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Tony Evers, Governor
Dan Hereth, Secretary

VIRTUAL/TELECONFERENCE
PHYSICIAN ASSISTANT AFFILIATED CREDENTIALING BOARD
Virtual, 4822 Madison Yards Way, Madison
Contact: Tom Ryan (608) 266-2112
October 30, 2025

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.

AGENDA

9:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1-4)

B. Approval of Minutes of August 28, 2025 (5-6)

C. Reminders: Conflicts of Interest, Scheduling Concerns

D. Introductions, Announcements and Recognition

E. Administrative Matters – Discussion and Consideration
1. Department, Staff and Board Updates
2. Board Members – Term Expiration Dates
   a. Collins, Clark A. – 7/1/2027
   b. Edwards, Jacqueline K. – 7/1/2025
   c. Fischer, Jean M. – 7/1/2027
   d. Holmes-Drammeh, Emelle S. – 7/1/2028
   e. Jarrett, Jennifer L. – 7/1/2028
   f. Lange, Amanda C. – 7/1/2028
   g. Martin, Cynthia S. – 7/1/2027
   h. Sanders, Robert W. – 7/1/2028
   i. Streit, Tara E. – 7/1/2027
3. Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards' Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest – Update

F. APPEARANCE: Stef Simmons, MD, Chief Medical Officer, Lorna Breen Heroes' Foundation – "Wellbeing First for Healthcare" (7-90)

G. Credentialing Matters – Discussion and Consideration (91-115)
1. New and renewal application questions
   a. Application Language Revisions referring to Medical Conditions **(92-99)**
   b. Health Regulatory Research Institute Workforce Survey Questions **(100-113)**
2. Wall Certificate Update **(114-115)**

H. Administrative Rule Matters – Discussion and Consideration (116-118)

1. Other Rule Updates: **(117)**
   a. Med 21, Patient Health Care Records
   b. Med 27, Relating to Provisional Licensure for International Physicians
   c. N 1 to 8, Relating to APRNs and Comprehensive Review
   d. Pod 1 and 9, Relating to Supervision of Physician Assistants
2. Pending or Possible Rulemaking Projects
   a. Rule Projects Chart **(118)**

I. Ongoing Discussions with the Medical Examining Board Liaison – Discussion and Consideration

J. Legislative and Policy Matters – Discussion and Consideration

1. Senate Bill 274/Assembly Bill 273

K. Controlled Substances Board Update – Discussion and Consideration

L. Physician Assistant Interstate Compact Update – Discussion and Consideration

M. DSPS Interdisciplinary Advisory Committee Liaison Report – Discussion and Consideration

N. Wisconsin Academy of Physician Assistants – Update

O. American Academy of Physician Assistants – Update

P. Federation of State Medical Board (FSMB) Matters – Discussion and Consideration

Q. Professional Assistance Procedure (PAP) Discussion of Expansion to Include Mental Health Disorders Update – Discussion and Consideration

R. Discussion and Consideration of Items Added After Preparation of Agenda:

1. Introductions, Announcements and Recognition
2. Administrative Matters
3. Election of Officers
4. Appointment of Liaisons and Alternates
5. Delegation of Authorities
6. Education and Examination Matters
7. Credentialing Matters
8. Practice Matters
9. Administrative Rule Matters
10. Public Health Emergencies
11. Legislative and Policy Matters
12. Liaison Reports
13. Board Liaison Training and Appointment of Mentors
14. Informational Items
15. Division of Legal Services and Compliance (DLSC) Matters
16. Presentations of Petitions for Summary Suspension
17. Petitions for Designation of Hearing Examiner
18. Presentation of Stipulations, Final Decisions and Orders
19. Presentation of Proposed Final Decisions and Orders
20. Presentation of Interim Orders
21. Petitions for Re-Hearing

22. Petitions for Assessments
23. Petitions to Vacate Orders
24. Requests for Disciplinary Proceeding Presentations
25. Motions
26. Petitions
27. Appearances from Requests Received or Renewed
28. Speaking Engagements, Travel, or Public Relation Requests, and Reports

S. Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85(1)(b), and 440.205, Stats.); to consider individual histories or disciplinary data (s. 19.85(1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.).

T. Deliberation on DLSC Matters

1. Proposed Stipulations, Final Decisions and Orders

a. 23 PAB 031 – Matthew C. Trom **(119-124)**

2. Case Closings

a. 24 PAB 005 – S.L.K. **(125-134)**

b. 24 PAB 0016 – E.E.P. **(135-140)**

U. Deliberation of Items Added After Preparation of the Agenda

1. Education and Examination Matters
2. Credentialing Matters
3. DLSC Matters
4. Monitoring Matters
5. Professional Assistance Procedure (PAP) Matters
6. Petitions for Summary Suspensions
7. Petitions for Designation of Hearing Examiner
8. Proposed Stipulations, Final Decisions and Order
9. Proposed Interim Orders
10. Administrative Warnings
11. Review of Administrative Warnings
12. Proposed Final Decisions and Orders
13. Matters Relating to Costs/Orders Fixing Costs
14. Case Closings
15. Board Liaison Training
16. Petitions for Assessments and Evaluations
17. Petitions to Vacate Orders
18. Remedial Education Cases
19. Motions
20. Petitions for Re-Hearing
21. Appearances from Requests Received or Renewed

V. Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

W. Open Session Items Noticed Above Not Completed in the Initial Open Session

X. Vote on Items Considered or Deliberated Upon in Closed Session if Voting is Appropriate

Y. Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

ADJOURNMENT

VIRTUAL/TELECONFERENCE

ORAL INTERVIEW OF CANDIDATES FOR LICENSURE

10:00 A.M. OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING

CLOSED SESSION – Reviewing Applications and Conducting Oral Interview of **Zero** (**0**) (at time of agenda publication) Candidates for Licensure – **Jean Fischer** and **Clark Collins**.

NEXT MEETING: DECEMBER 18, 2025

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held virtually unless otherwise indicated. In-person meetings are typically conducted at 4822 Madison Yards Way, Madison, Wisconsin, unless an alternative location is listed on the meeting notice. In order to confirm a meeting or to request a complete copy of the board's agenda, please visit the Department website at https:\\dsps.wi.gov. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of any agenda item may be changed by the board for the convenience of the parties. The person credentialed by the board has the right to demand that the meeting at which final action may be taken against the credential be held in open session. Requests for interpreters for the hard of hearing, or other accommodations, are considered upon request by contacting the Affirmative Action Officer or reach the Meeting Staff by calling 608-267-7213.

HYBRID (IN-PERSON/VIRTUAL)
PHYSICIAN ASSISTANT
AFFILIATED CREDENTIALING BOARD
MEETING MINUTES
AUGUST 28, 2025

PRESENT: Clark Collins, Jean Fischer *(Virtual)*, Emelle Holmes-Drammeh *(Virtual) (excused at 9:31 a.m.)*, Jennifer Jarrett, Cynthia Martin *(Virtual)*, Robert Sanders *(Virtual) (excused at 9:52 a.m.)*, Tara Streit

ABSENT: Jacqueline Edwards, Amanda Lange

STAFF: Tom Ryan, Executive Director; Jameson Whitney, Legal Counsel; Nilajah Hardin, Administrative Rules Coordinator; Tracy Drinkwater, Board Administrative Specialist; and other Department Staff

CALL TO ORDER

Jennifer Jarrett, Chairperson, called the meeting to order at 9:00 a.m. A quorum was confirmed with seven (7) members present.

ADOPTION OF AGENDA

MOTION: Tara Streit moved, seconded by Robert Sanders, to adopt the Agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES OF JUNE 26, 2025

MOTION: Tara Streit moved, seconded by Robert Sanders, to approve the Minutes of June 26, 2025, as published. Motion carried unanimously.

ADMINISTRATIVE RULE MATTERS

Final Rule Draft: PA 1 to 4, Relating to Implementation of the Physician Assistant Licensure Compact

MOTION: Tara Streit moved, seconded by Clark Collins, to authorize the Chairperson to approve the Legislative Report and Draft for Clearinghouse Rule 25-029 (PA 1 to 4), Relating to Implementation of the Physician Assistant Licensure Compact for submission to the Governor's Office for approval, notification to the Legislature, and approval and submission of the Adoption Order to the LRB for publication. Motion carried unanimously.

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP) USAGE

MOTION: Tara Streit moved, seconded by Robert Sanders, to approve the recommended PDMP usage reminder notice plan and standard letter as presented in the August 28, 2025, agenda materials. Motion carried unanimously.

Emelle Holmes-Drammeh excused at 9:31 a.m.
Robert Sanders excused at 9:52 a.m.

CLOSED SESSION

MOTION: Tara Streit moved, seconded by Clark Collins, to convene to closed session to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85(1)(b), and 440.205, Stats.); to consider individual histories or disciplinary data (s. 19.85(1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.). Jennifer Jarrett, Chairperson read the language of the motion. The vote of each member was ascertained by voice vote. Roll Call Vote: Clark Collins-yes; Jean Fischer-yes; Jennifer Jarrett-yes; Cynthia Martin-yes; and Tara Streit-yes. Motion carried unanimously.

The Board convened into Closed Session at 9:55 a.m.

DLSC MATTERS

Monitoring Matters

N.B.L. – Requesting Full Licensure

MOTION: Cynthia Martin moved, seconded by Jennifer Jarrett, to grant the request of N.B.L. for full licensure. Motion carried unanimously.

RECONVENE TO OPEN SESSION

MOTION: Tara Streit moved, seconded by Clark Collins, to reconvene in Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 10:02 a.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

MOTION: Tara Streit moved, seconded by Cynthia Martin, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

(Be advised that any recusals or abstentions reflected in the Closed Session motions stand for the purposes of the affirmation vote.)

DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

MOTION: Tara Streit moved, seconded by Clark Collins, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Tara Streit moved, seconded by Clark Collins, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:04 a.m.

Wellbeing First for Healthcare

Wellbeing First for Healthcare

We envision a world where seeking mental health care is universally viewed as **a sign of strength** for health workers.

We believe every health worker should have **access to mental health care and professional wellbeing support** that they may need, at every moment in their career.

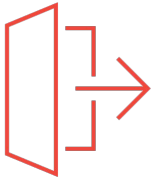
We are dedicated to addressing the operational practices and processes driving health worker burnout, while changing how the healthcare industry supports health workers' mental health.

Why We Protect Health Workers' Professional Wellbeing and Mental Health

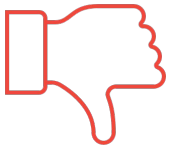
Twenty-two million U.S. health workers are caring for the health of our entire country.

To care for others, health workers must also be cared for—but our **health workers are experiencing a burnout and mental health crisis**.

46% of health workers experienced **burnout** in 2022 (up from 32% in 2018)



44% of health workers intend to **leave their job** (up from 33% in 2018)



Higher levels of **poor mental health** days and **being harassed** compared to all other type of workers

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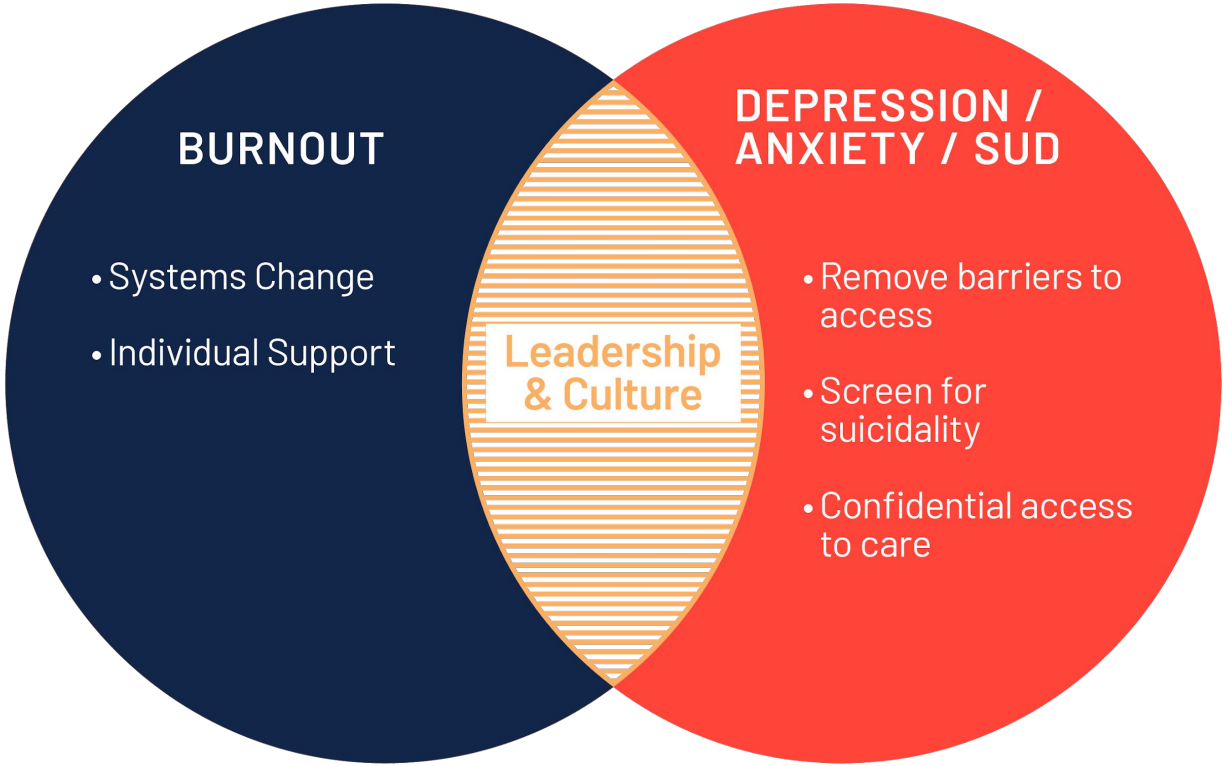
Our Workforce Deserves Comprehensive Wellbeing Solutions



Healthcare Professionals Have an Increased Suicide Risk

PRIMARY DRIVERS OF SUICIDE IN THE HEALTH CARE WORKFORCE - FIGURE 1.

DRIVER

Stigma associated with talking about and seeking behavioral health care

- Fear from clinicians that seeking care may have a detrimental effect on their ability to renew or retain their state medical license
- Fear of losing hospital privileges via the credientialing process
- Fear of being perceived as "weak" or unable to perform on the job
- Feeling of being judged or unsupported by peers, managers, and/or senior leadership for seeking behavioral health care
- Fears about treatment confidentiality, especially when care is accessed at or provided by clinicians practicing at the same hospital or health system as the person receiving care

DRIVER

Inadequate access to behavioral health education, resources, and treatment options

- Long wait times between referrals and starting care
- Behavioral health providers in the employee's health not having convenient office hours that accomodate a health care worker's schedule
- Out-of-pocket expenses for treatment exceeding the individual's ability to pay for care Uncertainty about how to access free resources from the EAP or Human Resources

DRIVER

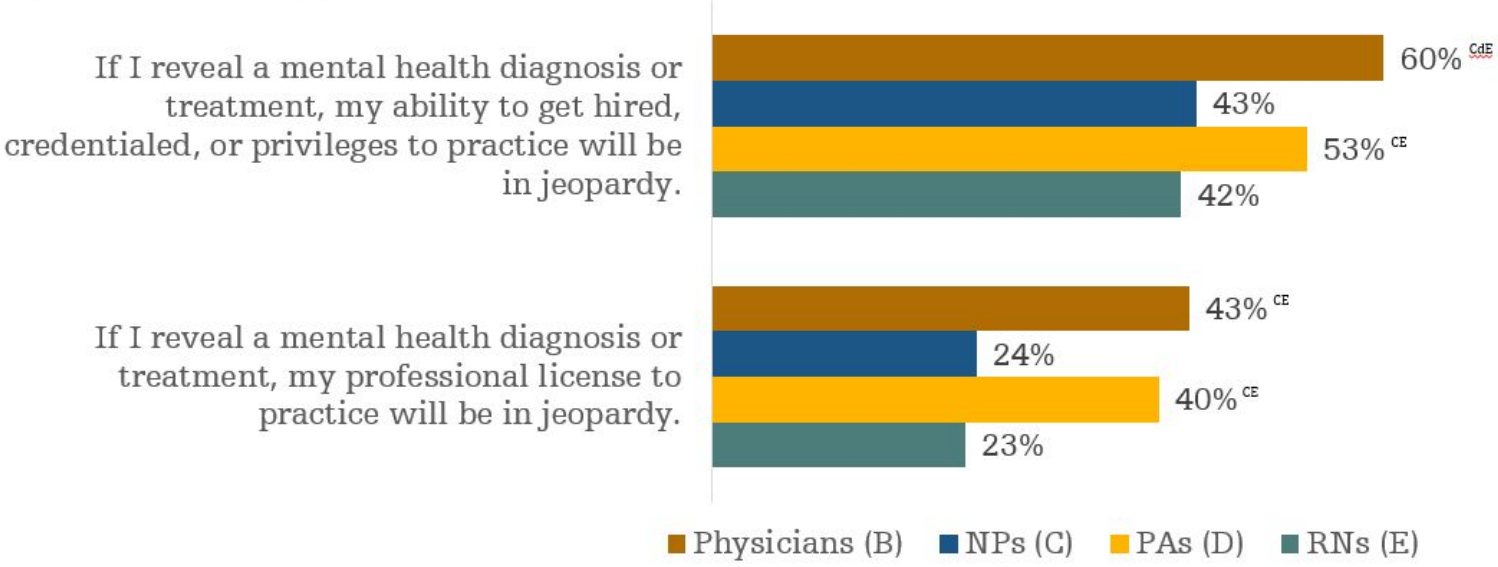
Job-related stressors

- Repeated exposure to death and dying
- Workplace violence
- Emotionally draining work
- Lack of support that acknowledges human limitations in a time of extreme work hours, uncertainty, and intense exposure to critically ill patients
- Lack of appropriate rewards (financial, social or intrinsic)
- Lack of connection with others in the workplace
- Lack of perceived fairness and mutual respect
- Mismatch between personal values and leadership/organizational values or organizational values and actual practice
- Insufficient control over resources needed or insufficient authority to pursue work more effectively

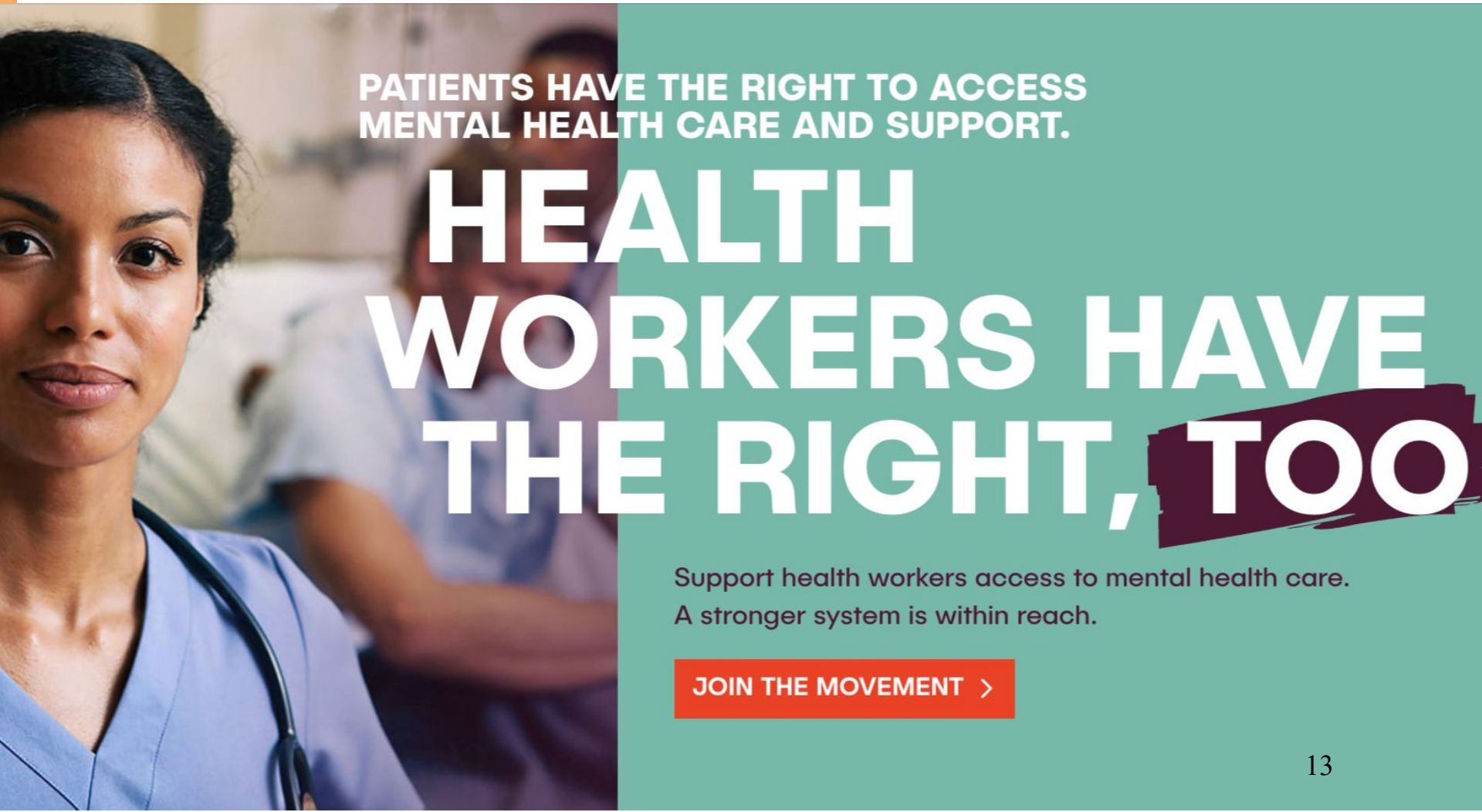
www.aha.org/suicideprevention/health-care-workforce/suicide-prevention-guide

PAs believe revealing mental health diagnosis or treatment puts their careers at risk

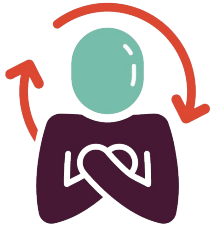
"To what extent do you agree or disagree with each of the following statements?" (agree or strongly agree)



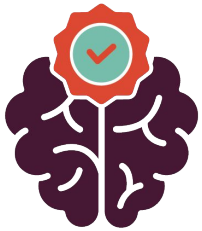
Base: 750 physicians, 250 NPs, 251 PAs, 765 RNs
Scale: Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval


PATIENTS HAVE THE RIGHT TO ACCESS
MENTAL HEALTH CARE AND SUPPORT.
HEALTH
WORKERS HAVE
THE RIGHT, TOO
Support health workers access to mental health care.
A stronger system is within reach.
JOIN THE MOVEMENT >

ALL IN for Health Workers Mental Health



ACCESSIBLE AND AFFORDABLE MENTAL HEALTH CARE

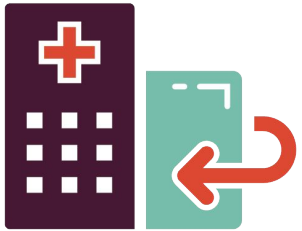


CONFIDENTIAL PROFESSIONAL/ PHYSICIAN HEALTH PROGRAM SUPPORT

EQUAL PRIVACY IN MENTAL HEALTH CARE

CONFIDENTIAL PEER SUPPORT

EDUCATION AND TRAINING ON MENTAL HEALTH AND PROFESSIONAL WELLBEING



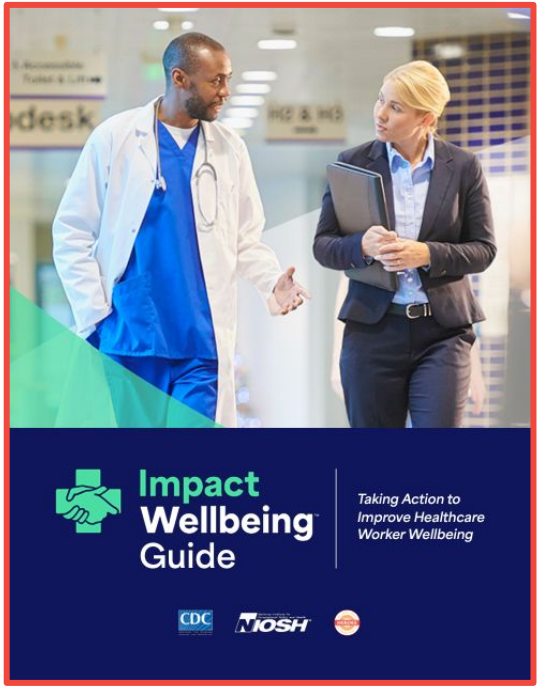
SUPPORTIVE PATHWAY FOR RE-ENTRY

Caring for Caregivers

Caring for Caregivers

Caring for Caregivers (C4C) builds learning communities to assist healthcare organizations, such as hospitals and medical groups, in improving workplace policies and practices that reduce burnout, normalize help-seeking, and strengthen professional wellbeing—**accelerating impact to improve health workers' wellbeing and mental health**.

Guided by experts, healthcare organizations participate in three phases of work to **implement the evidence-informed strategies in the *Impact Wellbeing™ Guide*** to go beyond encouraging self-care and individual resilience to focus on operational-level improvements.



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Our C4C Communities

We partner with organizations to guide effective leadership and culture transformation that creates better workplace environments for health workers' wellbeing and mental health.

Caring for New Jersey's Caregivers

in collaboration with

MSNJ Medical Society of New Jersey

New Jersey Health Care Quality Institute

To health! NJHA New Jersey Hospital Association

NJSNA New Jersey State Nurses Association

Caring for North Carolina's Caregivers

in collaboration with

NCCPRW North Carolina Clinician and Physician Retention and Well-Being Consortium

NCHA North Carolina Healthcare Association

NC MS North Carolina Medical Society

NCNA North Carolina Nurses Association

Caring for Virginia's Caregivers

in collaboration with

Virginia Hospital & Healthcare Association — An alliance of hospitals and health delivery systems

MSV Medical Society of Virginia

VNA Virginia Nurses Association

HIMSS Virginia Chapter

Caring for Wisconsin's Caregivers

in collaboration with

WHA Wisconsin Hospital Association — Advocate. Advance. Lead.

Wisconsin Medical Society

WNA Wisconsin Nurses Association

Caring for J+C's Caregivers

in collaboration with

Jackson + Coker Locum Tenens

Caring for Caregivers is supported by

J&J Foundation

The Physicians Foundation

stryker

MCW Medical School

Advancing a Healthier Wisconsin Endowment

Our Impact
Caring for Virginia's Caregivers

- **12 health systems** made up of **48 hospitals** with **129,827 physicians, nurses, and other health workers** serving **11,570,283 people**, completed the curriculum and now implementing an EHR optimization project that integrates improving professional wellbeing
- **75% of hospitals** in Virginia awarded the Wellbeing First Champion Badge for Credentialing
  - Published in ***American Journal of Public Health***
- **State law changed** to protect all licensed health workers
- Catalyzed credentialing change at multi-state (including VA) health system, HCA Healthcare, across **186 hospitals & 124 surgery centers impacting 45,000 health workers**

Augusta Health
Ballad Health
BON SECOURS MERCY HEALTH
CARILION CLINIC
CENTRA
Children's Hospital of The King's Daughters
Inova
Mary Washington Healthcare
Sentara
UVA Health
VCU Health
VHC HEALTH
For you. For life.

Wellbeing First Champion Challenge

Like everyone, health workers deserve the right to pursue mental health care without fear of losing their job.

However, institutional practices have subjected health workers to overly invasive questions about their mental health in licensing, credentialing, and insurance applications—impacting health workers willingness to seek help, which can increase the risk of suicide.

The **Wellbeing First Champion Challenge** supports licensure boards, hospitals, medical centers, clinics, and other care facilities in auditing and changing their applications to be free of intrusive mental health questions and stigmatizing language.

A Transparent Source of Truth

It is Safer for

1.85 Million Licensed and 357,000 Credentialed Health Workers to Seek Mental Health Care

The Wellbeing First Champion Badge serves as a visual recognition for health workers.

When health workers are deciding in which state or organization to work, the Badge serves as a **standardized form of education & communication** that a location will not require health workers to answer intrusive mental health questions.

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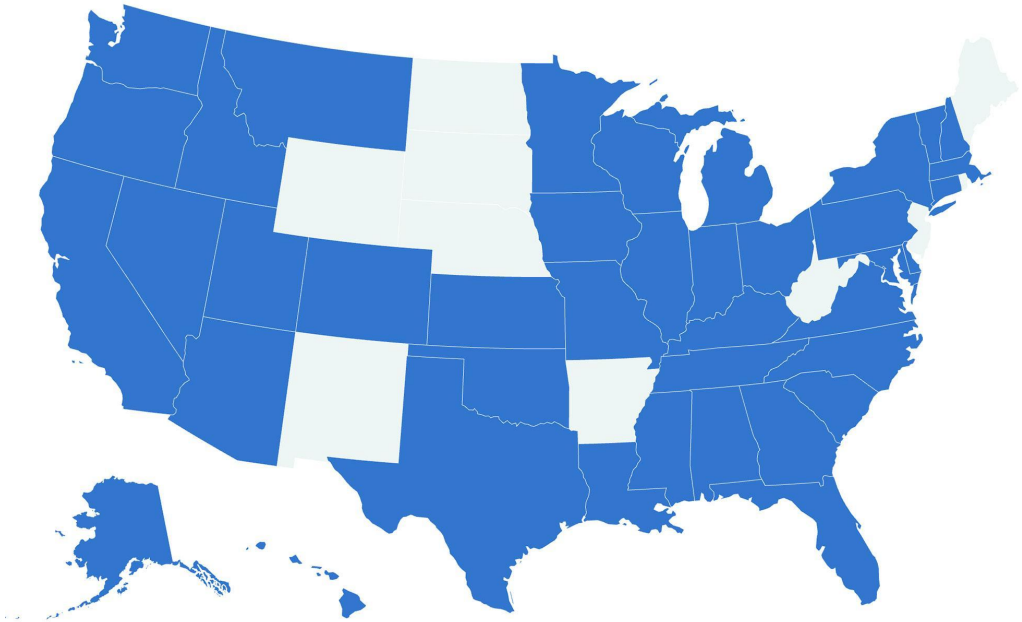
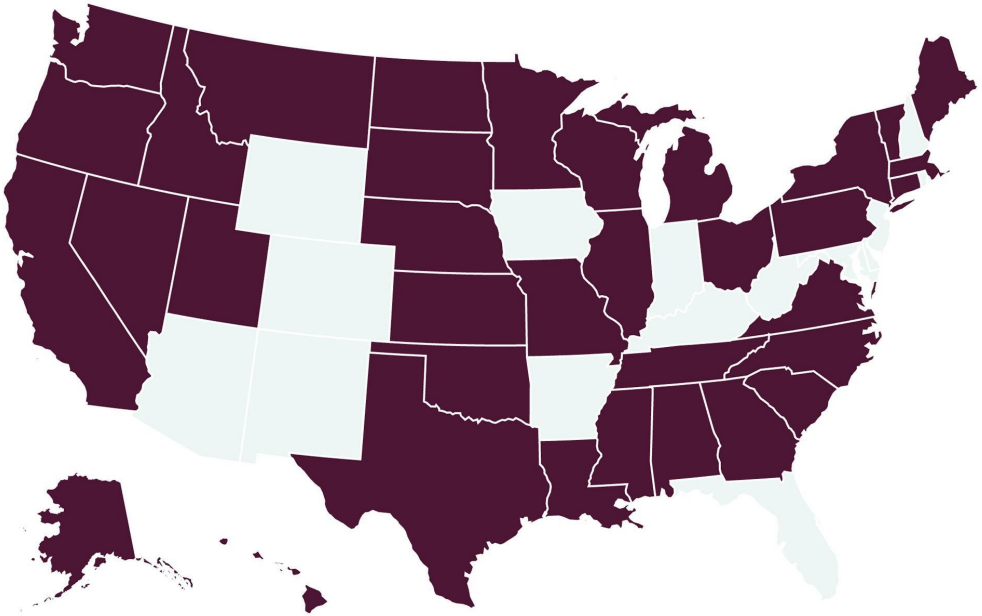
Our Impact
Wellbeing First Champions for Credentialing



- As of Sept. 19, 2025, **1,850 hospitals, medical centers, clinics, & other care facilities** verified their credentialing applications do not include intrusive mental health questions—benefiting nearly **357,000 credentialed health workers**.
- Also, 2 insurance companies (PacificSource Health Plans and Providence Health Plan) verified their credentialing applications—benefiting 52,000+ health workers.
- Additionally, Jackson and Coker Locum Tenens, Envision Healthcare, Vituity, and LocumTenens.com verified their internal applications and forms—benefiting 38,000 health workers.

Our Impact

Wellbeing First Champions for Medical Licensing



As of Sept. 19, 2025, **40 medical licensure boards** verified their licensure applications do not include intrusive mental health questions—**benefiting more than 1 million physicians**.

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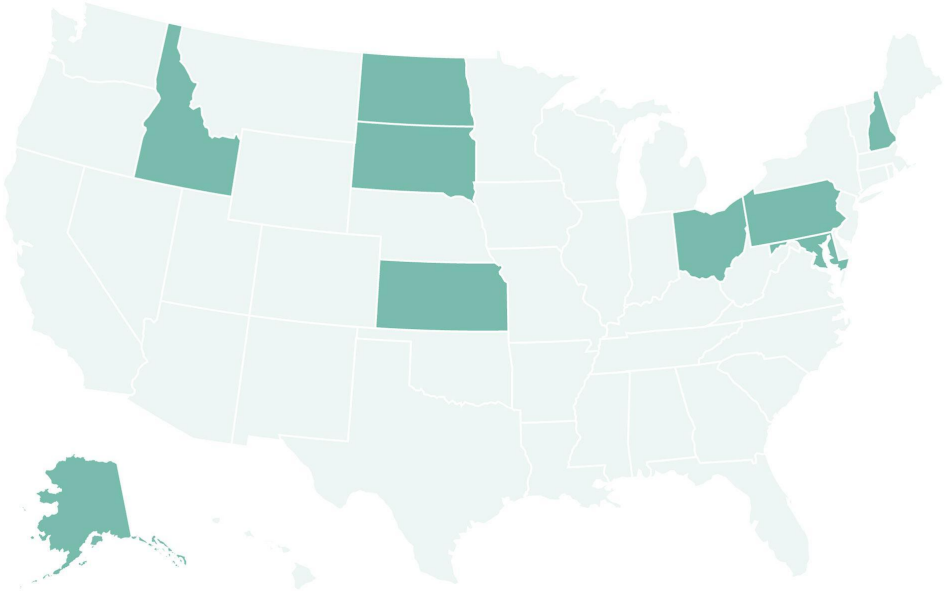
Our Impact

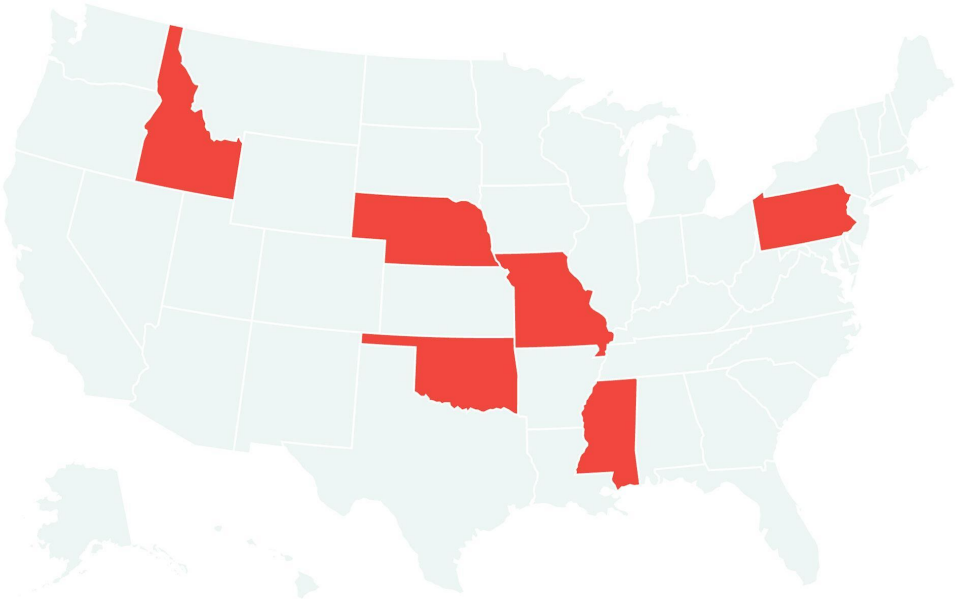
Wellbeing First Champions for Pharmacy Licensing



As of Sept. 19, 2025, **9 pharmacy licensure boards** verified their licensure applications do not include intrusive mental health questions—**benefiting 155,000+ pharmacy professionals**.

Our Impact

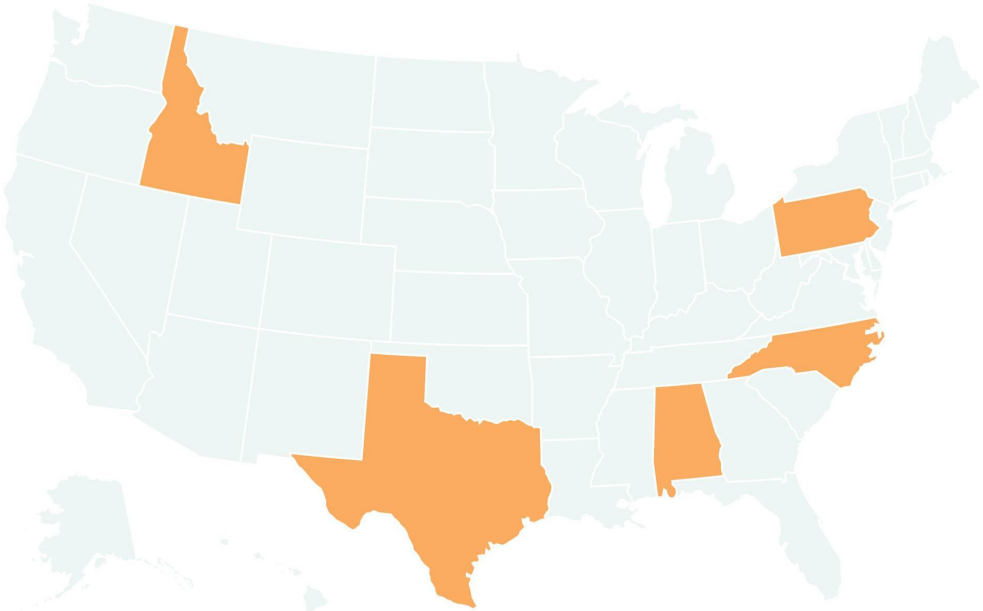
Wellbeing First Champions for Nurse Licensing



As of Sept. 19, 2025, **6 nursing licensure boards** verified their licensure applications do not include intrusive mental health questions—**benefiting nearly 580,000 nurses**.

Our Impact

Wellbeing First Champions for Dental Licensing



As of Sept. 19, 2025, **5 dental licensure boards** verified their licensure applications do not include intrusive mental health questions—benefiting nearly **65,000 dental professionals**.

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Thank You

stefanie@drbreenheroes.org

If you or someone you know is in crisis, call or text 988 or chat at 988lifeline.org.

A research collaboration between:

Heart of Safety **Coalition**

Inspiring transformation for care team safety and wellbeing

ALL IN Wellbeing First for Healthcare
a coalition led by

DR. LORNA BREEN HEROES' FOUNDATION

Report: Clinician perceptions of barriers to access mental health care

- Research provides insight from more than 2,000 nurses, physicians, nurse practitioners and physician assistants

Introduction 1

The research 3

Understanding clinician perceptions 3

Key findings 4

Data in detail 6

Barriers to access mental health care 6

Structural barriers 8

Institutional stigma and perceived discrimination 12

Licensure and credentialing 12

Attitudes about physician or professional health programs 20

Negative attitudes and judgment 25

Internal and external attitudes and beliefs 25

Judgment of others 31

Privacy and behavioral barriers 34

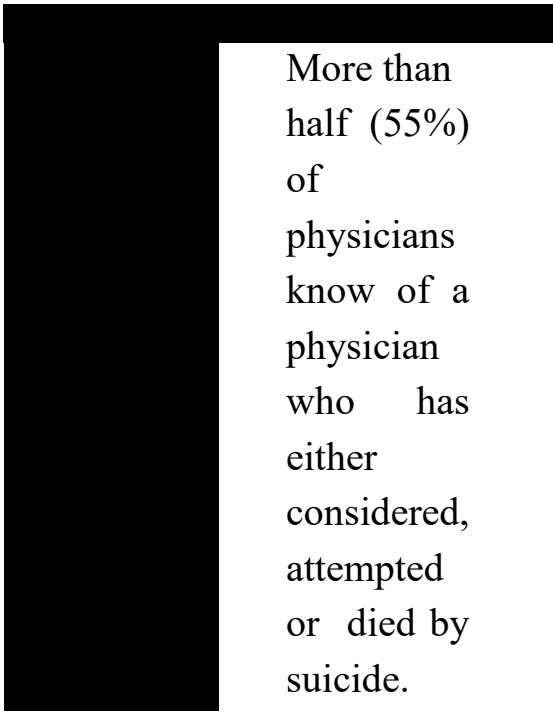
Solutions to support access to mental health care 38

Discussion 42

About the survey 45

References 51

Dr. Lorna Breen was a dedicated emergency physician and director of the emergency room (ER) at Allen Hospital in New York City when the COVID-19 pandemic started. She and her colleagues worked around the clock during that first, overwhelming peak of disease, fear and uncertainty — with limited PPE, insufficient supplies, not enough oxygen, not enough beds, not enough help. There were patients dying in the waiting room and the hallways. After 12-hour shifts, Lorna and her co-workers would stay because the surge of sick patients didn't slow throughout the day or night. Lorna contracted COVID, recovered (barely) and returned to work until she literally couldn't stand. That's when her family intervened. They removed her from the incessant demands of emergency care during the pandemic and got her the mental health care she needed and deserved. But for Lorna, that lifeline felt like an end to her lifelong dream of serving her community as a physician. She was worried that she would lose her medical license or be ostracized by her colleagues because she was suffering due to her work. On April 26, 2020, Lorna Breen, physician, sister, aunt, friend, died by suicide.



More than half (55%) of physicians know of a physician who has either considered, attempted or died by suicide.

Sadly, Lorna's experience is all too common in healthcare. More than half (55%) of physicians know of a physician who has either considered, attempted or died by suicide. Twenty percent know of a physician who has either considered, attempted or died by suicide during the COVID-19 pandemic.[1] And suicide rates among female nurses (the majority of the nursing workforce) are alarmingly higher when compared to the general population.[2]

Source: The Physicians Foundation 2024 Report

Many clinicians think they should be able to rise above any challenge without psychological or emotional support. And fear of judgment from peers and leaders, or concerns that accessing mental health care will lead to loss of license or job opportunities prevent them from getting the help they need and deserve. Clinicians face extraordinary pressures and rigors throughout the course of their careers. They carry the burden of life and death decisions made with imperfect information and insufficient resources. They experience moral distress when resource constraints interfere with their commitment.[3] They live with feelings of broken trust as a result of working in environments where workplace incivility and violence can be a daily occurrence.[4,5] And

Introduction

they balance the demands of careers that may call on one's time and skills day or night, including weekends and holidays.[6]

Not all mental stress or distress experienced by care team members results in suicide, and work stressors are not usually the only contributors to suicidal ideation or action.[7] Outside of work, clinicians also experience the kinds of typical mental health ebbs and flows that most people encounter as they navigate life, including managing finances, spending quality time with family and friends, caring for an ailing loved one, experiencing loss or building skills for better relationships. Accessing mental health care can benefit people both personally and professionally, enhancing their emotional, psychological and social wellbeing. Understanding, learning and practicing coping skills can be especially beneficial in human-centered environments such as healthcare.

The research

Many healthcare workers who seek help receive effective and potentially lifesaving mental health care. This care may come in the form of peer support, counseling, therapy, medication or a myriad of other modalities that help people process difficult experiences, build skills, create community or manage a mental health condition.

Accessing mental health care can benefit people both personally and professionally, enhancing their emotional, psychological and social wellbeing.

When clinicians are afraid to seek mental health care, they can suffer and so can the people around them, including patients and team members. Barriers to mental health care for clinicians, whether cultural or structural, can have widespread implications that affect cultures of safety, quality of care, staff retention, system resilience and more.[8]

Understanding clinician perceptions

With this research, the Heart of Safety Coalition, in collaboration with the Dr. Lorna Breen Heroes' Foundation and its ALL IN: Wellbeing First for Healthcare Coalition, set out to gain a deeper understanding of the structural and cultural barriers that physicians, nurses, nurse practitioners and physician assistants face when accessing mental health care. The research also explores clinician perspectives on some promising approaches to removing or lessening those barriers. It is our shared belief that healthcare workers need and deserve workplaces that support the three pillars of safety: psychological and emotional safety, dignity and inclusion, and physical safety.

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Our survey was fielded through Medscape's clinician panel from Jan. 30, 2025 through February 12, 2025. Our sample included 765 registered nurses (RNs), 750 physicians (MDs/DOs), 251 physician assistants (PAs) and 250 nurse practitioners (NPs) with a response rate of 36% and an incidence rate of 93%. For this research, we chose to use the language "mental health care" and did not use explicit language about specific type of condition treated, such as substance use disorders, mood disorders or others. See the "About the survey section" at the end of this report for more details.

Key findings

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Summary of key findings from the survey

- **Costs and schedule inflexibility create structural barriers to access.**

  The cost of mental health services without insurance and lack of schedule flexibility created the greatest logistical barriers to accessing mental health care for all clinicians. Female MDs/DOs experienced these barriers more significantly than their male counterparts, while female RNs reported that lack of schedule flexibility is a barrier more often than male RNs. But cost challenges strike younger and mid-career RNs more than older RNs with no difference by gender.

- **Licensure, credentialing and job application practices build stigma and perceptions of discrimination.**

  Half of clinicians reported that concerns about their ability to get hired, credentialed or privileges to practice creates a barrier to accessing mental health care. More than 40% reported concerns about professional insurance and license renewals if they seek care. In all cases, MDs/DOs had the highest concerns.

- **Low awareness of physician or professional health programs (PHPs) limits access to resources.**

  Fewer than one in five MDs/DOs, NPs, PAs and RNs said they had a good understanding of PHPs. Among those with opinions, most expressed positive sentiments about what PHPs offer to support clinicians' mental health and recovery from impairment.

- **Personal and interpersonal stigma and judgment create cultural barriers to care access and further privacy behaviors.**

  More than half of all respondents agreed or strongly agreed that healthcare workers experience internal, external and institutional stigma that prevents them from accessing mental health care. One in ten MDs/DOs and roughly one in 20 other clinicians said they would have concerns about a colleague's ability to practice in a competent, ethical and professional manner if they learned that colleague accessed mental health care. Across all clinicians (including those who have not sought mental health care) 14% have sought care in another city, state or health system to maintain confidentiality, and 13% have paid out of pocket for mental health care to avoid a paper trail.

- **Clinicians favor structural changes and resources that support mental health care access.** More than two thirds of respondents reported that controlling costs and supporting schedule flexibility would be highly effective in improving healthcare workers' ability to access mental health care. Roughly half of respondents also believe that removing stigmatizing questions from hiring, credentialing, privileging and professional insurance applications would be highly effective in removing barriers and improving access to mental health care.

> "Healthcare workers face significant barriers to accessing mental health care, including stigma, time constraints, limited access, financial concerns and fear of professional consequences. Many feel pressured to appear strong, fearing judgment from colleagues or negative impacts on their careers. Long shifts and unpredictable schedules make it difficult to find time for therapy, and many mental health services operate during standard business hours. Finding providers who understand the unique stressors of healthcare can be challenging, with long wait times and limited resources in some areas. Cost is another barrier, as not all insurance plans cover mental health care adequately, and high out-ofpocket expenses can make treatment unaffordable. Additionally, concerns about licensing, job security and mandatory reporting discourage many from seeking the help they need."
>
> **Primary care nurse**
> Female, 34, North Carolina

Many factors influence whether clinicians can, or believe they can, access mental health care services or treatments without fear of negative personal, interpersonal or professional repercussions. In this report, we examined:

- structural barriers to access, including cost and schedule flexibility.
- institutional stigma and perceived discrimination, including licensure and credentialing questions as well as physician/professional health programs.
- negative attitudes and beliefs about oneself, about one's peers and colleagues, and from those in power.
- behaviors around mental health care, including help-seeking and privacy.
- attitudes around potential solutions to internal, external and institutional barriers.

Barriers to accessing mental health care

> "Being in a smaller specialty, I think one of the main barriers is the sense that you will be leaving more work for your partners if you take time off for mental health. Even if you take a sick day, those patients will likely be shifted onto someone

The first question in our survey asked respondents to describe the biggest barriers that prevent healthcare workers from accessing mental health care. When we analyzed the openended responses, we learned that 59% of respondents said that a lack of availability was a key barrier. This could mean lack of ability to schedule appointments around work, lack of providers in network or who could assure privacy, or other factors. Many also cited costs, lack of adequate insurance coverage, fear of judgment (both of themselves and from others), and lack of privacy and fear of professional repercussions. MDs/DOs were significantly less likely to cite availability and costs concerns, and significantly (95% confidence interval) more likely to cite fear of judgment and professional repercussions than their NP, PA or RN counterparts (see Figure 1).

Figure 1: Lack of availability of mental health care resources that fit within schedule constraints is the top barrier to access

Urological surgery physician

”

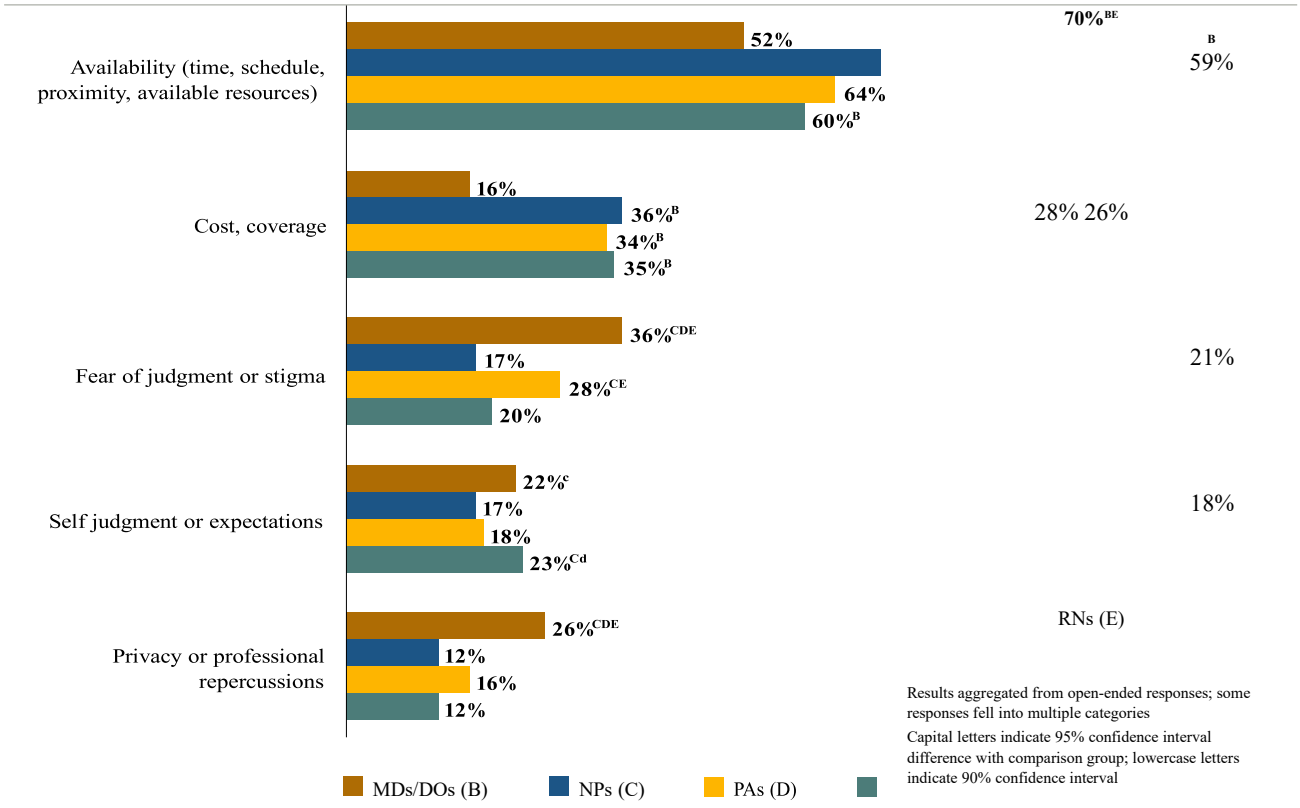
else’s workload.

Male, 38, California

Data in detail

“From your experience, what are the biggest barriers that prevent you and other health workers from accessing the mental health care you may need?”

All respondents



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Structural barriers to access

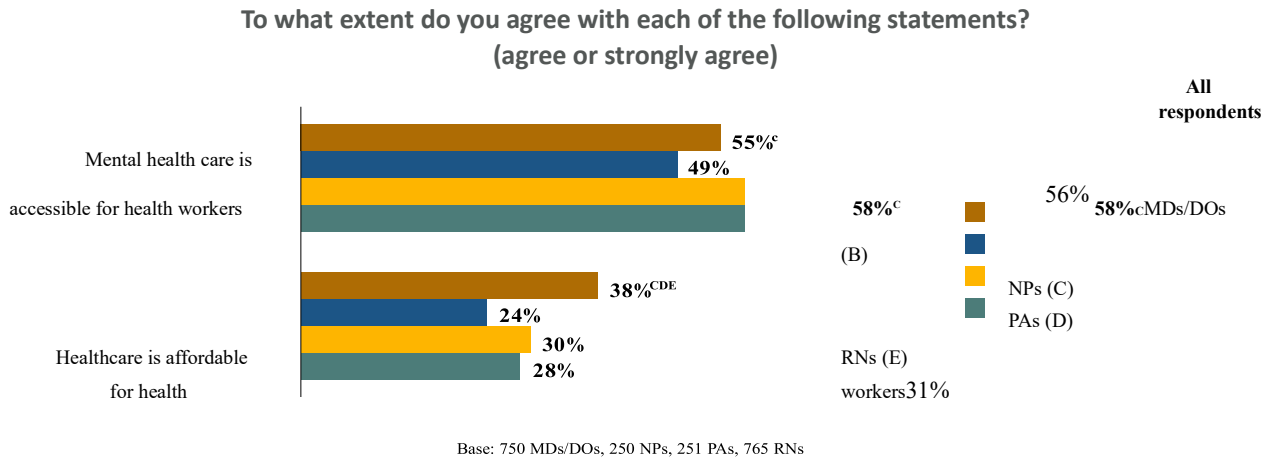
Structural barriers to mental health care access are those that make it logistically difficult to access mental health care, separate from concerns about stigma or possible institutional discrimination. These center on accessing affordable mental health care options.

Only a slight majority of respondents (56%) said they agree or strongly agree that mental health care is currently accessible for health workers. And only about a quarter to a third agreed that mental health care is affordable for care team members (see Figure 2).

When we looked more deeply, we saw that the costs of mental health care without insurance were moderate, significant or prohibitive barriers for more than 80% of NPs, PAs and RNs. The same was true for 72% of MDs/DOs. The numbers are substantially better for affordability with insurance, though MDs/DOs still rated insured mental health care as significantly more affordable than their NP and RN counterparts (95% confidence interval). However, 61% of clinicians reported that their insurance only covers treatment with practitioners who work at their same health systems and expressed subsequent worries about privacy as moderate, significant or prohibitive barriers. For these clinicians, their benefits structure puts them in a position where they must weigh trade-offs between cost and privacy that may force a more difficult decision about whether to pursue mental health care at all.

Another common barrier to access reported by clinicians related to the ability to work around professional schedules that may be unpredictable, inflexible and subject to change with little notice. Eighty percent of respondents said the lack of ability to schedule mental health care around their work schedule created a moderate, significant or prohibitive barrier, while 79% said the same about the lack of flexibility in scheduling when their schedule changes (see Figure 3).

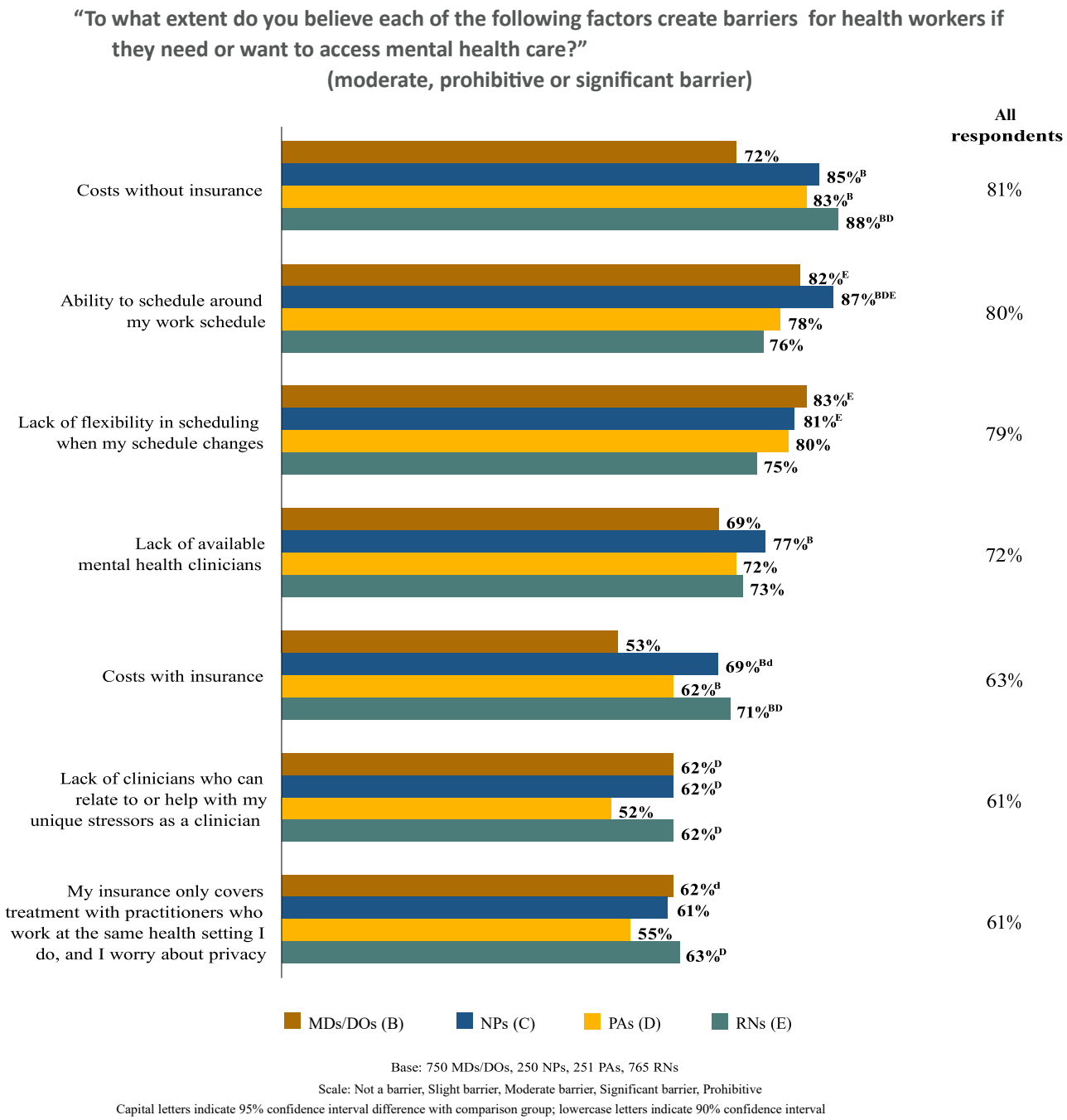
Figure 2: Fewer than one third of clinicians report that mental health care is affordable



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Scale: Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Figure 3: Costs and lack of schedule flexibility create significant barriers to mental health care access



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Scale: Not a barrier, Slight barrier, Moderate barrier, Significant barrier, Prohibitive

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Looking at demographics, we found that male MDs/DOs were significantly more likely to agree that mental health care is accessible and affordable than their female counterparts. We also see that MDs/DOs aged 60 and older cite less burden from cost and access barriers, though these barriers are still common (see Figure 4).

Female RNs and those under age 40 were significantly more likely to cite schedule barriers to accessing mental health care than their male and older counterparts. This result may be because women are still more likely to shoulder a greater proportion of household chores and family caregiving responsibilities than men are, even when they contribute financially.[9] Younger RNs were also more likely to report costs with insurance to be at least moderate barriers to accessing mental health care (see Figure 5).

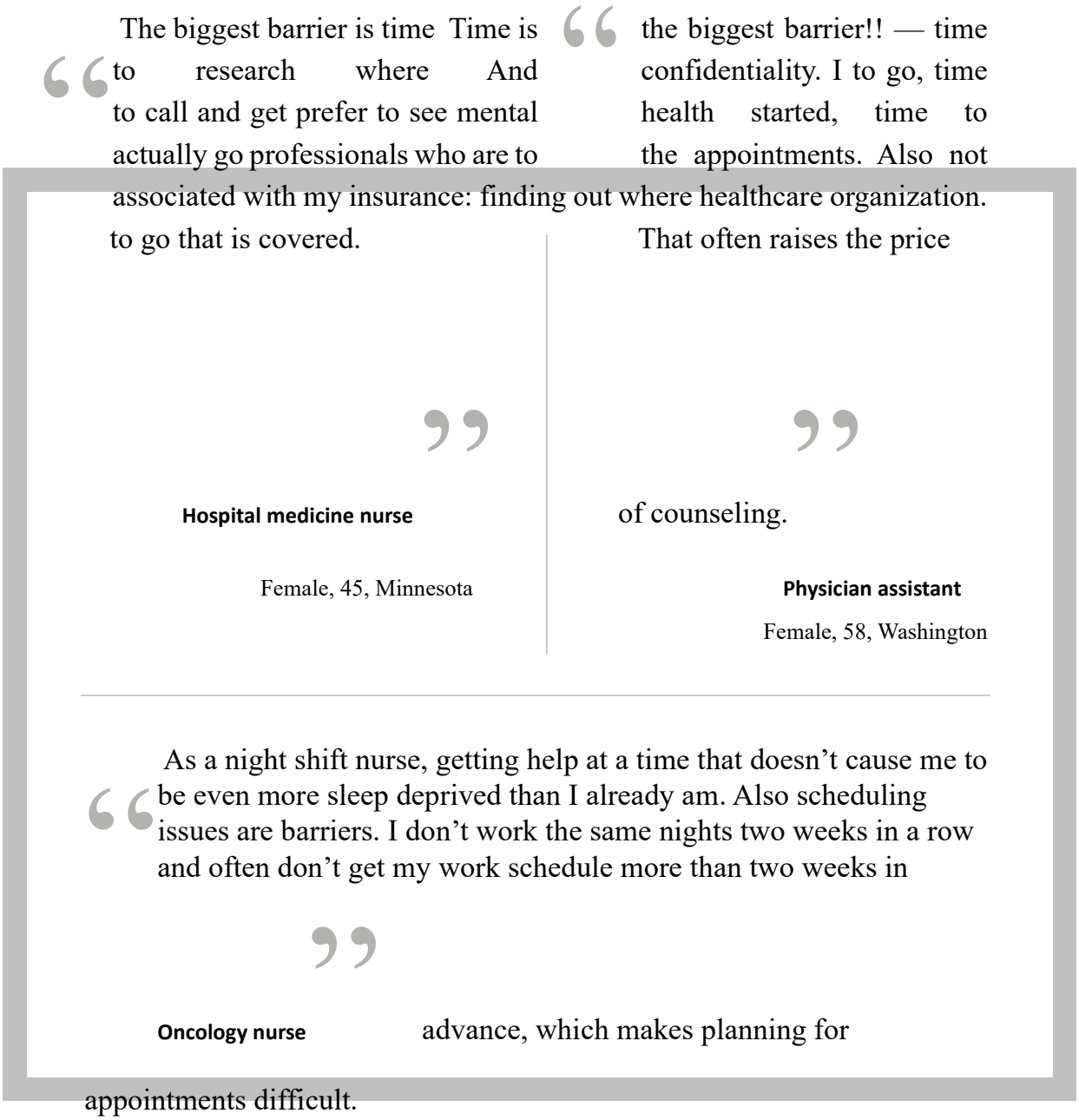


Figure 4: Female MDs/DOs are more likely than their male counterparts to cite barriers to accessing mental health care

Physicians (MDs, DOs)

To what extent do you agree with each of the following statements? (agree or strongly agree)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Mental health care is accessible for health workers	60%F	49%	51%	52%	58%	61%op
Mental health care is affordable for health workers	41%F	33%	37%	38%	38%	38%
To what extent do you believe each of the following factors create barriers for health workers if they need or want to access mental health care? (moderate, prohibitive or significant barrier)	**Male (M)**	**Female (F)**	**<40 (O)**	**40 – 49 (P)**	**50 – 59 (Q)**	**60+ (R)**
Costs without insurance	69%	77%M	70%	70%	74%	75%
Ability to schedule around my work schedule	77%	90%M	88%R	85%R	82%r	74%
Lack of flexibility in scheduling when my schedule changes	79%	90%M	90%pR	84%R	85%R	73%
Lack of available mental health clinicians	64%	78%M	67%	72%	73%	66%
Costs with insurance	49%	59%M	48%	55%	53%	55%
Lack of clinicians who can relate to or help with my unique stressors as a clinician	57%	69%M	55%	68%Or	65%	60%
My insurance only covers treatment with practitioners who work at the same health setting I do, and I worry about privacy	57%	70%M	62%	63%	60%	63%

Base: 750 physicians (MDs/DOs)

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Figure 5: Schedule barriers impact younger and mid-career RNs' ability to access mental health care

Nurses (RNs)

To what extent do you agree with each of the following statements? (agree or strongly agree)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Mental health care is accessible for health workers	64%	57%	49%	58%o	58%o	63%O
Mental health care is affordable for health workers	36%	27%	19%	24%	31%O	36%OP
To what extent do you believe each of the following factors create barriers for health workers if they need or want to access mental health care? (moderate, prohibitive or significant barrier)	**Male (M)**	**Female (F)**	**<40 (O)**	**40 – 49 (P)**	**50 – 59 (Q)**	**60+ (R)**
Costs without insurance	78%	89%M	90%	88%	88%	87%
Ability to schedule around my work schedule	71%	77%	80%R	79%r	76%	72%
Lack of flexibility in scheduling when my schedule changes	64%	77%M	83%pqR	76%	76%	69%
Lack of available mental health clinicians	55%	75%M	73%	78%qR	71%	70%
Costs with insurance	68%	71%	82%PQR	72%R	68%	62%
Lack of clinicians who can relate to or help with my unique stressors as a clinician	59%	63%	62%	59%	67%P	62%
My insurance only covers treatment with practitioners who work at the same health setting I do, and I worry about privacy	50%	64%M	70%PR	59%	66%	58%

Base: 765 nurses (RNs)
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Institutional stigma and perceived discrimination

Stigma and discrimination are related but different. Stigma is defined as "a set of negative and unfair beliefs that a society or group of people have about something."[10] Discrimination occurs when stigma is translated into behaviors, actions or policies that result in unfair or unequal treatment.[11] Whether or not discrimination actually occurs, lack of transparency and trust can lead clinicians to believe they are being discriminated against as a result of their mental health care disclosures.

Institutional stigma is what happens when organizational practices contribute to unfair beliefs about mental health, but it rises to the level of discrimination when there are professional repercussions for accessing mental health care for either support or treatment of symptoms or conditions that don't impair a clinician's ability to practice in a competent, ethical and professional manner. These barriers center on policies and practices that limit or delay clinicians' ability to get or renew professional licenses, get hired, or get credentials or privileges to practice in specific healthcare institutions. They also include limitations on the ability to get access to reasonably priced professional insurance, or access the services of a physician/professional health program (PHP) that serves to prevent or help recover from impairing conditions without loss of privacy or undue financial burden. And perceptions of discrimination can be as much a barrier to clinicians' access to mental health care as reality.

Licensure and credentialing

One of the structural barriers that may limit clinicians' ability to access mental health care is the real or perceived impact on their professional license or ability to get credentialed and/or hired to practice in certain health systems, hospitals, clinics and other settings. This fear arises because many of these applications ask broad questions about clinicians' past mental health history without specifying whether the clinician has a current, unmanaged condition or symptoms that would impair their ability to practice. The way these questions are often framed, clinicians are required to respond affirmatively if they've ever taken part in anything from family counseling to treatment for postpartum depression to inpatient or outpatient psychiatric treatment, regardless of whether their experience is current or has any impact on their ability to practice in a competent, ethical or professional manner. In addition, these questions are often asked in proximity to or in the same question as requests for disclosure around felonies, pedophilia or other concerns that imply either deviance or criminality. Even if no action is taken, this kind of phrasing contributes to stigma against mental health treatment. When an affirmative response results in delays or denials of license renewal or the ability to work in a given healthcare setting, which can harm or derail a clinician's employment prospects, this can rise to the level of discrimination.

> "Concerns about impact on life insurance or health insurance accessibility, state licensure and stigma. People don't want to run into other professionals they know in a mental health office."
>
> **Psychiatrist**
> Female, 55, South Carolina

In our study, MDs/DOs were significantly more likely than RNs, NPs and PAs to report that impacts on licensure, credentialing, job access and insurance were significant or prohibitive barriers to accessing mental

health care. At 63%, their highest concerns were about potential impacts on credentialing and hiring, followed by professional insurance (58%) and licensure (54%). NPs, PAs and RNs showed significantly less concern in all three domains (95% confidence interval), though more than 40% of all three groups expressed concerns about impacts on job prospects. PAs were significantly more likely than NPs and RNs to report that impacts on their state license was at least a moderate barrier to accessing mental health care (see Figure 6).

> "The top barrier by far is external stigma in the form of state licensure, malpractice insurance and hospital credentialing requiring answers to invasive questions regarding mental health diagnosis or treatment even for usually simple and very prevalent mental health conditions such as anxiety or depression.

Hospital medicine

”

physician

Male, 32,
California

Interestingly, when we asked a similar question about whether revealing a mental health diagnosis or treatment would put licensure, credentialing, privileging or hiring processes in jeopardy, the “agree” or “strongly agree” response rates tracked more closely with the rate
of respondents who reported that impacts create a moderate barrier in addition to those who selected “prohibitive” or “significant” barrier for hiring and credentialing, and somewhere between “moderate” and “prohibitive” or “significant” for licensure (see Figure 7). This suggests two things: First, even a moderate barrier to licensure, hiring and credentialing is perceived as jeopardizing work prospects by many clinicians; and second, the licensure process may feel less risky to those respondents. This may also reflect the fact that reasons for license denial are typically clearly documented, whereas denials of employment or practice privileges are often less transparent, providing clinicians with limited ability to contest decisions related to their mental health history or care.

Figure 6: More than half of MDs/DOs reported that impact on license or credentialing is a moderate or greater barrier to accessing mental health care

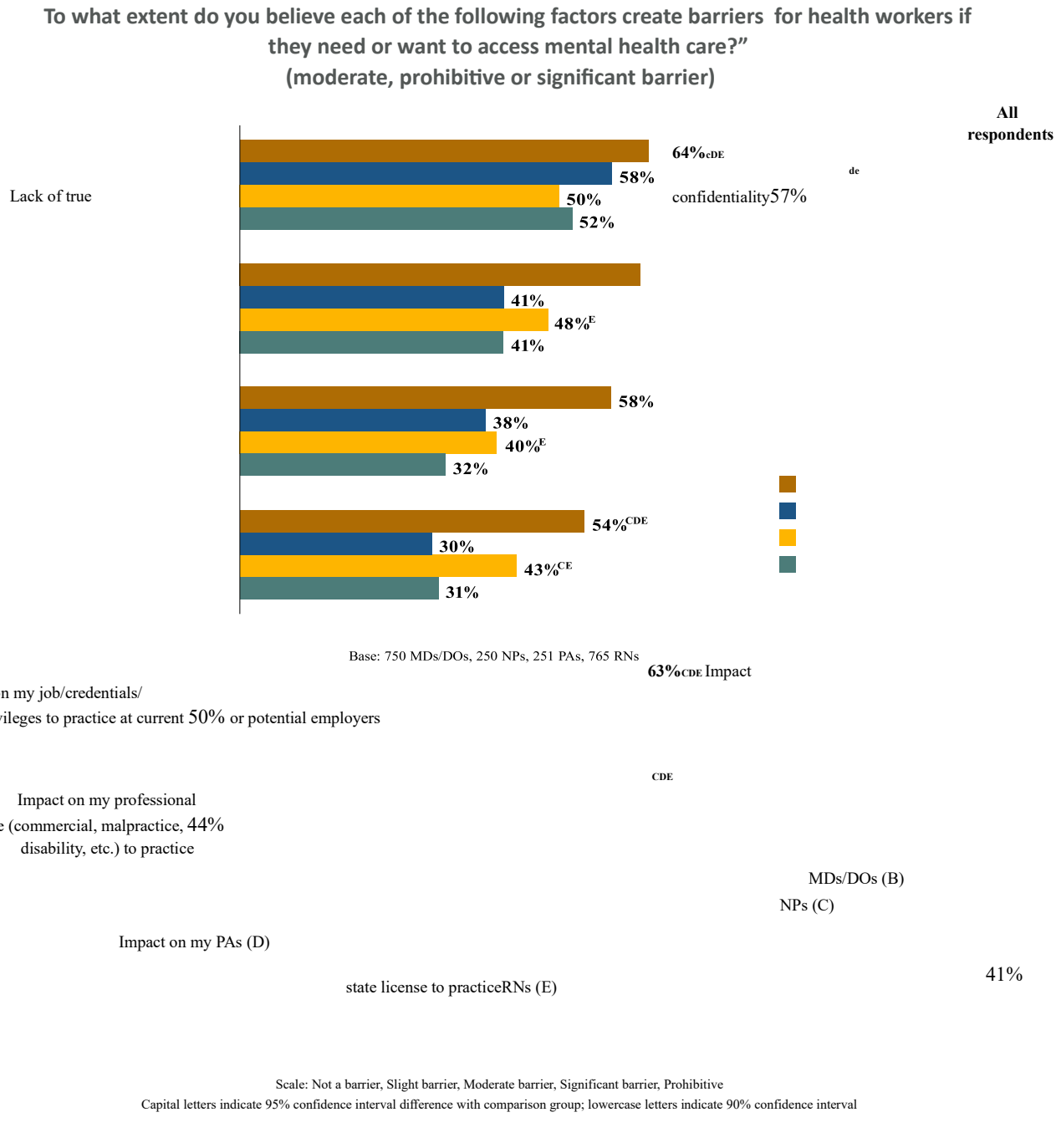
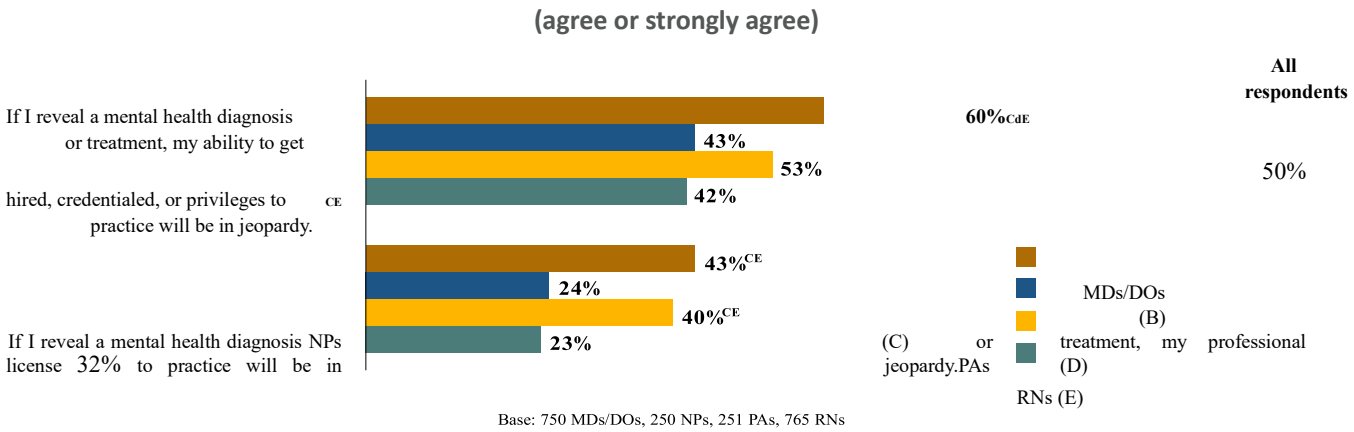


Figure 7: Half of clinicians believe that revealing a mental health diagnosis or treatment puts their ability to practice in jeopardy



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Scale: Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Looking at demographics related to beliefs around institutional stigma and perceived discrimination, we saw a few interesting divisions. Among MDs/DOs, female MDs/DOs were more likely than male counterparts to fear negative impacts on their license to practice if they openly seek mental health care, and they believe that confidentiality is more tenuous. Mid-career and older clinicians were more likely to believe that seeking mental health care puts their ability to get credentialed or hired in jeopardy (see Figure 8).

Among RNs, those aged 50 and older had less trust in the confidentiality of accessing mental health care than their younger counterparts (see Figure 9).

> “I don’t seek mental health care because I often have to apply for a nursing license in a non-compact state. There are often questions about past or current treatment for mental health issues.”
>
> **Primary care nurse**
>
> Female, 60, Colorado

“Afraid of being reported, labeled as unsafe.”

Hospital medicine nurse

Female, 38, Kansas

“It is easier to deal with alone than risk losing my job.”

Orthopedic surgery physician assistant

Female, 54, California

Figure 8: Female MDs/DOs had more concerns about the impact of institutional stigma on their licenses

Physicians (MDs, DOs)

To what extent do you believe each of the following factors create barriers for health workers if they need or want to access mental health care? (moderate, prohibitive or significant barrier)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Lack of true confidentiality	62%	68%m	64%	64%	62%	66%
Impact on my job/credentials/privileges to practice at current or potential employers	63%	62%	56%	65%o	65%o	66%o
Impact on my professional insurance (commercial, malpractice, disability, etc.) to practice	57%	59%	55%	63%r	60%	54%
Impact on my state license to practice	52%	58%	46%	61%O	56%o	54%
To what extent do you agree or disagree with each of the following statements? (agree or strongly agree)	**Male (M)**	**Female (F)**	**<40 (O)**	**40 – 49 (P)**	**50 – 59 (Q)**	**60+ (R)**
If I reveal a mental health diagnosis or treatment, my ability to get hired, credentialed, or privileges to practice will be in jeopardy.	59%	60%	49%	61%O	65%O	65%O
If I reveal a mental health diagnosis or treatment, my professional license to practice will be in jeopardy.	38%	48%M	37%	43%	50%O	41%

Base: 750 physicians (MDs/DOs)

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Figure 9: Older RNs showed less confidence in mental health care confidentiality

Nurses (RNs)

To what extent do you believe each of the following factors create barriers for health workers if they need or want to access mental health care? (moderate, prohibitive or significant barrier)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Lack of true confidentiality	58%	51%	46%	47%	57%^{OP}	55%
Impact on my job/credentials/privileges to practice at current or potential employers	45%	41%	44%	37%	41%	42%
Impact on my professional insurance (commercial, malpractice, disability, etc.) to practice	38%	32%	34%	28%	37%^{P}	30%
Impact on my state license to practice	33%	30%	34%	31%	30%	29%
To what extent do you agree with each of the following statements? (agree or strongly agree)	**Male (M)**	**Female (F)**	**<40 (O)**	**40 – 49 (P)**	**50 – 59 (Q)**	**60+ (R)**
If I reveal a mental health diagnosis or treatment, my ability to get hired, credentialed, or privileges to practice will be in jeopardy.	38%	42%	43%	36%	46%^{P}	42%
If I reveal a mental health diagnosis or treatment, my professional license to practice will be in jeopardy.	29%	22%	27%^{R}	26%^{R}	22%	16%

Base: 765 nurses (RNs)

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

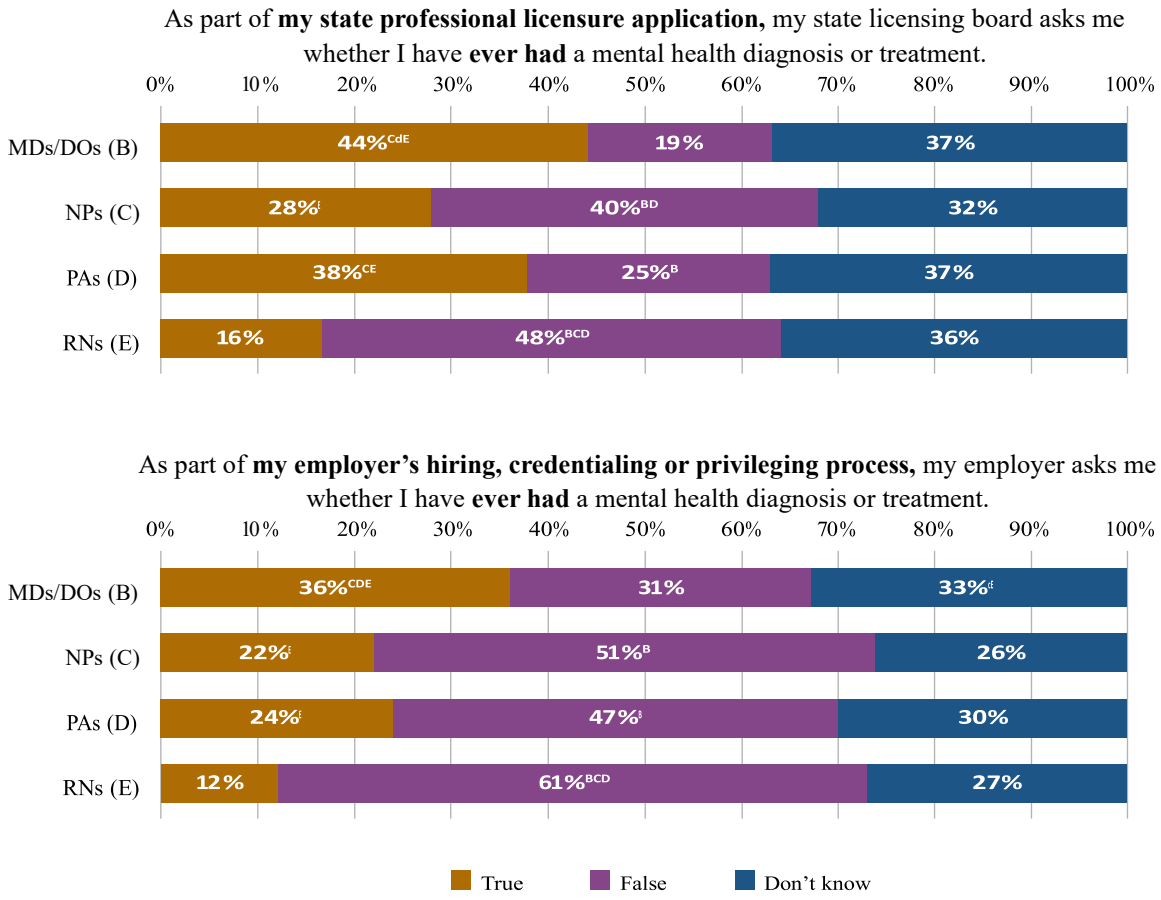
Individual perceptions about barriers to licensure, credentialing and hiring can arise from direct experiences, colleagues' stories, anecdotes or cultural beliefs or a combination thereof. To understand the basis of reported beliefs, we asked respondents if their licensure, hiring, credentialing or privileging application process included any stigmatizing language or practices, specifically, whether these processes asked about any mental health diagnosis at any time in the past or present (as opposed to focusing solely on current impairment).[12] At 44% and 38% respectively, MDs/DOs and PAs were significantly (95% confidence interval) more likely than their NP (28%) and RN (16%) counterparts to report intrusive questions in licensure applications. RNs were the least likely to report these stigmatizing questions. For hiring, credentialing or privileging, MDs/DOs again were the most likely to report intrusive mental health questions at 36%, with 24% of PAs, 22% of NPs, and 12% of RNs reporting the same (see Figure 10). Interestingly, more than a third of all clinicians don't know whether their licensure application asks these questions, and more than a quarter don't know if their employer's hiring, credentialing or privileging process or application asks the same.

Because many clinicians told us they don't know whether their state or employer's licensure, hiring or credentialing applications include questions about past mental health history, we were curious if those respondents thought that revealing a mental health diagnosis or treatment would jeopardize their license or ability to be hired. Our data showed that those who knew their state licensure applications or their employer's hiring process asked about past mental health experiences were significantly more likely to believe their license or job prospects would be at risk than those who said this was false. Interestingly, those who said they didn't know fell somewhere in between (with the exception of PAs on the hiring/ credentialing question), suggesting that as organizations reform their licensure, hiring, credentialing and privileging processes they need to make sure clinicians know about their improvements so as to reduce mental health stigma (see Figure 11).

> The possibility of it impacting a physician's competence is the biggest barrier. If someone fills out a physician's peer evaluation and mentions anything about mental health, the ability to be on staff or stay on staff could be compromised.
>
> **Pediatric physician** Female, 51, Florida

Figure 10: More than one third of clinicians don't know if their licensure application asks intrusive mental health questions

For each of the following statements, please indicate whether it is true or false.



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Figure 11: Lack of knowledge about licensure, credentialing and hiring questions may contribute to clinician fears

If I reveal a mental health diagnosis or treatment, my professional license to practice will be in jeopardy.
Response = agree or strongly agree
(dependent variable)

As part of my state professional licensure application, my state licensing board asks me whether I have ever had a mental health diagnosis or treatment. (independent variable)

	True	False	Don't know
MDs/DOs	57%	26%	34%
NPs	40%	9%	27%
PAs	62%	19%	32%
RNs	39%	16%	23%

If I reveal a mental health diagnosis or treatment, my ability to get hired, credentialed or privileges to practice will be in jeopardy.
Response = agree or strongly agree
(dependent variable)

As part of my employer's hiring, credentialing or privileging process, my employer asks me whether I have ever had a mental health diagnosis or treatment. (independent variable)

	True	False	Don't know
MDs/DOs	78%	48%	51%
NPs	61%	34%	45%
PAs	81%	46%	41%
RNs	65%	35%	46%

Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Attitudes about physician or professional health programs

When individual MDs/DOs have a mental health condition that risks impairing their ability to practice in a competent, ethical and professional manner, they can self-refer or be referred to a state-based PHP, which is designed to provide them with the treatment they need independent of state licensing or regulatory bodies. Many PHPs have extended resources beyond treatment for impairment to support clinician wellbeing, and many have opened their doors to PAs, NPs, RNs, pharmacists and dental professionals. PHPs provide confidential access to resources and treatments as well as a path back to practice when impairment risk is resolved, though states vary in best practices and consistency and some boards require reporting of certain safety risks.

Given that PHPs provide an essential safety net for clinicians in need of mental health support for potentially impairing conditions, we wanted to understand respondents' perspectives on these programs. We found that the majority of MDs/DOs, NPs, PAs and RNs didn't have a good understanding of how a PHP in their state works (see Figure 12). As a result, the majority of respondents neither agreed nor disagreed when asked questions about the potential benefits of their PHPs, though the majority with opinions expressed positivity (see Figure 13).

> "Make the PHP program more well-known. And make sure that all mental health treatment stays confidential. Cover out-of-network providers to ensure confidentiality."
>
> Female, 29, New York

Family medicine physician assistant

> Make PHPs much less punitive. The services PHPs provide should be free. These should not be for-profit organizations that get benefits from referrals to certain treatment centers. The fear of PHP keeps many from admitting to

OB/GYN Physician

mental health/addiction issues.

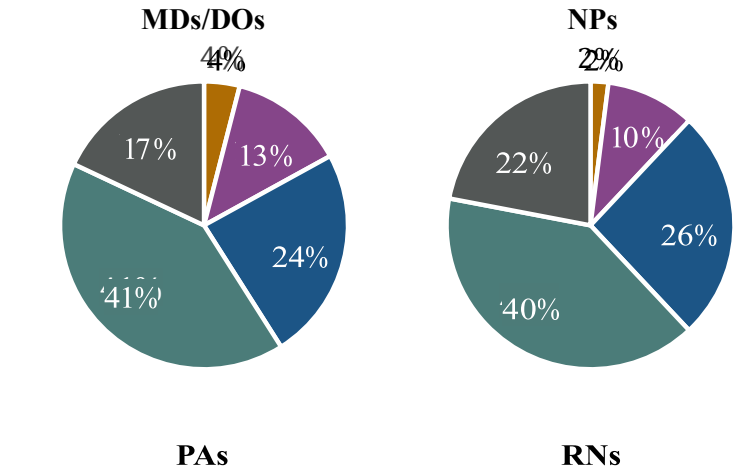
Male, 35, Washington

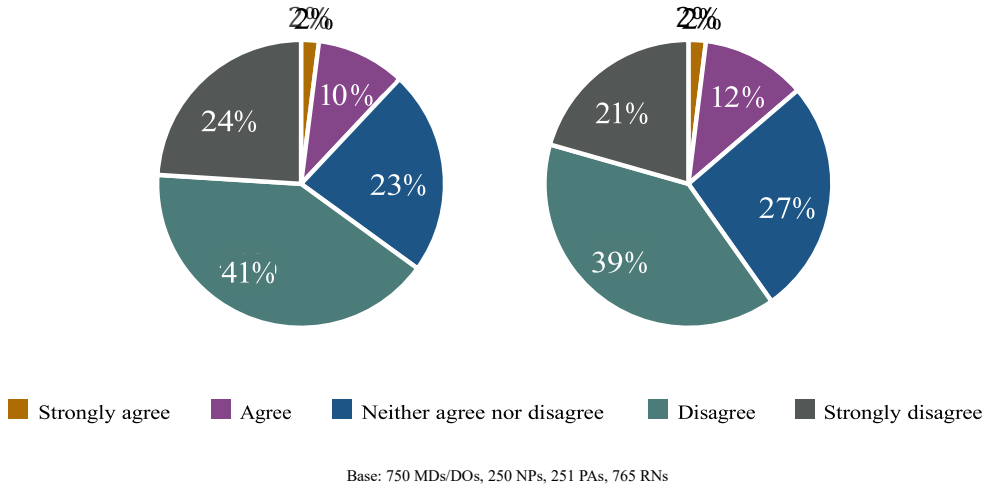
Figure 12: Most clinicians don't have a good understanding of how their state PHP works

The goal of FSPHP-recognized PHPs is to encourage referrals prior to any patient safety concerns and separate from any adverse actions related and legal safeguards for participants. With this in mind, to what extent do you agree with each of the following statements?"

to licensure, hospital privileges, and credentialing, while ensuring privacy

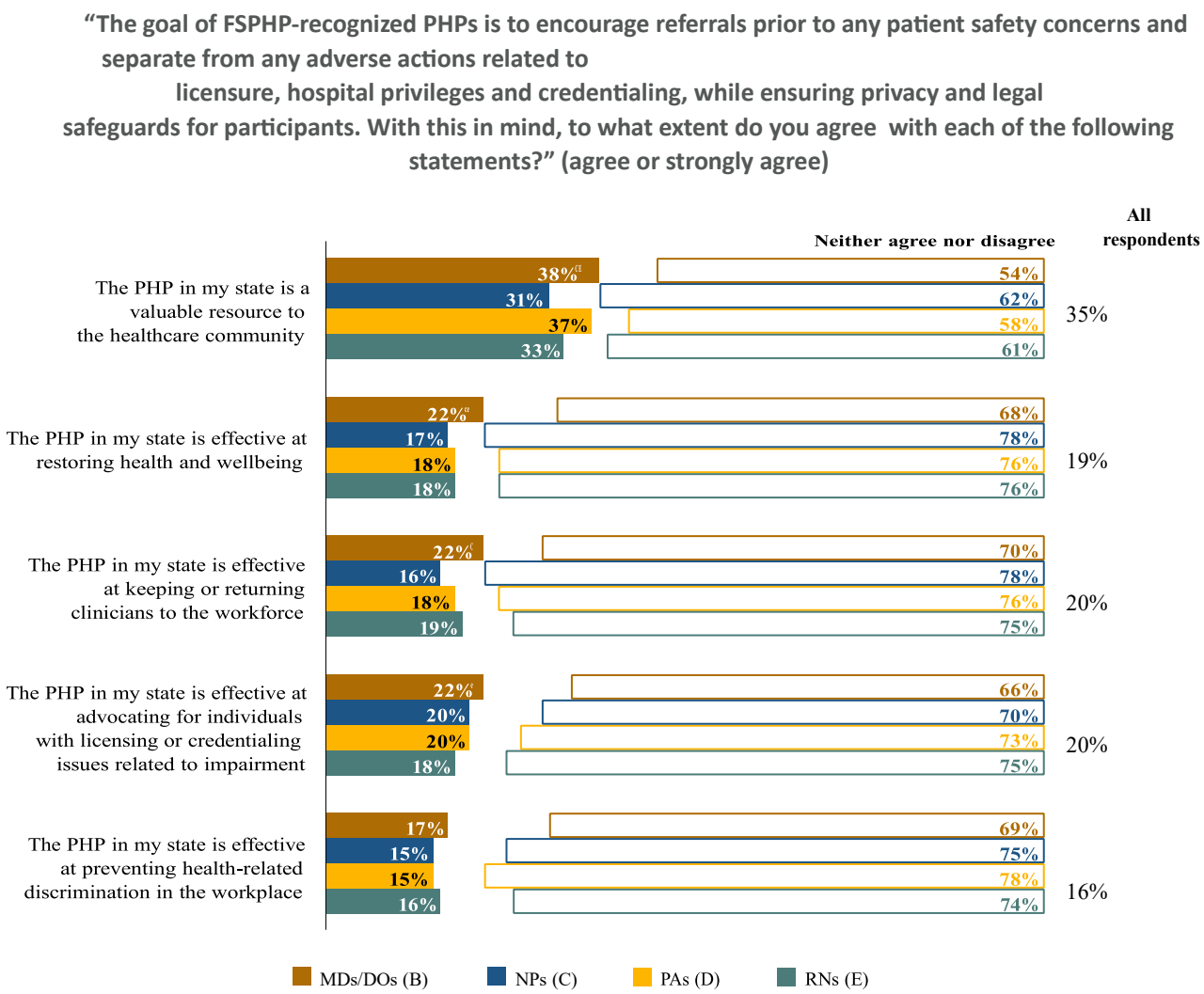
"I have a good understanding of how the PHP in my state works."





Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Figure 13: More than one third of respondents agree or strongly agree that the PHP in their state is valuable



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs
Scale: Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

However, despite the lack of familiarity with PHPs, 70% of survey respondents agreed or strongly agreed that shame or fear of judgment or discrimination are barriers to using PHPs. NPs and MDs/DOs cited the highest concerns at 73% and 72% respectively (see Figure 14). Even so, almost two-thirds of respondents said they would self-refer to a PHP, and slightly more than two thirds would refer a colleague if they were at risk of an impairing illness (see Figure 15). Given the essential role that PHPs play in providing care and monitoring for clinicians who experience or have experienced impairment, stigma and fear remain barriers to using PHPs for some clinicians who may benefit from these programs and their resources.

> "Allow mandated evaluation and treatments as dictated by the PHP to be through the most affordable provider available, for example to seek a provider utilizing one's health insurance, instead of providing you with a list of five cash-pay-only providers that may be hours away from your location and who don't take your insurance. The cost is prohibitively high, especially for a physician in residency who is severely in debt."
>
> **Psychiatrist**
> Female, 34, Florida

> "I didn't even know the PHP was a thing. How can people learn more about this more regularly in the workplace?"
>
> **Pediatric physician assistant**
> Male, 32, Utah

Figure 14: More than two thirds of clinicians agree or strongly agree that shame or fear of judgment or discrimination hampers PHP use

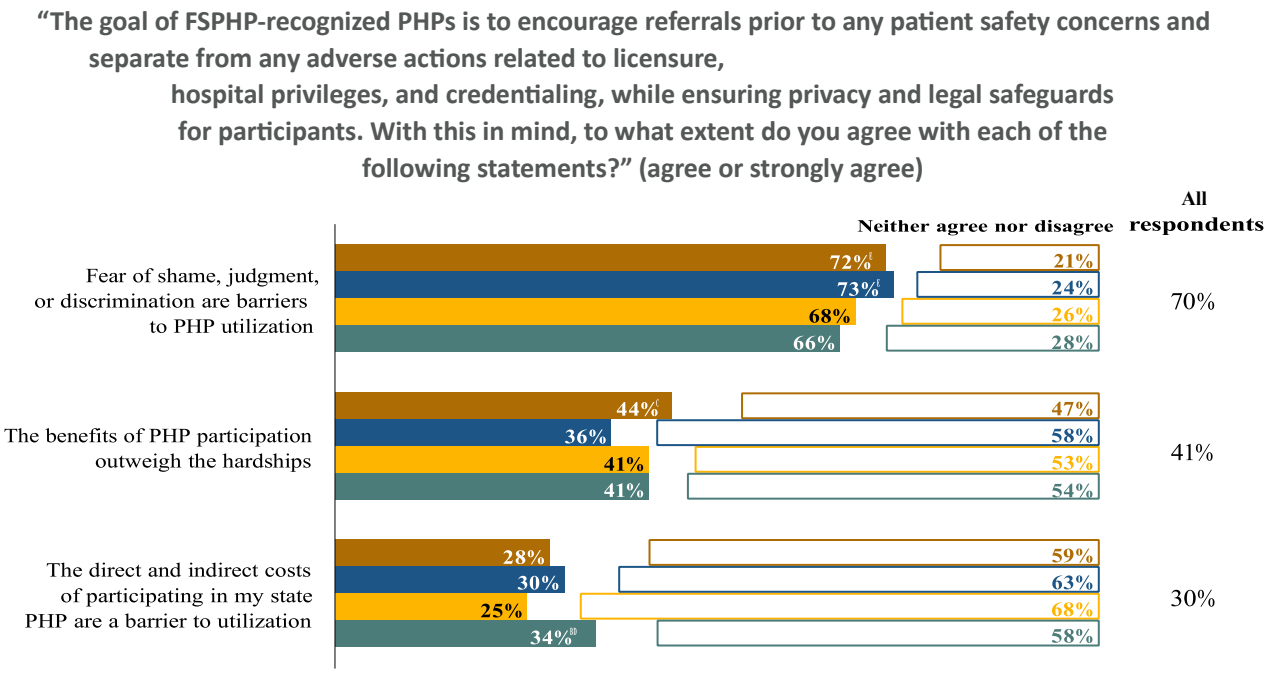
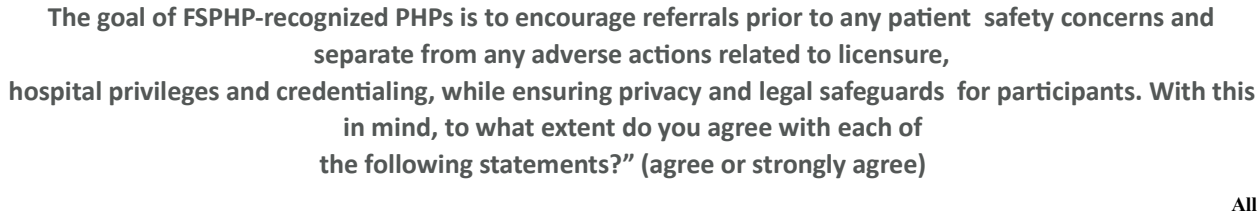
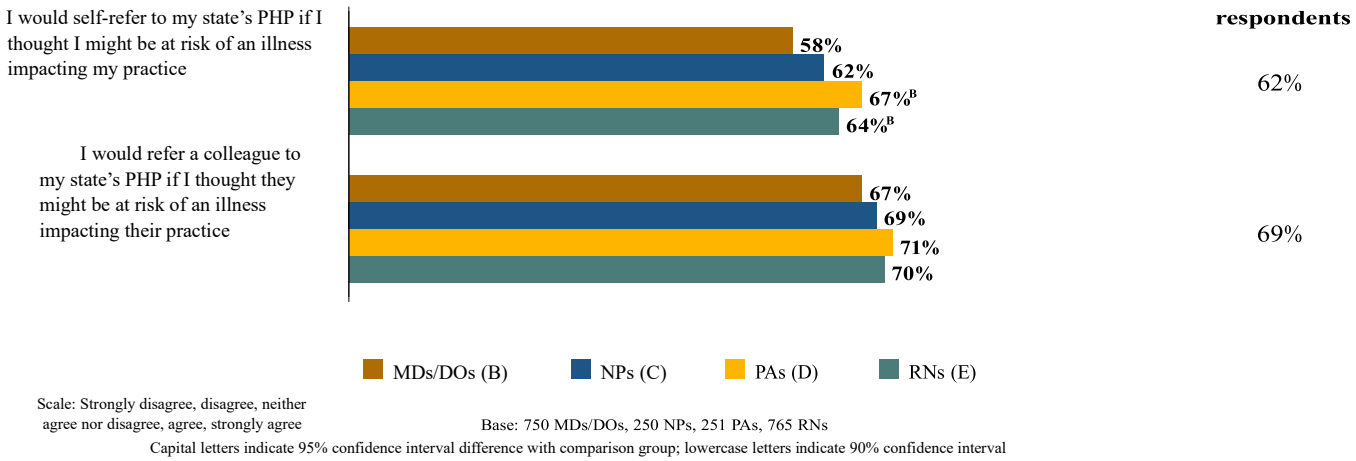


Figure 15: Almost two thirds of clinicians would self refer to a PHP





Negative attitudes and judgment

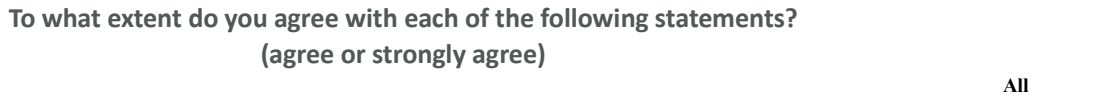
Mental health stigma can include conscious and unconscious beliefs that clinicians with mental health needs or conditions or those seeking mental health care will be compromised in their ability to practice in a competent or ethical manner — regardless of whether their mental health condition or treatment has any actual impact on their ability to practice. This stigma is tied to prevailing cultural beliefs that healthcare professionals are supposed to be "too strong" to need mental health support.[13]

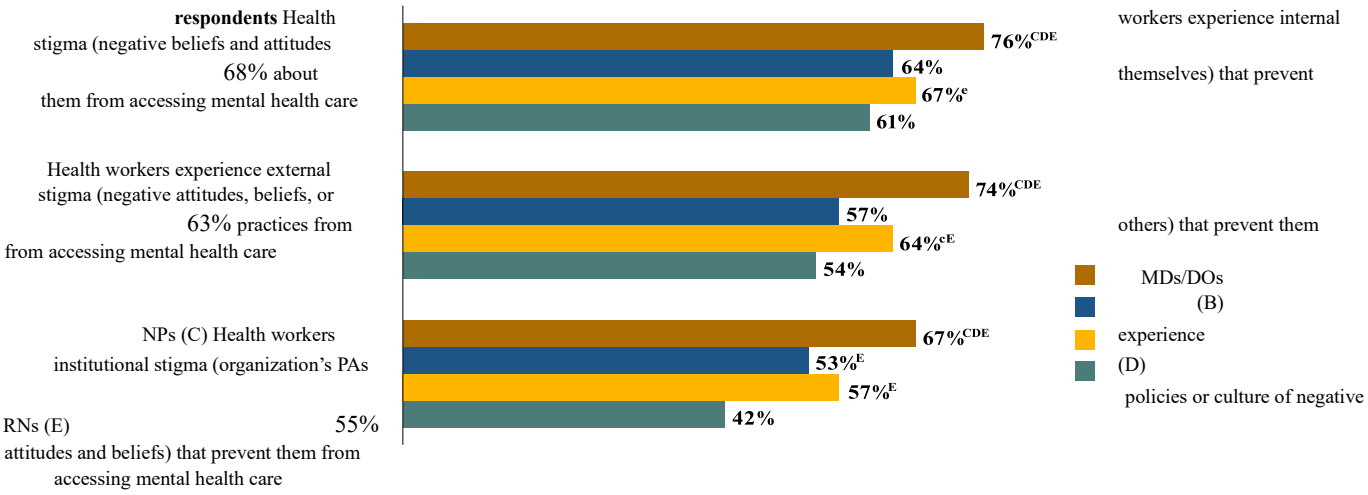
These unfair judgments and beliefs can lead clinicians to be wary of seeking (or being seen seeking) mental health care for fear of discrimination or judgment by their peers, leaders, or even patients.

Internal and external attitudes and beliefs

The source of negative attitudes and beliefs is not always external. To understand stigma and its source, we asked respondents whether they and their colleagues experience internal, external or institutional stigma. Overall, 68% of respondents agreed or strongly agreed that healthcare workers experience negative beliefs and attitudes about themselves that prevent them from accessing mental health care. Sixty-three percent cited external sources and 55% pointed to institutional types of stigma. MDs/DOs were significantly (95% confidence interval) more likely to cite all three types of stigma compared with their other clinical counterparts (see Figure 16).

Figure 16: MDs/DOs are most likely to agree that stigma prevents health workers from accessing mental health care





Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs
Scale: Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

We also asked for details about the sources of stigma and whether they create barriers to accessing mental health care. While responses varied between the impact of judgment of self, from peers colleagues and leaders, and from the community, respondents said all sources created barriers to accessing mental health care. Personal beliefs and negative attitudes were the biggest barriers, followed by negative perceptions from peers, leaders and the professional healthcare community at large. Negative attitudes and beliefs from patients were the lowest level of concern but were still reported as barriers by more than one third of respondents. Once again, MDs/DOs were significantly (95% confidence interval) more likely to cite all sources of stigma as barriers than their clinical counterparts (see Figure 17).

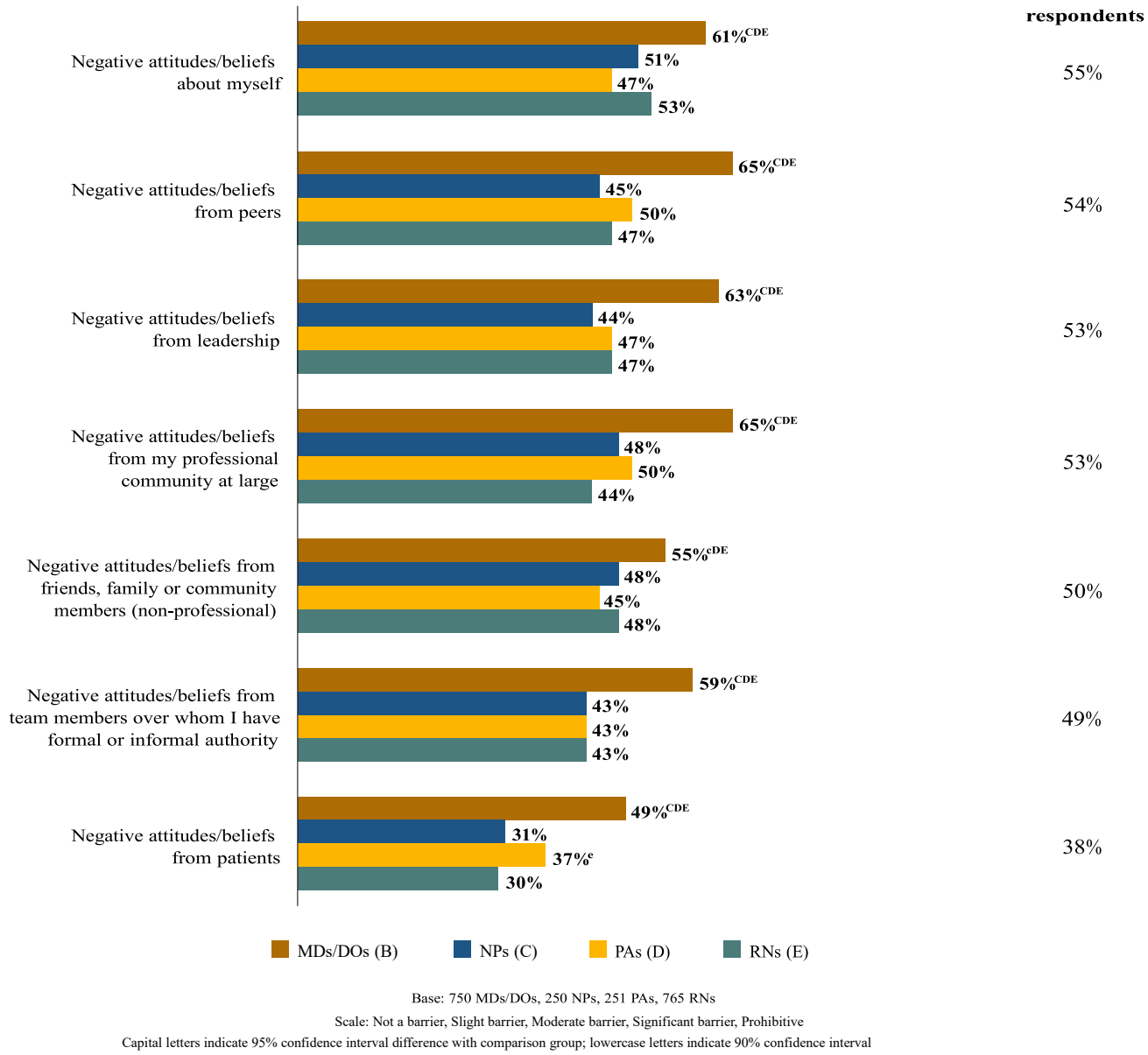
> "The belief that doctors should be able to handle anything and aren't allowed to be vulnerable, which is often internally and externally reinforced. Medical training is traumatic itself, and physicians are often discouraged from self-care."
>
> **Psychiatrist**
>
> Female, 45, Utah

> “Feeling like everyone else can handle the daily stresses of inpatient care just fine, and I’m the one who stresses the most. I have a lot of anxiety leaving work, usually feeling like I’ve forgotten something even when nothing is brought up at all in a later shift. I do hold on to memories of many bad outcomes patients had. But all that to say, I look around and think, ‘Why would I need to look for **OB/GYN nurse** help when everyone else seems to be fine?’”
>
> Female, 34, Oregon

Figure 17: Perceived stigma creates moderate, significant or prohibitive barriers to mental health care access for more almost two thirds of MDs/DOs

To what extent do you believe each of the following factors create barriers for health workers if they need or want to access mental health care?” (moderate, prohibitive or significant barrier)

All



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Scale: Not a barrier, Slight barrier, Moderate barrier, Significant barrier, Prohibitive

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Given the growing conversations and increasing acceptance of mental health conditions and available support in the general population, we expected to see a distinct age gradient in the reports of stigma, with younger clinicians reporting less stigma than older clinicians.[14] That assumption was partly true, although the wording of our question made a difference in how some respondents answered. Our first question asked if stigma prevents access, using thirdperson language in the responses. Answers to this question showed that younger MDs/DOs and female MDs/DOs were more likely to recognize stigma than their respective counterparts. However, when we asked the question using first-person language — whether the respondent experienced negative attitudes or beliefs from different sources themselves — we saw significantly lower levels of stigma reporting among MDs/DOs under the age of 40, and gender differences virtually disappeared (see Figure 18).

Figure 18: Older MDs/DOs are more likely to report that stigma is a barrier when asked using firstperson language

Physicians (MDs, DOs)

To what extent do you agree with each of the following statements? (agree or strongly agree)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Health workers experience internal stigma (negative beliefs and attitudes about themselves) that prevent them from accessing care	72%	81%[M]	mental health	81%[qR]	77%	72%	72%
Health workers experience external stigma (negative attitudes, beliefs, or practices from others) that prevent them from accessing mental health care.	70%	81%[M]		77%[R]	74%	78%[R]	68%
Health workers experience institutional stigma (organization's policies or culture of negative attitudes and beliefs) that prevent them from accessing mental health care.	65%	70%		66%	65%	72%	65%

To what extent do you believe each of the following factors create barriers for health workers if they need or want to access mental health care? (moderate, prohibitive or significant barrier)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Negative attitudes/beliefs about myself	62%	58%	58%	68%[OqR]	58%	57%
Negative attitudes/beliefs from peers	66%	64%	56%	67%[O]	65%[o]	71%[O]
Negative attitudes/beliefs from team members over whom I have formal or informal authority	59%	57%	50%	61%[O]	60%[o]	63%[O]
Negative attitudes/beliefs from leadership	63%	63%	56%	66%[O]	66%[o]	65%[o]
Negative attitudes/beliefs from my professional community at large	63%	68%	64%	64%	61%	69%
Negative attitudes/beliefs from friends, family or community members (non-professional)	57%	51%	53%	57%	54%	54%
Negative attitudes/beliefs from patients	51%	46%	40%	49%[o]	53%[O]	56%[O]

Base: 750 physicians (MDs/DOs)

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

> "A barrier is knowing that other healthcare workers will now be always weighing and judging my decisions based on knowledge of my mental health. If I make a mistake, it might be taken as relapse or poor judgment on my part due to being mentally ill."
>
> **Psychiatry nurse**

> "Stigmas: The erroneous notion that healthcare workers are somehow impervious to mental health issues and diagnoses. We're always supposed to heal, not be sick."
>
> Male, 55, **Pediatric nurse** South Carolina

Male, 34, Texas

> As caregivers, we often forget that **Psychiatry nurse** we also need a giver of care.
>
> Male, 53, California

> One of the biggest barriers is the stigma that is still there around seeking help especially in a profession where resilience and strength are often expected. There is an unspoken fear that admitting that I need support might be seen as a weakness or could even impact how I am seen professionally. On top of that, the sheer demands of the job such as long shifts, unpredictable schedules and constant responsibilities make it hard to find the **Anesthesiologist** time to prioritize my own wellbeing.
>
> Male, 45, Illinois

Interestingly, the age gradient was not as clear among RNs. Like MDs/DOs, younger RNs were more likely to recognize external stigma. However, RNs under 40 were most likely to report negative attitudes or beliefs about themselves were barriers to mental health care access, while RNs in their 40s were significantly less likely than both their younger and older counterparts to say that stigma from those over whom they have formal or informal authority were a barrier (see Figure 19).

Figure 19: Age has mixed impact on RNs' perception of stigma as a barrier to mental health care access

Nurses (RNs)

To what extent do you agree with each of the following statements? (agree or strongly agree)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Health workers experience internal stigma (negative beliefs and attitudes about themselves) that prevent them from accessing mental health care	59%	62%	64%	62%	62%	57%
Health workers experience external stigma (negative attitudes, beliefs or practices from others) that prevent them from accessing mental health care.	51%	54%	59%R	56%	54%	48%
Health workers experience institutional stigma (organization's policies or culture of negative attitudes and beliefs) that prevent them from accessing mental health care.	45%	42%	43%	39%	46%	42%

To what extent do you believe each of the following factors create barriers for health workers if they need or want to access mental health care? (moderate, prohibitive or significant barrier)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Negative attitudes/beliefs about myself	57%	53%	60%PR	50%	53%	50%
Negative attitudes/beliefs from peers	54%	46%	45%	41%	51%p	49%
Negative attitudes/beliefs from team members over whom I have formal or informal authority	47%	42%	44%p	35%	46%P	45%P
Negative attitudes/beliefs from leadership	43%	48%	46%	42%	51%	49%
Negative attitudes/beliefs from patients	36%	30%	31%	24%	37%Pr	29%
Negative attitudes/beliefs from my professional community at large	50%	44%	45%	40%	49%p	44%
Negative attitudes/beliefs from friends, family or community members (non-professional)	49%	49%	52%p	43%	52%	47%

Base: 765 nurses (RNs)

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Judgment of others

To better understand clinicians' fears about potential judgment from others if they reveal mental health needs, we asked respondents how they perceive colleagues who access mental health care. We learned that 10% of MDs/DOs and 4% to 5% of NPs, PAs and RNs would have somewhat or extremely negative attitudes and beliefs about that colleague's ability to practice in a competent, ethical or professional manner. It could be easy to look at those numbers and believe they are low. But imagine if one in ten (or even one in twenty) of your colleagues judged you harshly for asking for help or accessing resources to help improve your mental wellbeing, even resources that could positively impact your ability to collaborate with team members and better care for patients. If any of those people have authority or influence over your daily work or career opportunities, it might seem reasonable to hide or avoid accessing mental health care resources, even if that led to poor mental health outcomes.

> I think our access is good, but the reality is, unless it's for burnout and despair/depression, there maybe should be stigma about a doctor with bipolar disorder or schizophrenia — some diagnoses do potentially put patients in harm's way. Personality disorders might. *
>
> **Pediatric physician**
> Male, 40, Oregon

> Depending on the mental reason I would not want them as my caregiver. *

Oncology nurse

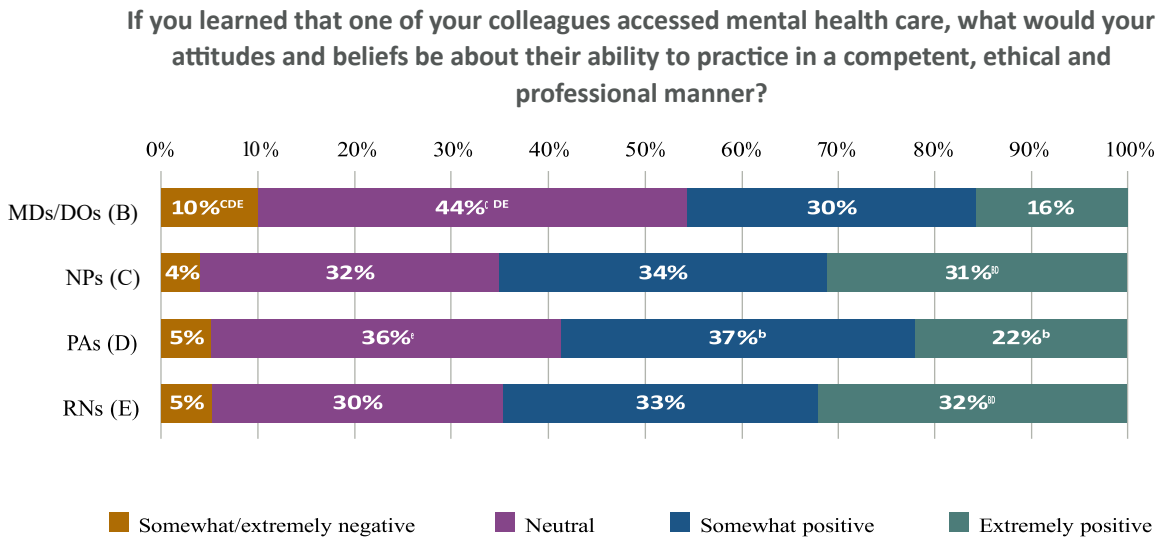
Female, 49, Alabama

The positive news is that more than half of NPs, PAs and RNs and almost half of MDs/DOs view mental health care access in a positive light, suggesting there are allies to help turn the tide against mental health stigma and potential discrimination (see Figure 20).

As previously mentioned, in examining these data in detail, we hoped to find a clear age gradient, with lower levels of judgment among younger clinicians who have grown up with greater awareness of the value of mental health care. This assumption would suggest that bias may "age out" as younger clinicians enter the workplace and older workers retire. We did not find a clear age pattern among either MDs/DOs or RNs when it comes to negative attitudes or beliefs. However, MDs/DOs under 40 and RNs under 50 were significantly more likely than their older counterparts to view mental health care access in a positive light (see Figure 21).

* Like medical conditions, mental health conditions can be impairing, but with effective treatment (which may be ongoing), it is possible for clinicians to practice in a competent, ethical and professional manner. Treating potentially impairing mental health conditions differently than potentially impairing physical condition (such as diabetes) perpetuates stigma and potential discrimination.

Figure 20: One in 10 MDs/DOs and one in 20 NPs, PAs and RNs report negative attitudes toward colleagues who seek mental health care



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

> This is a slippery slope, some mental health diagnoses are very treatable in outpatient setting, more severe/debilitating diagnoses are not. Sometimes it's a fine line between functional and on the edge. *
>
> **Other specialty nurse**
> Female, 63, Alaska

* Like medical conditions, mental health conditions can be impairing, but with effective treatment (which may be ongoing), it is possible for clinicians to practice in a competent, ethical and professional manner. Treating potentially impairing mental health conditions differently than potentially impairing physical condition (such as diabetes) perpetuates stigma and potential discrimination.

Figure 21: MDs/DOs under 40 and RNs under 50 are more likely to have positive attitudes toward peers who access mental health care

Physicians (MDs, DOs)

If you learned that one of your colleagues accessed mental health care, what would your attitudes and beliefs be about their ability to practice in a competent, ethical and professional manner?	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Somewhat or extremely negative	11%	8%	7%	12%^{o}	12%^{o}	9%
Somewhat or extremely positive	43%	53%^{M}	58%$_{PQR}$	42%	46%	41%

Nurses (RNs)

If you learned that one of your colleagues accessed mental health care, what would your attitudes and beliefs be about their ability to practice in a competent, ethical and professional manner?	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Somewhat or extremely negative	8%	5%	4%	8%^{o}	4%	6%
Somewhat or extremely positive	57%	66%	70%^{qr}	69%^{qr}	61%	61%

Base: 765 nurses (RNs), 750 physicians (MDs/DOs)
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

> Being an ED nurse I have been in some very stressful and traumatic situations. I called employee assistance (EAP) and talked through terrible events and was able to process them. I have coworkers that did not take advantage of what is offered and they end up leaving the department.
>
> **Emergency medicine nurse**
> Female, 59, Utah

Privacy and behavioral barriers

One way to uncover peoples' views about mental health care is to understand their behaviors with regard to help-seeking. When we asked respondents whether they've participated in mental health education or wellbeing training, we learned that RNs and NPs were significantly more likely than MDs/DOs and PAs to have done so. While education and training in mental health have become more common, fewer than half of MDs/DOs and PAs have participated in training. We saw similar trends with regard to informally seeking help from peers, suggesting that RNs and NPs (whose professional experience began as RNs) may have broader access to curricula, communities and cultures that are more accepting of mental health help-seeking. Regardless, only 11% of all respondents reported using their organization's peer support program, though this number may be artificially low because not every organization offers a formal peer support program (see Figure 22).

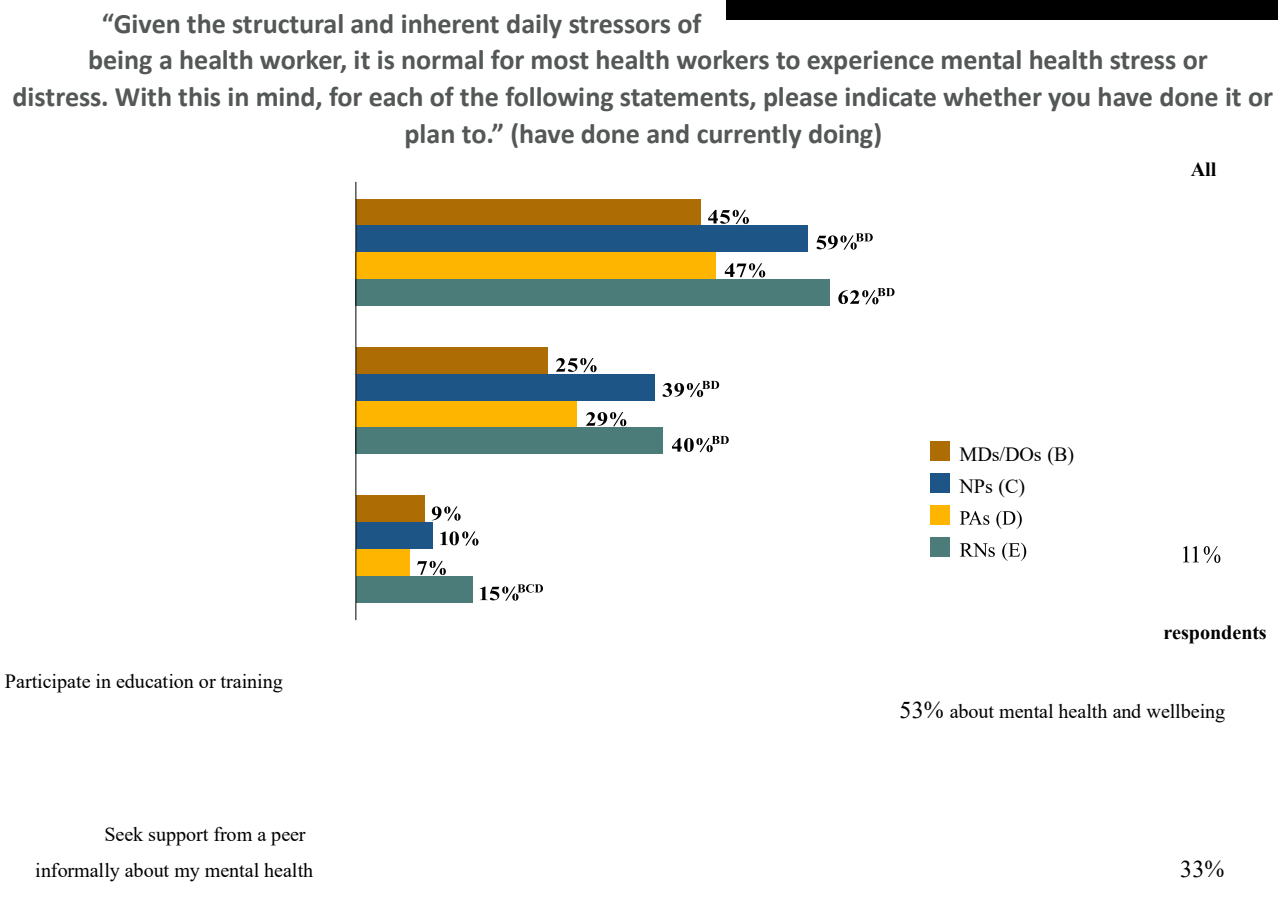
> “I work in a small community so I have to travel outside of the area to see someone who I haven’t treated either themselves or their family members. I don’t want to use my insurance for fear that my hospital based insurance finds out about it. So I’m forced to use cash only which
>
> **Orthopedic surgery** becomes very expensive.”

We also asked respondents about their behaviors regarding privacy with help-seeking. More than a quarter of clinicians reported that they have hidden or are currently hiding their mental health needs and/or mental health conditions at work. This reticence is not necessarily problematic, as a certain level of emotional self-regulation and professionalism are required in any work setting. However, 14% of respondents said they have sought or are seeking mental health care in another town, city or health system to maintain confidentiality, 13% have paid for mental health care out of pocket to avoid a paper trail, and 3% have used a pseudonym when seeking mental health care to keep records inaccessible (see Figure 23). This level of secrecy highlights the need for greater universal protections for health workers' use of mental health care, especially given the context that roughly 23% of U.S. adults experienced mental illness in 2021.[15]

[redacted]

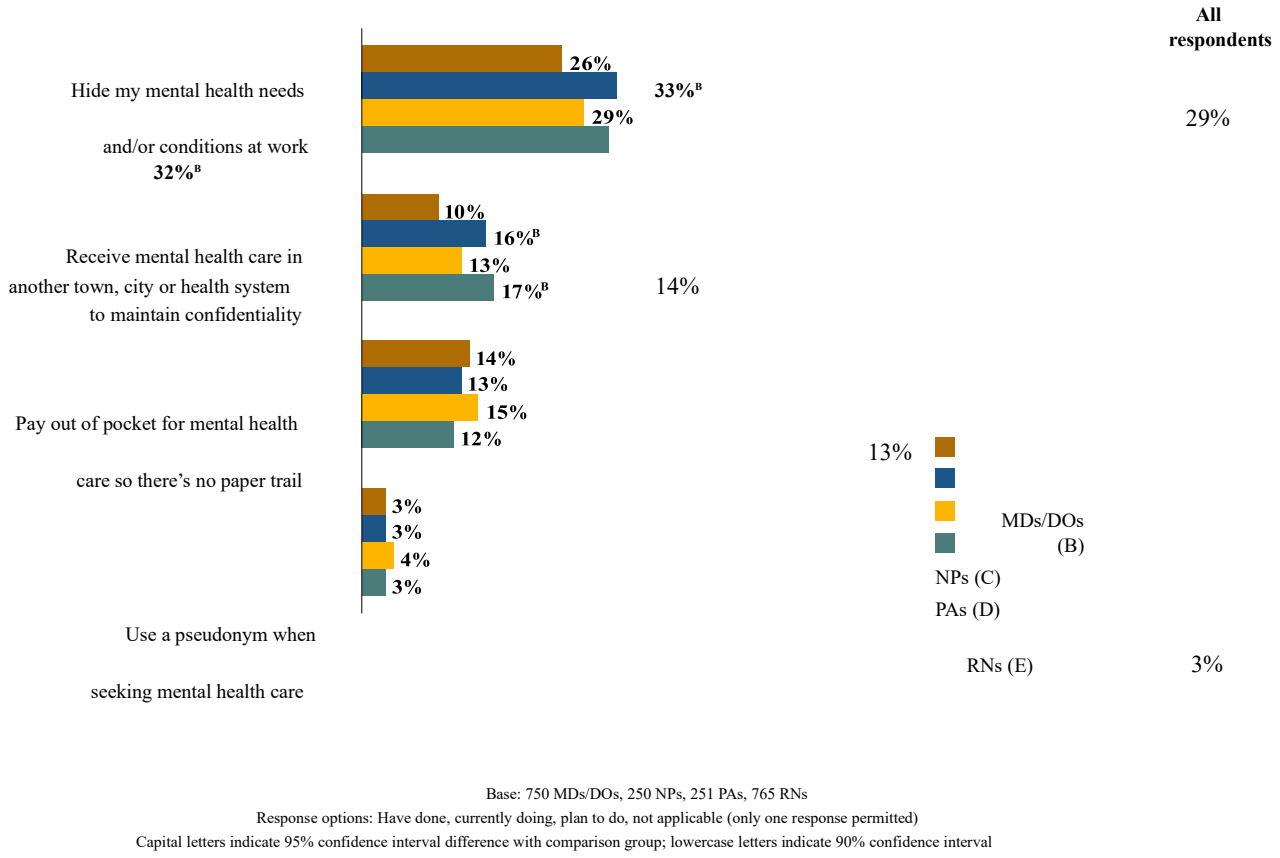
physician assistant Female, 32, North Carolina

Figure 22: RNs and NPs showed higher levels of most help-seeking behaviors



Use my organization's peer support program

Figure 23: More than a quarter of respondents reported hiding mental health needs and/or conditions at work



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs
Response options: Have done, currently doing, plan to do, not applicable (only one response permitted)
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Digging into the demographics we see that while female MDs/DOs were more likely to participate in mental health education and seek informal support from peers, male MDs/DOs were more likely to take advantage of peer support programs. This may be because of the confidentiality promised by most peer support programs. MDs/DOs under 40 were more likely to report all help-seeking behaviors than their older counterparts. Interestingly, we saw that female and younger MDs/DOs were more likely to report most privacy behaviors, though it's not clear if some of this difference is attributable to higher levels of help-seeking overall.

RNs showed minimal gender differences in behavior, but like MDs/DOs, younger RNs showed both more help-seeking and more of most behaviors that indicate a desire for privacy (see Figure 24).

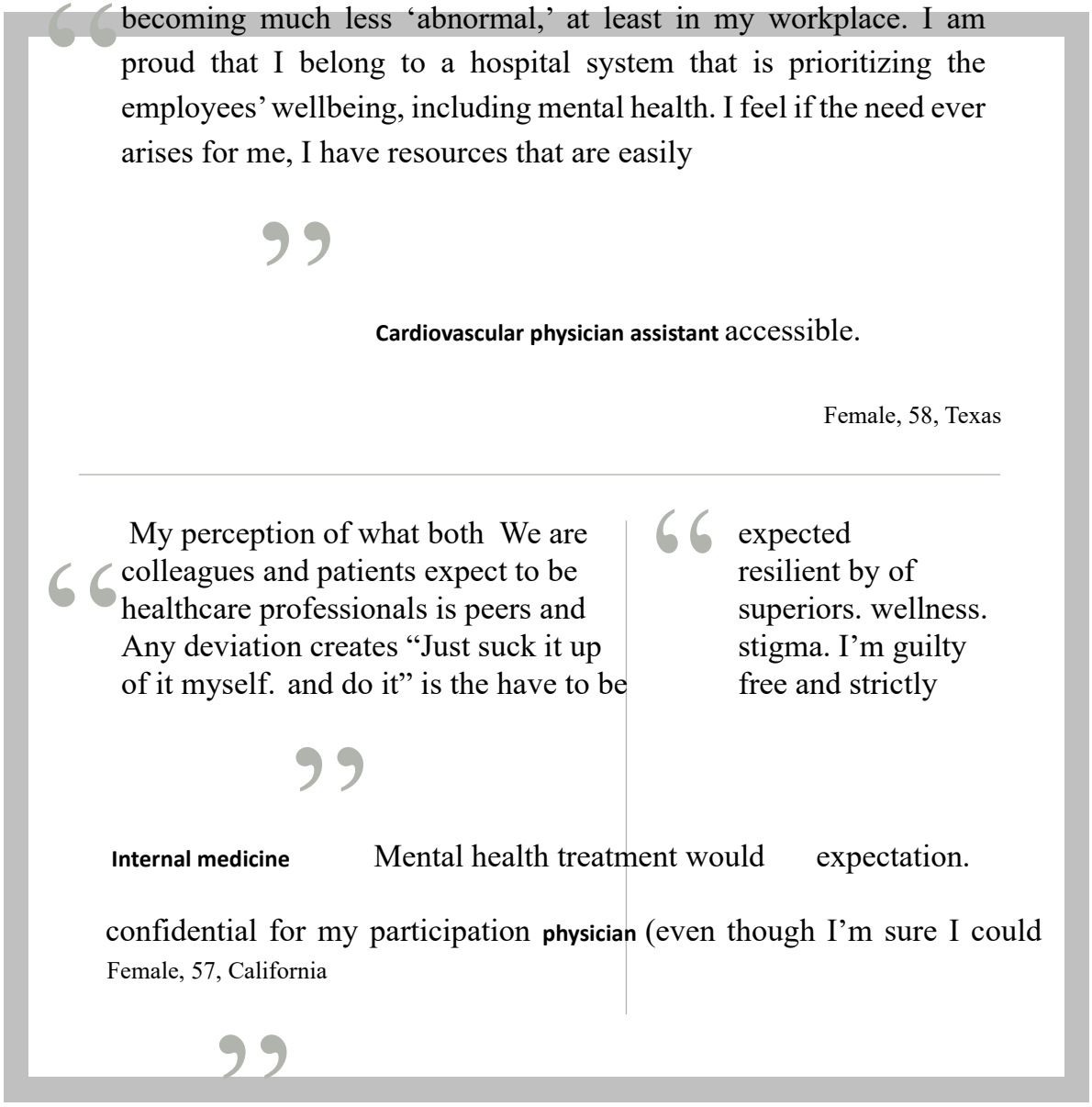


Figure 24: Female and younger MDs/DOs and RNs reported both more help-seeking and more privacy behaviors

Physicians (MDs, DOs)

Given the structural and inherent daily stressors of being a health worker, it is normal for most health workers to experience mental health stress or distress. With this in mind, for each of the following statements, please indicate whether you have done it, are doing it or plan to do it. (have done plus are doing)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Support						
Participate in education or training about mental health and $_{M}$ 41%51% wellbeing			57%^{PQR}	41%	46%^{r}	36%
Seek support from a peer informally about my mental health	21%	33%^{M}	41%^{PQR}	22%	22%	17%
Use my organization's peer support program	27%^{F}	19%	29%^{pq}	21%	21%	25%
Privacy						
Hide my mental health needs and/or conditions at work	21%	33%^{M}	36%^{QR}	28%^{R}	23%	16%
Receive mental health care in another town, city or health system to maintain confidentiality	9%	13%^{m}	18%^{QR}	12%^{qR}	6%	4%
Pay out of pocket for mental health care so there's no paper trail	10%	20%^{M}	15%	15%^{r}	15%^{r}	9%
Use a pseudonym when seeking mental health care	3%	4%	3%	5%^{R}	4%^{r}	1%

Base: 750 physicians (MDs/DOs)
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Nurses (RNs)

Given the structural and inherent daily stressors of being a health worker, it is normal for most health workers to experience mental health stress or distress. With this in mind, for each of the following statements, please indicate whether you have done it, are doing it, or plan to do it. (have done plus are doing)	Male (M)	Female (F)	<40 (O)	40 – 49 (P)	50 – 59 (Q)	60+ (R)
Support						
Participate in education or training about mental health and wellbeing	55%	63%	69%^{r}	61%	61%	59%
Seek support from a peer informally about my mental health	36%	40%	49%^{QR}	42%^{r}	37%	34%
Use my organization's peer support program	17%	15%	15%	16%	13%	17%
Privacy						
Hide my mental health needs and/or conditions at work	26%	33%	41%^{qR}	34%^{R}	32%^{R}	23%
Receive mental health care in another town, city or health system to maintain confidentiality	20%	16%	27%$_{pQR}$	19%^{R}	15%^{R}	9%
Pay out of pocket for mental health care so there's no paper trail	14%	12%	21%$_{PQR}$	11%^{R}	13%^{R}	5%
Use a pseudonym when seeking mental health care	3%	3%	2%	4%	4%	1%

Base: 765 nurses (RNs)
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Solutions to support access to mental health care

When we asked respondents an open-ended question regarding what solutions or actions would best create change to improve systems, policies and cultures that prevent health workers from accessing mental health

care, they were largely split between improving availability (structural change) and changing culture (see Figure 25).

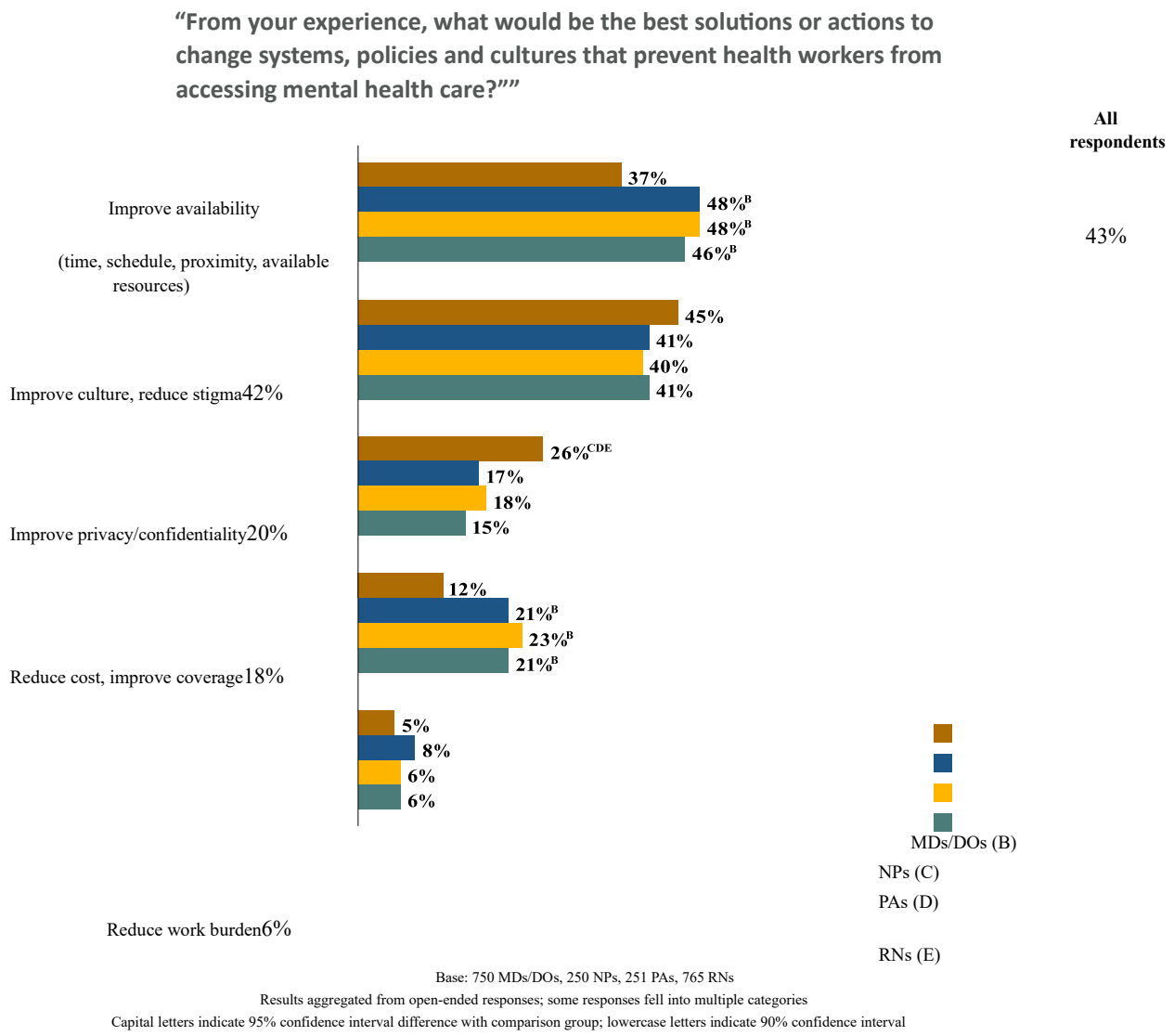
We also asked a more directed question about solutions. Almost three quarters of respondents said that making mental health care free, affordable or covered by health insurance would be highly effective for improving access, and more than two thirds said making mental health care available outside of standard business hours would be similarly effective. More than half of respondents also indicated workplace policies and cultures that don't penalize time off for accessing care would be highly effective as well as state-based programs providing confidential mental health care. RNs showed the highest level of confidence in all solutions and MDs/DOs the lowest (see Figure 26).

We also asked whether eliminating stigmatizing language and discriminatory policies from licensing, hiring, credentialing and insurance applications and practices would improve access to mental health care for health workers. Roughly half of respondents across clinical roles said these solutions would be highly effective (see Figure 27).

> "Have more mental health professionals so that "taking" an appointment from a patient wouldn't seem like a bad thing. And if more people could get an appointment, then the value would be recognized and there would be less stigma."
>
> **Primary care nurse**
> Female, 69, Colorado

> "I would like to actually see mental health participation incentives in the workplace, similar to preventative care measures such as vaccines."
>
> **General surgery nurse** Female, 43, Wisconsin

Figure 25: Respondents were split between structural and cultural solutions to barriers



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Results aggregated from open-ended responses; some responses fell into multiple categories

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

> "From my own experience, the best solution to address the systemic policy and cultural barriers preventing healthcare workers from accessing mental healthcare would involve a combination of structural changes, policy reforms and cultural shifts. First, normalizing mental healthcare in the workplace is essential and mental health resources should be integrated into employee wellness programs by offering anonymous access to counseling and encouraging open conversations that are

led by senior leaders. Also, we should expand insurance coverage for mental health

”

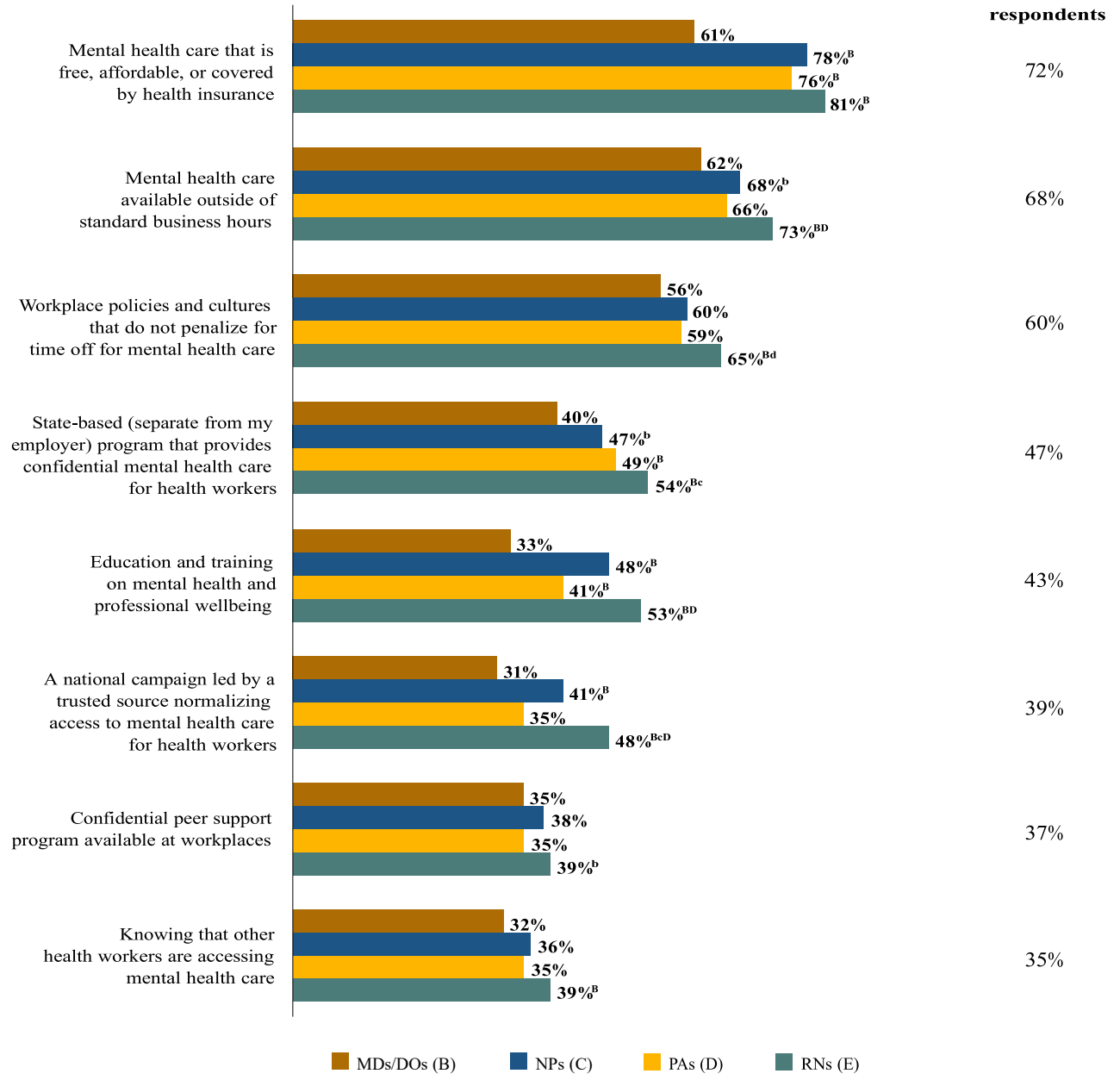
care Anesthesiologist including affordable therapy and crisis intervention.

Male, 45, Illinois

Figure 26: Respondents showed confidence in a range of approaches to improve mental health care access

“To what extent do you believe the following would be effective in improving health workers’ ability to access mental health care?” (highly effective)

All



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

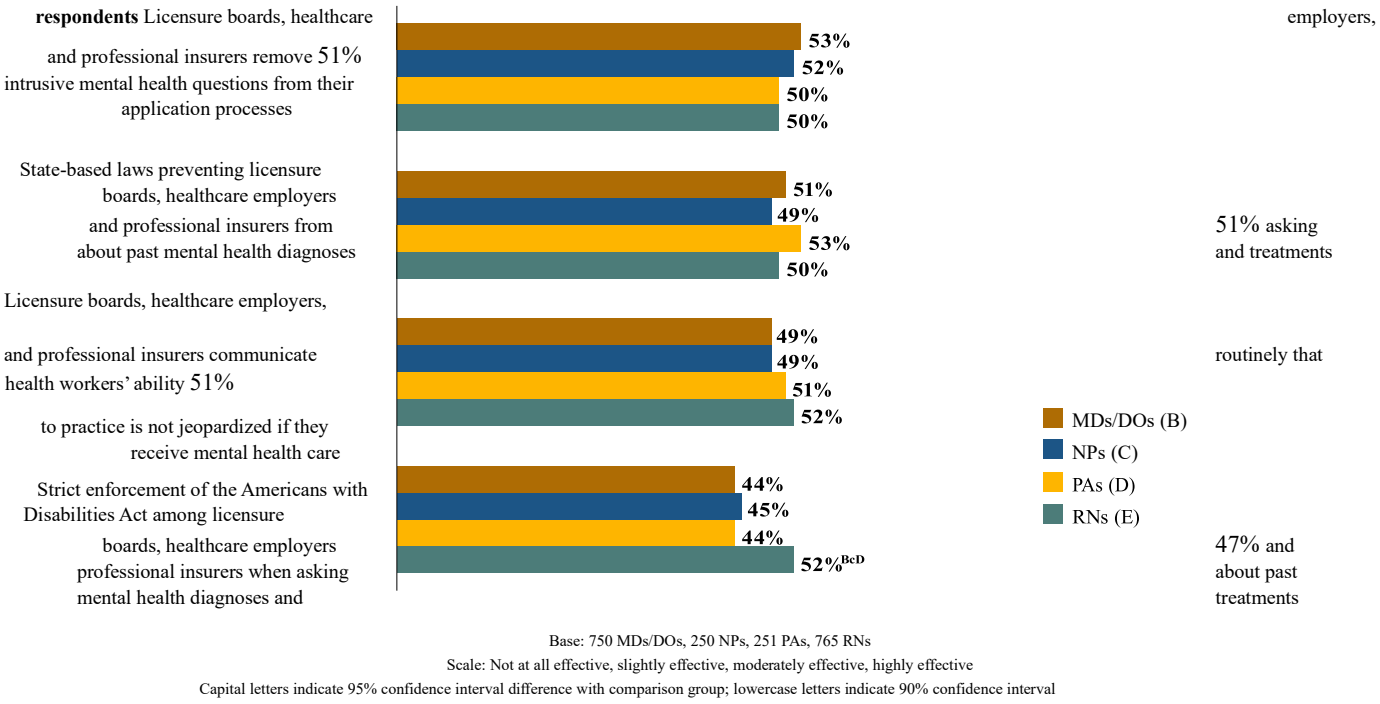
Scale: Not at all effective, slightly effective, moderately effective, highly effective

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

Figure 27: About half of respondents said removing discriminatory policies from licensure, hiring, credentialing and insurance would be highly effective in improving access to mental health care

"To what extent do you believe the following would be effective in improving health workers' ability to access mental health care?" (highly effective)

All



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs
Scale: Not at all effective, slightly effective, moderately effective, highly effective
Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

"1) R emove "mental health" diagnoses and treatment from medical license and laws to prevent applications. healthcare workers

2) Increase resources for medical providers from losing health care confidentially. job. I know a doctor

3) R educe insurance costs to seek mental who sought mental health care. health

treatment 4) H ave the confidence to discuss mental

health issues with colleagues and

any judgment"

"We need very strict employment

their to seek mental

Family medicinephysician administrators without

Female, 56, Washington

”

Family medicine physician bias.

Male, 39, Washington

Discussion

Changing systems and culture can be complex, but we believe that improving healthcare workers' access to mental health care without fear of bias, judgment or discrimination is both necessary and possible. As of May 22, 2025, 50 state licensure boards and 635 hospitals and care facilities reviewed and updated (if necessary) their licensure or credentialing applications through the Wellbeing First Champion Challenge program. Additionally, the American Medical Association (AMA) and the Dr. Lorna Breen Heroes' Foundation (LBF) have been collaborating with state organizations across the country to advance legislation that champions equal privacy in mental health care.

Mental health can be a sensitive topic, and it's difficult to determine the origins and factors that contribute to personal, interpersonal and institutional stigma and perceived discrimination in a single survey. Additional research is needed to parse the underlying forces, as well as the most effective strategies to counter the barriers that limit or prohibit clinicians' access to mental health care.

However, there are evidence-based, evidence-informed and emerging resources that leaders, employers, policy makers and other decision makers can use to help remove the structural and cultural barriers to accessing mental health care.[16] These include but aren't limited to:

- **Design employee benefits to support mental health realities.** Survey respondents told us that cost and scheduling inflexibility were among the top barriers to accessing mental health care, particularly costs without insurance. Based on this, we encourage leaders at health systems and staffing agencies to explore ways to ensure clinicians have access to covered mental health services with guaranteed privacy, including freedom to see providers outside of the system in which the clinician works. Additionally, clinical and administrative leaders should work together to solve challenges of managing mental health care access scheduling challenges. This can be accomplished by protecting clinicians' time to access mental health care against schedule incursions or by negotiating mental health coverage that allows care access outside working hours and does not penalize clinicians if their work schedule changes unexpectedly. For clinicians who work as independent contractors, legal protections must ensure mental health parity and preclude discrimination when accessing professional or disability insurance. Individuals and organizations can explore the ALL IN For Mental Health initiative for helpful resources, including links to free, confidential counseling services. Some organizations are already setting up opt-out counseling sessions for students, interns and other clinicians that help normalize the idea of help-seeking and direct participants to further resources as needed.

- **Review and remediate licensure and credentialing questions.** Licensure, credentialing or hiring questions that ask intrusive questions about past mental health care, or that stigmatize mental health conditions by asking about them

  in proximity to issues such as felony convictions (rather than in conjunction with questions about physical conditions that require accommodation) reinforce a cultural message that having mental health needs is not okay for healthcare workers. To remove intrusive and stigmatizing

questions, organizations and licensing boards can join the Wellbeing First Champion Challenge program. The ALL IN Coalition has created a step-by-step resource for licensure and credentialing reform, and it tracks the status of licensure questions for physicians (including PAs) and nurses (including NPs). To comply, organizations and licensing bodies can either omit questions about mental health history, ask only about current impairing conditions, or ask applicants to attest to their physical and mental fitness to practice in a competent, ethical and professional manner. The Wellbeing First Champion Challenge program is a source of truth for health workers — helping them in deciding in which state or organization to work because they know they will not be required to answer intrusive mental health questions.

- **Reimagine education and increase awareness.** Education and awareness building are essential to shifting perceptions about the real need for mental health support for clinicians. Storytelling vehicles, such as the medical drama "The Pitt", are helping to bring visibility to the psychological, emotional and physical challenges clinicians face hour-by-hour with the goal of driving greater awareness and structural changes within the industry.[17] Leaders in organizations can contribute to culture change by sharing their own experiences, as well as modeling help-seeking behavior.[18] In addition medical, nursing, PA and NP schools should include education about the importance of mental health help-seeking, as well as the various kinds of help that support clinicians' mental health and wellbeing. This education should continue throughout clinical training and across clinical careers. State-based PHP leaders should consider launching awarenessbuilding campaigns, especially as they expand their reach to support additional clinician groups and provide preventive resources. And, as with all things related to care team safety and wellbeing, a commitment to and communication about changes made to remove the structural barriers needs to be ongoing — and bidirectional, allowing clinicians to provide feedback on how systems should adapt and evolve to ensure safety.

- **Create a culture of safety and mental wellbeing.** One of the surprising delights of analyzing the open-ended responses to survey questions was reading comments from clinicians who felt fully supported by their organizations, leaders and peers as they navigated the mental and emotional challenges of caregiving. These respondents prove that it's possible to create structures and cultures in which clinicians can access the mental health care they need without fear of judgment or negative repercussion. The LBF's Breen Scale™ helps organizations assess their maturity in supporting health workers' wellbeing and access evidence-informed resources to further implementation efforts. And programs such as the AMA's Joy in Medicine® program and the American Nurse Credentialing Center's Well-Being Excellence™ program help organizations create a roadmap for a culture of safety and wellbeing. In addition, the ALL IN for Mental Health initiative outlines six actions that help eliminate the systemic barriers to mental health care access to build a system that prioritizes mental health for health workers. Leaders can also look at programs such as Psychological First Aid to help leaders and team members recognize signs of stress and distress in their colleagues.[19] And clinicians at any level in their organization who have positive associations with clinicians seeking mental health support (the majority of NPs, PAs and RNs, and almost half of

MDs/DOs in our survey) can communicate their allyship so colleagues know they are a safe person to lean on.[20]

The Heart of Safety Coalition is dedicated to fostering a future in which all care team members experience psychological and emotional safety, dignity and inclusion, and physical safety. As part of that future of caring, healthcare workers deserve mental health care that is accessible and affordable and without fear of bias, judgment or discrimination. Like the Dr. Lorna Breen Heroes' Foundation and ALL IN Coalition, we envision a world where seeking mental health services is universally viewed as a sign of strength for healthcare professionals. Change is possible. Please join us.

> "It's simple: A healthy workforce is essential for safe, compassionate patient care. The current mental health crisis among health workers is contributing to unprecedented burnout rates, staff shortages and declining patient care. Together, we can create environments where health workers feel safe, supported and empowered to seek the help they need and deserve. Let's change the culture and future of healthcare by eliminating stigma, breaking down barriers and building a system that respects"
>
> **J. Corey Feist, JD, MBA**

the mental health of those who care for us.

Co-founder and CEO, Dr. Lorna Breen Heroes' Foundation

About the survey

The survey informing this report was conducted as a collaboration between the Heart of Safety Coalition, the Dr. Lorna Breen Heroes' Foundation (LBF) and its ALL IN: Wellbeing First for Healthcare Coalition (ALL IN). Subject matter experts from the Heart of Safety Coalition and LBF drafted the survey based on market knowledge and review of published surveys and data sets focused on clinician perceptions about accessing mental health care. The proposed survey was then shared with ALL IN coalition members, which included healthcare leaders from 35 organizations at the time, who provided additional feedback based on their experience and expertise.

The survey was fielded by Medscape from January 30, 2025 through February 12, 2025. The sample included 765 registered nurses (RNs), 750 physicians, 251 physician assistants (PAs) and 250 nurse practitioners (NPs) with a response rate of 36% and an incidence rate of 93%.

Survey participants were recruited as a convenience sample from Medscape's panel of healthcare professionals. Medscape's panel is derived from healthcare professionals who have joined Medscape to access its clinical content (news, condition and drug information, journal articles, CME activities and clinical tools such as pill identifier, drug interaction tool and clinical calculators). Medscape validates physician participants via the AMA database. A representative sample was requested based on age, gender, race, ethnicity, geography and practice specialty. Survey participants were offered an honorarium according to Medscape's policies. No personally identifying information (name, practice name, date of birth, etc.) was shared with the Heart of Safety Coalition, LBF or ALL IN. To protect and respect all survey respondents' privacy, they were not asked whether or not they currently have or previously had any mental health conditions, impairing or otherwise.

For this research, we chose to use the language "mental health care" and did not use explicit language about specific types of condition treated, such as substance use disorders. We understand that medically, substance use disorders are considered mental health conditions, and we know that many respondents will have included substance use disorder treatment under the umbrella of mental health care. (We saw some evidence of this in the open-ended comments). We also know, that for people (including some clinicians) who do not fully understand the biological and psychological mechanisms that underlie substance use disorders, the levels of stigma and bias can differ between substance use disorders and other mental health conditions. Substance use can often be more stigmatized than other mental health conditions.[21] Additional research to understand perceptions of internal, external and institutional stigma and discrimination that may be unique to substance use disorders among clinicians would be valuable.

For open-ended questions, we analyzed responses using AI to identify response categories and then reviewed the categories and organized them into themes. These themes are represented in Figures 1 and 25.

One intent of the original data analysis was to combine NPs and PAs into a collective group of advanced practice providers, but we found that many of the two group's attitudes, particularly around cultural barriers, diverged. In addition, the demographics were significantly different. NPs skew female within the broader healthcare profession, as does our survey sample.

We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

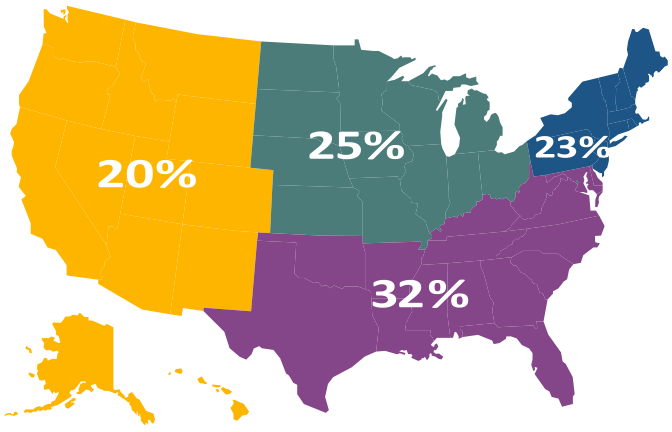
Further research is necessary to determine what drives the differences in beliefs and perceptions among certain clinician groups and what potential interventions could have the greatest impact to change both structural and cultural barriers to accessing mental health care. This survey also did not delve into the many factors of healthcare work environments that create mental stress or distress, many of which can be ameliorated to create better, safer and more supportive working environments.

40 – 49

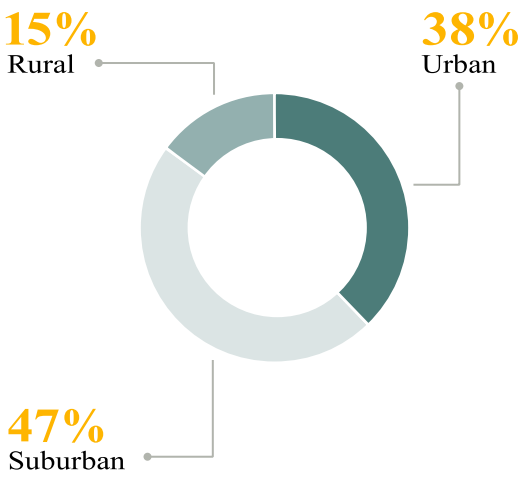
50 – 59 60+

765 registered nurses

Region



Communities



Care settings

5% Community/FQHC	29% Hospital outpatient
4% Emergency dept.	9% Other outpatient
37% Inpatient hospital	3% Solo practice
4% Non-hospital group	9% Other

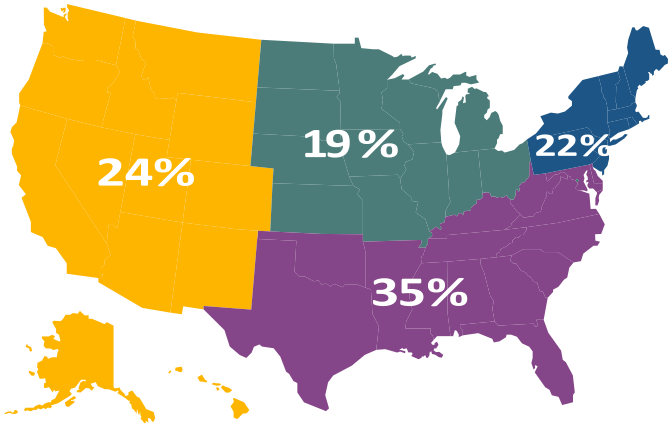
Demographics

Female	89%
Male	10%
Asian	7%
Black	4%
Hispanic	5%
White	83%
Other/ Prefer not to answer	4%
<40	21%
	25%
	26%
	28%

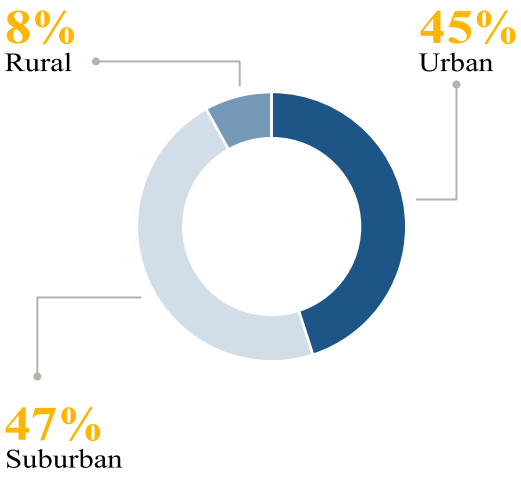
We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

750 physicians

Region



Communities

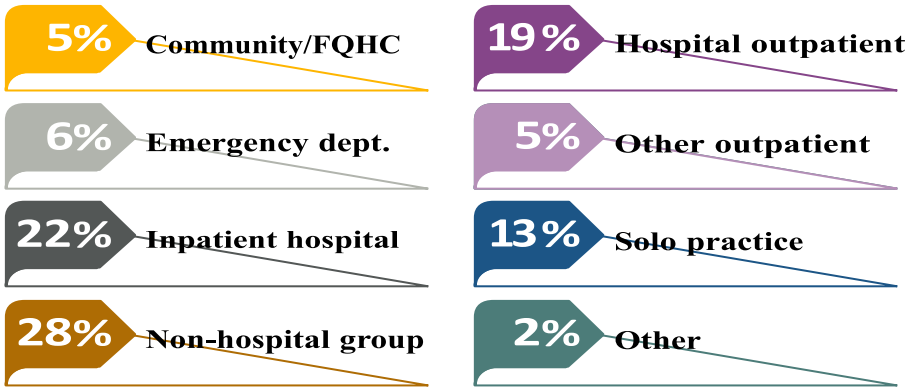


40 – 49

50 – 59 60+

We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

Care settings



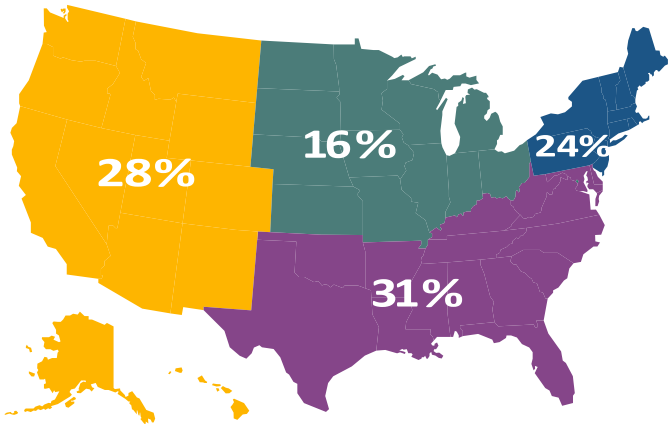
Demographics

Female	39%
Male	60%
Asian	19%
Black	7%
Hispanic	11%
White	58%
Other/ Prefer not to answer	11%
<40	24%
40 – 49	29 %
50 – 59	21 %
60+	27 %

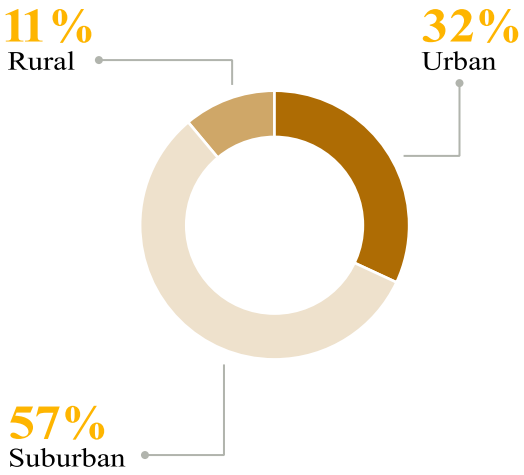
We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

251 physician assistants

Region



Communities

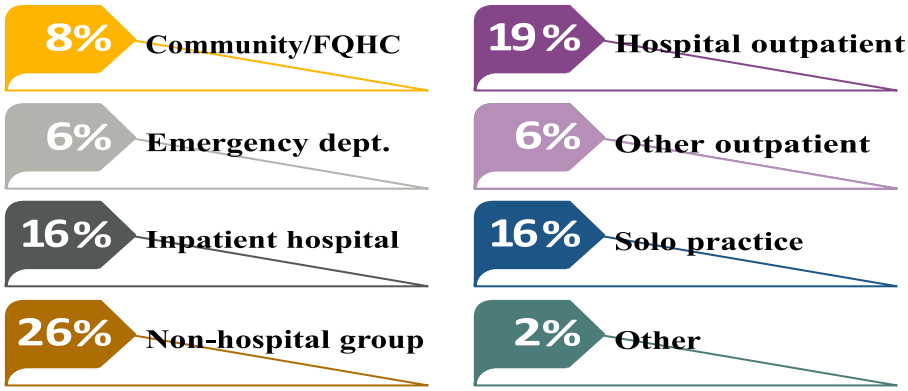


40 – 49

50 – 59 60+

We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

Care settings



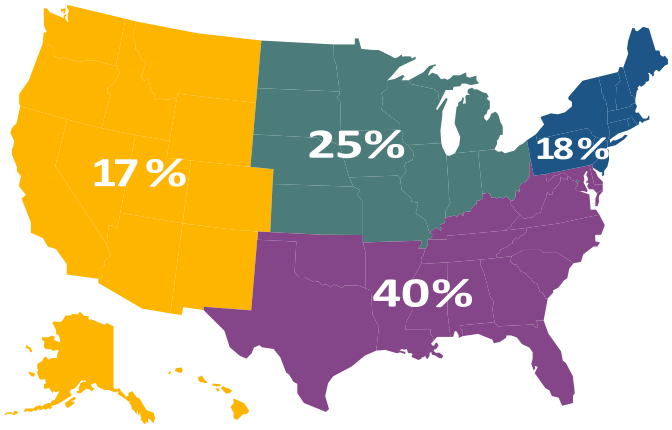
Demographics

Female	77%
Male	23%
Asian	13%
Black	5%
Hispanic	7%
White	73%
Other/ Prefer not to answer	4%
<40	41%
40 – 49	32 %
50 – 59	19 %
60+	8%

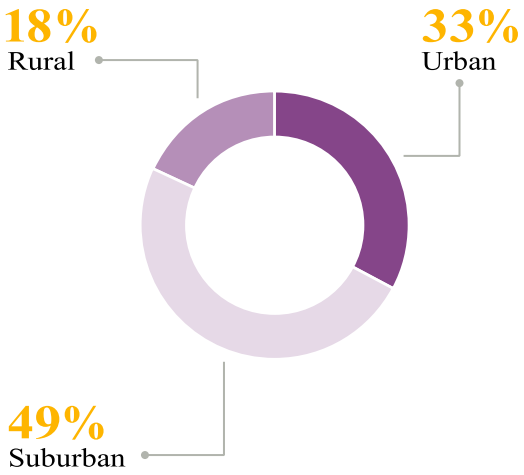
We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

250 nurse practitioners

Region



Communities

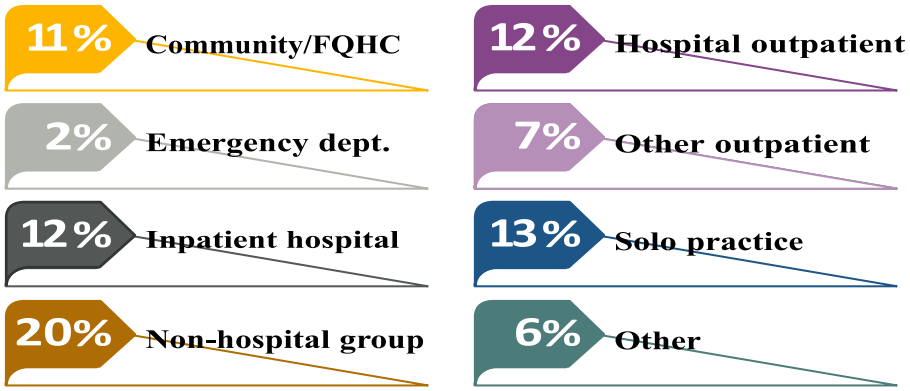


40 – 49

50 – 59 60+

We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

Care settings



Demographics

Female	**89%**
Male	**9%**
Asian	**10%**
Black	**7%**
Hispanic	**3%**
White	**78%**
Other/ Prefer not to answer	**9%**
<40	**33%**

30%

21%

16%

40 – 49

50 – 59 60+

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Heart of Safety Coalition

The Heart of Safety Coalition places care team member safety at the heart of healthcare. This national community of industry leaders, learners and advocates ensures that voices are heard, connections are made, and standards are raised to inspire systemic, team and individual change that improves working and healing environments. The Coalition's three pillars of care team safety advance the Heart of Safety Declaration,

which intersects the essential wellbeing principles of dignity and inclusion, physical safety, and psychological and emotional safety.
Driven by its mission to make healthcare better, Stryker supports and manages the Coalition. Learn more at www.HeartofSafetyCoalition.com.

Dr. Lorna Breem Heroes' Foundation

The Dr. Lorna Breen Heroes' Foundation's vision is a world where seeking mental health care is universally viewed as a sign of strength for health workers. We believe every health worker should have access to the mental health care and professional wellbeing support that they may need, at every moment in their career. We carry out this mission by accelerating solutions, advancing policies and making connections that put our healthcare workforce's wellbeing first. Learn more at www.drlornabreen.org.

ALL IN: Wellbeing First for Healthcare Coalition

ALL IN: Wellbeing First for Healthcare, led by the Dr. Lorna Breen Heroes' Foundation, is a coalition of national healthcare organizations committed to advancing a state where the healthcare workforce's wellbeing is prioritized, and individual health workers feel valued and supported so they can sustain their sense of purpose and meaning in their work. Coalition members include America's Health Insurance Plans, American Association of Colleges of
Nursing, American College of Emergency Physicians, American Dental Association, American Foundation for Suicide Prevention, American Hospital Association, American Medical Association, American Nurses Association, American Nurses Credentialing Center, American Psychiatric Association Foundation, American Society of Health-System Pharmacists, American Urological Association, CAA Foundation, CHARM, Emergency Nurses Association, Epic, Federation of State Physician Health Programs, FEMinEM, Harvard T.H. Chan School of Public Health, Heart of Safety Coalition, Institute for Healthcare Improvement, Johnson & Johnson Foundation, Medicine Forward, Moral Injury of Healthcare, National Black Nurses Association, National Medical Association, Organizational Wellbeing Solutions, Philippine Nurses Association of America, The Physicians Foundation, The Schwartz Center for Compassionate Healthcare and Thrive Global Foundation.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request: Jennifer Jarrett, PAACB Chair		2) Date when request submitted: 9/24/2025 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Physician Assistant Affiliated Credentialing Board			
4) Meeting Date: 10/30/2025	5) Attachments: ☒ Yes ☐ No	6) How should the item be titled on the agenda page? Review of new and renewal questions on the physician assistant licensing applications	
7) Place Item in: ☒ Open Session ☐ Closed Session	8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)* ☒ Yes Stef Simmons, Chief Medical Officer, Lorna Breen Heroes' Foundation ☐ No	9) Name of Case Advisor(s), if applicable: N/A	

10) Describe the Issue and Action that should be addressed:

The Lorna Breen Heroes' Foundation will review all of the questions on PA licensing applications prior to this meeting to ensure they meet the standards set forth by the MEB as mentioned in its September meeting and to flag any questions that do not meet the standards. Chair Jarrett would like the Board to vote on any recommendations made by the Lorna Breen Heroes' Foundation. She would like the reviewed questions used for the February 2026 renewal.

11) Authorization

Jennifer Jarrett Signature of person making this request	9/24/2025 Date
Supervisor (Only required for post agenda deadline items)	Date
Executive Director signature (Indicates approval for post agenda deadline items)	Date

Directions for including supporting documents:
1. This form should be saved with any other documents submitted to the Agenda Items folders.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request: Paralegal Richanda Turner on behalf of Attorney Renee Parton			**2) Date when request submitted:** 10/20/25 **I/tems will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting**
3) Name of Board, Committee, Council, Sections: Physician Assistant Affiliated Credentialing Board			
4) Meeting Date: 10/30/25	**5) Attachments:** ☒ Yes ☐ No	**6) How should the item be titled on the agenda page?** Credentialing Matters – Discussion and Consideration Physician Assistant Application Medical Condition language updates	
7) Place Item in: ☒ Open Session ☐ Closed Session	**8) Is an appearance before the Board being scheduled?** *(If yes, please complete Appearance Request for Non-DSPS Staff)* ☐ Yes ☒ No	**9) Name of Case Advisor(s), if applicable:**	
10) Describe the issue and action that should be addressed: The Board will discuss language updates in the PA application relating to medical conditions			
11) Authorization **Signature of person making this request** Richanda Turner		**Date** **10/20/25**	
Supervisor (Only required for post agenda deadline items)		**Date**	
Executive Director signature (Indicates approval for post agenda deadline items)		**Date**	

Directions for including supporting documents:
1. **This form should be saved with any other documents submitted to the Agenda Items folders.**
2. **Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.**
3. **If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.**

Physician Assistant Initial Application – Updates to Consider October 2025

For the purposes of these questions, the following phrases or words have the following meanings:

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to musculoskeletal impairments, visual, speech, and hearing impairments, neurological conditions, intellectual disability, behavioral health conditions, specific learning disabilities, substance use disorder, alcohol use disorder, other substance use disorders or any communicable infectious diseases, such as hepatitis.

"Chemical Substances" is to be construed to include alcohol, marijuana, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

11. Do you have a medical condition, as defined above, which currently impairs or limits your ability to practice medicine with reasonable skill and safety?

Yes, please describe the medical condition and any limitations and/or impairment, including whether you require any accommodation to ensure safe, competent practice.

No

12. Do you use chemical substance(s), as defined above, that currently impairs or limits your ability to practice medicine with reasonable skill and safety?

Yes, please describe your chemical substance(s) use and any limitations and/or impairment, including whether you require any accommodation to ensure safe, competent practice.

No

13. Have you ever been diagnosed as having, or have you ever been treated for, pedophilia exhibitionism, or voyeurism?

Yes, please describe your diagnosis and any limitations and/or impairment, including whether you require any accommodation to ensure safe, competent practice.

No

Additional Renewal Requirements

Verify Professional Specialties:

Please check here if you are willing to serve as an expert witness in disciplinary proceedings.

Medicine and Surgery Renewal Addendum

For the purposes of these questions, the following phrases or words have the following meanings:

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to musculoskeletal impairments, visual, speech, and hearing impairments, neurological conditions, intellectual disability, behavioral health conditions, specific learning disabilities, substance use disorder, alcohol use disorder, other substance use disorders or any communicable infectious diseases; such as hepatitis.

"Chemical Substances" is to be construed to include alcohol, marijuana, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

For any **YES** answers below, please upload a detailed statement and supporting documents on the Supporting Documents page.

* 1. Do you have a medical condition, as defined above, which currently impairs or limits your ability to practice medicine with reasonable skill and safety that has not been previously disclosed?
  - Yes, please describe the medical condition and any limitations and/or impairment, including whether you require any accommodation to ensure safe, competent practice.
  - No
* 2. Do you use any chemical substance(s), as defined above, that currently impairs or limits your ability to practice medicine with reasonable skill and safety that has not been previously disclosed?
  - Yes, please describe your chemical substance(s) use and any limitations and/or impairment, including whether you require any accommodation to ensure safe, competent practice.
  - No
* 3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism that has not been previously disclosed?
  - Yes, please describe your diagnosis and any limitations and/or impairment, including whether you require any accommodation to ensure safe, competent practice.
  - No

From: Stefanie Simmons <stefanie@drbreenheroes.org>
Sent: Friday, March 28, 2025 12:46 PM
To: Garrett, Jennifer E - DSPS <jennifer.garrett@wisconsin.gov>
Subject: Wisconsin Department of Safety and Professional Services -- Physician / Physician Assistant / Nurse | DLBHF: Licensing Review Feedback

Hello Jennifer,

The following is our analysis of the physician, nurse and PA applications with suggested revisions. You will notice a callout under the nurse application about "alternative programs". It is important to recognize the difference between the interstate compact application and an individual state application regarding this question.

I am happy to meet with you and discuss any specific recommendation. Our paralegal, Shari, is also available for discusssion.

Best regards,

Stef Simmons

The Wisconsin Department of Safety and Professional Services physician, physician assistant and nursing applications were reviewed by our ALL IN team to evaluate for consistency with the Dr. Lorna Breen Heroes' Foundation, American Medical Association and Federation of State Medical Board recommendations to ensure well-being for our healthcare workforce. If the information below is not clear, or if you have any further questions, please let me know.

Before we get into the analysis, however, we always try to explain the process a little. We've read the applications in their entirety, differences in language are to be expected, and where there are opportunities to suggest revisions, we try to use the existing language from institutions, if possible, to minimize challenges in the revision process. The main goal is to remove language that mandates disclosure of treatment of mental health or substance use disorders when impairment does not exist and focus only on whether a current impairment exists that adversely affects patient safety and the ability to competently practice medicine. We also try to revise subjective language to give the

applicant or peer reference clear direction as to what a particular question might ask as well as the information to be provided to the institution.

WISCONSIN PHYSICIAN ASSISTANT LICENSING APPLICATIONS

Physician Assistant Initial Application:

The following are recommendations for the Wisconsin physician assistant initial application, and here's why:

Link to Physician Assistant Initial Application (Application for License as a Physician Assistant-Form #580 (Rev. 04/2022)) - submitted for review March 12, 2025

Additional Declarations

For the purposes of these questions, the following phrases or words have the following meaning:

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

- **Analysis**: In **"Medical Condition"** Rather than using the terms "drug addiction" or "alcoholism," we recommend using the current medical terminology "substance use disorder," "alcohol use disorder" or "other substance use disorders."

- **Recommended Revision:**

"Medical Condition" *includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism substance use disorder, alcohol use disorder, or other substance use disorders.*

<u>Question 11</u>: "Do you have a medical condition, which in any way impairs or limits your ability to practice as a Physician Assistant with reasonable skill and safety?. **If yes, please explain on an attached sheet."**

- **Analysis**: While this question is largely consistent with our recommendations, we recommend a slight revision to increase its clarity. We believe the use of "currently" would increase the objectivity of the question and help ensure that the focus is on the currency of the ability to practice medicine. The term "in any way" could be read to suggest an open-ended qualifier not limited to an applicant's current status. We strongly support an applicant answering whether a current condition exists that would adversely affect patient safety and the ability to competently practice medicine. We suggest the following minor revisions:

- **Recommended Revision**:

Do you have a medical condition, which in any way <u>currently</u> impairs or limits your ability to practice as a Physician Assistant with reasonable skill and safety? ***If yes, please explain on an attached sheet.***

<u>Question 12</u>: "Does your use of chemical substance(s), in any way impair, or limit your ability to practice as a Physician Assistant with reasonable skill and safety? **If yes, please explain on an attached sheet."**

- **Analysis**: This question is consistent with our recommendations, but certain improvements could be made to more closely emphasize "currently" and remove "in any way" which raises the issue of subjectivity. The question can be made clearer with the following minor revisions:

- **Recommended Revision**:

Does your use of chemical substance(s), in any way <u>currently</u> impair, or limit your ability to practice as a Physician Assistant with reasonable skill and safety? ***If yes, please explain on an attached sheet.***

<u>Question 13</u>: "Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication), or participate in a monitoring program? **If yes, please explain on an attached sheet."**

<u>Question 14</u>: "Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain on an attached sheet. **If yes, please explain on an attached sheet."**

- **Analysis**: On one hand, if there is a limitation and/or impairment, the health system needs to know, including whether the applicant is requesting an accommodation. On the other hand, this question goes further by requiring disclosure of treatment. One of the reasons healthcare professionals do not seek care is the fear that they will have to disclose it to a future employer. If a physician or trainee is receiving care, the care provider–if licensed–has obligations to report if there is a current threat to patient safety. Including this question will deter treatment and arguably not benefit the institution. Replacing the current questions 13 and 14 with the language below allows the applicant to describe the limitation, and also provides the system with the necessary information to conduct follow-up inquiries, as appropriate. It does not, however, necessarily require the applicant to disclose treatment on the application itself. And if the limitations are fully ameliorated, and there is no current impairment, there should not be the mandated disclosure at the outset of the application process. Consider, too, that if a limitation or impairment is "reduced," it still should be disclosed to the medical staff.

- **Recommended Revision**:

Question**: 13. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication), or participate in a monitoring program? **If yes, please explain on an attached sheet.

Question**: 14. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain on an attached sheet. **If yes, please explain on an attached sheet.

<u>If yes to Question 11, please describe the limitation and/or impairment, including whether you require an accommodation to ensure safe, competent practice.</u>

<u>Question 16</u>: "Are you currently engaged in the illegal use of controlled dangerous substances?"

- **Analysis**: Retaining the question is not inconsistent with our overall recommendations; however, we point out that it is highly unlikely an individual will answer yes.

Question 17: "If yes, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain on an attached sheet."**

- **Analysis**: We recommend deleting this question in its entirety. One of the primary reasons physicians and other healthcare professionals do not seek care is the fear that they will have to disclose it to a future employer. If a physician or other healthcare professional is receiving care, the care provider typically has obligations to report or intervene if there is a current threat to patient safety. It's common for a physician health program (or other similar program) to require the practitioner to let an institution know if an on-site monitor is needed as a condition of return to practice. Fear and stigma is a powerful and common reason why physicians and other healthcare professionals do not seek care and including this question will deter treatment and arguably not benefit the institution.

- **Recommended Revision**:

If yes to Question 15, are you participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

Physician Assistant Renewal Application

The renewal application is consistent with our recommendations, and no changes are required.

Link to Physician Assistant Renewal Application (Physician Assistant Renewal 1/11/2026-2/28/2026 - screenshots) - submitted for review March 12, 2025

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request: Jennifer Jarrett, Board Chair		2) Date when request submitted: 10/24/2025 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Physician Assistant Affiliated Credentialing Board			
4) Meeting Date: 10/30/2025	5) Attachments: ☒ Yes ☐ No	6) How should the item be titled on the agenda page? Health Regulatory Research Institute Workforce Survey Questions – Consider Adding to February 2026 Renewal Application	
7) Place Item in: ☒ Open Session ☐ Closed Session	8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)* ☐ Yes ☒ No	9) Name of Case Advisor(s), if applicable: N/A	
10) Describe the issue and action that should be addressed: Chair Jarrett and DSPS Deputy Secretary Jennifer Garrett request that the Board consider adding the HRRI workforce survey questions to the February 2026 license renewal form.			
11) Authorization Jennifer Jarrett/Jennifer Garrett Signature of person making this request		9/24/2025 Date	
Supervisor (Only required for post agenda deadline items)		Date	
Executive Director signature (Indicates approval for post agenda deadline items)		Date	
Directions for including supporting documents: 1. This form should be saved with any other documents submitted to the Agenda Items folders. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

Core Minimum Data Set Questions

Suggestions and Questions for Physician and Dental Renewals

1. What is your gender?

a. Male

b. Female

c. Transgender

d. Gender Non-binary

e. Other

f. Prefer not to answer

2. What is your race? Mark one or more boxes.

[MULTI-SELECT AVAILABLE]

a. American Indian or Alaska Native

b. Asian

c. Black or African American

d. Native Hawaiian/Pacific Islander

e. White

f. Some Other Race

3. Are you of Hispanic, Latino/a, or Spanish origin?

[SINGLE-SELECT]

a. No

b. Yes

4. What is your birth year?

[OPEN FIELD]

5. What is your highest level of education?

[SINGLE-SELECT]

a. Bachelor's Degree

b. Master's Degree

c. Post-graduate training

d. Professional/Doctorate Degree

e. Postdoctoral training

6. Where did you complete the education program/degree that first qualified you for this license?
(Note: for online programs, please select the location where this program was housed)

a. [LIST OF U.S. STATES and territories] [SINGLE-SELECT]

b. Another Country (not U.S.) [OPEN FIELD]

7. In what state(s) and/or jurisdiction(s) do you hold an active license or have authority to practice?
(Select all that apply)

[MULTI-SELECT]

[LIST OF U.S. STATES and territories]

8. What is your employment status?

[SINGLE-SELECT]

a. Actively working in a position that requires this license

b. Actively working in a position in the field of medicine/dentistry that does not require this license

c. Actively working in a position in a field other than medicine/dentistry

d. Not currently working

e. Retired

9. What best describes your employment plans for the next 2 years?

[SINGLE SELECT]

a. Increase hours in a field related to this license

b. Decrease hours in a field related to this license

c. Seek employment in a field unrelated to this license

d. Retire

e. Continue as you are

f. Unknown

Specialty (Standard question, Flexible response)

10. Which of the following best describes the specialty/field/area of practice in which you spend most of your professional time?

11. Telehealth may be defined as the use of electronic information and telecommunications technologies to extend care to patients, and may include videoconferencing, store-and forward imaging, streaming media, and terrestrial and wireless communications. Do you use telehealth to deliver services to patients?

[SINGLE SELECT]

a. No

b. Yes

12. In what state is your primary practice location? If this does not apply, please select "N/A"

[LIST OF U.S. STATES AND TERRITORIES AND OPTION FOR N/A]

13. What is the five-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"

OPEN TEXT FIELD

14. In what state is your secondary practice location? If this does not apply, please select "N/A"

[LIST OF U.S. STATES AND TERRITORIES AND OPTION FOR N/A]

15. What is the five-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A"

OPEN TEXT FIELD

16. In what state is your third practice location? If this does not apply, please select "N/A"

[LIST OF U.S. STATES AND TERRITORIES AND OPTION FOR N/A]

17. What is the five-digit ZIP code of your third practice location? If this does not apply, please indicate "N/A"

OPEN TEXT FIELD

18. Which of the following best describes your current employment arrangement at your principal practice location?

MULTI-SELECT

a. Self-employed/Consultant

b. Salaried employee

c. Hourly employee

d. Temporary employment/Locum tenens

e. Other

f. Not Applicable

19. Please identify the role/title(s) that most closely correspond(s) to your primary employment/practice type.

MULTI-SELECT

a. Administrator

b. Clinical Practice

c. Faculty/Educator

d. Researcher

e. Other

f. Not Applicable

20. Which of the following best describes the practice setting at your primary practice location?

{SINGLE-SELECT}

- ☐ Hospital (Medical/Surgical, Alcohol or Drug Abuse (AODA)/Psychiatric, Long-Term Acute Care)
  - Hospital
    - ☐ Hospital, emergency/urgent care
    - ☐ Hospital, outpatient/embedded primary care
    - ☐ Hospital, inpatient mental health/substance abuse
    - ☐ Hospital, other departments
    - ☐ Hospital, I work in several/all hospital units
    - ☐ Hospital, education department
- ☐ Extended Care, such as Adult Family Homes (AFH), Community-Based Residential Facilities (CBRF), Residential Care Apartment Complexes (RCAC)
  - Extended Care Such as Adult Family Homes
    - ☐ Nursing home
    - ☐ Skilled nursing facility
    - ☐ Hospice facility
    - ☐ Residential intellectual/developmental disability facility
    - ☐ Assisted living facility
    - ☐ Rehabilitation facility/group home/CBRF
    - ☐ Long-term acute care
- ☐ Home Health (Private Home)
  - Home Health
    - ☐ Home health agency
    - ☐ Home health service
    - ☐ Hospice
- ☐ Community and Public Health
  - Community and Public Health
    - ☐ Public health (governmental: federal, state, or local)
    - ☐ Community health organization
    - ☐ Occupational health or employee health service
    - ☐ School health services (K-12, college, and universities)
    - ☐ Senior services (center, agency)

Continued on next page

- [ ] Tribal Health
  - Tribal Health
    - [ ] Health clinic
    - [ ] Long term care facility
    - [ ] School health (K-12, college, or university)
    - [ ] Other community organization or site
    - [ ] Public health
- [ ] Educational Institutions
  - Educational Institutions
    - [ ] Four-year college or university
    - [ ] Technical or community college
- [ ] Correctional Care
  - Correctional Care
    - [ ] Prison (federal or state)
    - [ ] Jail (county or local)
- [ ] Other (Insurance, call center etc.)
  - Other Insurance or Call Center
    - [ ] Call center/tele-nursing center
    - [ ] Government agency other than public/community health
    - [ ] Government agency other than public/community health (Veterans Affairs Medical Center (VAMC) and Community-Based Outpatient Clinics (CBOC), Veterans home etc.)
    - [ ] Non-governmental health policy, planning, or professional organization
    - [ ] Insurance company claims/benefits
    - [ ] Self-employed/consultant
    - [ ] Other

21. Estimate the average number of hours per week spent at your primary practice location. If this does not apply, please select "not applicable."

[SINGLE-SELECT]

a. 0 hours per week/Not applicable

b. 1 – 4 hours per week

c. 5 – 8 hours per week

d. 9 – 12 hours per week

e. 13 – 16 hours per week

f. 17 – 20 hours per week

g. 21 – 24 hours per week

h. 25 – 28 hours per week

i. 29 – 32 hours per week

j. 33 – 36 hours per week

k. 37 – 40 hours per week

l. 41 or more hours per week

22. Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your primary practice location. If this does not apply, please select "not applicable."

[SINGLE-SELECT]

a. 0 hours per week/Not applicable

b. 1 – 4 hours per week

c. 5 – 8 hours per week

d. 9 – 12 hours per week

e. 13 – 16 hours per week

f. 17 – 20 hours per week

g. 21 – 24 hours per week

h. 25 – 28 hours per week

i. 29 – 32 hours per week

j. 33 – 36 hours per week

k. 37 – 40 hours per week

l. 41 or more hours per week

23. What type of degree/credential first qualified you for this license?

[SINGLE SELECT]

- [ ] Technical/Vocational Certificate
- [ ] Associate Degree
- [ ] Bachelor's Degree
- [ ] Master's Degree
- [ ] Post-graduate training
- [ ] Professional/Doctorate Degree
- [ ] Postdoctoral training

24. What year did you complete the education program/degree that first qualified you for this license?

[OPEN TEXT FIELD]

25. In what city is your primary practice located? If this does not apply, please indicate "N/A"

[OPEN TEXT FIELD]

26. What is the street address of your primary practice location? If this does not apply, please indicate "N/A."

[OPEN TEXT FIELD]

27. Please indicate the population groups to which you provide services. Please check all that apply.

[MULTI-SELECT CHECKBOXES]

a. Newborns

b. Children (ages 2-10)

c. Adolescents (ages 11-19)

d. Adults

e. Geriatrics (ages 65+)

f. Pregnant women

g. Veterans

h. Incarcerated individuals

i. Individuals with disabilities

j. Individuals who speak a language other than English

k. Medicaid

l. Medicare

m. Sliding Fee Scale

n. None of the above

END OF SURVEY

Physician Specialties

I am currently certified as:

Academic Medicine - 37

Administrative Medicine - 71

Aerospace Medicine - 33

Alcoholism - Chemical Dependency - 49

Allergy - Immunology - 01

Anesthesiology - 02

Aviation Medicine - 32

Dermatology - 03

Emergency Medicine - 31

Endocrinology - 56

Family Medicine - 925

Gastroenterology - 06

General Practice - 08

Genetics - 61

Geriatrics - 29

Hand Surgery - 64

Hebiatrics - 46

Hematology - 07

Hyperbaric Medicine - 65

Immunology - Infectious Diseases - 47

Institutional Medicine - 39

Internal Medicine - 04

Internal Medicine - Cardiology - 05

Internal Medicine - Pulmonary Medicine - 45

Neonatology - 63

Nephrology - 40

Neurology - 10

Neuromuscular Medicine - 926

Neurophysiology - 51

Nuclear Medicine - 23

Obstetrics and Gynecology - 12

Occupational Medicine - 30

Oncology - 38

Ophthalmology - 13

Orthopedic Surgery - 14

Otolaryngology - 67

Otorhinolaryngology - ENT - 15

Pain - 66

Pathology - 16

Pathology - Clinical - 17

Pathology - Surgical Anatomic - 72

Pediatrics - 18

Pediatrics - Other - 60

Perinatology - 62

Pharmacology - Clinical - 48

Physical Medicine and Rehabilitation - 19

Preventive Medicine - 09

Proctology - 36

Psychiatry - 20

Psychiatry - Child - 21

Public Health - 22

Radiation - Oncology - 70

Radiology - 53

Radiology - Diagnostic - 43

Radiology - Nuclear Medicine - 68

Radiology - Ultrasound - 69

Radiology – Interventional - 946

Research - 34

Retired - 24

Rheumatology - 57

School Physician - 52

Surgery - Cardiovascular - 44

Surgery - Colon and Rectal - 54

Surgery - General - 25

Surgery - Maxillofacial - 58

Surgery - Neurological - 11

Surgery - Peripheral Vascular - 59

Surgery - Plastic - 26

Surgery - Thoracic - 27

Urology – 28

Physician Wellness and Burnout

Report and Recommendations of the Workgroup on Physician Wellness and Burnout

Adopted as policy by the Federation of State Medical Boards

April 2018

Executive Summary:

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D. to identify resources and strategies to address physician burnout.

While the Workgroup examined the issue of physician burnout from a broad perspective, reviewing as many facets of this complex issue as possible, including existing research, resources, and strategies for addressing it, the recommendations for state medical and osteopathic boards (hereinafter referred to collectively as "state medical boards") found in this report focus first and foremost on the licensing process. The Workgroup also saw fit to include commentary and recommendations on several other aspects of physician wellness and burnout, though some of these areas may not be under the direct purview of the FSMB or its member boards. The FSMB recognizes the importance of collaboration for effectively supporting physicians and protecting patients in the face of circumstances that lead to burnout, which is ultimately a patient safety issue. A shared accountability model that includes responsibilities to be carried out by providers from all the health professions, including physicians and physician assistants, and with organizations from across the health care community is therefore recommended as the most promising course of action to address this important issue.

Recommendations for state medical boards related to the licensing process include considering whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure or their renewal, and whether the information these questions are designed to elicit, ostensibly in the interests of patient safety, may be better obtained through means less likely to discourage treatment-seeking among physician applicants.

Where member boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, several recommendations are included in this report for the appropriate phrasing of such questions, including focusing only on current impairment, which may be more meaningful

in the context of a physician's ability to provide safe care to patients in the immediate future.

State medical boards are also encouraged to approach physician wellness and burnout from a non-punitive perspective, avoiding public disclosure of any information about a physician's diagnosis during licensing processes and offering "safe haven" non-reporting options (mentioned later in this report) to physicians who are under treatment and in good standing with a recognized physician health program (PHP) or other appropriate care provider.

It is also recommended that boards take advantage of all opportunities available to them to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and make meaningful contributions to the ongoing national dialogue about burnout in order to advance a positive cultural change that reduces the stigma among and about physicians seeking treatment for mental, behavioral, physical or other medical needs of their own.

The Workgroup's recommendations to external organizations and stakeholders focus on increasing the awareness and availability of information and resources for addressing physician burnout and improving wellness. The value of noting and listing the availability of accessible, private, confidential counselling resources is a particular point of emphasis in this report, as is dedicating efforts to ensuring that any new regulation, technology, or initiative is implemented with due consideration to any potential for negative impact on physician wellness.

This report, which follows two years of careful study, evaluation and discussion by Workgroup members, FSMB staff, and various stakeholders, is intended to support initial steps by the medical regulatory community to begin to address the issues associated with promotion of physician wellness and mitigation of burnout, to the extent that is possible. The information and recommendations contained herein are based on principles of fairness and transparency, and grounded in the primacy of patient safety. They emphasize a responsibility among state medical boards to work to ensure physician wellness as a component of their statutory right and duty to protect patients.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request: Jennifer Jarrett, Board Chair		**2) Date when request submitted:** 9/24/2025 **Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting**	
3) Name of Board, Committee, Council, Sections: Physician Assistant Affiliated Credentialing Board			
4) Meeting Date: 10/30/2025	**5) Attachments:** ☒ Yes ☐ No	**6) How should the item be titled on the agenda page?** Physician Assistant License Update – Board Review	
7) Place Item in: ☒ Open Session ☐ Closed Session	**8) Is an appearance before the Board being scheduled?** *(If yes, please complete Appearance Request for Non-DSPS Staff)* ☒ Yes ☐ ☐ No	**9) Name of Case Advisor(s), if applicable:** N/A	
10) Describe the issue and action that should be addressed: Chair Jarrett requests a status update on the amendment to the PA license certificate to ensure it is being sent from the PAACB.			
11) **Authorization**			
Jennifer Jarrett			**9/24/2025**
Signature of person making this request			**Date**
Supervisor (Only required for post agenda deadline items)			**Date**
Executive Director signature (Indicates approval for post agenda deadline items)			**Date**

Directions for including supporting documents:

1. **This form should be saved with any other documents submitted to the Agenda Items folders.**
2. **Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.**
3. **If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.**

NO. XXXX- 23

EXPIRES: 02/28/2026

The State of Wisconsin
Department of Safety and Professional Services
PHYSICIAN ASSISTANT AFFILIATED CREDENTIALING BOARD

Hereby certifies that

was granted a license to practice as a

PHYSICIAN ASSISTANT

in the State of Wisconsin in accordance with Wisconsin Law
on the 24th day of September in the year 2025.
The authority granted herein must be renewed each biennium by the granting authority.
In witness thereof, the State of Wisconsin
Physician Assistant Affiliated Credentialing Board
has caused this certificate to be issued under
the seal of the Department of Safety and Professional Services

DSPS Secretary

Chairperson

Secretary

This certificate was printed on the 20th day of October in the year 2025

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request:	2) Date when request submitted:
Nilajah Hardin **Administrative Rules Coordinator**	**10/17/25** Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting

3) Name of Board, Committee, Council, Sections:

Physician Assistant Affiliated Credentialing Board

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
10/30/25	☒ Yes ☐ No	**Administrative Rule Matters Discussion and Consideration** 1. Other Rule Updates: a. Med 21, Patient Health Care Records b. Med 27, Relating to Provisional Licensure for International Physicians c. N 1 to 8, Relating to APRNs and Comprehensive Review d. Pod 1 and 9, Relating to Supervision of Physician Assistants 2. Pending or Possible Rulemaking Projects a. Rule Projects Chart

7) Place Item in:	8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)*	9) Name of Case Advisor(s), if required:
☒ Open Session ☐ Closed Session	☐ Yes ☒ No	**N/A**

10) Describe the issue and action that should be addressed

Attachments:

1. **Other Rule Updates**
2. **Rule Projects Chart**

Pending Rule Project Page: https://dsps.wi.gov/Pages/RulesStatutes/PendingRules.aspx

11) Authorization

Nilajah D. Hardin — 10/17/25

Signature of person making this request — **Date**

Supervisor (if required) — **Date**

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — **Date**

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
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Other Rule Updates (as of 10/17/25):

- **Med 21, Patient Health Care Records**
  - **Public Hearing held at 10/15/25 meeting**
  - **Next step is drafting Final Rule and Legislative Report**
- **Med 27, Relating to Provisional Licensure for International Physicians**
  - **Effective 10/1/25**
- **N 1 to 8, Relating to APRNs and Comprehensive Review**
  - **Draft Scope Statement ready for next meeting**
  - **10/9/25 meeting cancelled due to lack of quorum**
- **Pod 1 and 9, Relating to Supervision of Physician Assistants**
  - **Drafting proposals to be discussed at 10/22/25 meeting**
  - **Next step is Drafting a full Preliminary Rule**

Physician Assistant Affiliated Credentialing Board
Rule Projects (updated 10/17/25)

Clearinghouse Rule Number	Scope #	Scope Expiration	Code Chapter Affected	Relating clause	Current Stage	Next Step
25-029	091-24	02/12/2027	PA 1 to 4	Implementation of the Physician Assistant Licensure Compact	Final Rule Draft and Legislative Report Submitted to Legislature for Notification and Adoption Order Submitted for Publication on 10/16/25	Rule Publication; Effective Date TBD
25-002	065-24	12/03/2026	PA 4	Physical Examinations	Effective 10/1/25	N/A