and that is peer review. So in Massachusetts, the program falls under the peer review statute. So those records are protected by peer review. For any physicians that get referred, that's a really great confidentiality protection. All physician health programs have confidentiality protections. That's just an extra layer gold standard of confidentiality that I think should exist for every state physician health program. There's other immunities through legislation that PHPs have achieved over their 30 years. There's 42 C F R that protects the record. So there's a lot of extra record and confidentiality protections for a healthcare professional when seeking care at A P H P versus elsewhere. So when should you call A P H P?

Speaker 6 (00:34:36):

I think now's a good time when you leave this session. I think get to know your P H P deeper than what you might know now. Ask how it works. Ask how it might be that you might refer a patient that's a healthcare professional. Ask them if they're open to doing an education session at your workplace or institution. Partner with them. Ask them if they have a committee, a volunteer committee that you can serve on to help get involved and become an expert in helping healthcare professionals. You all answered at the beginning that you have patients that are healthcare professionals that puts you in a great position to be a resource to your state physician health program. And also to learn more about how that program can help you should you want to refer your patient that's a healthcare professional for added resources to that state physician health program.

Speaker 6 (00:35:30):

So a little bit more about our partnerships and really just to reaffirm our 30 year commitment with confidentiality, eliminating stigma in reform in 2018, one of our many projects we've done with the Federation of State Medical Boards is the president at that time, Dr. Art Hera created a work work group on physician wellness and burnout. This report, it's 2018, physician and Wellness and Burnout report on the Federation of State Medical Board sites is fantastic. It's still a very relative resource that you can find

on their website. And among its many recommendations for the workforce, is it called for every state licensing board to eliminate invasive questions about health conditions so that physicians would not be required to disclose that they've received treatment? I know in 2016 when I went from the Mass Medical Society to the Federation State Medical Boards Federation, state Physician Health Programs, I was shocked to hear from some state physician health programs that their licensing applications asked, have you ever received treatment or therapy?

Speaker 6 (00:36:39):

I was shocked to hear that because we had been in a very different place in Massachusetts, Federation of State Medical Boards and F SS P H P and the A M A have worked to eliminate questions like that for 30 years. I didn't think they existed anymore. There was lawsuits back in the 1990s in New Jersey against medical boards that had questions like that that violate the A D A I just assumed they were all eliminated. But over time, they creeped back in and they don't unfortunately just exist on licensing applications. They exist on credentialing applications and professional liability applications. So when that report came out, it really raised attention to many state medical boards. But the Laundre Foundation has accelerated that as you know, incredibly successful in moving the needle with all licensing boards to change those application questions. And their state physician health program, another reason to connect with them, they have great relationships with their state medical boards.

Speaker 6 (00:37:30):

So they've been able to take the Lorna Breen toolkit and use that as yet another hammer with their state medical boards to say, we need to change these licensing application questions. I'll still see questions that almost conform to what's recommended. It'll say, have you ever had an impairment? But then it'll say, for example, substance use and mental health. Those ones particularly frustrate me because why are we calling out mental health and substance abuse? Why aren't we calling out diabetes? Or did you break your arm this year? I don't know, but I don't know why they're calling out. And there's still questions that say separately from that question, have you ever had a substance use disorder? Disappointing and stigmatizing questions, but a lot has happened. There's over 20 such states that have celebrated that the l Bri and Foundation and the Federation and State Medical Boards have given an award to for changing these questions.

Speaker 6 (00:38:19):

And I just came from the Medical Professional Liability Association to speak to all the liability. Carrie is about changing their questions and we're going to participate in a workshop in the fall to ask the underwriters to change the questions to conform to what? The free foundation. Oh, thank you. And again, partnerships is what it's all about. Dr. Monier gave me a great idea to create a slide in the future about all these partnerships. We're working with the American Psychiatric Association and the A M A and F, SS M B and Lorna Bre Foundation and others. We've worked with the American Board of Medical Specialties and they now have a professionalism policy that says if a physician is compliant with the state physician health program, they should not be excluded from sitting from their boards. And in fact, a compliant statement from a physician health program should allow them to continue uninterrupted with their certification. So a lot of progress is being made. We still have to move the needle. As Dr. G said at the beginning, there's still more to be done. This slide here is just to give you a framework for understanding confidentiality and safe haven and the number of different ways that it needs to be achieved at your state Physician health programs. We talked about the licensing questions is one way that we need to decrease the barriers for disclosure. Which way did I go here?

Speaker 6 (00:39:45):

Here we go. Licensing questions that allow for non-reporting. This is what we want to continue to achieve. I gave you examples of that. There's a lot of other great legislative and licensing board ways that we can enhance access to care. So many states have mandated reporting laws and some states have exceptions to those mandated reporting laws that says if a physician that you know, you might feel you're a mandated reporter if they're impaired by drugs or alcohol, you can refer that physician to your state physician health program in lieu of reporting them to the medical board. So it's a really great lever because it gives you an option of getting that person help instead of referring to the medical board. It gives an institution an opportunity to get someone help instead of referring them to the licensing board. And it also acts as a lever to help that physician get help because they have to comply with the state physician health program so that person can be relieved of their mandated reporting obligation.

Speaker 6 (00:40:41):

So just another great confidentiality mechanism that allows for access to care instead of discipline. And then of course, this state legislation. Many states have legislation that authorize the P H P to do what it does confidentially and record protections, we've talked about those quite a bit. So this is just a little bit of an example of the future state of physician health programs that is helping us as a national organization enhance all physician health programs. We want physician health programs to be understood as an essential protective service to its healthcare professionals. We want there to be few treatment barriers. I should look at this

Speaker 7 (00:41:25):

Outside,

Speaker 6 (00:41:26):

Few treatment barriers and no stigma to seeking care, A central database that facilitates research and identification of barriers for imposed outcomes. So we do have some great research. I didn't get to talk about that, but we do have some great outcomes that show that physician health programs for substance use disorders and mental health for physicians that have completed two to three years monitoring are successful with their recovery in the 80% range, which is high above the general population. We have had Dr. DuPont do a study of these programs with the sole purposes of using it as a model for the general population. And I think that's a really great initiative. We want uniformity of P H P. So this is why I ask you to get to know your P H P. I know everything I'm talking about might not exist exactly as I've described it to the P H P.

Speaker 6 (00:42:16):

This is what we're trying to achieve best practices. Some PHPs are really underfunded and we're going to work on that as a national organization. Some PHPs have somewhere in the ballpark of three to $500,000 of an annual budget and a better funded. P H P is more in the three to four to $5 million range to provide services and education. They're all trying to provide education and prevention services, and they need the resources to do that. In many states, since c Ovid 19 are stepping up and increasing their funding to position health programs, but we have more work to do there. So P H P services are delivered consistently across the country. That's our goal. And we are working towards training and credentialing programs for physician health programs to be credentialed against our best practices that we've developed in the past few years. And we're also working to credential treatment and evaluation centers that have special expertise with dealing with physicians. And so that's our goal that we're launching both

of those programs in the next year. So thank you for your time. I was, I don't, I think the Lorna Breen Foundation does.

Speaker 5 (00:43:27):

We have a list of the states that don't have them

Speaker 8 (00:43:32):

The WE to

Speaker 6 (00:43:38):

Disseminate. Yes,

Speaker 8 (00:43:40):

Yes. I would love to have that. Residents and physicians, you can say these are the ones

Speaker 6 (00:43:51):

That are needs more work. Yeah, it

Speaker 5 (00:43:53):

Is. If you look, there's a QR code, and I have it on my phone. I can share with you guys after this that on the website for the foundation, it has in purple all the states that have complied where they don't have these intrusive questions on their applications for licensure.

Speaker 8 (00:44:10):

I think we need to get the reverse.

Speaker 6 (00:44:13):

Yeah,

Speaker 6 (00:44:15):

Yeah, it's true. And I know that the loaner breed foundation's working hard, as is the Federation of State Medical Boards. The reason a list doesn't exist transparently is because some states licensing board applications are hidden behind a wall. So until you go in and fill out the application, you can't a copy of it. So F SS M B and Lorna Breen Foundation is asking all medical boards, make sure there's a P D F of that application on the website so we can create that list. Great idea. And this is a websites fshp.org. There's state programs. There's a list of every state physician health program. So you can look up your state physician health program there.

Speaker 9 (00:44:53):

Thank you, Dr. Bernstein, for advocating for change and pushing back more. Good morning everyone. I'm Mary Moffitt, and I am the director of the resident and faculty. Is the mic on? Yeah. No, you have to go closer. Closer. Okay. There we go. How's that? Better? Thank you. And then look this way. Okay, so glasses. That was a mess. We're talking today about interventions and what I would like to share with you is looking upstream when a physician or healthcare worker is struggling with psychological or

occupational stress, the question often becomes, what is a safe path and how can we build a system, a program that physicians primarily will actually access? And so in 2004, we asked this question and we were grateful to have funding from Department of Psychiatry and O H SS U Hospital. We have no disclosures other than that. And what we asked several years ago was what are the barriers?

Speaker 9 (00:46:27):

We did a little survey, what is the need and what are the barriers? What are the fears? What limits physicians from accessing personal healthcare when they need it? And of course we've talked about them today. Stigma, confidentiality, cost. Certainly for our residents, cost is a very big factor. And so we designed a program intentionally to lower these barriers. So our program is free, highly confidential, and we provide coaching, counseling, psychiatric consultation, and medication management. We also coordinate cases with others in the community that may be more specialized, perhaps eating disorders or substance abuse clinicians. And we refer to these specialists as well. We also have an active consultation model with the program directors, faculty leadership of course, without disclosing any information unless we have an R O I. But we do a great deal of educational outreach as well as research. So one important I think point is that we did not build a coaching and counseling program and sit in our office and wait for people to come and make an appointment.

Speaker 9 (00:47:54):

We went out into the university, into each of the training programs, beginning with the residents, and then moving on in a few years to faculty and essentially met with the resident leadership, met with the program leadership, and told them about the services that we provide and ask questions, sorry, ask questions and answer questions. And I want to mention, given our topic today that it was probably 2005 when at the back of the room, a senior resident raised his hand and was very dismissive and said, okay, just so everyone knows, I would never, ever go to a program like this. None of you should. It will show up on your license. The medical board will find out, do not do this in the back of the room within a year of starting this program. So that was very important information because that was the word on the ground.

Speaker 9 (00:49:02):

And to some extent, that's still the case. It's much improved in almost 20 years. But we made it a point to advocate with our medical board and to speak to the leadership throughout the university to address misinformation and to where it was accurate to change it. So in addition to doing educational outreach, we also put in place the amazing I S P, the suicide prevention protocol that drier told you about this morning. And we established a peer support program that I can tell you more about this morning after we talk as a panel. So why do people come and meet with us?

Speaker 9 (00:49:50):

This was a survey done and published by my colleague, Dr. I in 2021. So this is after the first year of the pandemic, 76% reported workplace concerns. This is all very familiar to each of you. I'm certain burnout, uncertainty about their career direction, having a nightmare supervisor, lack of connection with their colleagues, feeling isolated, conflict with a colleague, and perhaps an adverse event. Exposure to trauma in the workplace is prevalent, as we all know. In addition, over 96% reported personal concerns, interpersonal challenges in their marriage and their relationships, perhaps isolation because they are not currently receiving adequate social support concerns about family loss or grief. Now, this was during

the pandemic that we did these questions that we asked our participants. Some of them had lost family members, some of them had lost colleagues, both back east as well as here on the West coast.

Speaker 9 (00:51:09):

And there may be their own emotional or personal health concerns. The average number of concerns reported in our meetings were three. And you can imagine it, it can range quite higher. So how confidential is this program? To address that question from the resident back in 2005, of course there are limits. If someone is at imminent risk of danger to self or others or at imminent risk to patient's safety, then we actively refer them to our physician health program that I can talk more about this afternoon. And we also make certain that everyone knows that nothing is reportable, not to the G M E, not to the Oregon Medical Board, not to the professional board or the credentialing body in our institution. So our mantra became, and this was our mantra that we took out when we did our little presentations all over the campus. Impairment is reportable and we will help guide you. Impairment is reportable, treatment is not. And we were confident in our state of Oregon that treatment was not reportable because we had advocated to have the questions on the medical licensing exams address impairment at that time and not treatment.

Speaker 9 (00:52:40):

We decided to locate our services in a private nonclinical location. It was a bit of a walk. Most of our meetings now are by telehealth, although we do offer in-person if indicated, and we made a decision to have no dual role. So no one on our team has any supervisory relationship with a resident or faculty member with whom they meet and provide clinical services. So it was, again, how safe is this? We wanted to make certain that it was safe. And very importantly, our charting is not in epic. We do not document in the hospital clinical system. There's not a single record. I have never had EPIC training. People are so envious when I tell them this, but the residents and faculty get it. They're like, oh, you actually developed a separate charting system. Yes, we did. And everyone in our team charts in the same system so that we can certainly help provide a team resource and not just an individual resource.

Speaker 9 (00:54:02):

So what was the result? Beginning in 2005 through 2020, you can see what happened to our utilization. I am only showing you O H S U residents. We also see O H S U faculty. We also see residents from another community-based hospital program. But this is the difference that designing a program to address valid concerns about confidentiality and safety and reporting concerns, this is what can happen to your utilization. And I don't know if anyone saw these title slide of my talk, which was if you build it, they will come. One of my favorite movies, yes, if you build it, they will come. And here is an indication of that. So during the pandemic, this is what we saw. We anticipated a reduction in utilization. We in fact saw an increase. And here are the numbers here. And these numbers include faculty as well as residents from the Providence Hospital system.

Speaker 9 (00:55:16):

So in comparison, you all know this in comparison, this is what we're used to seeing 10% perhaps in Dr. Hassan's paper in academic medicine last year, she was able to find at most 25% utilization among residents we see accessing mental health care. But we've been able over years to sustain. Now over 40% of eligible trainees at O H S U participate in our program. So how to build your own program, and this is something that people frequently ask and certainly have been asking over the past several years. And our number one answer is start small. Start small and grow. Show demonstrate utilization, demonstrate

need, start small and grow. We began with 0.5 F T E of a psychologist and 0.1 F T E of a psychiatrist. Absolutely do not with one clinician. You need two. Even if they're both 0.5, you need to have a team. This is a complicated, difficult cohort population to work with. This should not be just one individual, no matter who they are, how amazing they are. So start small and grow and do a needs assessment Survey the people that you think could benefit anonymously, of course, and see if there's a way that you can find and show their leadership that actually there is an unmet need among your trainees, among your faculty. And I'm not emphasizing on faculty today, but please focus on your faculty. They are struggling significantly right now.

Speaker 9 (00:57:15):

And know the licensing questions in your state. Know them, know when they change, interact with your medical board. That's part of what we did. I was well-known. I would call over there, Mary's on the phone again. So yeah, we kind of kept advocating for them, and I'll talk more about this, but when someone does need to be referred to the physician health program or to the board, we sit in the room with them while they make that call themselves. We do not pick up the phone and report them to anyone, but we tell them, we have done this before. We will guide you and we will get you through this. So what else please offer? The Universal Gold standard is the American Foundation's Protocol. The anonymous protocol that we've talked about this morning. It's very important to have an anonymous channel for people to access. And again, offer both educational outreach and collect data, do some clinical research, and if possible, some peer support as well. And what else? Oh, and over time, as you collect your data, you'll be able to demonstrate the need for additional F T E and funding.

Speaker 9 (00:58:40):

And sometimes it helps having an I R B protocol that will demonstrate to your participants as well as to your leadership, that actually this is protected clinical research that we are doing in collecting this information. And I think on that note, I will close, oh, one more thing. Every other month we are hosting, I'm hosting a national bimonthly online meeting where clinicians from all across the country, probably about 24 different institutions are involved right now of clinicians who are working with physicians and other healthcare workers providing coaching counseling. So these would be master's level, PhD level, and MD level clinicians who are providing care to their colleagues. Join us every other month for one hour on a Thursday afternoon to connect and to share ideas. And we have wonderful guests and leaders from throughout the country, including drier and Dr. G, who have joined us. So please email me if you would like to join our bi-monthly meeting that is held online. Thank you again,

Speaker 1 (01:00:09):

Thank you all for all the hard work that you've done. I don't know if this crossed your mind, but it did to me. If you heard the stories. We are in the heart of Silicon Valley. And so the word innovation means something to these folks. What you heard was 30 year old program, 40 year old problems, 50 year old problems. So you might say, well, how is this innovation then? It's not an app, it's not chat G p T. So why does this count as innovation? Well, innovation just means it's new to them. Alright? And that's both fortunate and unfortunate is that so much of this stuff we have to get into awareness. It was mentioned earlier, is if you talk to the frontline workers, this is news to them. They don't know about the PHPs, they don't know about I S P. They don't know about the internal EAPs and how Oregon's been doing this for 25 years.

Speaker 1 (01:01:08):

And there's no excuse for us to not have this program everywhere. And so to me, innovation can have many meanings. And that's something that I hope the leaders in the room consider would love for you to ask. Any questions you have through the mics, I'll ask them as well, but want to make sure you have your questions answered as we move forward. I think the other thing I'll add is, as you all know, as leaders, timing matters. This is the time where if you have been thwarted on any of these ideas in the past, as I have many times in the last decade, take another look. Try again on that same idea. The reception you might get is quite different. And so at Northwestern Medicine, we said, okay, we want to improve recovery. We want to improve mental health. Well, that means a lot of things, as you've heard, right?

Speaker 1 (01:02:02):

Each of these interventions is at different steps of the pathway. Awareness, stigma, reduction and credentialing, providing care, providing peer support, providing coaching. There is something to do at a lot of different steps. And so if at one of those steps you are thwarted, I hope you don't give up. There's another part of the step that may be open to you at this time. And for us, what we have tried to do at Northwestern is create a campaign around this where we're building a lot of these things in. We're proud to say we just changed all our credentialing language for 40,000 workers at 11 hospitals. We just changed our e a P to add 33% more visits and much more diverse providers. We included mental health for this year across all our employee resource groups, so that every group is talking about the impact of mental health in these unique groups.

Speaker 1 (01:02:56):

We've started peer support for all our nurses, apps, and physicians, and have started doing peer support training across the institution so that leaders can provide peer support organically. My ideal world would be we don't need peer support because people support themselves where they work. And so when you start putting it all together and people are seeing, okay, at all these various needs I have, there is something out there. If you build it, they will come, is an important message. So I encourage you to do so because everything I just told you, I have been rejected for the last 10 years. This time. They're like, all right, sure. And so I was like, okay. And so the timing matters greatly in all. Change management. Any questions from you all, feel free to come to the mic.

Speaker 10 (01:03:48):

Thank you all for the presentations and the ideas and the thoughts. One of the things that I think each of you has emphasized in reducing barriers is voluntariness and lowering barriers, but letting people come to you and finding ways to make that easy. I wonder if you could talk about each time something bad happens, what I hear from our organization is we should make everybody go see a mental health professional. And I wonder if you could share your answers to how you field those questions about mandatory appointments or opt-outs that aren't,

Speaker 9 (01:04:28):

Well, I can start. I'm not sure if the mic is on, but this has come up and it is called opting out. So some institutions are now essentially telling, and they're starting with trainees. They're telling their residents that they must make an appointment with a clinician with one of their psychologists or they have to, it's required when they join their intern year. I see it two ways. One is of course there is unmet need out there. I think it's coming from a good place. This idea that, well, if we get everybody to go in, then in that moment that person who is really struggling will be identified and will be able to have an intervention

and then we won't have an adverse event or et cetera. But I believe that the significant number of people working with physicians and other healthcare clinicians as psychologists or psychiatrists will probably agree with me that mandated treatment is monitoring, it is not treatment, it is not moving the needle forward and that it is far more successful to bring the information to your intern group so that they know, have the chief resident talk about what it was like for them when they were an intern and how helpful it was to talk to Dr.

Speaker 9 (01:06:24):

Jones or Dr. Smith, lower the barriers in other ways, but to mandate treatment. I believe it will be a check of the box. And I think as a clinician I can tell you that those interactions are not rewarding or therapeutic. So I know there's a lot of thoughts across the spectrum on this. Please, other people jump in. What do you think, Carol?

Speaker 11 (01:06:54):

I see Christine's at the, well, there's two pieces and I want to thank you for that question because I'd like to take it, there's two parts to it. One is the issue of opt out or opt-in mental health check-ins, which is not treatment and it's not mandatory treatment. And we just completed both opt-in and mandatory check-ins for interns in medicine at Montefiore Einstein. And I'm going to be very curious to see if there's a difference. And there was, because we have two medicine programs and the two program directors had different issues that they wanted to address. But there's a separate issue that's related, which is that what I've seen is anytime anybody has an emotional reaction to something in the healthcare space, it's like call the psychiatrist or the psychologist. And that is a big problem because it contributes to the access issue. We don't have enough people to treat people.

Speaker 11 (01:07:58):

So what my view is and what we're hopefully working towards, I really believe that psychiatry has to be the gateway because we know the difference about it needs when it's burnout, when it's stress management, when it needs meditation, when it needs peer support. That's one piece. And then there are other people who really need mental health treatment. And it's conflated, it's conflated in the literature and it's conflated in all the work that's come about wellbeing. So I do think as Gee was saying, this is our time and we need to take leadership to do that.

Speaker 4 (01:08:35):

Carol was your check-ins, were they advising, mentoring or treatment?

Speaker 11 (01:08:41):

None of the above. It was really what we decided and that the request came from the medicine program directors saying, we just want people with a mental health background. There were seven of us in the department that did this just to have a conversation. How are things? We did it in January and February in the middle of the intern year. How are you doing? Talk about anything you want. No notes, no nothing. Completely confidential really to provide a face for treatment. So it was absolutely not treatment. But this sort of came, I'm sorry I'm taking so much time here. This came out of something we did during covid, which we had a program called mesa, which was Montefiore Emotional Support Allies, where we assigned 160 people in our department of psychiatry to reach out to 2601st providers on the front lines. And basically the outreach was, here I am, if you want to talk, let me know and if not, you don't need to respond at all.

Speaker 11 (01:09:51):

We had about a 10 to 15% uptake, but this is part of the outreach, but to not just only de-stigmatize, but to have a face. And I will tell you just anecdotally, we haven't analyzed, we did an I R B and a pre-survey and a post-survey of the interns. I will tell you that 94% of them said that the check-ins were a good idea again, and I think this effort was started at Columbia where Laurel Mayer found the same thing. But that's different than saying you need to get treatment, but it's really to say you have a face and I have had several of the interns reach out and say, I'd really like to get set up with therapy. Can you help with that afterwards? So again, differences. But I think this piece of what do people need? What is the issue, what's the culture and treatment and diagnosis is different.

Speaker 9 (01:10:55):

Thank you. Those are very important. So it's more of an educational approach, psycho-ed in a way. Yeah.

Speaker 4 (01:11:03):

The only thing I would add, I totally agree with this conversation, and in part in a way it's what we call it, but the heart of the intent is just a check-in that there's a community around you of knowledgeable psychiatrists and people who are here for you. It's a way to connect those dots. I was thinking that energy and resources would be better spent in a more structured mentoring program that everybody participates in, that all trainees and ideally faculty as well or peer-to-peer. And then I was thinking about the way that you could connect and educate those individuals who are not psychiatrists, educate everybody. So everybody's acting in concert about what are the resources, when is treatment, what is the difference between burnout and depression? And I know that's a tricky one, especially for non mental health professionals.

Speaker 1 (01:12:03):

I want to just make sure and also give you a little flavor of the videos. So for instance, Dr. Moodier talked about I S P. You're sitting in the room, Dr. Moodier, how would someone say, you know what I heard about this I S P thing at a p A this year. How would they contact you or what would you recommend they do with their organization to say, Hey, let's take a look into this intervention

Speaker 4 (01:12:30):

Very concretely afsp.org. Go there. You can just probably Google search A F S P I S P and it'll take you to the page and there's a request for more information button where you can fill that out. And then you're going to get to my team who have conversations with interested healthcare leaders and actually across other industries as well, to have a conversation about where is the organization, what are you really looking for? Is there a matchup? I S P is customized in any number of ways. It's not only for what we think of as boundary communities within a school or a workplace. It's now being offered to an entire state of their physicians through the Tennessee Medical Foundation. It's being offered to the nation's veterinary medical professionals through the A V M A. So there are ways to utilize telehealth as the program counselor. You don't have to have that in-house necessarily.

Speaker 1 (01:13:34):

Thank you very much. Similar question to you, Dr. Deje. All right. I'm tired of the credentials. The state seems scary to me. So I want to start locally. Who would you tell somebody to say, who should you talk to? Where should you start in your system to say, Hey, you should go partner with this person to see if there's something to be done around the credentialing language?

Speaker 5 (01:13:54):

So I'm kind of wearing two hats because I mentioned I'm a locum tenants hospitalist, meaning I am going to different healthcare networks and seeing actually these credentialing licensing, having peers apply and do these reference forms. So I can tell you from experience, actually, when I did find an organization that had these intrusive questions and I was able to contact through email like, Hey, did you know that this question that you asked me, it's actually against, it's a violation of the a d a. And furthermore, I can refer them to the Dr. Lorna Breen website because through collaborations with c a Thrive Global through organizations that you hear here, we have a toolkit that actually has sample templates and letters and emails. So you don't even have to do the work. All you have to do is put your name, what you found, and it then includes the organization to audit the rest of their credentialing forms.

Speaker 5 (01:15:03):

And hey, here are examples of how you can change the language and how you can then submit it to the respective organization or the state board. So a lot of the legwork already has been done. We just want to let people know that clue these organizations in, like you said, these forms have been there for years and people are not constantly updating them. So when it is found, and like I said, go to the website, we have the templates for you, you just fill it out, you send it so that you can audit it, then you can change it. We have language that removes this intrusive language there and then you need to communicate it to everyone in the organization. I think that's where we're kind of failing. The rest of the team members, us healthcare workers have no idea. We really don't until we're faced with it.

Speaker 5 (01:15:59):

And by then, that's where the triggers actually can be pulled up. For me, and I'm an example of that. I was in New York City and going to here, how have you ever been treated for a mental illness? And it's like, have you ever, I'm like, man, I've lived for years, I've passed that point. But it's something that really needs to be put out there and let your team members know that this is a language that you value and that you do have their wellbeing that you're constantly monitoring and making sure that we are up to date with the change that everyone is looking for. So the three things to remember, audit what you have in your own organization, audit, what the state medical boards and licensing companies, insurance companies are doing, audit that when you see there needs to be a change because of the intrusive language being used, change it. You can go to our website and see examples of how it can be changed. And lastly, communicate it with every one of your members. If we don't know about it, we think it's the same as it was 20 years ago. So that's what I would say,

Speaker 1 (01:17:08):

And really is plug and play. I took their slides, went to the CMOs meeting, I went to the medical exec committee, I presented their slides. They said, what should we change it to? I told them the question, they told me to ask them. And then when we finished, and to your point, Dr. Je, I think it was interesting to train our communications. Our communications is often sort of bland, like, Hey, this happened. That's great. Their communication was, rah rah, are you guys, this is amazing what we are doing to support you. And they were like, oh, that's how we can talk. I said, used to, we can certainly talk that way. And so it really is plug and play and you sort of meander your way towards figuring out who to talk to in your system. But it was actually really easy. Surprisingly.

Speaker 5 (01:17:56):

One more thing I wanted to add, because we have now started a recognition campaign where we are offering badges for states who are now in compliance with the removal of these intrusive mental health language. So right now you mentioned earlier we have of 21 states and it's growing that have removed these intrusive stigmatizing language and their credentialing and licensing application. So through the all in wellbeing first for healthcare, we now have created these badge champions for those who are in concert with us trying to move this forward so that all healthcare systems are on this path.

Speaker 9 (01:18:40):

Timing. It's the time. Yeah,

Speaker 5 (01:18:42):

This is the time,

Speaker 1 (01:18:45):

Linda. I think having worked with PHPs for my whole career, the place that I work is a approved treatment center for healthcare providers. And I think that that's a really important thing. Going back to what we started this conversation with is there are unique needs to healthcare workers. I still think a lot of people think PHPs are, I should only contact them if I'm in trouble or if I have substance abuse. But the innovation you shared with us on your video was that where you're going really is around serving as a navigator towards healthcare providers that are of high quality, that have demonstrated certain criteria that says, Hey, you know what? You're P H P approved because you know how to take care of healthcare providers. Can you speak a little bit to that? Because what I see right now is people say, Hey, I know I need help, but I don't know where to go. No one's available. That person doesn't get my life. They're like, Hey, why don't you take an hour lunch? Well, there's no hour lunch in medicine. And so I want someone who will get to me. Could you speak to that?

Speaker 6 (01:19:49):

Yeah, sure. I'm thinking about that. So I guess I'd say a couple of things. My experience at the Mass Medical Societies program for 25 years was on the receiving end of some of these calls from residency directors, hospital leaders, physicians themselves, sometimes family members of physicians. The call often started with, I don't know if I've called the right place. And the range of what followed the but was so wide. And yet I don't think there was ever a time that I would say you didn't call the right place. So it could be that they're calling because they're burnt out, because they're stressed because they want to take time off, and they're worried about whether that will trip up a response on a licensing application or a healthcare leader that's just seen some signs of concerns and they're not sure where to go with it. And it's a great resource to call the P H P and just really have that conversation.

Speaker 6 (01:20:45):

Just the way I described it, and what I can say is 80% of those referred to the Massachusetts Physician Health Program did not have an impairing condition that resulted in treatment and monitoring. But that person still needed resources. Being connected with a therapist or having sometimes a couple meetings with the P H P medical director and staff was enough to get them on course with whatever it was that they were experiencing. So most, if not all, PHPs are really trying to elevate awareness about their ability to connect individuals with therapy and support separate from when there's a known potentially impairing condition. They're trying to do a lot more work there. And just having spent years cultivating resources of psychiatrists that have experience treating healthcare professionals and treatment centers

that work with healthcare professionals, they often are a phone call away from connecting that healthcare professional to a resource. And we know right now, finding therapists and psychiatrists that are available is really challenging. And physician health programs have relationships with providers that are used to treating healthcare professionals, and they go to the top of the list and they get prioritized. So I mean, those are some reasons to call early on, I guess, for care. Does that bother

Speaker 1 (01:22:17):

Us? I think it's a really big deal. And again, from an awareness perspective, I think our program directors, our chairs, our chief nursing executives, our chief medical officers, that can be an intervention that anyone in this room can do is educate them about this issue because they have no idea about any of these services, and they're going to be the first people to hear about this and to know about that gives a big, big deal and can be a lifesaver. So I appreciate everyone's time and attention. Thank you for attending and hope that you'll be a part of the change moving forward. Thank you all. Thank you.