Missouri Association of Osteopathic Physicians and Surgeons’ Physician Health Program

Procedure and Policy Handbook

Approved
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C. Preston Chester, D.O.
Physician Health Committee
Strategic Plan

- **Mission** – To provide the best service possible when assisting healthcare professionals in Missouri attain and maintain their health status. To ensure all have an avenue to regain and/or maintain their professional status.

- **Vision** – To be the premier Physicians Health Committee

- **Values**
  - Access
  - Commitment
  - Confidentiality
  - Education
  - Support
  - Advocacy

- **Goals**
  - Quality program
  - Excellent relationships
  - Financial soundness
  - Acceptance

Approved by the MAOPS and Wetzel Board of Trustees on September 7, 2003

THE MISSION OF THE M.A.O.P.S. PHYSICIAN HEALTH PROGRAM

The mission of the Missouri Association of Osteopathic Physicians and Surgeons’ Physician Health Program is to provide the best service possible when assisting healthcare professionals in Missouri attain and maintain their health status. To ensure all have an avenue to regain and/or maintain their professional status.

THE VISION OF THE M.A.O.P.S. PHYSICIAN HEALTH PROGRAM

The M.A.O.P.S. Physician Health Program is to be a premier holistic health professionals’ program of choice in Missouri with the best people, service, and outcomes.

THE GOALS OF THE M.A.O.P.S. PHYSICIAN HEALTH PROGRAM

The goals of the M.A.O.P.S. Physician Health Program are to promote early intervention, diagnosis, and treatment for healthcare professionals with illnesses, and to provide monitoring service as an alternative to board discipline. Early intervention enhances the likelihood of successful treatment, before clinical skills or public safety are compromised.
I. The Value of the M.A.O.P.S. Physician Health Program

A. Protect the public.
B. Proactive response to problem physicians.
C. Prevent patient harm.
D. Promote early recognition of illnesses before impairment.
E. Save considerable operational costs.
F. Help in the containment of malpractice costs.
G. Retaining qualified physicians/practitioners practicing in Missouri.
H. Educating the medical student population about alcoholism and drug dependence in the general public.
I. Maintain and ensure confidentiality of participants when allowed to do so.
J. Promote education regarding the health and well-being of professionals in the healthcare fields.
K. Maintain a consistent stance of advocacy for participants and support for themselves and their families.

II. M.A.O.P.S. Physician Health Program Purpose and Philosophy

A. Rehabilitation of physicians and other allied health professionals with potentially impairing health conditions is the primary function of our PHP.
B. M.A.O.P.S. Physician Health Program provides a non-disciplinary, therapeutic program for healthcare practitioners with health conditions which may compromise their ability to practice with reasonable skill and safety.
C. M.A.O.P.S. Physician Health Program is dedicated to excellence in medical practice and will not compromise patient care by supporting licensees practicing medicine during a period of impairment.
D. Non-board-mandated physician health participants are granted full confidentiality, and their treatment is not disclosed to the licensing authority if they maintain compliance and successfully complete the physician health program.
E. The M.A.O.P.S. Physician Health Program accepts referrals from the licensing agencies in this state to monitor practitioners under board mandate.
F. The M.A.O.P.S. Physician Health Program assists its participants in avoiding discrimination by documenting their recovery and verifying that they are not impaired in their ability to practice medicine by reason of their health condition while it is in remission and/or appropriately controlled.
G. The M.A.O.P.S. Physician Health Program provides steadfast support and advocacy before the state medical boards and other agencies such as BNDD to help prevent discrimination against recovering physicians.
H. The M.A.O.P.S. Physician Health Program promotes activities that support physical wellbeing. This involves sponsoring, encouraging, and/or conducting educational programs.
III. Administrative Needs as a Physician Health Program

The M.A.O.P.S. Physician Health Program is sponsored by the Missouri Association of Osteopathic Physicians and Surgeons and Capital Region Medical Center.

A. The M.A.O.P.S. Physician Health Program has independent, confidential, administrative, and clinical oversight by a board whose members are experienced in addressing the health conditions commonly found in the population of monitored healthcare professionals. This board is designated by the Missouri Association of Osteopathic Physicians and Surgeons executive committee.

B. The M.A.O.P.S. Physician Health Program has at all times access to legal counsel and is represented by legal counsel for the association.

C. The M.A.O.P.S. Physician Health Program works collaboratively with other state programs when interstate monitoring or transfer is involved.

D. The M.A.O.P.S. Physician Health Program has a designated medical director who is committed to physician rehabilitation, and who has appropriate experience, training, and skills including expertise in addictions. The medical director will work through the Federation of State Physician Health Programs and other appropriate organizations to stay abreast of developments in the field of physician health.

IV. Functions of the M.A.O.P.S. Physician Health Program

A. The M.A.O.P.S. Physician Health Program has mechanisms in place to accept and follow up on reports of physicians and other professionals with potentially impairing health conditions. The M.A.O.P.S. Physician Health Program accepts self-referrals and referrals from others concerned about a practitioner’s wellbeing. When a referral or a self-referral is received, the following takes place:

1. An assessment of the validity/eligibility of a referral when a concern is first reported.
2. An intervention or initial contact is made for the purpose of having the professional complete an appropriate evaluation.
3. Arrangements are made for an evaluation and/or treatment as indicated.
4. Aftercare monitoring and case management of the potentially impairing health condition is arranged after completion of primary/stabilizing treatment.
5. Adjustment of treatment/aftercare/monitoring is undertaken based upon ongoing evaluation of the monitored health condition of each physician as they progress or diminish.
6. Relapse detection and management for participants with substance use disorders is ongoing.
7. Documentation of recovery/disease stability and the compatibility of the physician’s health status with their ability to practice medicine will be used to provide advocacy for the physician.
B. The M.A.O.P.S. Physician Health Program promotes practitioner wellness and the treatment of all health conditions including substance use disorders and other addictions, mental and behavioral disorders, and physical illness.

1. The Physician Health Program cultivates a relationship with state medical schools and residency programs to promote education of the next generation of practitioners regarding the family illness of substance use disorders, mental and behavioral disorders, physical illness, and other addictions commonly affecting healthcare professionals.

2. The M.A.O.P.S. Physician Health Program fosters its relationships with hospital staffs and colleagues to promote education, identification of illness, appropriate referral, treatment, and monitoring for professionals.

3. The M.A.O.P.S. Physician Health Program interacts with the licensure authorities in the state and reinforces the disease concept of addiction and educates the licensing authorities about the availability of successful treatment options for all health conditions which may be used in the practice of disciplinary action.

V. Maintenance of Records

A. The M.A.O.P.S. Physician Health Program maintains documentation on participants for a minimum of 10 years after case closure unless otherwise required by law or records retention policies. Preferably, records will be kept indefinitely.

B. Participant records are stored under double lock such as in a locked file within a locked office, except when in use.

C. The usual record contents may include: Intake, assessment, evaluation, and treatment records; consents to release information; monitoring agreements and informed consent; toxicology and/or other lab reports, monitoring/compliance records; workplace reports, group records, and therapist reports; consultations; self-reports; meeting attendance logs; medication logs; pertinent medical records; correspondence; progress notes; and anecdotal information.

VI. Quality Assurance Measures

A. Program utilization may be reflected by referral numbers, enrollment numbers, non-enrollment numbers (ineligible, no diagnosis, refused services, etc.), the frequency of consultation requests, and the number of recurrent customers along with the reason for program re-involvement. Utilization rates are shared at each MAOPS Physician Health Program committee meeting which meets on a quarterly basis.

B. User friendliness is measured through participant satisfaction surveys, satisfaction surveys from boards and professional organizations, number of participants requesting further program services after program completion, and the number of complaints received. A survey of active participants is to be completed and to be shared with the MAOPS committee and Capital Region Medical Center.
C. Budget and financial statements document fiscal responsibility and cost effectiveness for the M.A.O.P.S. Physician Health Program. Information will be shared on an annual basis with the MAOPS committee and Capital Region Medical Center.

D. Personnel and staffing levels and documentation of staff continuing education activities reflect the quality of program management for the M.A.O.P.S. Physician Health Program. When feasible the Physician Health Program staff should attend the Federation of Physician Health Programs conference annually.

VII. Funding of the M.A.O.P.S. Physician Health Program

A. The funding required to support all program services is primarily underwritten by Capital Region Medical Center for the M.A.O.P.S. Physician Health Program. Resources are also received from the M.A.O.P.S. association and from fees received from the participants and those who are monitored.

B. The funding sources include, but are not limited to, the participant fees, professional societies’ contributions and associations, hospitals and other health care organizations, benefactors, endowments, and grants.

C. Program participants in the M.A.O.P.S. Physician Health Program are personally responsible for payment of further medical costs including required evaluations, primary treatment, and aftercare/monitoring costs.

D. Participant fees that are presently leveled at $200.00 per month and $100.00 per month for allied health professionals are fair and equitable and are shared with full disclosure at the time of intake with each participant.

VIII. Management of Substance Use Disorders

A. The M.A.O.P.S. Physician Health Program provides aftercare and monitoring for physicians with substance use disorders in accord with the parameters that are outlined below.

1. The minimum period of monitoring for substance dependence is 5 years, which is consistent with the Federation of Physician Health Programs’ policy.

2. The minimum period of monitoring for substance abuse is 1 year and a maximum of 2 years, assuming no additional concerns are raised during the monitoring period.

3. Basic contractual components between the M.A.O.P.S. Physician Health Program and its participants, whether voluntary or mandated, include the following components:
   a. An agreement for good faith participation.
   b. Agreement for abstinence and the requirement to immediately report any use of alcohol or mood-altering chemicals.
   c. Agreement to not prescribe scheduled drugs for family members and a strong recommendation to refrain from treating their family members.
   d. Agreement to not manage one’s own medical care.
e. Agreement to attend self-help groups such as A.A./N.A.
f. Agreement to attend a facilitated weekly support group for recovering professionals or an approved alternative when not available.
g. An agreement to maintain consent for ongoing communication with an approved workplace monitor/contact.
h. An agreement to abide by any specified workplace restrictions.
i. An agreement to maintain consent for the physician health program to speak with the participant’s family as needed.
j. An agreement to submit to biological specimen monitoring without question.
k. A statement of confidentiality provided and the limitations of the same.

4. Evaluation of recovery stability is ongoing for the duration of the monitoring period. Documentation of recovery is used as evidence that the participant’s ability to practice medicine is not impaired by a substance use disorder.

5. Toxicology testing.
a. Urine drug screens are routinely employed.
   (1) A random schedule.
   (2) Frequency as determined clinically appropriate.
   (3) Chain of custody is utilized on all specimens.
   (4) Witnessed collection is the gold standard.
b. Toxicology test panels need to be as comprehensive and as sensitive as possible. The M.A.O.P.S. Physician Health Program tests for the commonly abused pharmaceuticals on a routine basis. All positive drug screens are reviewed by the medical director.

GUIDELINES FOR ADDRESSING RELAPSE BEHAVIOR AND CHEMICAL RELAPSE

A. The M.A.O.P.S. Physician Health Program insists that each relapse be evaluated clinically with a graduated response tailoring treatment intensification to relapse severity.
B. The M.A.O.P.S. Physician Health Program responds immediately to any toxicology confirmed positive for drugs of abuse. Depending on circumstances, an immediate withdrawal from practice pending further evaluation may be indicated.
C. Immediate reporting to the licensing authority is required when any relapse occurs, whether it is a mandated referral or a self-referral. Behaviors that elicit reporting to the licensure authority include when the practitioner refuses to cease practice and is required to, treatment recommendations have been rejected by the client, and/or when the participant is under board order, therefore requiring reporting.

MANAGEMENT OF OTHER PSYCHIATRIC DISORDERS

The physician health program must be capable of flexibility in designing individualized aftercare and monitoring services for physicians and other practitioners with psychiatric disorders. The
The typical period of monitoring for psychiatric disorders is 1 to 5 years. The specific aftercare components for clients with psychiatric disorders incorporate recommendations from the evaluation and the treatment resources. Ongoing treatment will normally require followup with a treating psychiatrist and frequently with additional mental health providers. The consents for release of information between providers and the M.A.O.P.S. Physician Health Program must be maintained. Evaluation of mental/emotional stability is ongoing for the duration of the monitoring. The M.A.O.P.S. Physician Health Program requires that a qualified psychiatrist who serves as a consultant regularly assess the client in a face-to-face contact. As in substance use problems for physicians, abstinence from alcohol and other drugs of abuse is incorporated when clinically indicated for a practitioner with psychiatric difficulties.

GUIDELINES FOR ADDRESSING RECURRENT EPISODES OF PSYCHIATRIC DISORDERS

A. Immediate reporting to the licensing authority is required in certain cases.
B. If the participant is under order by the board, reporting is required.
C. Any time there is a threat to public safety and immediate intervention efforts are required, they are reported to the board.

ASSESSMENT AND TREATMENT SERVICES ARE REQUIRED TO MEET THE FOLLOWING STIPULATIONS OF THE M.A.O.P.S. PHYSICIAN HEALTH PROGRAM

A. The treatment program must use an abstinence-based model.
B. The treatment program must have a strong family program which is mandatory.
C. The treatment services must include intervention and denial reduction, detoxification, family treatment, group and individual therapy, educational programs, mutual support experiences in A.A. and N.A., development of continuing care plan, and relapse prevention training.

Under normal circumstances, all evaluations for participation in the M.A.O.P.S. Physician Health Program are performed by two agencies: 1) the Acumen Assessment Center in Lawrence, Kansas, under the direction of Dr. Scott Stacey, Psy. D and Dr. Peter Graham, Ph.D. (Phone number is 785-856-8218, email address is www.acumenassessments.com). 2) The Professional Renewal Center in Lawrence, Kansas under the direction of Dr. Betsy Williams PhD (phone 785-842-9772 email: www.prckansas.org) The treatment centers of choice are the Elmhurst Professionals Program, 360 W Butterfield Rd., Suite 340, Elmhurst, Il 60126 (Phone 630-615-7800.) Contact is Robin Pullman 630-615-7807. Positive Sobriety, Rivermend Health, Dan Angres M D, Kathy Wickenhuaser, 680 N Lake Shore Drive, Suite 800, Chicago, Illinois 60611 Phone 844-285-2826 email address is: info@positivesobriety.com or www.positivesobriety.com) Hazelden Betty Ford treatment Center 800-257-7800 or (www.HazeldenBettyFord.org)
ELEMENTS OF ASSESSMENT

The M.A.O.P.S. Physician Health Program requires a fitness for practice evaluation for all candidates who ask for advocacy of the physician health program. The fitness for practice evaluation includes:

A. A comprehensive evaluation which requires several days with repeated interviews and testing sessions.
B. An evaluation which determines if a health condition exists which impairs or is likely to impair normal professional performance.
C. The evaluation determines a working diagnosis.
D. The evaluation evaluates performance issues, answering such questions as:
   1. Is the professional capable of practicing medicine?
   2. Is further evaluation of professional skill or competency required, or is remedial training required?
   3. Is continuing work detrimental to health, safety, morale, or wellbeing of the physician or others?
   4. Are there functional limitations?
   5. Does the individual have the ability to comply with relevant laws, regulations, procedures, and codes of conduct?
   6. Under what conditions is the practitioner appropriate to resume medical practice?

It is the evaluation which makes treatment and/or monitoring recommendations to the program for the client.

ELEMENTS OF A TREATMENT PROGRAM

Characteristics of the treatment programs which are appropriate for M.A.O.P.S. Physician Health Program referrals include:

A. The ability of the M.A.O.P.S. Physician Health Program to visit the site periodically to evaluate quality of care and treatment given at the facility.
B. The business office for the treatment center must be capable of and willing to work with insurance providers and should have avenues available to assist with payment plans for the indigent physician.
C. The treatment facility must have a peer professional patient population and a staff accustomed to treating this population of physicians or other medical personnel.
D. The staff-to-patient ratio should be conducive for each patient to receive individualized attention.
E. The treatment facility must keep the M.A.O.P.S. Physician Health Program informed throughout the treatment process. This includes verbal reports from the therapist involved as well as written reports.
F. A strong family program is desired by the M.A.O.P.S. Physician Health Program.

G. Immediately report to the M.A.O.P.S. Physician Health Program threats to leave AMA, AMA discharges, therapeutic discharges, any other irregular discharges or transfers, hospitalizations, positive urine drug screens, noncompliance, significant change in treatment protocol, significant family or workplace issues, or other unusual occurrences.

H. Must have the medical, psychiatric, and addiction staff necessary to fully address all health issues.

I. The treatment team must have a multidisciplinary team approach that should be used and include psychological, psychiatric, and medical stabilization.

J. The participants are responsible for the payment of all required treatment.

K. The length of stay must be clinically driven and justified by the treatment program.

L. Discharge planning and coordination must be done in conjunction with the patient.

M. A discharge summary must be forwarded to the M.A.O.P.S. Physician Health Program.
MISSOURI ASSOCIATION OF OSTEOPATHIC PHYSICANS AND SURGEONS

PHYSICIAN HEALTH PROGRAM DAILY PROCEDURES

The Program Administrators, the members of the Physician Health Committee of M.A.O.P.S and hand-chosen physicians and individuals with experience in addiction medicine carry out the necessary functions of the physician health program

The first step in the process is an intervention/interview with the affected physician/individual to determine whether a problem exists, and if the physician/individual accepts that the problem exists.

The initial step is performed by the Program Administrators.

If the physician/individual is willing to accept that a problem exists, he/she is referred to an accredited facility for evaluation chosen by the Program Administrators. The PHP staff recommends that the initial evaluation be performed by the Acumen Assessment Center in Lawrence, Kansas, or the Professional Renewal Center in Lawrence, Kansas.

The contacts are:

1. The Professional Renewal Center
   1201 Wakarusa, Ste E200
   Lawrence, KS 66049
   Phone: 877-978-4772
   http://www.prckansas.org/index_home.htm
   Contact:
   Betsy White Williams, PhD, MPH,

2. Acumen Assessments, LLC
   730 New Hampshire, Suite 222
   Lawrence, Kansas 66044 Telephone: (785) 856-8218
   http://www.acumenassessments.com
   Contact: Dr. Scott Stacy or Dr. Peter Graham

Once the evaluation is completed, the treatment plan for the participant is designed, depending on the need of the individual. An appropriate treatment facility is sought based on the needs as assessed on the evaluation.
The duration is determined by the Medical Director of the treatment center, and varies on the progress of the individual. Normally, the treatment is 3 months.

The inpatient treatment centers utilized and the contacts are the same as the evaluation centers.

Following the individual’s release from the treatment center, the Program Administrators establish a monitoring system and a support program to assist the individual in the recovery process.

The length of time the physician is required to participate in the Program varies, depending on the progress and stability of the participant. If mandated to the Program by the Board of Registration for the Healing Arts, the final decision is made by the Board, following a recommendation from Program Administrators.

PROGRAM ADMINISTRATORS’ DUTIES

The Program Administrators normally:

- Contact the individual to discuss progress,
- Require the individual to go to a designated physician, monitor, or lab for a urine screening,
- Require the individual to attend support group meetings,
- Require the individual to meet with the Program Administrators periodically,
- Require the name of the individual’s personal physician,
- The laboratory of choice is National Toxicology Specialists 866-534-1888. Contact: Dr. Greg Elam, Medical Review Officer and Chelsea Trotter, program coordinator- ctrotter@drugtestinfo.com
- Each candidate receives kits sent by NTS that contain a chain of custody and paperwork that requires client and monitor information. Monitors are required to mail the specimen with the chain of custody to NTS laboratory. All urine screens are to be personally witnessed.

POSITIVE URINE SCREEN PROCEDURE

- If a urine screening is positive, confirmation is received from NTS that indeed the sample was positive, and details regarding the positive screen are received.
- The individual who has the positive screen is then contacted and confronted with the information in hand by the Medical Review Officer.
• The individual is then contacted by the Program Administrators and additional colleagues if necessary, who formally recommend that the individual seek treatment for the relapse behavior. Normally, if the individual has received treatment prior to the relapse, they are required to return to the treating facility.
• The recommendation is that relapse treatment begin with haste. The medical director for the Physician Health Program is then contacted and informed of the relapse behavior and the suggested recommendations.
• If the individual has a contract with MAOPS PHP and/or a mandate from the Board of Healing Arts, immediate contact is made with the Executive Director of the Board of Healing Arts (573-751-0104) or the Chief Investigator for the Board (573-751-5496). It suffices for one to be contacted.
• A formal report is sent to the Board to indicate non-compliance with probation requirements. Included in the report are the recommendations that the program is making to the physician. Also included is a description of the physician’s response to the recommendations and their level of compliance with the requirements of our program.
• All documentation and all correspondence that leave the PHP office are carbon copied to the M.A.O.P.S. Physician Health Program Medical Director.

PHYSICIAN NON-COMPLIANCE PROCEDURE

If a physician/professional is determined to be impaired after an intervention and refuses treatment, the following steps are to be taken:

• The Medical director is informed of the actions of the physician/professional
• A formal statement is made to the Board of Healing Arts and also included in that is a reference to the level of impairment and the ways in which his or her practice might be affected by the impairment.
• The individual then becomes a major responsibility of the Board of Healing Arts, which tends to rather quickly investigate the issues at hand.

Hospital personnel, colleagues, the Board of Registration for the Healing Arts, family members, and friends can contact the Physician Health Program, requesting an evaluation/intervention of a physician/individual. The Program has traditionally assisted any health care professional.

A physician or individual may also contact the Program Administrators to request assistance, if they realize they are impaired, and require help.

If a physician or individual enters the program voluntarily, the physician or individual is reported to the Board of Registration for the Healing Arts by number.

If the Board of Registration for the Healing Arts mandates a physician into the Program, the Program Administrators report to the Board on his/her progress on a quarterly basis.
If a physician in the program is non-compliant with his/her treatment, monitoring, screening, etc., the Program Administrators take the same steps as for an obviously impaired physician / professional who refuses treatment, as listed above.

Each physician/individual who enters the Physician Health Program must sign a contract authorizing care, payment for services provided, and agreement of the program treatment plan.

Only those physicians/individuals who sign the contract will be accepted into the Physician Health Program.

**PARTICIPANT EXPENSES**

The costs of the physician/individual’s program are the financial responsibility of the participant.

The cost to the participant will vary depending on the treatment plan designed to meet the needs of the individual.

Expenses include:

- Evaluation at an accredited facility,
- An inpatient program, if necessary,
- Monthly administrative fee,
- Laboratory cost,
- Personal physician charges

The Board of Registration for the Healing Arts states financial responsibility by the physician /professional is part of the treatment and should be paid by the participant.

M.A.O.P.S pays an administrative fee annually to Capital Region Medical Center for the Program Administrators’ services but does not pay for participant costs.

**M.A.O.P.S. PHYSICIAN HEALTH PROGRAM REPORTING REQUIREMENTS**

The Program Administrators complete a report on the progress of the participant and with the participant’s written authorization may be sent to:

- The Board of Registration for the Healing Arts,
- Personal physician,
- Hospital designee,
- Medical Director of the Physician Health Program,
- Managed Care Insurance Companies,
- Professional Liability Insurers, and/or
- Others who may have a right/need to know
The Program Administrators report to the Board of Registration for the Healing Arts on the participant’s activities and progress, on request, and as designated quarterly by the Board of Healing Arts. Sample report attached.
Both the Board of Healing Arts hereinafter referred to as the Board, and the Missouri State Medical Association (MSMA) Physician Health Program (MPH)/Missouri Association of Osteopathic Physicians and Surgeons Physician Health Program (PHP) have a recognized responsibility to protect the health and welfare of the public by insuring that quality medicine is being practiced in the state of Missouri. Therefore, physicians deemed to be impaired need to be directed to obtain proper treatment and an acceptable plan of aftercare before resuming practice. The purpose of this Memorandum of Understanding is to develop a cooperative relationship between the two organizations that will both safeguard the public and provide the physician the opportunity to return to practice through a system of detection, early intervention, effective treatment and monitoring.

The following definitions, conditions and reporting requirements establish the parameters that will govern the relationship between the two organizations in this important activity.

I. DEFINITIONS:

For the purpose of this Memorandum of Understanding (MOU) the following terms are defined as:

The Program – Missouri State Medical Association, Physician Health Program/Missouri Association of Osteopathic Physicians and Surgeons Physician Health Program.

Mandatory Client – Any individual who either enters an impairment program: (1) as a conditional requirement of his/her formal disciplinary agreement or order with the Board of Healing Arts or (2) in lieu of possible formal disciplinary action by the Board; is considered a mandatory client. Said individual will be required to sign the respective program’s contract. If a mandatory participant fails to comply with any provision of the contract, the Executive Committee and/or the Program, will report the individual to the Board as stipulated in the MOU.

Voluntary Client – Any individual who decides to participate in impairment program either on his own or through referral and whose identity is not known by the Board of Healing Arts and is only referred to by code number is considered a voluntary client. Said individual will be required to sign the respective program’s contract. If a voluntary participant fails to comply with any provisions of the contract, the Executive Committee and/or the Program, will report the individual by code number to the Board of Healing Arts as stipulated in the MOU.

Noncompliance – Any breach by the mandated or voluntary client of the provisions designated in the respective contract is deemed to be in noncompliance.
Evaluation Report – A memorandum that details the initial examination of the client and which at a minimum shall include: the reason for referral to the Program, (if applicable), clinical history and diagnosis, treatment and aftercare plan and return to work recommendations.

Progress Report – A quarterly memorandum that provides a statement of compliance. Updated information on results of drug screenings, aftercare performance, monitoring meetings, AA/NA meetings and record of attendance, therapy, recommended revisions, any legal action or other relevant information will be provided in this report.

II. Guidelines Specific to Mandated Clients

1) The Board agrees to provide to the Program a copy of the signed order for all mandated clients within 14 days of the date signed.
2) The Program agrees to provide to the Board a copy of the signed impairment agreement for all mandated clients within 14 days of the date signed.
3) The Program agrees to provide to the Board a program evaluation report as specified in the definition for all mandated clients within 14 days.
4) The Program agrees to provide to the Board quarterly progress reports as specified in the definition.
5) The Program agrees to notify the Board the next working day by telephone and to follow-up in writing no later than 14 days either positive urine or blood tests, failure to submit to screen, habitual absence (leaving the Program), substantiated complaints of noncompliance, including relapse or other physical or mental indicators observed by the Program staff. The Board agrees to the same reporting as listed above to The Program.
6) The Program agrees to have the Director or designee and the attorney (at the client’s discretion) to accompany the client; to meetings of the Board should the Board have reason to believe the client is not complying with terms of the agreement.

III. Guidelines Specific to Voluntary Clients

1) The Program agrees to provide to the Board by code number within 14 days of joining the Program, a Program Evaluation Report. When this is not possible, the Program agrees to provide a preliminary report within 14 days followed by a complete program evaluation within a reasonable period of time.
2) The Program agrees to provide to the Board quarterly progress reports (including any noncompliance) by code number as specified in the definition.
3) The Board may request and the Program may recommend that certain coded clients be revealed due to a pattern of noncompliance with the contract.
4) The Board agrees that when a voluntary client’s name has been released by the Program due to a pattern of noncompliance with the contract, the Board will consult with the Director of the Program as to the patient’s stability before initiating its investigation.
5) The Program agrees to notify the Board the next working day by telephone and to follow-up in writing no later than 14 days either positive urine or blood tests, failure to submit to screen, habitual absence (leaving the Program), substantiated complaints
of noncompliance, including relapse or other physical or mental indicators observed by the Program staff. The Board agrees to the same reporting as listed above to The Program.

IV General Guidelines

1) Psychiatric/disruptive Licensees need to be evaluated with a multi-disciplinary assessment the same as chemically impaired Licensees. Once that report is received by the program they should follow the recommendations from the assessment program.

2) The Program agrees to utilize comprehensive drug screenings when initially testing all clients whether mandatory or voluntary and will continue with the comprehensive tests if the results of the initial test are positive. If the results of the initial test are negative, it is agreed the Program may utilize simpler testing. It is also agreed that if a client has a positive urine drug screen it will be followed initially by a comprehensive drug screen. If the screen is negative, the client will then be subject to a simpler test.

3) In Lieu of Discipline Licensees shall allow the Board to obtain random specimens at the Board’s discretion, but the Licensee’s expense. This should be in the contract between the Licensee and the Physician’s Health Program.

4) The Program agrees to provide to the Board a directory of all hospitals and clinics utilized by the Program and to notify the Board when a hospital or clinic or other health facility is added or deleted. When the hospital or clinic or other health care facility is deleted the Program agrees to notify the Board in writing why the relationship was terminated.

5) Should such condition arise that might require or lead to discipline of that client’s license, the Board agrees to take into consideration that client’s participation and compliance in the program before final discipline is decided.

6) The Program agrees the Board reserves the right to evaluate the Program.

This agreement may be amended by written consent of both parties; it may be terminated by either party upon advance 30 day notice from one party to the other.

MISSOURI ASSOCIATION OF OSTEOPATHIC PHYSICIANS

______________________________    ________________
Chief Executive Officer    Date

MISSOURI STATE BOARD OF HEALING ARTS

______________________________    ________________
President of the Board    Date
Addendum B

Missouri Association of Osteopathic Physician and Surgeons (MAOPS)
Physician Health Program (PHP)
**Assistance for Chemical Dependence Agreement**

*The PHP can assist physicians by documenting their health, abstinence from mood altering drugs or alcohol, and compliance with recommendations. The undersigned physician agrees there has been a problem with substance abuse or misuse, however, inappropriate or unauthorized use of mood altering prescription or illicit drugs would be problematic. The purpose of this agreement is to provide a mechanism to document abstinence and compliance with treatment recommendations.*

Last Name: ____________________ First Name: ____________ DOB: ______ SS#: ____________

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Email Address: __________________________________________ Date: ______________________

*(Place asterisks besides preferred telephone number. Mail will be sent to your home address marked “Confidential and Personal.”)*

Significant other or emergency contact: Name: __________________________ PHONE: ____________

I, ____________________________, recognizing that I suffer from the disease of alcoholism and/or chemical dependence, and desiring to enroll in the treatment programs sponsored by the Missouri Association of Osteopathic Physicians and Surgeons (MAOPS), Physician Health Program (PHP), agree to the following conditions:

1. I agree to cooperate with any recommendations for treatment or further evaluation that result from the initial evaluation by the PHP. If the recommendation is for inpatient treatment or evaluation, I agree to abide by the regulations and requirements of that inpatient program. _____ (Initials)

2. I agree and understand that PHP will make recommendations for aftercare and recovery either separately or with an evaluation or treatment program. I agree to abide by any recommendations for aftercare or recovery recommended by any inpatient treatment or evaluation, including subsequent
treatment or evaluation by the same inpatient facility as well as any recommendations made by PHP for aftercare or recovery. These recommendations may include Alcoholics Anonymous, Narcotics Anonymous, the opportunity for individual or family psychotherapy, individual drug and/or alcoholism counseling, and any other recommendations specific to my disease.

_______ (Initials)

3. I agree to cooperate with PHP as it assumes responsibility for monitoring my recovery progress or aftercare program following any treatment or further evaluation.

_______ (Initials)

4. I agree to notify PHP in the event of a relapse.

_______ (Initials)

5. In consideration for being allowed to participate in PHP, I expressly acknowledge that neither PHP, the Missouri Association of Osteopathic Physicians and Surgeons, nor any of their employees, board members, agents or independent contractors will be responsible for or provide any professional services to me, and I expressly waive and release PHP, the Missouri Association of Osteopathic Physicians and Surgeons, their employees, board members, agents or independent contractors from any and all claims, whether now existing or arising, related to or arising from my participation in the PHP or any services provided to me under this program, including, but not limited to any claims that I might assert that PHP, the Missouri Association of Osteopathic Physicians and Surgeons, their employees, board members, agents or independent contractors were negligent, committed any acts or omissions that were negligent or that were acts of professional malpractice, and I am forever barred by this waiver and release from making or asserting such claims now or at any time in the future and if such claims are ever made by me, my heirs or assigns, or anyone else on my behalf, that I will be immediately disqualified and discharged from participation in this program.

Signature: ___________________________________________ Date: ________________

Witness Name and Address: __________________________________________________________

6. I agree that PHP will represent me before all interested and authorized entities and may provide a copy of my signed agreement to state boards and commissions, state and federal agencies, and other organizations including, but not limited to the Missouri State Board of Registration for the Healing Arts, Bureau of Narcotics and Dangerous Drugs, Drug Enforcement Administration, employers, HMO’s, PPO’s, other managed care entities, physician health programs in other states, liability carriers. I understand and agree to provide such releases as are necessary for these entities to obtain this information.

_______ (Initials)

7. I agree to completely abstain from alcohol, marijuana, cocaine, stimulants, narcotics, sedatives, tranquilizers and all other mind altering and/or potentially addicting drugs or medication. In the event such medications may be needed as a legitimate part of my medical care, I agree to notify the PHP immediately.

_______ (Initials)

8. I agree not to write prescriptions of any mind altering or potentially addicting drugs for myself or members of my family.
9. I agree to inform my personal physician, Dr._________________________ of the conditions of this agreement and request that he/she not prescribe any medications for me unless there is no reasonable alternative medically. If he/she does need to so prescribe, I will ask her/him to inform the PHP. I give permission for my personal physician to release information to the PHP and authorize the PHP staff to contact my personal physician.

_____ (Initials)

10. I agree to obtain an initial physical examination from my personal physician and to get similar examinations on an annual basis as long as I am a participant in the PHP. I authorize release of the examination results to the PHP and authorize the PHP to contact my personal physician.

_____ (Initials)

11. I agree to inform any doctor with whom I have any formal practice or association of my history of alcoholism and/or chemical dependence and of the conditions of this agreement, including permission to contact the PHP if there is ever any concern about my using alcohol, drugs or about my behavior.

_____ (Initials)

12. I agree to inform my office manager and/or nurse (name)___________________________________, (title)_____________________________, of conditions of this agreement, including permission to contact the PHP if there is ever any concern about my using alcohol, drugs or about my behavior. I give permission for the PHP to contact the above mentioned person.

_____ (Initials)

13. I agree to inform my spouse or significant other, (name)_____________________________, of the conditions of this agreement including permission to contact the PHP if there is ever any concern about my using alcohol, drugs or about my behavior. I give permission for the PHP to contact my spouse or said significant other person.

_____ (Initials)

14. I agree to attend the monthly support meeting of physicians sponsored by the PHP. I understand that regular attendance is required.

_____ (Initials)

15. I understand that chemical monitoring is an integral part of this program. I, therefore, agree to submit voluntarily to random urine and/or blood examinations as requested.

_____ (Initials)

16. I agree to meet with any member of the PHP as requested to discuss my progress at any time.

_____ (Initials)

17. I understand that in any instance in which it is believed by the PHP that I may be impaired in my practice, I will be reported to the Physician Health Committee of the Missouri Association of Osteopathic Physicians and Surgeons.

_____ (Initials)

18. I currently have privileges at the following hospitals:

(Hospital)_________________________________  (City)__________________________________
I agree to inform each hospital of the conditions of this agreement, including their permission to contact the PHP. I give permission to the PHP to contact these hospitals. I also agree to inform the PHP of any changes in my hospital status, including any new hospitals to which I might apply for privileges.

(Initials)

19. I give permission for the PHP to make regular reports to the Physicians Health Committee of MAOPS regarding my status.

(Initials)

20. If I have been mandated for care and treatment to the MAOPS PHP by the Missouri State Board of Registration for the Healing Arts, or any other state or federal licensing board, as a condition for my continued practice of medicine, employment, education or other related activities, I hereby give permission and release the MAOPS PHP to provide reports as needed or as agreed to by me and the Missouri State Board of Registration for the Healing Arts, or any other state or federal licensing board. In the event of any relapse, I agree that relapse is automatically a reportable event regardless of any agreement between me and the Missouri State Board of Registration for the Healing Arts, or any other state or federal licensing board.

(Initials)

21. If I am participating voluntarily and in lieu of discipline by the Missouri State Board of Registration for the Healing Arts, or any other state or federal licensing board, I agree to allow the Missouri State Board of Registration for the Heating Arts, or any other state or federal licensing board to request and obtain urine samples for testing when required.

(Initials)

22. If I voluntarily joined the treatment program for the MAOPS PHP, whether or not in lieu of discipline by the Missouri State Board of Registration for the Healing Arts, or any other state or federal licensing board, any failure by me to comply with the recommendations of the PHP or ill cease participation without permission from the PHP, will immediately result in notification to the Missouri State Board of Registration for the Healing Arts, or any other state or federal licensing board. I agree that I am authorizing my name, care, treatment, progress, and this agreement to be reported under the circumstances outlined in this paragraph.

(Initials)

23. I agree to pay $150.00 per month to Capital Region Medical Center for the services provided to me by the medical center and the PHP.

(Initials)

24. I agree to join and become a member of the Missouri Association of Osteopathic Physicians and Surgeons who, in conjunction with Capital Region Medical Center, provide the care, treatment, monitoring and counseling for my rehabilitation.

(Initials)

25. I agree to abide by the terms of this contract until released by the MAOPS Physician Health Committee.

(Initials)
IMPORTANT. By your signature, you acknowledge understanding of all items set forth herein.

X _______________________________ Date: ________________________
(participant’s signature)

_______________________________________________________ Date _________________________
(witness)

Participant Information Sheet

Date:_____________________

Participant Name: _____________________________________________________________________
Last                                        First                          Middle                   Degree

Address: ____________________________________________________________________________
Street                                                                                         Apt. #
____________________________________________________________________________
City                                                                      State                                                  Zip

Home Phone:__________________________________  Work Phone: ___________________________

Spouse/Significant Other: _______________________________________________________________
Last                                            First                                          Middle

Participant Employer: __________________________________________________________________

Date of Birth:______________________  Social Security No. __________________________________

In Case of Emergency Contact:_________________________________ Phone: ____________________

Personal Physician:___________________________________________Phone: ___________________

Other Physicians Regularly Seen: _________________________________________________________

HOSPITAL WITH PRIVILEGES:

Hospital                                   City

_________________________________________  _____________________________________
Monitor Name: ___________________________________________  Phone: ____________________

Office Manager/Nurse: ______________________________________

Share Call/Assoc. With: _______________________________________
# Psychiatric Assistance Agreement

The PHP can assist physicians by documenting their health, abstinence from mood altering drugs or alcohol, and compliance with recommendations. The undersigned physician agrees there has been a problem with stress, adjustment, behavior, and/or mental illness (such as depression, anxiety, or other). Additionally there may or may not be a problem with substance abuse or misuse, however, inappropriate or unauthorized use of mood altering prescription or illicit drugs would be problematic. The purpose of this agreement is to provide a mechanism to document abstinence and compliance with treatment recommendations.

Last Name:__________________ First Name:______________ DOB:___________ SS#: ____________

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| Phones | Home Phone: (___)____________ | Office Phone: (___)____________ | Beeper: (___) __________ |
|        | Mobile Phone: (___)____________ | Fax: (___)____________ | Other ( ): (___) __________ |

Email Address:____________________________________________  Date: ______________________

*(Place asterisks besides preferred telephone number. Mail will be sent to your home address marked “Confidential and Personal.”)

Significant other or emergency contact: Name:_________________________ PHONE: ____________

1. I, ______________________________, agree to the terms of this agreement. This agreement may be extended if warranted. Alterations in this agreement cannot be made without prior approval from the program director.
   ______ (Initials)

2. I agree to abstain from any and all mood-altering chemicals (including but not limited to alcohol, marijuana, tranquilizers, sedatives, stimulants, narcotics, ultram (tramadol), nubain, antidepressants, and sporifics, androgenic steroids, scheduled and/or unscheduled drugs, mood altering over-the-counter medications, etc.) except as prescribed by my physician and only after consultation with PHP. If any mood altering and/or potentially addictive medications are required, I will have my prescribing physician supply documentation to PHP verifying the need for said medications, and if ongoing, will renew verification every 90 days. I also agree to avoid dietary use of poppy seeds.
   ______ (Initials)
3. I will secure a primary care physician to treat my medical problems and give him/her authorization to communicate directly with my Psychiatrist, counselor, and/or PHP on my progress. This physician will be ____________________, Phone: ____________________
   Street_____________________________________ City______________________ Zip ________
   _____ (Initials)

4. I will not treat myself for any illness but will contact one of my physicians as appropriate.
   _____ (Initials)

5. I agree to obtain counseling and/or treatment from ____________________________ located at
   ____________________________, home telephone # ____________________, and office telephone #
   ____________________, and if deemed necessary by PHP staff to provide free and unlimited release of all information concerning my health and participation in treatment to the PHP Director and staff. I understand the need for and have requested that my treating clinician, named above, notify the PHP immediately of:
   A) failure to progress in treatment;
   B) any change of medication;
   C) discontinuation of therapy;
   D) change of treating professional;
   E) failure to appear for appointments, continue prescribed medications, or cooperate in the
   therapeutic process.
   _____ (Initials)

5a. I agree to obtain Psychiatric treatment from ____________________________ located at
   ____________________________, home telephone # ____________________, and office telephone #
   ____________________, and if deemed necessary by PHP staff to provide free and unlimited release of all information concerning my health and participation in treatment to the PHP Director and staff. I understand the need for and have requested that my treating clinician, named above, notify the PHP immediately of:
   A) failure to progress in treatment;
   B) any change of medication;
   C) discontinuation of therapy;
   D) change of treating professional;
   E) failure to appear for appointments, continue prescribed medications, or cooperate in the
   therapeutic process.
   _____ (Initials)

6. I agree to request a letter from my treating clinician(s) (as in item #5 and 5a above) to PHP indicating continued participation and continued progress in treatment. This letter must be received by PHP on a quarterly basis. Supplying this letter is essential to continued assistance by PHP and is my responsibility. I agree to notify the PHP of any changes in physical or mental health, address or employment.
   _____ (Initials)
7. I will submit to urine/blood/sputum/hair or other screening tests. These screens will be random, observed, and chain of custody. PHP, with or without cause, may request additional tests. I agree to adhere to the urine testing notification and collection procedures and protocols as established by PHP. I further understand that if I do not receive notification to proved screening tests, it is my responsibility to notify PHP. I also agree that it is my responsibility to assure that all urine specimen collections are observed by a lab personnel. If urine specimen collection is not observed the results are invalid.

_____ (Initials)

8. I agree to notify PHP of changes in my office or home address or telephone number.

_____ (Initials)

9. I understand that if I fail to meet the conditions of this agreement, I may loose the support of this Committee. In case of unauthorized use of controlled substances, I agree to withdraw from practice immediately and enter evaluation and/or treatment. Such use or failure to meet conditions may require reporting such to the Missouri State Board of Registration for the Healing Arts.

_____ (Initials)

10. I authorize the PHP to make inquiries to, and receive information from, any hospital at which I hold medical staff privileges, and any physicians or non-physicians with whom I associate in the practice of medicine, members of my immediate family, and my employer concerning any and all aspects of my compliance with the provisions of this Assistance Agreement. I agree to execute an authorization for release of information to the PHP authorizing any physicians or other treatment agents whom I have consulted for care and treatment to release all information concerning my mental and physical health.

_____ (Initials)

11. During the duration of this PHP agreement, I understand that when requested, information concerning my status will be given by PHP to

_____ a. Missouri State Board of Registration for the Healing Arts

_____ b. Bureau of Narcotics and Dangerous Drugs (BNDD)

_____ c. My medical liability insurance carrier:

________________________________________

________________________________________

_____ d. Credentials committees at the following hospitals:

________________________________________

________________________________________

_____ e. Managed care organizations:

________________________________________

________________________________________

_____ f. Other physician/medical groups:
12. I agree to report my status to all hospitals where I have privileges, and to allow the PHP to send progress reports to designated persons at these hospitals when requested. These designated individuals are ________________________________ and ________________________________ ______ (Initials)

13. I understand that the PHP program is not responsible for insuring compliance to restrictions or probationary orders issued by the Missouri State Board of Registration for the Healing Arts or other state or federal regulatory agencies. I will inform all hospitals or other organizations for which I have requested assistance by PHP where I have privileges of this information. ______ (Initials)

14. I agree to neither prescribe mood-altering chemicals to my family nor to keep samples of such chemicals in my home. _____ (Initials)

15. I understand the PHP program only provides assistance for me to the extent of my participation in the program, and not to my qualifications or competence as a physician. ______ (Initials)

16. I understand that the PHP program assumes no responsibility for verification of my qualifications, background or history except as it relates to my treatment and participation in the program. ______ (Initials)

17. I hereby release and hold harmless the MAOPS Impaired Physicians Committee from any claims whatsoever arising out of actions taken by the Committee in good faith without malice in furtherance of the objectives of this Assistance Agreement. ______ (Initials)

18. Inherent in this contractual agreement is a requirement of the participant to be appropriately cooperative and courteous to the PHP staff and pay all appropriate fees in a timely manner. _____ (Initials)

19. In the event that I move from Missouri or practice in another state, I agree to notify PHP. ______ (Initials)

20. In the event it becomes necessary for the MAOPS PHP to render a report to the Missouri State Board of Registration for the Healing Arts, I authorize release to the Missouri State Board of Registration
for the Healing Arts any records in the possession of the MAOPS PHP which related to my participation in the PHP program including but not limited to records of evaluations and/or treatment for alcohol and drug abuse. I understand that this authorization and release permits the Missouri State Board of Registration for the Healing Arts to receive and examine the records described herein and, if deemed necessary by the Board, to utilize such records in an administrative proceeding instituted by the Board.

______ (Initials)

21. I agree to pay $150.00 per month to Capital Region Medical Center for the services provided to me by the Medical Center and the PHP.

______ (Initials)

IMPORTANT. By your signature, you acknowledge understanding of all items set forth herein.

X______________________________________________________Date: ________________________
(participant’s signature)

_______________________________________________________Date _________________________
(witness)

Participant Information Sheet

Date:______________________

Participant Name: _____________________________________________________________________

Last                                        First                          Middle                   Degree

Address: ____________________________________________________________________________

                        Street                                                                                    Apt. #

City                                                                      State                                                  Zip

Home Phone:__________________________________  Work Phone: ___________________________

Spouse/Significant Other: _______________________________________________________________

                        Last                                            First                                          Middle

Participant Employer: __________________________________________________________________

Date of Birth:______________________  Social Security No. __________________________________

In Case of Emergency Contact:_________________________________ Phone:__________________
LETTERS OF RECOMMENDATION

This is testimony from David, D.O.: “I ran into one of my classmates, and I shared a reunion with this classmate at a CME program that I attended. I told him my story with some shame and embarrassment, and it was through telling my story that I heard from this friend that you and
your program through M.A.O.P.S. was what I needed for my own recovery. I will never forget first talking to you, Jim. You were sincere and honest, and willing to help. I felt compassion and understanding. When you suggested the steps to take, I did so with the feeling of your willingness to help. I was so impressed with the program you referred me to for the fitness for duty evaluation in Lawrence, Kansas. I have had experiences with programs in the past that did 3-day evaluations, and none were as intense and as complete as I experienced in Kansas. When I met you for the first time, I was so delighted to finally shake your hand and talk with you. I know that you also have a calling, and that you were doing that calling now. I will never forget the path that led me to you over the years, and I look forward to working with your program as I enter into the practice of medicine in Missouri. Thank you so much for your hard work and time you spent with me, and encouraged me and assisted me.”

David, D.O.

*****

This is a letter of recommendation from Brad, D.O.: “I am writing in support of the M.A.O.P.S. Physician Health Program. As a recovering alcoholic and addict, this program has been very important in my professional life. Jim’s program was able to help bridge the gap between treatment and my return to medical school. In addition, the M.A.O.P.S. Physician Health Program added a framework of support for afterwards. In my case, the advocacy provided by the program has facilitated a Missouri state license, malpractice insurance, managed care participation, disability insurance, and even life insurance.

Jim Wieberg does an excellent job and has a relationship with the state board that is second to none. I would like to believe that we at M.A.O.P.S. put a premium on both the health of our members, and the quality of the service we provide to the public. I can assure you that my health and the care I provide have both been improved by my participation in the M.A.O.P.S. Physician Health Program. I suspect the same is true for the many osteopathic physicians and heliopathic physicians who have been through the program. Statistically, 1 in 10 of our members will appear before an examining board during their professional careers. We at M.A.O.P.S. need to make a financial commitment necessary to preserve the M.A.O.P.S. Physician Health Program in order to help our doctors, and thus our patients. Thank you very much for your concern in this matter. If I can be of help, please do not hesitate to call.” Brad, D.O.

*****

This is a letter of support from Dr. A. He says in his letter: “I was in a deep down-spiral, but with one voluntary call to the physicians’ hotline, I was directed to a great recovery program focused for professionals, and I enrolled in that program, which is the M.A.O.P.S. Physician Health Program. Today, four years later, I am a grateful recovering-addict physician practicing without any restrictions on my license. It saved my livelihood, but more importantly the program saved my life.

P.S.: I really do mean to say thanks. You did save my life. Thanks.” Craig

*****
August 16, 2016

Mr. Brian Bowles, Executive Director
Missouri Association of Osteopathic Physicians & Surgeons
1423 Randy Lane
Jefferson City, MO  65101

RE:  MAOPS Physician Health Program

Dear Mr. Bowles:

I am writing to you and the MAOPS Board on behalf of the MAOPS Physician Health Program.

I have been practicing in Jefferson City, Missouri since 1980. During all of that time, I have been involved with physicians who have struggled with emotional and addiction issues. During the first ten years of my practice, our firm served as General Counsel for the Missouri State Board of Registration for the Healing Arts. Thereafter, I have represented many physicians and other professionals who struggle with emotional and addiction issues.

MAOPS Physician Health Program, under the direction of Jim Wieberg, provides an extremely valuable resource for Missouri’s physicians. In many instances, colleagues refer physicians to the program before the Board of Healing Arts intervenes. In other instances, physicians are mandated by the Board to select a program. As you know, physicians have two options – the MAOPS Physician Health Program and the MSMA Missouri Physicians Health Program. Both are excellent programs; however, Missouri physicians deserve a choice.

Just as Missouri’s patients benefit by having a choice of physicians, Missouri physicians benefit by having a choice of programs. Some patients simply do not mesh with a given physician. In that situation, the relationship is not beneficial for the physician or the patient. In some instances, a physician has a bad experience with one program and should not participate in that program. If it were not for the option of having two programs, then that physician would be forced to work with a program that will not benefit the physician’s recovery.

The dental community is not blessed with two programs. While the Dental Well Being Committee is a fine program, sometimes dentists simply do not mesh with the program and refuse to participate. Unfortunately, dentists have no alternative.

No patient should be tied to one physician. Likewise, no physician should be tied to one program. One size does not fit all.

I have represented many physicians who worked with Jim Wieberg and the MAOPS Physician Health Program. Mr. Wieberg and his program are well respected by the Board of Healing Arts. When the Board knows that Mr. Wieberg is monitoring a physician, the Board has confidence that Mr. Wieberg will be honest and straight forward with the Board. While he
advocates for the physician involved in his program, Mr. Wieberg understands patient safety issues and he understands that the integrity of his program and the Board’s confidence in his program can only be maintained if he is candid with the Board.

As an attorney, I can always rely on Mr. Wieberg to be honest and straightforward with me. That is essential in my ability to represent your members. If a physician is not progressing, Mr. Wieberg will bring that issue to my attention and the physician’s caregivers so we can all impress upon the physician the importance of compliance with the program in order to maintain licensure and patient safety.

On behalf of Mr. Wieberg and the MAOPS Physician Health Program, I urge you to continue your support of the program for the benefit of your members and the patients they serve.

If you have any questions concerning this matter, then please do not hesitate to contact me.

Sincerely,

BRYDON, SWEARENGEN & ENGLAND P.C.

By:

Johnny K. Richardson

JKR/st

cc: Mr. Jim Wieberg