

Editor's Message

By CHWEN-YUEN ANGIE CHEN, MD, FACP, FASAM



C.Y. ANGIE CHEN, MD

This has been an eventful spring for CSAM and the field of Addiction Medicine. Alongside the announcement of Addiction Medicine as a board-recognized medical sub-specialty comes the sweeping opioid prescribing reforms from the FDA, CDC and President Obama himself. These are changes that have been decades in the making and many CSAM veterans have been instrumental in steering this lumbering ship that has hit a watershed this year.

The perception of addiction and its treatment has been transforming. The purview of addiction treatment was primarily 12-Step programs, which were rather cutting edge for a time, followed by methadone maintenance for the marginalized heroin addict. What used to be the scourge of "reefer madness" has seen state after state thumb its nose at federal laws. A 74-year-old grandmother who was once jailed for possession now grows plants for personal medical use. What does this mean for the 16-year-old grandson who lives and smokes with her? Sanatoriums have been replaced by a cottage industry of rehabilitation centers and sober living environments answering an opioid epidemic that is caused, in part, by lack of physician training. Heroin is back, and is now in the mainstream with budding legislative initiatives to allow for safe injecting sites. With the return of the old comes the new: unpredictable, highly addictive synthetic compounds such as Flakka, that seem to shape shift as often as a new upgrade for a smartphone app and are as evasive as the dark web.

In this issue we have surveyed CSAM membership about being in a private addiction medicine practice. It is heartening to hear that

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Results of a CSAM Member Survey

Starting Your Own Addiction Medicine Private Practice

Choosing to start a practice in addiction medicine is as exciting as it is terrifying. To assist those considering making this leap, CSAM News conducted a survey of members who have recently, or not so recently, started an addiction medicine practice.

There are many reasons addiction medicine physicians moved to private practice. Many wanted to serve the community in ways that were not possible in their organizations. One commented that they were "Looking for an opportunity to help the broadest age range, socio-economic, and multi-cultural population by working in the community." Others felt constrained by their previous practice. As one respondent said, "It allowed me to provide treatment that is tailored to the specific patient, family, and situation, rather than the kind of "cookie cutter" treatment that is provided at most addiction treatment settings." Others sought more personal satisfaction. One person said that he made the change "because the commute was killing me."

Eighty-seven percent of those surveyed said that they were glad they started a private practice. One person said, "It's fun working with a team but I value my independence more." Another said, "I'm my own boss now which has advantages: financially, in setting practice patterns, and scheduling."

Following are the answers to the questions posed by CSAM News.

What did you do before you started your private practice?

- VA drug and alcohol unit.
- Education, training, teaching, and wide range of interactional laborious jobs in multiple settings.
- Emergency Medicine.
- OB/GYN practice, part time addiction medicine.
- Still do county part-time.
- Medical Director at a men's residential drug and alcohol rehabilitation program.
- Medical Director of a rehabilitation program.
- Veterans Administration Medical Center.

What has been the most challenging aspects of being in private practice?

- Having to run the business side of the practice.
- Balancing self-care with family care with patient care with business care with community.

IN THIS ISSUE:

- Supervised Injection Sites: A Public Health Approach
- Flakka: A New Designer Drug in California
- Essentials of Addiction Medicine Conference

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Supervised Injection Sites: Part of a Comprehensive Public Health Approach

By MICHAEL BARACK, CCMEP

Supervised injection facilities (SIFs) are legally-sanctioned health care settings where people can more safely inject drugs under clinical supervision and receive health care, counseling and referrals to health and social services, including drug treatment. They are designed to reduce the health and public safety issues often associated with public injection. SIFs are intended to complement — not replace — existing prevention, harm reduction, and treatment interventions.

There are approximately 100 SIFs operating in at least 66 cities within nine countries around the world (Switzerland, Germany, the Netherlands, Norway, Luxembourg, Spain, Denmark, Australia and Canada) — but none in the United States.

Recently there have been moves toward establishing SIFs in the U.S. Mayor Svante Myrick of Ithica, New York has called for his city to become the first in the U.S. with an SIF. In San Francisco, Supervisor David Campos has called for a facility to be integrated into one of the homeless navigation centers that he is proposing. An Assembly Bill, AB 2495, has been introduced to the California legislature by Assembly Member Susan Eggman, which would permit state or local health departments to set up such programs. As this article goes to press, AB 2495 was voted down in Committee but it will be introduced again in 2017.

SIFs Improve Safety and Health

Numerous evidence-based, peer-reviewed studies^{1,2} have proven the positive impacts of SIFs, including:

- Increased uptake into addiction treatment, especially among people who distrust the treatment system and are unlikely to seek treatment on their own.
- Reduced public disorder, reduced public injecting, and increased public safety.
- Attracting and retaining a high-risk population of people who inject drugs; those who are at heightened risk for infectious disease and overdose.
- Reducing HIV and Hepatitis C risk behavior (i.e. syringe sharing, unsafe sex).
- Reducing the prevalence and harms of bacterial infections.
- Successfully managing hundreds of overdoses and reducing drug-related overdose death rates.
- Cost savings resulting from reduced disease, overdose deaths, and the need for emergency medical services.
- Providing safe injection education, and a subsequent increase in safer injecting practices.
- Not increasing community drug use.
- Not increasing initiation into injection drug use.
- Not increasing drug-related crime.
- Increased delivery of medical and social services.



A REGISTERED NURSE HOLDS A TRAY OF SUPPLIES TO BE USED BY A DRUG ADDICT AT THE InSITE SAFE INJECTION CLINIC IN VANCOUVER.

Vancouver's InSite

Vancouver's SIF, InSite, has been the most extensively studied SIF in the world, with more than two dozen peer-reviewed articles now published examining its effects on a range of variables, from retention to treatment referrals to cost-effectiveness.⁴ These reports are in line with reviews of the Australian and European SIFs, which show that these facilities have been successful in attracting at-risk populations, are associated with less risky injection behavior, fewer overdose deaths, increased client enrollment in drug treatment services, and reduced nuisances associated with public injection.⁵ For example, one study found a 30 percent increase in the use of detoxification services among InSite clients.⁶

InSite has proved to be cost-effective in terms of overdose and blood borne disease prevention as well.⁷ One cost-benefit analysis of InSite estimated that the facility prevents 35 cases of HIV each year, providing a societal benefit of more than \$6 million per year.⁸

InSite also saves lives. A 2011 study published in *The Lancet* found that the fatal overdose rate in the immediate vicinity of InSite decreased by 35 percent since it began operating in 2003, while the rest of the city experienced a much smaller reduction of nine percent.⁹

A survey of more than 1000 people utilizing InSite found that 75 percent reported changing their injecting practices as a result of using the facility. Among these individuals, 80 percent indicated that the SIF had resulted in less rushed injecting, 71 percent indicated that the SIF had led to less outdoor injecting, and 56 percent reported less unsafe syringe disposal.¹⁰

InSite has produced a "large number of health and community benefits with no indications of community or health-related harms."¹¹

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Flakka: A New Designer Drug in California

By MATTHEW GOLDENBERG DO, GREG SKIPPER MD, AND KAREN MIOTTO MD

Synthetic cathinones, commonly referred to as “plant food,” “bath salts,” or “research chemicals,” are structurally related to the psychoactive alkaloid cathinone found in the flowering plant, *Catha edulis* (Khat). The social custom of chewing Khat, for caffeine-like effects, dates back a thousand years in the Horn of Africa and the Arabian Peninsula where *Catha edulis* grows natively.¹

In contrast, synthetic cathinones have MDMA and amphetamine-like psycho-stimulant effects. This new class of synthetic stimulants has gained popularity amongst drug users over the past 10 years due to its high potency, low cost and ease of procurement often through smoke shops or Internet sales. Suppliers and users also favor constantly evolving chemical structures that are designed to circumvent regulatory controls and the detection of drug testing.¹

One of these new synthetic cathinones has recently made headlines in Florida, as police have reported a growing number of cases of bizarre and uncontrollable behavior linked to Flakka. Flakka, or alpha-pyrrolidinovalerophenone (α -PVP), is a synthetic cathinone recently classified as Schedule I by the U.S. Drug Enforcement Administration (DEA). According to the DEA, reported Flakka cases have increased 780% between 2012

outcomes. However, as marketing and distribution has advanced, MDPV, methylone, and mephedrone are now referred to as first generation bath salts. Second generation synthetic cathinones include both ethylone and Flakka (α -PVP). Jim Hall, an epidemiologist from Florida, described the marketing and distribution efforts that are driving the popularity of second-generation synthetic cathinones:³

“The 21st century trends in drug supply are creating new brand names like Flakka and building its popularity and then selling anything. The main issue with this whole category is that the users just don’t know what they’re taking or the strength of what they’re taking. Often the dealers might not even know what they’re selling.”

Flakka comes in a crystalline rock and can be swallowed, snorted, injected or smoked (including vaped using an e-cigarette). The desired effects of Flakka include feelings of euphoria, a heightened sense of awareness, stimulation and energy. There are a growing number of case reports of individuals who have taken drugs containing α -PVP (or other synthetic cathinones) and developed multisystem organ toxicity, loss of consciousness, seizures, hyperthermia, rhabdomyolysis and, in some cases, death.^{1,4-6} Additionally, many individuals exhibit bizarre and dangerous behaviors, including agitation and paranoia.^{1,4-6} In a typical case, a user may report paranoia. For example, they fear being chased by people trying to kill them.

The exact mechanism underlying α -PVP-induced neurotoxicity is unknown.⁵ However, the potent pharmacological effects of α -PVP are thought to be mediated by inhibition of dopamine uptake at the dopamine transporter (DAT), as well as possible stimulation of dopamine release. This causes a stimulatory CNS effect, which is mediated at least in part, by the D1 and D2 receptors.^{5,7} Accordingly, synthetic cathinones have high abuse and addiction potential. This highlights the importance that all physicians, especially those in emergency medicine and professionals who treat individuals with substance use disorders, are aware of synthetic cathinones and their psychoactive effects on users.

It is also important that providers are aware that a routine drug screen panel does not pick up synthetic cathinone use. However, when suspected, analysis of specimens by liquid chromatography/mass spectrometry (LC-MS), can confirm the identity of any and all known synthetic cathinones and other designer drugs, from an ever-growing database. This quantitative testing method can utilize samples from urine, oral fluid or blood. While most commonly a send out lab, recently a rapid screening test was developed to provide analysis in real-time.^{8,9}

Flakka use is already widespread in Europe and parts of the U.S., such as Florida. While not making the same headlines on the West Coast, there is evidence that Flakka and other second-



A SYNTHETIC CATHINONE DRUG, ALPHA-PYRROLIDINOPENTIOPHENONE (ALPHA-PDP), POPULARLY KNOWN AS FLAKKA, IS BEING REPORTED.

to 2014.² α -PVP use may be more widespread than realized because in other parts of the country Flakka is called “gravel” due to its pebble like appearance.

There was some hope that the use of synthetic cathinones (bath salts), including methylenedioxypyrovalerone (MDPV), methylone or mephedrone, would decrease with increasing public reports of agitated delirium and adverse medical

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Starting Your Own Addiction Medicine Private Practice

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- Running a business (insurance, employees, payroll, benefits).
- Coverage and reimbursement.
- Spending time outside schedule on phone calls.
- Administrative work (phone calls, billing, office maintenance, etc.) and marketing.
- Returning calls.
- Prior Authorizations.
- Finding a network of other clinicians.

What was the biggest surprise you encountered?

- The amount of managed care requirements to authorize medications and the amount of medical leave and disability forms.
- Intentional, cruel, abusive, disruptive systemic behaviors by some, from insurance companies and their medical employees, governmental medical and management employees, and even other healthcare professionals.
- Difficulty in getting insurance to pay for treatment.
- How easy my transition was.
- When I give myself enough time to talk to patients and learn about the contributors to their disease I came to understand that addiction (and psychiatry in general) is far less “medical” than it is psychological.
- Even with more time on my hands I still don't like to exercise.
- How quickly people started referring.

What have you outsourced?

- Bookkeeping.
- Accounting, bookkeeping, and administration.
- Benefits, payroll.
- Insurance billing.
- Accounting and legal.

How have you handled your insurance, your retirement, and other such items previously covered by an employer?

- I started my own retirement account and eventually hired a financial consultant.
- Consultation with financial, business, accounting, legal, and real estate experts for physical workplace needs.
- I have a lot of retirement savings and I pay my own insurance.
- I rolled over my 401K to an investment advisor. I have another job which covers health insurance so I'm lucky to not have to worry about it.

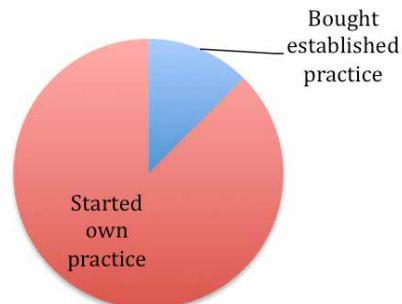
How do you handle electronic health records?

- Free Practice Fusion software, but we're looking at other products.
- Type notes during the session.
- Practice Fusion.
- I don't do electronic records and think they are a huge

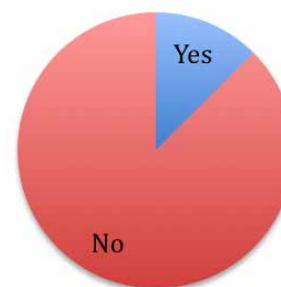
mistake for anyone in the addiction field or in psychiatry.

- I use Ntreatment.com. It's simple but gets the job done.

Did you start your own practice or buy an established practice?



Did you take on a partner?



How do you handle billing/collections and general accounting?

- I rarely send something to collections. My bookkeeper does the accounting and generates statements.
- With staff hired and trained for the private practice business situation.
- I use an in-house billing person along with third party software.
- Credit card machine.
- I use QuickBooks and Square, and handle all my own billing.
- I explain on the phone to patients that I expect payment at the time of the visit. I give them a receipt for their insurance. I accept checks, cash and credit cards.
- Credit card payments go through my EMR. I have an accountant for general accounting.

What type of insurance coverage do you take?

Most of those who replied said that they do not take private insurance and most have also opted out of Medicare and Medi-Cal.

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Top Line Briefing: Public Policy Matters That Affect You and Your Patients

BY RANDOLPH HOLMES, MD, CHAIR, COMMITTEE ON PUBLIC POLICY



RANDOLPH HOLMES, MD

CSAM's Committee on Public Policy hit the ground running in 2016. Presented to the Committee for review were over 40 legislative bills of interest to addiction medicine. Committee members thoroughly reviewed, debated, and recommended positions that were approved in April by CSAM's Executive Council. Topping the list of priorities are

the following measures:

1. **Creating a Physician Health & Wellness Program for California to protect public safety while supporting physicians who themselves are facing challenging health issues.**

SB 1177 (Galgiani), which strives to create such a statewide program, has been a legislative priority of CSAM since the 2007 closure of the former Physician Diversion Program operated by the Medical Board of California (MBC). This new legislation calls for the MBC to contract with an entity that has the capability to carry out the essential functions of such a program as a means to rehabilitate physicians and surgeons dealing with substance abuse, mental health, burnout, or other similar conditions. There have been four previous bills: AB 2346 (Gonzalez, 2014); SB 1483 (Steinberg, 2012); AB 526 (Fuentes, 2009); and AB 214 (Fuentes, 2008).

2. **Raising California's tobacco tax to save lives, reduce health care costs, and fund treatment, research, and prevention.**

Increasing cigarette excise taxes is an evidence-based policy approach to accomplishing the critical public health goals of reducing the number of current and potential smokers. Along with several bills that would raise the smoking age, regulate e-cigarettes and fight youth smoking, CSAM is endorsing the ballot initiative calling for a \$2-per-pack cigarette tax.

3. **Supporting creation of Supervised Injection Facilities (SIFs) to reduce the spread of HIV and Hepatitis C, reduce overdose deaths, and provide cost savings.**

AB 2495 (Eggman) was introduced to allow state or local health departments in California to establish Supervised Injection Facilities (SIFs). CSAM supports this because there is robust scientific evidence that a SIF can increase access to addiction treatment, reduce public injecting and other problem behavior, reduce HIV and Hepatitis C transmission, reduce overdose deaths, and provide cost savings. All this can be accomplished without increasing drug use. With the opioid epidemic ravaging communities across the country, CSAM is providing leadership,



DAVID KAN, MD, CSAM PRESIDENT-ELECT, TESTIFIES IN SUPPORT OF SB 1177 WHICH, IF PASSED BY THE LEGISLATURE AND SIGNED BY THE GOVERNOR, AUTHORIZES A PHYSICIAN HEALTH PROGRAM FOR CALIFORNIA

as it did supporting needle exchange legislation previously. Both are a sound public health approach to reducing the harms of drug use. Similarly, CSAM's goal is to inform about evidence supporting SIFs as it did about needle exchange. Unfortunately, AB2495 will not pass this year, but CSAM plans to continue its support for this public health approach.

4. **Preventing or reducing use of cannabis by youth and mitigating harm to youth from cannabis use.**

With the advent of legislation and proposed ballot initiatives legalizing cannabis that may increase availability of cannabis, an addictive drug, CSAM has presented credible and evidenced-based positions to prevent addiction, prevent harm to vulnerable populations, and promote access to quality treatment. These positions have been outlined in a *CSAM Cannabis Policy Statement* which is available on the CSAM website: www.csam-asam.org (search: marijuana). CSAM has been working to ensure that whatever initiative is presented or eventually adopted takes measures to mitigate public health harms associated with expanded access to and use of cannabis.

5. **Developing policy position on abuse deterrent formulations of controlled substances.**

Prescription opioid analgesics are an important component of pain management. However, abuse and misuse of these products has created a serious and growing public health problem. The committee is closely reviewing and has not yet taken a position on AB 1977 (Wood and Waldron), a bill that would require any individual

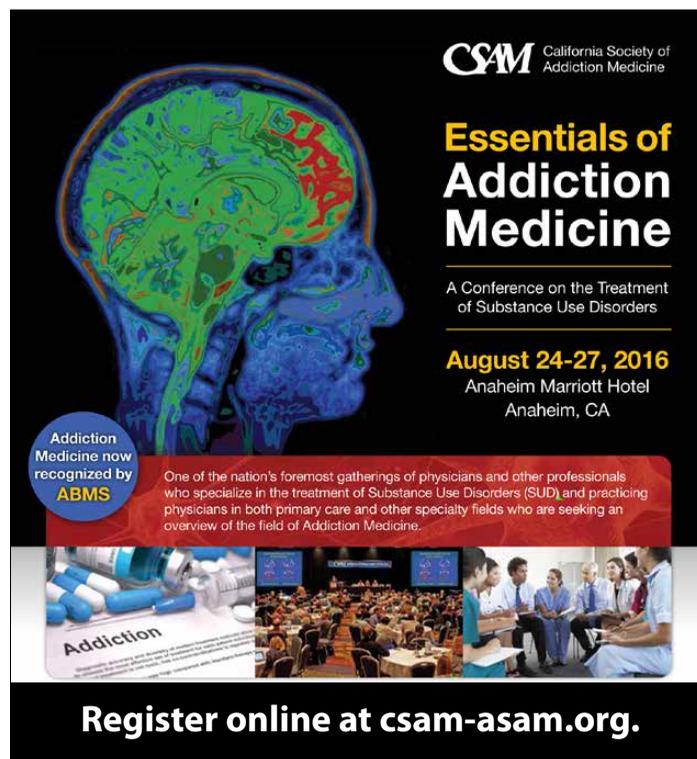
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Essentials of Addiction Medicine

August 24-27, 2016

Anaheim Marriott, Anaheim CA

The CSAM conference this year occurs at a time of both tragedy and triumph in the field of addiction medicine. The prescription drug epidemic has resulted in more than 500,000 overdose deaths, and stems, in no small part, from collective ignorance on the part of the medical profession of how to prevent, detect, and intervene to treat substance use disorders. Cannabis use among young people is on the rise, while cannabis legalization is either being implemented or considered in many states. While we grapple with these major challenges, we also have cause for celebration. After decades of struggle, the American Board of Medical Specialties (ABMS) has at long-last embraced addiction as a bona fide medical specialty, promising increased visibility and prestige to the field, increased access to addiction treatment services, and a board certification that meets the “gold standard” of ABMS.



The poster features a central image of a human head in profile, filled with a colorful, abstract pattern representing the brain. To the right, the text reads: "CSAM California Society of Addiction Medicine", "Essentials of Addiction Medicine", "A Conference on the Treatment of Substance Use Disorders", "August 24-27, 2016", "Anaheim Marriott Hotel", "Anaheim, CA". Below the head image is a red banner with the text: "Addiction Medicine now recognized by ABMS" and "One of the nation's foremost gatherings of physicians and other professionals who specialize in the treatment of Substance Use Disorders (SUD) and practicing physicians in both primary care and other specialty fields who are seeking an overview of the field of Addiction Medicine." At the bottom, there are three small images: a stack of blue and white pills, a large conference room with many people seated at tables, and a group of people in white coats sitting around a table. The bottom of the poster has a black banner with the text: "Register online at csam-asam.org."

CONFERENCE HIGHLIGHTS

- **The View from Indiana: HIV Infection and Injection Drug Use** - *Joan Duwve, MD, MPH*
- **Alcohol - Neurobiology of Addiction**
George Koob, PhD
- **Is Addiction a Brain Disease?**
A Dialogue with George Koob, PhD, Anna Lembke, MD, Kent Dunnington, PhD
- **Opioid Addiction and Treatment** - *Judith Martin, MD*
- **Pain and Addiction** - *Corey Waller, MD, MS*
- **Addiction in Pregnancy** - *Mishka Terplan, MD*
- **Co-occurring Disorders** - *Steven Eickelberg, MD*
- **Addiction in Adolescents** - *Sharon Levy, MD, MPH*
- **Sedative Hypnotics** - *Steven Batki, MD*
- **New Drugs of Abuse** - *Silas Wheelock Smith, MD*
- **Behavioral Addictions** - *Larry Ashley, EdS*
- **Stimulants** - *Larissa Mooney, MD*

PRE-CONFERENCE WORKSHOPS

AUGUST 24

Full Day Workshop

Keys to Physician Wellness: From Burnout to Professional Satisfaction — Personal and Organizational Stories and Solutions

Morning Workshops

- **Legal Marijuana: International Trends, Research, Youth Interventions, Treatment, and Rational Policy Implementation**
- **Battling Bias and Silos: Integrating Addiction Treatment into Primary Care and Other Systems of Care**

Afternoon Workshops

- **Buprenorphine in Office-Based Treatment of Opioid Use Disorders**
- **No Wrong Door: Treating Opioid-Dependent Patients Where You Meet Them**
- **Motivational Interviewing for Busy Clinicians**

Register online at csam-asam.org.

CONFERENCE PLANNING COMMITTEE



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Conference Chair

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Kenneth Saffier, MD

SPECIAL EVENTS

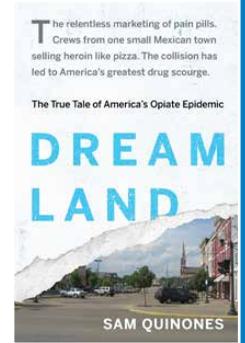
Dessert Reception

Sam Quinones, Author of *Dreamland:*

The True Tale of America's Opiate Epidemic

"With prose direct yet empathic, he interweaves the stories of Mexican entrepreneurs, narcotics agents, and small-town folks whose lives were upended by the deluge of drugs, leaving them shaking their heads, wondering how they could possibly have resisted."

— Mother Jones



Conference Dinner

Unwind and have fun with your colleagues at an al fresco dinner in the beautiful Grand Plaza at the Anaheim Convention Center surrounded by palm trees and alongside the "mountain fountain" leading to a river of lights.

Credit

Up to 26 Units of AMA/PRA Category 1 Credit™ and ABAM MOC Credit™.



Addiction Medicine Recognized as New Medical Subspecialty

Change brings about important changes to certification and recertification

Good news arrived this Spring with the announcement that Addiction Medicine has now been recognized as a new medical subspecialty by the American Board of Medical Specialties (ABMS) under the American Board of Preventive Medicine (ABPM).

Recognition makes it possible for addiction medicine fellowship training programs to seek accreditation by the Accreditation Council on Graduate Medical Education (ACGME) leading to increased access to funding for fellowship training. It also brings other benefits including health network inclusion for addiction medicine specialists and recognition that those who provide expert care meet the "gold standard" in board certification. This new development, as welcome as it is, unfortunately brings with it a delay in announcing the next certification exam date because additional time is needed for ABPM to prepare itself to become the new administering entity.

As a result, the conference curriculum for CSAM's Addiction Medicine Review Course has been modified to



**American Board
of Medical Specialties**

Higher standards. Better care.®

focus more broadly and has been renamed "Essentials of Addiction Medicine" and the Exam Preparation Track typically offered at the Review Course has been postponed pending announcement by ABPM of the next exam date. An online version of the Exam Preparation Track is available on cme.csam-asam.org. Physicians who plan to take the next examination are encouraged to utilize this year's course as one step in their preparation. As decisions related to practice pathway, future certification exams, and maintenance of certification (MOC) are announced by ABMS and ABPM, CSAM will keep its members informed.

More detailed information is available on the websites of ABPM at: www.theabpm.org and American Board of Addiction Medicine (ABAM) at: www.abam.net. ■

CSAM Physicians Making A Difference



MONIKA KOCH, MD

As a clinician practicing Addiction Medicine, CSAM has been a source of inspiration and connection to other physicians for me since I joined in 1998. I have seen it as an organization that supports physicians in a unique way and is also instrumental in fostering the development of Addiction Medicine as an accepted medical specialty, making it possible for our patients to have access to evidence based care and be less stigmatized in society.

How is CSAM effective now and in what direction can we grow in the next two years?

We can gauge CSAM's effectiveness in serving our membership by examining our Society's mission of being dedicated "to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addictions."

Education has been a major pillar of CSAM and its annual conferences attract an ever increasing number of participants, which have at times reached almost 900. Membership surveys show that members value the quality of the conference content as well as the overall conference experience, thanks to the diligence of the conference planners and expertise of CSAM staff. Members also value the track record of preparing participants successfully for the Addiction Medicine Board Exams. The high quality of addiction medicine education offered by CSAM reflects the caliber of addiction medicine physicians who are reliable leaders and spokespeople for the under-treated public health problem of substance use disorders.

Collegiality is often cited as a major attraction to our conferences. This is in part related to the unique aspects of Addiction Medicine: many clinicians work alone or in small groups with collaboration not readily available, so being at a conference with hundreds of like-minded practitioners (if there is such a thing in Addiction Medicine) is a huge networking and learning opportunity. Addiction Medicine clinicians are part of a relatively new and expanding field that crosses many specialties, integrating the bio-psycho-social-spiritual approach in very relevant ways, and fosters thinking beyond the confines of your primary specialty. Our conferences allow for substantive conversations at table-discussions where it is easy to reach out and exchange ideas.

Online resources are abundant for CSAM members and the general public. This includes documents relevant to setting clinical standards of care, such as the *Guideline for Physicians Working in California Opioid Treatment Programs*; summaries of current policy topics through white papers such as the

Youth First report and the recently published *CSAM Cannabis Policy Statement*. In December 2014, CSAM published the *CSAM Consumer Guide and Scorecard*, an online and printed guide to educate consumers shopping for health care plans that include the best addiction treatment coverage. The Affordable Care Act and parity laws for treatment of substance use disorders have improved access significantly, but as the *Scorecard* reveals, the health plans still vary significantly as to which specific substance use treatment services they offer. CSAM members can stay current and informed about issues on policy changes pertaining to Addiction Medicine practice in California through the Newsletter that is provided online and in print and through CSAM's monthly bulletin by email.

CSAM members have an active voice in legislation relevant to our patients. The members of our Committee on Public Policy hold monthly reviews of pending legislation, choosing bills to support or oppose and collaborate with other partner organizations to secure passage of supported bills. A recent achievement was the passage of Assembly Bill 848, which allows physicians and other licensed medical professionals to provide essential medical care to clients who are undergoing detoxification within residential treatment facilities, thus removing a major barrier for access to medical care for patients in residential programs. Our politicians and community at large look to us as medical experts in the field of substance use disorders and are influenced by our activism.

What are some of the challenges in the coming years and how can we continue to represent you effectively?

With Addiction Medicine now formally recognized as a subspecialty of the American Board of Medical Specialties, we will be asked to document that our treatments are effective, similar to our colleagues in other fields. These quality improvement measures will include patient-centered data that can be used by the clinician to monitor practice improvement, as well as data pertaining to the health care systems, such as utilization of emergency services, and public health data, such as reduction of overdose rates or new infection with hepatitis C. In line with these sweeping changes and growing demand for addiction services, CSAM has a new Committee on Integration and Access to Systems of Care, where we plan to draft a white paper on the topic of outcome measurement.

In November 2016, California voters will likely be deciding whether to legalize cannabis. This has obvious implications for our field and CSAM updated its policy on cannabis in 2015. While the outcome is not certain, we need to be prepared for possible legalization of recreational marijuana and effectively advocate for our current and future patients with cannabis use disorders. This will require coordination with other medical

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CSAM Executive Council and Committee Chairs



CSAM EXECUTIVE COUNCIL AND COMMITTEE CHAIRS, JANUARY 31 IN BERKELEY

FROM LEFT: KERRY PARKER, CAE; MARTY WUNCH, MD, RANDOLPH HOLMES, MD; SHARONE ABRAMOWITZ, MD; ANGIE CHEN, MD; KAREN MIOTTO, MD; ANNA LEMBKE, MD; MONIKA KOCH, MD; STEVEN EICKELBERG, MD; JUDITH MARTIN, MD; DAVID KAN, MD; JEAN MARSTERS, MD; ITAI DANOVITCH, MD.

NOT PRESENT: ANTHONY ALBANESE, MD; JEFFERY WILKINS, MD; ROMANA ZVEREVA, MD.

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Monika Koch, MD | koch_monika@hotmail.com
Kaiser Chemical Dependency Recovery Center, Vallejo

PRESIDENT-ELECT (and Chair, Committee on Opioids)

David Kan, MD | david.kan@gmail.com
Private Practice, General, Forensic, and Addiction Psychiatry, Walnut Creek

IMMEDIATE PAST PRESIDENT

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Fondly Remembering Garrett O'Connor



Garrett O'Connor, MD, a much-loved member and leader of CSAM died peacefully in Ireland on September 1, 2015.

Dr. Connor was an internationally renowned psychiatrist and addiction medicine physician. He was Medical Director of Beit T'shuvah Residential Treatment Center. He also served as President at the Betty Ford Institute and Chief Psychiatrist at the Betty

Ford Center for many years. He is remembered for combining scientific rigor and passion with honesty, wit, tenderness, and humor — and he played a mean harmonica.

Dr. O'Connor, with love and compassion, gave everything he could to help those suffering from the disease of addiction, including by sharing his own personal struggles with the disease. He played an important role in advocating for an evidence-based and compassionate policy for physicians in recovery.

He served as CSAM President in 1988 and received CSAM's Vernelle Fox Award in 1998. Within CSAM he was a strong advocate of medical education. He was proud to have organized CSAM's first workshop on spirituality in addiction medicine, and he consistently argued that as we come to a better understanding of the biological roots of addiction we must not lose sight of the psychological and social factors, especially the importance of spirituality in recovery.

In 2011, Dr. O'Connor received a Lifetime Achievement Award from CSAM; on the plaque given him was inscribed:

"To Garrett O'Connor, MD who speaks for the 'invisible people' and inspires us to do the same." ■

CSAM members remember Garrett O'Connor:

A Fond Time Capsule Remembrance:

"It was the 2001 CSAM State of the Art Conference and as a member of the Education Committee, Garrett insisted we battle the then popular NIDA-loving brain-science (the Peter Banys/Lori Karan camp) against the hardcore recovery-focused spiritual science (the Garrett O'Connor/Barry Rosen camp). Through intense negotiations, we debated whether to add a Spirituality workshop to the State of the Art 2001, being careful to frame it so as to pass CME standards. Unfortunately, at the conference, subtle personal tensions emerged as barbs and jabs flew from pew to podium. First 'It's the Brain!' then 'No, it's God!' Brain, God, Brain, God...neither side relenting — until the conference end when Garrett gave Peter a big slurping hug with Barry Rosen standing in amazement, all solemnified

"To Garrett O'Connor, MD who speaks for the 'invisible people' and inspires us to do the same."

— Inscription on CSAM's Lifetime Achievement Award presented to Dr. O'Connor in 2011

by Garrett's harmonica rendition of *Danny Boy*. It was a jaw dropping conference moment. I even recollect mention of love and forgiveness among old friends — which made up for years of fighting over cookies at Gail Jara's dining room table, home to CSAM's Prehistoric Board meetings. Ever since, CSAM has been a loving and hugging organization, all thanks to Garrett!"

— David Pating, MD

Garrett and the Serenity Prayer:

"The first time I met Garrett was in a 12-Step meeting at a CSAM conference. He explained to me that Serenity Prayer originally used 'us' instead of 'me'. He always said 'us' because Alcoholics Anonymous is a mutual-help program not a self-help program.

He was expressive and a little loud. I found him moderately frightening. As I got to know him over time, his passion and caring for those suffering with addiction greatly impressed me.

Now, every time I say the Serenity Prayer, I always say 'us' and think of him."

— Py Driscoll, MD



DR. O'CONNOR RECEIVES LIFETIME ACHIEVEMENT AWARD FROM KAREN MIOTTO, MD

CSAM On-line Education Center Expands

CSAM's Education Center — cme.csam-asam.org — hosts recordings of annual conferences, workshops, and webinars in one easy-to-access location. It contains materials for both addiction medicine specialists as well as primary care physicians. The following materials are now available at cme.csam-asam.org:

SYNAPSE TO SOCIETY: ADDICTION MEDICINE STATE OF THE ART 2015

Full Conference Registration (27 lectures/16.5 CME)

List of individual lectures/modules (can be purchased individually)

PRE-CONFERENCE WORKSHOPS (FROM 2015)

- **From X to Rx: Confronting Real World Obstacles to Buprenorphine Prescribing**
- **Prescription Drug Abuse: From Gabapentin to Buprenorphine and (Almost) Everything in Between**
- **Managing Challenges in the Assessment and Treatment of Cannabis Use Disorders**
- **Spirituality in Recovery: Insights from Non-Christian Perspectives**

ADDICTION MEDICINE REVIEW COURSE 2014

16.5 AMA/PRA Category 1 Credits™

ADDICTION MEDICINE BOARD EXAM PREPARATION TRACK

17 AMA/PRA Category 1 Credits™



WEBINARS

Free for CSAM members. 1 AMA/PRA Category 1 Credits™

- **Clearing the Air: Marijuana's Effect on Health**
Presented by Itai Danovitch, MD
- **Naloxone for Opioid Safety: A Tool for Saving Lives**
Presented by Phillip Coffin, MD and Eliza Wheeler, MA, MS
- **Buprenorphine/Naloxone and Methadone Maintenance Treatment Outcomes for Opioid Analgesic, Heroin and Combined User**
Presented by Jennifer Sharpe Potter, PhD, MPH

Flakka

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generation synthetic cathinones have already arrived in our backyard. One important source of information about emerging drugs of abuse is the data gathered from drug seizures. Analysis by the National Forensic Laboratory Information System (NFLIS) identified 201 seizures of synthetic cathinones by law enforcement in Los Angeles County in 2014. Of the synthetic cathinones seized, almost one in ten was found to be Flakka (α -PVP) [Ethylone (59%), Methylone (31%), α -PVP (8%)].¹⁰

However, there is hope that with China's recent prohibition on the exportation of α -PVP and 115 other chemicals in October 2015, followed by the subsequent decline in Flakka related deaths in Florida, this will mean Flakka will be kept at bay — that is, if we can continue to keep ahead of the constant development of new compounds.¹¹

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Drug Medi-Cal 1115 Demonstration Waiver

As most of you know, in California the *federal* Medicaid Program is administered by the state as Medi-Cal (California Medical Assistance Program). This program provides health care services to welfare recipients, low-income persons¹, and to disabled persons. The federal Centers for Medicare and Medicaid Services (CMS) oversees the program to ensure compliance with federal law, and at the state level the Department of Health Care Services (DHCS) administers the Medi-Cal Program. The DHCS further realigns Medi-Cal to county administrators and directors.

Since 2013, the Substance Use Medi-Cal Services (called Drug Medi-Cal) have also been part of DHCS.²

This past August 2015, DHCS received notice from CMS that California's application for a Drug Medi-Cal 1115 Demonstration Waiver had been approved.

What is this 1115 Waiver? This waiver essentially gives Medi-Cal beneficiaries with substance use disorders a broader range of services, including residential care, medical treatments, case management and recovery support services.³ The continuum of care will be based on the American Society of Addiction Medicine's (ASAM) placement criteria. Other elements of the Waiver include translation services, 24-hour client access line, youth services and tele-health services. The Waiver also emphasizes integration of substance use and mental health services with primary care. This is the closest we have come to parity since the inception of Drug Medi-Cal 35 years ago.

Among CSAM leadership, Judith Martin, MD, David Pating,

MD, and Kerry Parker, CAE were part of the Waiver Advisory Group that helped designed the Waiver, however we now need to continue the work of implementation of this Waiver with other CSAM members who work at the County level and are involved in developing delivery of the Waiver program.

If you are a CSAM member working in the county system and knowledgeable about the 1115 Demonstration Waiver, please email: csam@csam-asam.org.

For more information about the DMC/ODS demonstration waiver, see the DHCS website: <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>. ■

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1. Under the Affordable Care Act (ACA), as of 2014, people with low income qualify for Medicaid, whether or not they have children or are disabled. This is sometimes referred to as Medicaid expansion. As an incentive to the states to create a robust system of care, 'expansion' beneficiaries have higher federal subsidy than 'historic' beneficiaries.
2. (Previously, substance use services in California were managed by a separate state agency called the Department of Alcohol and Drug Programs, or DADP. This organization was dissolved, and its duties shifted to DHCS.)
3. Drug Medi-Cal Organized Delivery System (DMC-ODS) and as described by the California governmental website: "the DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care."

President's Message

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professional organizations to educate legislators about vulnerable populations and prevention as well as guide the funding stream towards treatment along with adequate monitoring of outcomes of legalization and treatment.

As mentioned above, Addiction Medicine physicians often have limited access to collaboration and consultation with colleagues. While our conferences are helpful, they are not occurring frequently enough to meet the varied local needs. CSAM has started a model called CSAM Connect and Consult Groups, where members (and invited guests or future members) meet monthly or bimonthly at a restaurant or member's home to discuss journal articles and/or cases. These activities are eligible for CME via CSAM and can be one of the most salient ways to learn. As most of us know, discussing real cases is how we are most likely to retain knowledge and apply it clinically.

California has not had a physician health program since 2008. CSAM has partnered with California Public Protection and Physician Health (CPPPH) and other organizations to support

legislation to create a new and improved program to support physician health while protecting the public. In the recent years major progress has been made, though we are not where we need to be yet.

Having a large and representative membership is important for Addiction Medicine advocacy in California and nationally. It also provides a basis to recruit members who want to be active in CSAM's committees or other leadership roles. Our Committee on Membership will reach out to members to find out about their needs and concerns in their specific setting and also encourage members to be active in our organization.

I tell my patients to work with their strengths when they come to recovery. For CSAM, our main strength is our network of colleagues, who inspire by their work and enthusiasm for Addiction Medicine, who donate a considerable amount of time and expertise for the cause, and are simply a lot of fun to be around. They make CSAM a great organization, ready to take on the tasks above and more. ■

New Leadership Takes the Helm at California Public Protection and Physician Health



2016 brings many changes to California Public Protection and Physician Health (CPPPH): a new President and Executive Director; new Guidelines are in preparation; and new workshops are being offered. CPPPH's mission remains true to its original vision — to support a healthy physician workforce in the state of California by developing programs that assist those who identify, refer, treat, and monitor physicians with potentially impairing conditions.

Karen Miotto, MD, of the David Geffen School of Medicine at UCLA and Chair of the CSAM Committee on Physician WellBeing, is the incoming Chair of CPPPH's Board of Directors. She will be filling the position previously held by Jim Hay, MD, who remains on the Board.

Barbara Thompson is the new Executive Director, taking over the position previously held by Gail Jara, who remains with CPPPH as Director of Educational Activities. Barbara Thompson served as Executive Director of the National Council on Alcoholism and Drug Dependence in Sacramento and has 30 years experience managing and directing medical and healthcare delivery organizations serving individuals and families with substance use disorder issues and providing resources for physicians, healthcare providers, and the community.

CPPPH will continue providing regional workshops, training sessions, consultations and guidelines that support its mission. Work is underway on a new *Guideline for Behaviors That Undermine A Culture Of Safety* coming out later this year.

A new website has been created at www.cppph.org, making it easier to access the many articles, guidelines, newsletters, policy statements, and sample documents along with other materials. ■

Upcoming CPPPH Regional Workshops

Confidentiality and Reporting Requirements For Wellbeing Committees, Medical Staff and Peer Review Bodies

- **May 7, 2016** – San Diego Region
- **June 25, 2016** – San Francisco Bay Area Region
- **July 23, 2016** – Los Angeles Region

Snapshots of Wellbeing Committees: A Closer Look At the Role of Financial Support (morning session)

Elements of Effective Treatment for Safety Sensitive Workers When They Are Physicians (afternoon session)

- **June 4, 2016** – Los Angeles Region

Upcoming CPPPH Conferences

Effective Functioning of Wellbeing Committees: An Overview

- **October 15, 2016** – Los Angeles
- **October 22, 2016** – San Francisco Bay Area

For information: www.CPPPH.org

A Pre-Conference Workshop at Essentials of Addiction Medicine

Keys to Physician Wellness:

From Burnout to Professional Satisfaction — Personal and Organizational Stories and Solutions

Wednesday, August 24, 2016
8:30 am to 5:00 pm - Anaheim Marriott

Jointly provided by California Public Protection and Physician Health (CPPPH) and the CSAM Committee on Physician Wellbeing.

This workshop is designed for medical staff leaders, the leadership of medical groups, medical staff services professionals and others interested in improving physician wellbeing on an individual and organizational level. Local and national experts will present the latest research on physician mental health, burnout and disruptive behavior.

The program will provide useful and implementable tools, techniques and solutions for physicians, and address system-wide approaches to the challenges of creating a supportive working environment that fosters collegiality and professionalism.

Workshop Planners: **Karen Miotto, MD; Py Driscoll, MD; Gail Jara**

Starting Your Own Addiction Medicine Private Practice

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What type of services are you providing?

- Outpatient psychotherapy, mild detox, buprenorphine.
- Adult, child, adolescent, geriatric, and addiction psychiatric medicine.
- Outpatient treatment, partial hospitalization, intensive outpatient treatment.
- All addictions appropriate to outpatient.
- Consults, professional evaluations, medication management.
- Psychotherapy, medication management, buprenorphine maintenance, detoxification, consultation services for local treatment programs.

- Evaluations, psychotherapy and medication management.
- Psychotherapy, medication management, brief family interventions, buprenorphine, naltrexone (PO/IM).

What is one big thing you've learned that you would give out as advice to someone who is stepping into private practice?

- Stay connected to other practitioners and develop a niche specialty.
- Have fun passionately, good interactional boundaries, and be philosophically humorous.
- Go for it. Being own boss is the best.
- There is a need for comprehensive services.
- Try to stay connected to peers as much as possible because it's easy to become isolated.
- Don't get involved with insurance companies because they are soul-sucking entities.
- For a psychiatric practice pay attention to the quality of furniture. Nobody knows if you are a good therapist but people can recognize good furniture and thusly you provide the perception of value. Rapid responsiveness is critical in patient satisfaction.
- Do not accept referrals if it gets too busy.
- I would take the risk and start a multidisciplinary clinic. ■

Public Policy

continued from page 5

or group health care service plan or any individual or group disability insurance policy to provide coverage on its formulary, drug list, or other lists of similar construct for at least one abuse-deterrent opioid analgesic drug product per opioid analgesic active ingredient. This bill would also prohibit a plan or insurer from requiring an enrollee to initially use a non-abuse-deterrent opioid product before covering the abuse-deterrent opioid product. A common theme of abuse-deterrent opioid products is an attempt to discourage people from altering the medication to snort, inject, smoke or otherwise ingest the product through an unintended route. While this is behavior commonly used by those with a long history of abusing drugs, it is rarely seen among people with pain who are prescribed these medications by their physician. Recent FDA guidance will likely bring about national policy from ASAM on abuse deterrent formulations of controlled substances and CSAM will be following this in determining its position on this legislation.

Please contact me if you have any questions or if you are interested in participating with CSAM on public policy issues. I can be reached at: Randolph.Holmes@pihhealth.org. ■

Editor's Message

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is not dead, yet it is interesting (but not surprising) to note that all who responded to our survey stated they did not accept Medi-Cal or Medicare. Also in this issue is news about a new Medi-Cal Waiver that increases support for substance use disorder treatment for the first time in decades. True parity will be put to the test. Will we have enough providers and resources to meet the demands?

This is an important time to be involved in advocacy and public service within CSAM; with all the legislative bills on the horizon there is much work to be done. CSAM is looking for members who work in county substance use treatment services to help with the delivery of the Drug Medi-Cal Waiver; and, as one of a handful of states still without a physician's health program, it is imperative that we protect patients by advocating for confidential mental health and substance use treatment for physicians.

We hope to see you in Anaheim this August 24-27, 2016 at the Anaheim Marriott Hotel for the Essentials of Addiction Medicine Conference where we welcome you to become involved in CSAM activities. ■

Supervised Injection Sites: —————

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A Public Health Approach

SIFs are a vital part of a comprehensive public health approach to reducing the harms of drug misuse. Local, state and national governments should explore the implementation of legal supervised injection facilities staffed with medical professionals to reduce overdose deaths, increase access to health services and further expand access to safer injection equipment to prevent the transmission of HIV and hepatitis C.

SIFs cannot prevent all risky drug use or related harms. However, evidence demonstrates that they can be remarkably effective and cost-effective at improving the lives of people who inject drugs and the public safety and health of their communities. ■

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AT THE SUPERVISED INJECTION FACILITY IN VANCOUVER, A POSTER DEMONSTRATES HOW TO SAFELY USE A SYRINGE.

Welcome New CSAM Members

- Seth Ammerman, MD - San Francisco
Aimie Apigian, MD, MS, MPH - Redlands
Aleen Avakian, MD - Glendale
Michael Bowen, MD - San Diego
Paul Chung, MD - Fullerton
Esther Currie, MD - Sacramento
Sarah Domb, MD - North Hills
Jared Garrison-Jakel, MD, MPH - Guerneville
Deirdre Habermehl, MD, MBA - Huntington
Standiford Helm, MD - Laguna Woods
Raymond Herr, MD - La Jolla
Emily Hurstak, MD, MPH - San Francisco
Melodie Isgro, MD, - San Diego
Robert Lee, MD - Oakland
L. R. Leiter, MD - Canyon Country
Stuart Markovitz, MD - Rancho Mission Viejo
Steven Mee, MD - Los Alamitos
Neal Mehra, MD, MBA - Carmichael
Rayek Nafiz, MD - Moreno Valley
Seanthang Pham - Newport Coast
Lyn Raible, MD - Oakdale
Pau Scipione, MD - Redding
Kathleen Seaton, MD - Stanford
Ole Snyder, MD - Del Mar
Angela Suen, MD - San Francisco
Jeff Unger, MD, ABFM, FACE - Rancho Cucamonga
Michael Valdez, MD - Redlands



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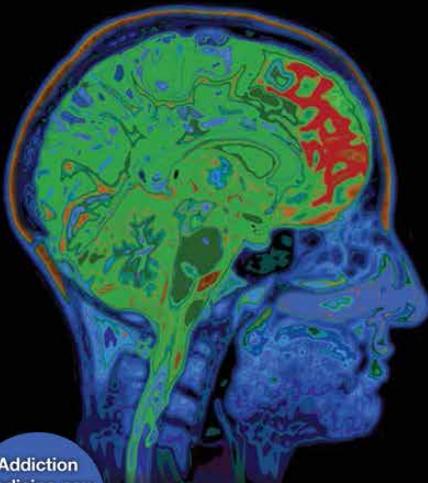
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CSAM California Society of
Addiction Medicine

Essentials of Addiction Medicine

A Conference on the Treatment
of Substance Use Disorders

August 24-27, 2016
Anaheim Marriott Hotel
Anaheim, CA



Addiction
Medicine now
recognized by
ABMS

One of the nation's foremost gatherings of physicians and other professionals who specialize in the treatment of Substance Use Disorders (SUD) and practicing physicians in both primary care and other specialty fields who are seeking an overview of the field of Addiction Medicine.



CONFERENCE HIGHLIGHTS

The View from Indiana: HIV Infection and Injection Drug Use | Joan Duwve, MD, MPH
Alcohol | Neurobiology of Addiction | George Koob, PhD
Is Addiction a Brain Disease? | A Dialogue with George Koob, PhD, Anna Lembke, MD, Kent Dunnington, PhD
Opioid Addiction and Treatment | Judith Martin, MD
Pain and Addiction | Corey Waller, MD, MS

Co-occurring Disorders | Steven Eickelberg, MD
Addiction in Adolescents | Sharon Levy, MD, MPH
Sedative Hypnotics | Steven Batki, MD
Workshops on | Integrating Addiction Treatment into Systems of Care | Legal Marijuana: Trends, Research, Youth Interventions, Treatment, and Policy | Keys to Physician Wellness | Managing the Pain Patient with Opioid Addiction | Motivational Interviewing for the Busy Clinician | Buprenorphine in Office-Based Treatment of Opioid Dependence

August 24-27, 2016 ANAHEIM, CA

CONFERENCE HIGHLIGHTS

- **The View from Indiana: HIV Infection and Injection Drug Use** - *Joan Duwve, MD, MPH*
- **Alcohol - Neurobiology of Addiction** - *George Koob, PhD*
- **Is Addiction a Brain Disease?**
A Dialogue with George Koob, PhD, Anna Lembke, MD, Kent Dunnington, PhD
- **Opioid Addiction and Treatment** - *Judith Martin, MD*
- **Pain and Addiction** - *Corey Waller, MD, MS*
- **Addiction in Pregnancy** - *Mishka Terplan, MD*
- **Co-occurring Disorders** - *Steven Eickelberg, MD*
- **Addiction in Adolescents** - *Sharon Levy, MD, MPH*
- **Sedative Hypnotics** - *Steven Batki, MD*
- **New Drugs of Abuse** - *Silas Wheelock Smith, MD*
- **Behavioral Addictions** - *Larry Ashley, EdS*
- **Stimulants** - *Larissa Mooney, MD*

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