CSAM news
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President's Message

What's Ahead for CSAM in 2018?

David Kan, MD

I am writing this article from Washington fresh from testifying before Congress. This is a reminder that we practice during challenging times. Our federal government has banned the Centers for Disease Control (CDC) from using terms including "evidence-based" and "vulnerable". Our President has proposed a six-billion-dollar budget increase for addressing the opioid epidemic but at the same time stripping funding for the Office of National Drug Control Policy. While $6 billion dollars may seem like a lot of money, HIV/AIDS care receives over $26 billion/year from the federal government. What are we as addiction medicine practitioners to believe?

The answer to our future lies in CSAM's past.

CSAM ratified the Youth First policy in 2011 declaring that cannabis should be regulated and taxed and the money dedicated to protecting those most vulnerable to cannabis-related damage: youth. Recreational cannabis became legal for distribution in California on January 1, 2018. Because of the voices of several CSAM members (Timmen Cermak and Peter Banys, among others), 60% of all tax revenue (estimated at $800 million/year) from recreational cannabis is now reserved for youth school retention, youth substance abuse prevention, and youth addiction treatment. CSAM is now advocating for standards for youth treatment in Sacramento. Annually CSAM is actively engaged in taking positions and advocating on more than 40 pieces of legislation each year through our Public Policy Committee

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Applying Your Addiction Medicine Know-How

By Mario San Bartolome, MD, MBA, MRO, QME, FASAM

Dr. Bartolome

Could there have been a more perfect storm than the opioid monsoon we are experiencing now to help accelerate the development of the addiction medicine specialty? A lump of coal becomes a diamond only under extreme pressure, and the current opioid crisis has provided the metaphorical pressure. The specialty of addiction medicine emerged from multiple specialties with a keen embrace to the biopsychosocial model. It is this comprehensive view, in the face of the chaos that pathologic drug and alcohol use brings to individuals and families, that makes the role of the addiction medicine specialist so critical and so relevant today—and the world is hungry to hear what you have to say. It is this distinct relevance that should draw us all to assemble at the battleground; not only to the trenches, but also to the battle tent where wisdom and strategy intersect and key decisions get made. Many of us feel quite comfortable when we are in front of our patients, and derive a spiritual dividend from our interactions when serving the people and loved ones of those who suffer from substance use

> *"Never before in the history of this country has your knowledge, spirit, and commitment as an addiction medicine professional been so important. It's time to get involved in activities outside of the individual patient care bubble as well. You have a unique skill set and this is a particularly vulnerable time for the country's leadership."*

disorders. The call to action here is to make yourself uncomfortable. Never before in the history of this country has your knowledge, spirit, and commitment as an addiction medicine professional been so important. It's time to get involved in activities outside of the individual patient care bubble as well. You have a unique skill set and this is a particularly vulnerable time for the country's leadership. Have you noticed that many of the policies you read or hear about don't make sense? Could your input change that?

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President's Message

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and other committees.

California legislation allowing pilot Safe Injection Facilities (SIF) or Safe Consumptions Sites (SCS) (AB-186) was co-sponsored by CSAM and almost passed last year, coming two votes short in the Senate. SIF/SCS reduce the risk of accidental overdose, increase the likelihood of entering treatment, and do not increase drug use. San Francisco is moving forward with a Safe Injection Facility as are other cities around the nation. I applaud San Francisco's courage in embracing the evidence against ideology. CSAM will continue to support improving public health in the upcoming legislative year.

CSAM has a track record of leadership in Sacramento. Public health and advocacy is a personal interest of mine. But more than public health, I want my Presidency to be marked by service to you, our members. We have a State of the Art Conference this year in San Francisco with a Addiction Board Exam Preparation workshop included. I encourage you to register, as it will represent the epitome of CSAM – innovation, education, and fellowship. You will get tools to become Board-Certified in Addiction Medicine. The CSAM Board of Directors conducted a member survey in January. Your voices have informed strategic planning for the year ahead.

In this uncertain time, I am certain that CSAM must continue to be the "Voice for Treatment" in California. CSAM members collectively represent a wealth of knowledge in treating addiction with skill and compassion. While we continue serve the legacy and tradition of CSAM as educator, I believe that as an organization we must move out of our comfort zone. We must continue our proud history of taking controversial stances to follow the evidence. ■

Membership Update

Vote to Include Associate Members Passes

By David Kan, MD, CSAM President

More than two years ago, ASAM revised its bylaws to include Associate Members. In our scheduled affiliation agreement renewal with ASAM, CSAM was forced to confront whether to accept Associate Members.

Identifying the process by which this would be decided was a long and complicated process for the CSAM Board. There were mis-steps along the way. Eventually, it became clear that our bylaws required a membership vote.

The Board voted several times to generate a majority opinion to guide the membership on this decision. Each time the Board was split. There were tensions inside of the Board mirroring the membership. Some felt it time Associate Members be allowed, as it reflected the setting in which we practice. There were others who felt that for CSAM such a change would alter the DNA of an association of physicians. Frequently one side couldn't hear the other side. Tempers flared, emails were sent, meetings were held. At times, friendships were strained.

Two Town Hall meetings on the issue were conducted, recorded and posted on the CSAM website with a discussion forum.

There was lobbying. Earlier on, there had been delays in the Board notifying the membership of the issue. Reaching agreement on how to present the issue to members required lengthy processing in sub-committees. Early on there were requests for statements to be sent out by groups of members opposed to Associate Membership. Was there precedent for this? Would this be fair given that the "pro" side was slower to organize?

ASAM declared voting against Associate Membership would be tantamount to disaffiliation from ASAM. Leading up to the vote, you received letters from CSAM members supporting Associate Membership distributed via ASAM's membership platform. You also received letters from CSAM members opposed to accepting Associate Membership. Emotions were heated up to the day of voting in a way that I have never seen within CSAM. This could only be settled one way…

In the end, you voted 101 to 77 in favor of accepting Associate Members into CSAM. More than 50% of our eligible members voted. A call for a re-vote at the Business Meeting occurred when those opposed to Associate Membership brought up due process concerns. The Board was criticized. A vote was held where the majority present at our business meeting were in favor of a re-vote but this motion was invalidated. CSAM's bylaws require proper notice of Business Meeting actions.

Where does this leave me? Many of you know that I was personally against Associate Membership. That was easy. The charge of being President is to honor the formal, noticed vote, the voice of CSAM's members in favor Associate Membership even if the process leading up to the vote was imperfect.

Where does this leave CSAM? This is harder. The Board personally contacted all who voted to solicit feedback and many welcomed the change, some even felt it was overdue. Some welcomed an end to the controversy. Some were concerned about the future of CSAM moving forward. We are, in a way, a house divided as we carry a diversity of opinion into our future. I ask that we now unite on common ground to be the Voice of Treatment as I referenced in my President's message. I and the Board will continue to seek your guidance as we move forward together. ■

The 2018-2019 CSAM Board of Directors

Thanks to all CSAM members who voted in the recent board election. In addition, thank you to Nominating Committee Chairman **Itai Danovitch, MD** for his leadership of the election, and to our elected board members for their service to CSAM. Your 2018-2019 board is as follows:

PRESIDENT
David Kan, MD, DFASAM
Addiction, Forensic, and General Psychiatry, Walnut Creek

PRESIDENT-ELECT
Anthony Albanese, MD, DFASAM
Veterans Affairs of Northern CA Office of Academic Affiliations, Mather

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Kaiser Permanente CDRP, Vallejo

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Randy Holmes, MD, FASAM
PIH Health Physicians, Whittier

CHAIR, COMMITTEE ON EDUCATION
Jean Marsters, MD, FASAM
Psychiatrist at Lifelong Medical Care, Oakland

The CSAM Board of Directors met for the Annual Board Meeting January 19-21 in Layfayette, CA.

CHAIR, COMMITTEE ON INTEGRATION AND ACCESS TO SYSTEMS OF CARE
Sharone Abramowitz, MD, FASAM
Integrative Psychiatry & Addiction Medicine Practice, San Francisco and Oakland; Internal Medicine Residency, Alameda Health System, Oakland

CHAIR, COMMITTEE ON MEMBERSHIP
Martha Wunsch, MD, FAAP, DFASAM
Greater Southern Alameda Area, Kaiser Permanente, Union City

CHAIR, COMMITTEE ON COMMUNICATIONS *(Newsletter Editor)*
Chwen-Yuen Angie Chen, MD, FACP, FASAM
Stanford University School of Medicine, Stanford

AT-LARGE MEMBER
Anna Lembke, MD, FASAM
Stanford University School of Medicine, Stanford
Mason Turner, MD, FASAM
The Permanente Medical Group Inc., Oakland

CSAM Welcomes a New Education Director

Anita Renzetti joined the staff of CSAM in January 2018, following the resignation of Michael Barack who formerly served as Education Manager. Anita is responsible for CSAM's education programs, management of CSAM's CME accreditation, and support of several CSAM committees.

CSAM Committee Updates

FROM THE COMMITTEE ON OPIOIDS

The Committee on Opioids issued a monograph entitled: "Use of Buprenorphine-Naloxone in the Emergency Department" by **David Kan, MD** and **Anna Lembke, MD**. Its key recommendations and conclusions were:

- Buprenorphine use in the ED does not appear to be associated with undue medical complications, such as precipitated withdrawal
- Buprenorphine use in the ED does not appear to promote drug-seeking in the ED where it is administered
- Patients who receive buprenorphine in the ED may be significantly more likely to engage in addiction treatment following ED discharge
- Home induction of buprenorphine initiated in the ED is a viable alternative for patients who are not yet in sufficient opioid withdrawal to be induced in the ED setting
- Patients who receive buprenorphine in the ED should be provided a follow-up appointment with a X-waivered provider. The appointment should be made as soon as possible, ideally within three days, due to statutory limits on ED medication administration.

The monograph is available for download at: **www.csam-asam.org**

FROM THE COMMITTEE ON INTEGRATION AND ACCESS TO SYSTEMS OF CARE (IASC)

CSAM's IASC Committee works to achieve access to patient-centered, evidence-based treatment for all patients at risk for substance use disorders, including a focus on access to treatment for the historically underserved.

The committee issued Standards For Access To Addiction Medicine Services. This represents the work of the "Other Systems of Care" work group (incarcerated settings, certified addiction treatment programs, community-based behavioral health systems). The workgroup is comprised of: **Roderick Shaner, MD**; **Angella Barr, MD**; **Py Driscoll, MD**; **Matthew Goldenberg, DO**; **Brian Hurley, MD, MBA**; **Lori Karan, MD**; **Dagmar Liepa, MD**; **Patricia Ordorica, MD**; **Gary Tsai, MD**; **Sharone Abramowitz, MD**, (*IASC Chair*).

The Standards document is available for download at: **www.csam-asam.org**

CSAM News
Editor: Chwen-Yuen Angie Chen, MD

For information contact CSAM
575 Market Street, Suite 2125
San Francisco, CA 94105
ph: 415-764-4855 | csam@csam-asam.org

FROM THE COMMITTEE ON PHYSICIAN WELL-BEING

CSAM has formed a 22-member task force of experts to address California's SB 1441 Uniform Standards. The Uniform Standards govern all healing arts boards in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program. These standards are being applied to the new Physician Health & Wellness Program (PHWP) now being developed by the Medical Board of CA as the result of CSAM sponsored legislation, SB1177 (Galgiani) that was signed by the Governor in September 2016. Additionally, in September 2017, SB796 (Hill) was signed by the Governor requiring the updating of Uniform Standards #4 pertaining to drug testing. Both the Medical Board and the Department of Consumer Affairs (DCA) have expressed strong interest in receiving recommendations from experts for changes to the Standards. The task force is addressing what is currently known about the science of treating Substance Use Disorders, ensuring that the Standards conform to the practice of evidenced-based medicine, addressing best practices across the country and abroad for the effective operations of a PHWP. The recommendations for changes will be delivered to the Department of Consumer Affairs' (DCA) Substance Abuse Coordination Committee (SACC) in early April 2018. The task force is chaired by **Karen Miotto, MD**. For more information, contact CSAM at: **csam@csam-asam.org**

FROM THE COMMITTEE ON PUBLIC POLICY

The CSAM Committee on Public Policy is responsible for recommending positions on legislation, testifying at hearings, communicating with legislators and policy makers, and representing CSAM on various policy matters. The committee is comprised of 20 members and is chaired by **Randy Holmes, MD**, who also serves as Vice Chair of the ASAM Public Policy Committee. CSAM employs a lobbyist/policy advisor in Sacramento named **Robert Harris** who has served in this capacity for more than 15 years.

There are more than 40 legislative measures CSAM will take positions on this year, and CSAM will provide input to the development of regulations in the following general areas:

- Harm reduction (e.g. Supervised Injection Facilities)
- The opioid crisis
- Drug Counselor licensing
- Access to treatment for Substance Use Disorder / Reimbursement
- CURES database
- Cannabis
- Residential Treatment Facilities

CSAM Implements Grant to Expand Medication-Assisted Treatment in California

CSAM was selected by the California Department of Health Care Services (DHCS) to be part of a statewide collaborative project that includes UCLA Integrated Substance Abuse Programs, to increase access to addiction treatment, reduce unmet treatment need, and reduce opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD). CSAM is providing training, education, and mentoring to primary care providers as part of this two-year $90 million federal grant under the 21st Century Cures Act that is targeting healthcare in counties and tribal communities having the highest rates of opioid-related overdose deaths or where treatment resources are inadequate compared to need. The program is called the "Medication Assisted Treatment (MAT) Expansion Project" and it is focused on populations with limited MAT access including rural areas, American Indian and Native Alaskan tribal communities, and providing access to buprenorphine, a medication used to treat opioid addiction in the privacy of a physician's office. One part of this project was the selection of 19 programs to serve as "hubs" in counties across the state to receive targeted funding, support for providers, training and other needed resources. CSAM is supporting this part of the project modeled after Vermont's "Hub and Spoke" system that dramatically increased access to medication assisted treatment (MAT), reduced stigma, and reduced overdose death rates by increasing access to medications used to treat opioid addiction.

As the result of this funding, CSAM is updating its "Guideline for Physicians Working in California Opioid Treatment Programs" last published in 2008. *The Guideline Update* is to be published by July 31, 2018. **Walter Ling, MD** and **Ernie Vasti, MD** are leading this project as a function of the Committee on Opioids. A host of CSAM members are contributing authors on the update.

Through its sister organization, the Medical Education and Research Foundation (MERF), CSAM received funding to offer 72 Scholarships/Mentored Learning Experiences (MLEs) to take place at the CSAM Annual Conference, August 29 - Sept 1, 2018, in San Francisco at the San Francisco Hilton Union Square. Applications for these opportunities are available via a link on the CSAM website at csam-asam.org. **Ken Saffier, MD**, President of the MERF Board of Directors is leading this effort.

And, finally CSAM will be producing two webinars on Medication Assisted Treatment (MAT) to be offered later this year and in early 2019. In 2017, CSAM sponsored a series of 12 monthly webinars to support the implementation of Medication Assisted Treatment (MAT) of opioid use disorders in primary care. The series of webinars was made possible by a grant from the CA Health Care Foundation (CHCF). These two webinars are an extension of that work and are being lead by **Jean Marsters, MD** Chair of CSAM's Committee on Education.

For more information on this grant, contact CSAM Project Manager Erica Murdock-Waters at: 415-764-4855 or csam.hss@gmail.com ■

Welcome New CSAM Members

Seth Ammerman, MD – *San Francisco*
Huzaifa Ashraf, MD – *Upland*
Alexander Bazazi, PhD – *San Francisco*
Lindsay Boothby, MD – *Sacramento*
Christopher Brown, MD – *Torrance*
Allen Bueno del Bosque, MD – *Salinas*
Chante Buntin, MD – *Santa Cruz*
Debbie Chang, MD – *Fontana*
Alison Clarke, MD – *Salinas*
Stephanie Constantino, MD – *San Diego*
Jerald Cook, MD – *San Diego*
Timothy Dauwalder, DO, HMDC – *Upland*
Yulsi Fernandez Montero, MD – *Santa Monica*
Natassia Gaznick, MD, PhD – *San Diego*
Melody Glenn, MD – *Emeryville*
Zeina Hijazi, MD – *Santa Monica*
Alexander Hu, MD – *Simi Valley*
Manjusha Ilapakurti, MD – *El Centro*
Michael Ingram, MD – *Riverside*
Jason Kellogg, MD – *Irvine*
Patricia Lutfy, MD – *San Diego*
Joseph Mega, MD – *Oakland*
Greer Murphy, MD, PhD – *Stanford*
Andrew Nangalama, MD – *El Dorado Hills*
Aichel Nateras, MD – *San Diego*
Kevin Nowrangi, MD – *Loma Linda*
Ralph Pulverman, MD – *Chino*
Randall Solomon, MD – *San Francisco*
John Van Doren, MD – *Huntington Beach*
Lisa Wilson, MD – *Victorville*

Applying Your Addiction Medicine Know-How

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In our training as healthcare professionals, we are generally exposed to very little information about policy-making processes, law, strategy, systems, management, IT, finance and quality metrics that drive healthcare. Remember your last conversation about insurance companies for a moment. I would venture to bet that if we describe the direction of the conversation or the visceral sentiment of the people you were talking with, words like frustration, anger, feelings of impotence likely dominated. "They always make things worse those 'fill in the blank' with their policies and mandates." I get it. In fact, when I was an undergraduate premed volunteering in the ED, I remember being struck with how much (therapeutic) complaining was happening among the docs—it was the era when managed care was developing. We can argue about the pro's and con's related to the various models of health care delivery until we are blue in the face. At the end of the day it is but a piece of clay and we are all in a big ceramics class called healthcare. I was very impacted by what I saw, particularly the palpable sensation of impotence—the feeling that despite being health care providers at the highest level, we could somehow not count on affecting the system in which we practice to serve our patients. What kind of a bait and switch is that? The complaining itself was not the problem; the problem had to do with the overwhelming feeling of defeat and the lack of our training involving the "other" things that make up our healthcare system. When we are acting as patient advocates, are we as effective in the board room as we are in the clinic? We need to translate the energy used in idle complaint to create positive impact. My experience with CSAM is that there are many welcoming leaders to provide guidance for your energy.

"The 'us' vs 'them' mentality has not served us as professionals, but what has is the progressive expansion of our tools. Our toolbelts are getting more diverse and more effective."

The "us" vs "them" mentality has not served us as professionals, but what has is the progressive expansion of our tools. Our toolbelts are getting more diverse and more effective. It's no longer rare to see a physician who also has a Masters in Business Administration (MBA), Masters in Public Policy (MPP) or Masters in Public Health (MPH). Yet it's worth saying that you don't need an additional degree to make change. Addiction medicine continues to evolve and we see evidence of our impact by state and federal policies that now value the science behind the use of evidence-based medications when indicated to treat disorders related to opioids, tobacco, and alcohol. Yet even with the availability and science behind these interventions, we have seen countless examples of systemic barriers to access in the form of financial and policy barriers. It is HERE that we can add value to the decision-making. Some are comical to us, "…in order to meet criteria for the use of buprenorphine you must first show that you can abstain from opioids…"! Some are in the gray zone, "…in order to meet criteria for the use of buprenorphine, you must provide evidence that the patient is attending regular counseling or therapy." As if it would be a good idea to deny access to buprenorphine to someone who is otherwise stable on the medication but not attending counseling sessions. On the other hand, many of the guidelines we have had a hand in crafting do stress the importance of comprehensive care in addition to agonist therapy. These are a couple of examples where you could appreciate that a pharmacist or non-addiction medicine administrator or healthcare professional could lose sight of how we define addiction and the harm reduction model. This is where your training and real world clinical experience offers a beacon of light that can shine on ineffective policy. Sometimes it's just a matter of communicating the gap between real-life and what is read in a pharmacopeia.

If you choose to work with groups outside of the clinic setting, it is valuable to understand the context and set of tools each group may have at their disposal to impact healthcare—each group has their own. A close and easy example would be CSAM. As an organization of addiction medicine professionals, CSAM has the "street-cred" to weigh in on proposed legislation, to create policy statements, to participate in drafting best practices, to collaborate with other similar organizations and to foster the development of the leaders among us. Of course CSAM does much more and is an exceptional organization. Compare that to a managed care organization (MCO). To many docs, this may conjure up an image of Darth Vader in a dark, smoke-filled room where Mr. Vader is twisting his imaginary moustache and plotting his next move to seize all of the healthcare universe while paying no more than a $1.25 per member per month. Despite historical examples of some sketchy moves from some managed care players, most are trying to do the right thing most of the time. Let's not forget that some physicians get arrested or find themselves in hot water for less than ethical behavior as well; but, the majority are clearly trying to do the right thing. But I digress. An MCO's tools are different than both a trade organization or an individual/group physician practice. An example of a valuable tool brought to the table by MCOs includes a robust information systems (Peter Druker's "If you can't measure it, you can't improve

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Applying Your Addiction Medicine Know-How

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it"). Organizations like Kaiser Permanente have contributed immensely to science and policy by way of leveraging their information systems to analyze outcomes and to create internal studies that would otherwise be difficult to carry out. MCOs also make policy decisions on medication coverage and medical benefits that affect millions. Often times their unique tools of prior authorization and multidisciplinary reviews have a hand in shaping prescriber behavior. Now I know there is not likely to be a single physician out there who "likes" prior authorizations (me included). But it is important to understand how this tool fits in the landscape of our healthcare industry. A concrete example of this involves the opioid crisis. With the mortality rate from opioid related overdoses continuing to climb, some state government agencies have become critical about high dose opioid regimens (for the indication of non-cancer chronic pain and not related to addiction treatment) and other risky regimens like combinations of opioids, benzodiazepines and carisoprodol. As a consequence of this pressure and the overall search for ways to impact the morbidity and mortality related to opioid use, many MCOs are using their information systems to analyze prescriber behavior and to create interventions in line with guidelines such as the CDC guidelines on prescribing opioids for chronic pain. We don't really know with certainty how well these types of intervention will work. Preliminary results have shown a drop in overall numbers of people on high dose regimens and risky combination regimens when these efforts are implemented. I firmly believe that THIS is another important place where your skills are needed as an addiction medicine specialist. There is a fine line between interventions that go too far into the relationship between the prescriber and the patient and it is of tremendous benefit to have the perspective of the addiction medicine physician to advise on such interventions. It's not always easy to balance the need for patient autonomy, the doctor-patient relationship, and the desperate race to intervene in an epidemiologic catastrophe with multiple variables. Advocating for expanded access and minimal barriers to medication-assisted treatment is another important role that an addiction medicine physician may play. History has demonstrated to us that most pharmacists, physicians and other healthcare professional struggle with understanding the role of controversial medications like buprenorphine, and it is important that we be the conduit to educate our colleague in and outside of medicine. The addiction medicine physician is poised to be of great value to clarify and contribute to the various processes involving screening, treatment access, and many other policies that MCOs and other insurance companies may be responsible for creating.

So now that you are charged up to be an agent of change, you simply have to pick the tools that you are most interested in using to get started. If you are of an academic flavor, volunteer to do grand rounds and noon conference for your local residency program—be the addiction medicine champion and tell the story of our wonderful patients to lessen their aversion as they progress in their training. If you are interested in public policy, join the efforts in CSAM or ASAM to review policies, create a position, and ensure that we are sticking to our organizational principles to improve the care of the families and people with substance use disorders. If you can stomach the board room, work with the various insurance companies you contract with to improve policies. You would be surprised at how impactful an involved addiction medicine physician could be to an organization—frankly they are not used to having that expertise readily available. If you are so inclined, become a physician leader working inside of an insurance company or MCO where you are leading the charge to develop sound policy and can be the conscience that balances the view through the lens of a budget with the view through the lens of humanity. If your time is limited but your passion is great, be the addiction medicine physician that testifies at hearings or answers the occasional question for a reporter on issues pertaining to addiction medicine. The possibilities are endless, the number of addiction medicine professionals are limited, and the need continues to grow now more than ever.

"As addiction medicine specialists we have a duty to serve our patients whether in the clinic or in the boardroom, and the addiction medicine professional is in a unique position to help keep policies relevant, effective, and humane."

The opioid crisis thrust addiction medicine to the forefront of discussion. As addiction medicine specialists we have a duty to serve our patients whether in the clinic or in the boardroom, and the addiction medicine professional is in a unique position to help keep policies relevant, effective, and humane. What a privilege it is to be in a position of such potential service. Go get your game on! ■

California Society of Addiction Medicine
575 Market Street, Suite 2125
San Francisco, CA 94105

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For those preparing for the Addiction Medicine Board Exam in October 2018, a full-day exam preparation course will be offered on Wednesday, August 29 alongside a host of other ground-breaking pre-conference workshops. Exam preparation workshop participants receive a web-based self-assessment tool with hundreds of board-style questions and an online study guide.

THE STATE OF THE ART IN ADDICTION MEDICINE

August 29-September 1, 2018
San Francisco, CA

Visit www.csam-asam.org to register today!

CONFERENCE HIGHLIGHTS

Recent updates on bupenorphine ▸ psychoactive medicine or malady? ▸ racialization of the opioid epidemic collaborative care ▸ addiction stigma and open recovery ▸ heroin vaccine to block lethal overdoses ▸ treating addiction in the criminal justice system ▸ opioids ▸ CSAM Trivia ▸ heroin vaccine ▸ ketamine ▸ cannabis ▸ cocaine ▸ nicotine