CSAM news
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THE VOICE FOR TREATMENT
QUARTERLY NEWSLETTER OF THE CALIFORNIA SOCIETY OF ADDICTION MEDICINE

President's Message

How Do We Measure Up?

Itai Danovitch, MD

How do you measure addiction medicine? Not the field as a whole, but individual clinicians. You and I. Do you measure "processes" of care or "outcomes" of care? Do you count the percentage of patients who have a recent drug screen on file? Or, is it the number of patients prescribed buprenorphine or naltrexone? Do you measure the quantity receiving some form of established therapy? Or, the quality of a relationship, the "patient alliance"? Is it a measure of symptom alleviation, function, or satisfaction? And who is best fit to make these measurements — our patients, their payers, our colleagues, or ourselves?

Until relatively recently, measuring processes and outcomes of care was the domain of administrators and researchers. In most cases, clinicians primarily concentrated on practicing above a general standard-of-care, and worried about keeping patients coming back or new referrals coming in. But the emerging focus on measuring care, both processes and outcomes, promises to affect all of us.

If you are practicing in a health system, you are already deep in the trenches — either being held to performance standards or looking to establish them to demonstrate the value of your work. If you have a freestanding out-of-network cash practice, you may not have an employer or payer breathing down your neck, but you will feel the impact as licensing, maintenance of certification, and hospital privileging become progressively tied to performance measures that extend beyond standardized tests.

On the whole, most would agree measuring

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Opioid Refugees: A Diverse Population Continues to Emerge

By Tauheed Zaman, MD and Joan Striebel, MD

Evidence continues to mount that opioid overdose and high risk opioid use behaviors endanger the lives of our patients and the wellbeing of our communities (Jones, 2015). The issue of overdose has reached epidemic proportions in several parts of the country, with Massachusetts, Maryland, and Arizona recently declaring states of emergency in response. As a result, state and federal governments, managed care organizations and local public health agencies have introduced educational outreach initiatives and overdose prevention efforts including restriction on prescribing.

Initiatives on the national level include the FDA's recent support for rescheduling hydrocodone from a Schedule III to II, new labeling for extended release and long-acting opioids (Sept 2013), and the Federation of State Medical Boards' revised Model Policy for the Use of Prescription Opioid Analgesics for Treatment of Chronic Pain (FSMB, 2013). Other measures include educational programs for prescribers such as the FDA's Risk Education and Mitigation Strategies (REMS), SAMHSA's Overdose Prevention Toolkit, the Prescriber's Clinical Support System for Opioid Therapies (PCSS-O) and Boston University's Safe and Competent Opioid Prescribing Education (SCOPE of Pain).

Local initiatives have mirrored the national efforts. These include efforts by Kaiser Permanente in Southern California to drastically reduce prescriptions of Oxycontin and Opana (Hyatt, 2013), and several Veterans Administration Hospitals' attempt to reduce risk related to opioids through implementation of Opioid Safety Initiatives (OSI) (National Pain Management Strategy, 2012).

Prescribers therefore find themselves faced with a host of new initiatives, as well as less obvious influences from the specters of enhanced oversight by the Medical Board and Drug Enforcement Agency (DEA), and Treatment Authorization Requests (TARs). Some practitioners welcome the recent changes of enhancements to public safety, even leveraging them as a potential means to opt out of opioid prescribing that they do not find beneficial for patients or rewarding as providers. Others may see the restrictions as intrusions into provider autonomy or barriers to the adequate care of patients in chronic pain. Indeed, several studies suggest ambivalence among providers about prescribing opioids (Hooten et al, 2011). Regardless of the view taken, the sea change in opioid prescribing practices has contributed to the emergence of a new subgroup of patients: *opioid refugees*.

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Report from the CSAM Task Force on Cannabis Policy

Although not yet written, an initiative to legalize cannabis is highly likely to appear on the 2016 California ballot. The CSAM Executive Council formed a task force to address the following question: In the advent of policy changes that may increase availability of cannabis, an addictive drug, what are credible and evidenced based positions that prevent addiction, prevent harm to vulnerable populations, and promote access to quality treatment? It is not necessary to support an initiative to work toward ensuring that whatever initiative is presented or eventually adopted takes measures to mitigate public health harms associated with expanded access to and use of cannabis.

The Task Force members are: Itai Danovitch, MD (co-chair); Monika Koch, MD (co-chair); Seth Ammerman, MD; Peter Banys, MD; Angella Barr, MD; Timmen Cermak, MD; Ihor Galarnyk, MD; Randolph Holmes, MD; Brian Hurley, MD; Cathy McDonald, MD; Mario San Bartolome, MD.

The Executive Council has approved the Task Force's recommendations for cannabis policy.

The following is an brief summary of the recommendations.

WHEREAS:

1. Cannabis contains potentially addictive substances; regular or heavy cannabis use at an early age may lead to Cannabis Use Disorder (CUD).
2. Current policies in California regarding the use of cannabis have failed to effectively protect California youth from potential medical, social, economic and psychological harm.
3. Current policies in California regarding the use of cannabis have failed to effectively protect Californians with psychotic disorders, or other distinct vulnerabilities, from cannabis related harms.
4. Criminal justice interventions have not been shown to be effective in preventing cannabis related harms.

THEREFORE:

1. CSAM opposes criminal sanctions for use or personal possession of cannabis by adults and youth.

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A Conversation with Peter Banys, MD, MSc

Policy Perspective on Marijuana Legalization

Peter Banys, MD, MSc

Peter Banys, MD is a Clinical Professor of Psychiatry at UCSF and Past-President of the California Society of Addiction Medicine. He co-authored CSAM's "Youth First - Reconstructing Drug Policy, Regulating Marijuana, and Increasing Access to Treatment in California." He is a member of Lt. Gov. Gavin Newsom's Blue Ribbon Commission (BRC) on marijuana reform and regulation and with Timmen Cermak, MD has contributed policy briefings to that work. This interview was done by the American Civil Liberties Union and appears on their website.

What brought you to the issue of marijuana, and the work of the BRC?

I came to the issue in late 2011, when a 2012 ballot initiative to legalize marijuana was in the works. Dr. Timmen Cermak and I were concerned about adolescents, a population we have both treated clinically. We decided to review the relevant research and propose realistic interventions. From that effort came the "Youth First" Report. It reviewed medical issues for adolescents using marijuana, but also covered aspects that weren't strictly medical, like the juvenile justice system, the marijuana industry, and drug education.

The Youth First Report was our starting point for our current Youth Education and Prevention Working Group briefing papers (posted online). We wanted to avoid some of the mistakes that were made with a prior initiative (Prop 36 — Treatment Rather than Incarceration), which, although effective, eventually ran out of money for treatment. We want the public to know that if voters legalize marijuana in 2016, we need to specify useful regulations and sustainable funding for prevention, education, and treatment of adolescents, whom we consider a uniquely vulnerable population.

The Youth First Report highlighted the problems of a juvenile justice emphasis, rather than remediation and treatment, for drug offenses. For minors in California, are there particular problems associated with arrest, prosecution, probation, or incarceration?

The situation in California has improved since 2011 when we made possession of small amounts of marijuana an infraction, rather than a crime; however, we still have inconsistent enforcement of these laws. Marijuana arrests remain low hanging fruit — they're easier and safer for law enforcement than dealing with violent or organized crime. Juvenile marijuana arrests still just about equal arrests for heroin and hard drugs like methamphetamine and cocaine combined. Law enforcement should not prioritize a drug with significantly fewer harms to the user and to society. This is law enforcement

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Update from CPPPH

Needed: 21st Century Physician Health Program

By Karen Miotto, MD, Chair, CSAM Committee on Physician Well-Being

UPDATE:
On July 31, 2015 the Medical Board of California voted to begin discussions with interested parties to work toward creating a Physician Health Program for California. This is a positive development and CSAM, CPPPH and others plan to be involved in the process.

Karen Miotto, MD

There was a time when "physician health" was code for alcohol and drug problems. Not anymore. Maintaining a healthy workforce now entails more than providing intervention, treatment and monitoring for substance use disorders.

Today's practice of medicine is characterized by change. We are no longer working in our grandfathers' hospitals and clinics. Healthcare organizations that did not exist five years ago have ushered in new technology, demands and requirements. Physician health programs must now address stress, burn out, disruptive behavior, and age-related competence. But none of that changes the incidence or prevalence of substance use disorders among our colleagues, which therefore must remain a primary focus.

CSAM and California Public Protection and Physician Health Inc. (CPPPH) are supporting the recently-formed Western States Health Care Professionals Group. This is a group of recovering health care professionals at the doctoral level, who host an annual meeting patterned after International Doctors in AA (IDAA). This meeting provides fellowship and a gathering place for the recovering physician community throughout the region. Their first meeting in March, unanimously described as "inspirational," brought together 50 people for a weekend of both CME activities and AA activities. CPPPH and CSAM are again collaborating with them to offer their second program on February 19-21, 2016 in Redondo Beach, CA. For details go to www.WSHCPG.com

Here is a rundown of other activities of CPPPH. We have all known a physician who worked past his or her prime. CPPPH offers a guideline for *Assessing Late-Career Practitioners: Policies and Procedures for Age-Based Screening*, posted at www.CPPPH.org and freely downloadable. This guideline is getting attention from the AMA, and it was presented at the 2015 annual meeting of the Federation of State Physician Health Programs.

CPPPH's next guideline will be on inappropriate and disruptive behavior. A work group has begun work on a document titled *Behaviors that Undermine a Culture of Safety: Policies and Procedures for Medical Staffs and Medical Groups*. Stay tuned, the first draft will be circulated for review and comment this fall.

If you do evaluations of physicians for substance use disorders or are considering offering this service, you will be interested in the CPPPH project for evaluators. The project is based on the guideline *Evaluating Impairment: Evaluating Health Care Professionals* and includes a workshop and a certificate for those who complete the project. See the CPPPH website www.CPPPH.org for the brochure and registration information for the workshops on November 21 in Oakland and on December 5 in Los Angeles.

CPPPH is expanding its scope of services. Expert consultations are now available to assist individual medical staffs and medical groups as they address the physician health and behavioral issues in the evolving healthcare culture. Consultants with experience and expertise will work with the medical leaders, the medical staff, and well-being committees, helping them to implement or revise the policies and procedures and provide best practice interventions. Fees will depend on the extent of the work performed for each hospital or group.

CPPPH is an organizational member of the Federation of State Physician Health Programs (FSPHP). CSAM hosted a meeting of the Western Region of the FSPHP during the Addiction Medicine Review Course last year and will do the same during the State of the Art course this year. It will bring together the directors of the physician health programs in Washington, Arizona, Texas, Montana and other states.

Please contact Karen Miotto (310) 658-0081 if you are interested in the CSAM Committee on Physician Well-being or CPPPH; also feel free to share your perspective on the pressing issues. For more information about any of these activities, please contact Ashley Burke at the CPPPH office, (415) 764-4899 or CPPPHInc@gmail.com. ▪

What is CPPPH?

California Public Protection and Physician Health Inc. (CPPPH) is an independent, non-profit California public benefit corporation established in 2009 to develop a comprehensive statewide physician health program so that California does not remain one of the few states without such a resource. It is a collaborative effort begun with funds from many medical organizations including specialty societies, county medical societies, as well as the California Medical Association, California Hospital Association and professional liability insurance carriers. It provides consultation, coordination, education and network-building. It promulgates guidelines for physician health service providers, and policies and procedures for physician health committees.

The CSAM Committee on Physician Well-being is a strong supporter of CPPPH and its mission to bring an effective physician health program to all California physicians. You can help by spreading the word in your own communities about what CPPPH is doing.

CSAM Holds Leadership Development Retreat

Front row (from left) Margaret Haglund, Walter Ling, MD; Karen Miotto, MD; Py Driscoll, MD; Sharone Abramowitz, MD; Kelly Clark, MD; Barry Zevin, MD; Carol Rogala, MD; Monika Koch, MD

Back row (from left): Kerry Parker, CAE; Jean Marsters, MD; Sean Koon, MD; Stacie Solt, MD; Claudia Landau, MD; Itai Danovitch, MD; Anna Lembke, MD; Jack McCarthy, MD; Nicola Longmuir, MD; David Kan, MD; Cathy McDonald, MD; Anton Bland, MD; Marty Wunsch, MD; Lee Snook, MD; Dana Harris, MD; Robert Harris

On June 26-28 CSAM held a Leadership Development Retreat at Quail Lodge in Carmel, CA. CSAM offers this retreat every other year. This year twenty-four CSAM members were joined by ASAM President **Jeffrey Goldsmith, MD** and ASAM President-elect **Kelly Clark, MD**, as well as CSAM Executive Director **Kerry Parker, CAE** and CSAM's Public Policy Advisor **Robert Harris**.

The retreat provided a mixture of skills-based training and discussions of relevant topics, with time to have fun, relax, and reflect. The event was by invitation and attendees paid their own way.

A primary focus of this year's retreat was on improving the ability of those present to project confidence and competency whether testifying before a government committee, meeting colleagues, or teaching educational subject matter. Author and lecturer Ed Alter guided participants to hone these skills. As part of this training participants broke up into groups corresponding to CSAM Committees, discussed the challenges and opportunities faced by each and reported on the content of the discussions to the full group.

The following are summaries of the work of CSAM Committees:

Committee on Integration and Access to Systems of Care

Anton Bland, MD reported on the Committee on Integration and Access to Systems of Care, chaired by **Sharone Abramowitz, MD**. This newly formed Committee's goal is to help colleagues in primary care treat their patients with addiction problems "right where they are." With the Affordable Care Act more patients than ever are now able to access primary care services, but the number of providers prepared to meet this demand is insufficient.

There were four challenges identified by the group:

- There are no clear models for future direction.
- There is a need for screening in primary care: if primary care providers (PCPs) do not ask about addiction, their efficacy in helping patients recover cannot be assessed, and addiction medicine specialists cannot help them with treatment if needed.
- There is a need to change the perception of PCPs who may still view addiction as a moralistic issue that needs social support services. PCPs need to be reminded this is a brain disease, just as likely to respond to interventions in a medical setting.
- There is a lack of resources to collect data and assess outcomes.

The group identified opportunities to work with other CSAM Committees on Public Policy and Education

Committee on Physician Well-Being

Py Driscoll, MD reported on the Physician Well-Being Committee, chaired by **Karen Miotto, MD**.

The group discussed the Committee's role:

- To review problems faced by physicians in terms of their health and their well-being;
- To support the newly created group called the Western

CSAM Holds Leadership Development Retreat

States Health Care Professionals Group and to help them organize their annual retreat meeting and conference that is patterned after the meetings of International Doctors in Alcoholics Anonymous (IDAA)

- To serve as a resource for hospital staff and hospital-based well-being committees;
- To develop CSAM position papers on issues related to physician health and well-being;
- To prepare activities such as workshops and demonstration 12-step meetings at CSAM Conferences;
- To liaison with California Public Protection and Physician Health (CPPPH), helping them work out guidelines, review evidence-based treatments, and support them in their activities.

Dr. Driscoll reported that the group identified three areas of focus for the Committee this year:

- Working together with other stakeholders on the goal of reinstatement of a physician health program in California. Forty-seven states have physician health programs, but California does not;
- Helping doctors navigate the stressors of residency;
- Sustaining meaning, purpose and energy amongst addiction medicine and psychiatry physicians.

Committee on Public Policy

Cathy McDonald, MD, reported for the Committee on Public Policy, chaired by **Christy Waters, MD**. Currently the Committee is working on polices related to marijuana legalization to provide funds that would reduce use and provide treatment especially among adolescents. Other current goals include: promoting dedicated taxes from alcohol and tobacco for prevention and treatment, expanding opioid overdose protection, and increasing awareness of the efficacy of Substance Abuse Disorder treatment.

Kelly Clark, MD, President-elect of ASAM, urged the Public Policy Committee to work closely with ASAM's Government Affairs Council to address public policy issues on a national level.

Robert Harris, CSAM's Policy Advisor, commented that CSAM has brought leadership, expertise and commitment to the legislative table, has cultivated legislative relationships, and due to past efforts is in a position to craft cannabis policies with national implications. He stressed the importance of consistency, clarity, unity and persistence in the message.

Committee on Education

Jean Marsters, MD, Chair of the CSAM Education Committee, began her report by noting that education is foundational to the vision and mission of CSAM. Education drives change among providers and policy makers; it improves quality of care and patient outcomes. CSAM's core educational offerings are the biennial Review Course alternating with the State of the Art Conference. Dr. Marsters said that CSAM's highly-rated educational offerings are "interactive, celebrate recovery, do not depend on commercial support, and take on controversial issues." CSAM also provides online course material and helps providers obtain CME and maintenance of certification. CSAM conferences attract new membership and are a major part of CSAM's financial success.

The Committee plans to integrate education into social media, expand online tools and diversity, and maintain the voice of physicians-in-recovery. It will work to align its offerings with ACGME addiction medicine curriculum, mostly ABAM through fellowships.

Dr. Marsters reported on the expansion of a recent initiative, Triple C or CSAM Consult and Connect groups, a model of peer-based education, small groups meeting in a living room or restaurant with CSAM members and nonmembers.

CSAM Committee on Opioids

Margaret Haglund, MD, reported for the Committee on Opioids (former Committee on the Treatment of Opioid Dependence), chaired by **David Kan, MD**. The name change reflects a broadening of scope and philosophy, including addressing issues regarding pain and opioid prescribing. She recently learned the U.S., with 5% of the world's population, uses 80% of the world's prescription drugs.

Dr. Haglund outlined the goals for the Committee that were discussed:

- Addressing opioid use in pregnancy. The safest treatment for both mother and fetus is to be maintained on opioids. Any physician can prescribe a three-day emergency supply of methadone to prevent severe withdrawal.

One goal would be to prepare a specific set of guidelines for treatment of pregnant women on opioids;

- Naloxone is an essential tool to address overdose deaths, but it remains prohibitively expensive. The Committee wants to work with the Public Policy Committee and advocate for naloxone to be accessible to everyone, possibly through government subsidy.
- Access to buprenorphine in California is inadequate. The Opioid Committee is presenting a workshop for people who have an X number but are not using it. ■

Opioid Refugees: A Diverse Population Continues to Emerge

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Opioid Refugees

Opioid refugees are patients who, by virtue of requiring prescriptions of now-unorthodox regimens of opioids for chronic pain, or due to concerning behavior around their medications, have been displaced from their usual relationships with primary care and pain medication providers. In 2013, Dr. Stephen Passik coined the term to describe patients who traveled from other parts of the state of Kentucky to his pain clinic because they could no longer receive their opioid medications in their own city due to changes in Kentucky state law (Passik, 2013). Though the evidence remains anecdotal, opioid refugees are similarly rising to clinical attention nationally. Several questions remain about this group: who are these patients, and how do they present? Which medical and mental health specialties take the lead in treating such patients? How do clinicians balance the need to provide for this group with the need for safety and compliance with regulations? Here, we present a short series of cases designed to illustrate a range of opioid refugees, and to begin a conversation about a reasonable approach to the treatment of these patients.

"Opioid refugees remain vulnerable to fragmented or inadequate care."

CASE 1:

Mr. R is an articulate, 71 year old, retired man living in a small rural community, who was started on opioid therapy 15 years ago for treatment of chronic pain resulting from multiple injuries sustained in a tractor accident. Over the years, his OxyContin dose was titrated to 160 mg TID with an addition oxycodone 5 mg TID as needed for breakthrough pain. He affirms that only these medications and doses have ever been helpful in letting him function. He admits to multiple side effects from chronic opioid therapy including hypogonadism, sleep apnea, and osteoporosis. He was discharged from a pain clinic after CURES report showed that he had obtained lorazepam 1 mg #30 from his sleep specialist, a "violation" of his chronic opioid agreement. He was unaware that this was a "prohibited medication."

On discharge, the pain clinic had referred him to another provider for treatment with buprenorphine. He was inducted onto buprenorphine/naloxone and his dose was titrated to 32 mg daily in divided doses. Soon after titration, however, he developed intolerable headaches secondary to the medication.

Mr. R was referred back to the pain clinic, which, in consultation with addiction psychiatry, referred Mr. R to a Methadone clinic. Given geography and limited local resources. Mr. R was forced to take on a one-hour commute in each direction to a Methadone clinic in a nearby city. While Methadone adequately managed his chronic pain and physical dependence, he continued to experience the ongoing side effects of full opioid agonist treatment, and to face the burden of a lengthy and expensive commute in order to manage his condition.

CASE 2:

Ms. G is a 55 year old employed woman who was referred to chemical dependency treatment by her primary care provider who suspected that she was misusing prescription opioids. On interview, she fulfilled criteria for phencyclidine use disorder in full sustained remission (30 years prior). To treat chronic back pain, Ms. P was prescribed morphine SR 30 mg BID, and hydromorphone 4 mg QID, alongside lorazepam 2 mg at nighttime for sleep. On interview, she described overusing her medication, running out a week prior to refill for the last several months, and obtaining medications from a girlfriend.

After careful consideration, she agreed to enter into outpatient chemical dependency treatment and deposited her medications with the program pharmacist for daily distribution. Despite a conversation with the primary care doctor regarding the patient and entry into treatment, citing the evidence for misuse, the primary care doctor abruptly discontinued all medications except the SR morphine. Seeing this as a betrayal, the patient completely disengaged from treatment.

CASE 3:

Mr. K. is a 37 year old male technology industry employee with a history of chronic, debilitating abdominal pain which developed status post splenectomy following a motor vehicle accident. After several years of treatment with high doses of oral hydromorphone, his use escalated till he began crushing and injecting approximately 200mg of hydromorphone daily. He was eventually found face down in his apartment by a partner, administered Naloxone by EMS, and admitted to the hospital where he was also diagnosed with multiple abscesses from injected drug use.

During his treatment in the hospital, which involved surgical drainage and debridement of his abscesses alongside antibiotic treatments, he continued to require large amounts of IV Dilaudid (up to 110mg daily) for pain management via both a PCA and breakthrough doses administered by a nurse. He frequently entered into loud arguments with staff regarding his pain management. With guidance from his primary team, he attempted several other opioid medications including a fentanyl patch, all of which he found inadequate compared to Dilaudid. He refused to consider Suboxone or Methadone as treatment options, repeatedly stating "I'm not an addict, I'm just trying to control my pain."

Mr. K was eventually discharged home on oral Dilaudid, with his medications placed in a lockbox and plans for dispensation by a visiting nurse in the short term. His PCP agreed to continue working with him on the long term management of his pain while reducing the risk of another overdose.

DISCUSSION:

As evidenced by our examples, opioid refugees hail from a diverse range of circumstances, and each case presents unique challenges for the prescribers in terms of diagnosis and treatment. In particular, many of these patients challenge the traditional definitions of addiction: patients may not exhibit the typical behaviors associated with a Substance Use Disorder until they encounter an abrupt change to, or discontinuation of, their usual opioid regimen. Indeed, patients may insist on their identification as pain patients trying to attain reasonable relief from their symptoms, rather than as "addicts." This begs the question of who manages treatment going forward: primary care physicians, pain specialists, addiction medicine or psychiatry, or some combination of these disciplines? One might argue that given the range of presentations, opioid refugees may not represent a cohesive population but a patchwork of different patients with varying presentations. Therefore, perhaps each case ought to be weighed individually and managed by a different set of clinicians depending on the needs of the patient.

Furthermore, these patients raise issues of scope of practice among clinicians of different specialties. Unsurprisingly, primary care providers frequently find themselves managing a range of complex pain and addiction issues for these patients, which strain provider time and resources. Additionally, the effective management of these patients may require pain providers to prescribe traditionally "psychiatric" treatments, or addiction providers to prescribe medications which treat pain, in ways which stretch the traditional notions of scope of practice. Other challenges in the management of these patients include too few Suboxone prescribers, limited experience prescribing Naloxone to high dose opioid utilizers, and a relative paucity of Methadone clinics or other substance use treatment facilities.

As a result of the combination of diagnostic uncertainty, scope of practice issues, limited resources and increasingly stringent prescribing guidelines, opioid refugees remain vulnerable to fragmented or inadequate care. We are aware that providers faced with these issues take different approaches to their patients and therefore we invite comments from readers to our newsletter about their perspectives on similar cases, so that we may continue the discussion of this emerging issue in future publications. ■

NOTE: The authors are indebted to Brad Shapiro, MD, for his contributions to this article.

AFFILIATIONS: *Dr. Zaman is Medical Director of the Prescription Opioid Safety Team (POST) at the San Francisco VA Medical Center in San Francisco, CA. Dr. Striebel is a staff psychiatrist at the University of California, San Francisco.*

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Executive Council

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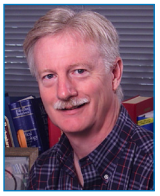
Update Your Clinical Skills at CSAM's Synapse to Society: Addiction Medicine State of the Art

October 21-24, 2015

Hyatt Regency San Francisco Airport

"The speed of change in the field of Addiction Medicine is accelerating. From Healthcare Reform to marijuana legalization and from drug trading on 'the hidden web' to pharmacogenetics, in this year's CSAM State of the Art conference entitled: Synapse to Society, we aim to provide tools to help you navigate this brave new world. The conference planning team has been working hard to bring you the topics most relevant to your practice, as well as topics you may soon find landing on your doorstep." — **Murtuza Ghadiali, MD,** *Conference Chair*

Conference Highlights



How Does Science Inform the Diagnosis, Prevention, and Treatment of Alcoholism?

George Koob, PhD

Dr. Koob is the Director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). As NIAAA Director, Dr. Koob oversees a wide range of alcohol-related research, including genetics, neuroscience, epidemiology, prevention, and treatment. Dr. Koob's work has significantly broadened the understanding of the neurocircuitry associated with the acute reinforcing effects of alcohol and other drugs of abuse, and of the neuroadaptations of the reward and stress neurocircuits that lead to addiction.

Gender Differences in Addiction: Implications for Women's Addiction Treatment

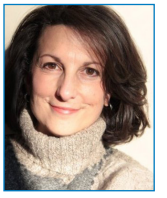
Shelly Greenfield, MD, MPH

Dr. Greenfield is Chief of the Division of Women's Mental Health at McLean Hospital in Boston and Professor of Psychiatry at Harvard Medical School. Dr. Greenfield has played an important role in documenting gender differences in the physiological effects of alcohol. Women initially metabolize only about a quarter as much alcohol in the stomach and intestines as men do. Consequently, more alcohol enters the bloodstream as ethanol. Women's generally lower body mass and lower body water content also act to intensify alcohol's effects. Due at least partly to these physiological differences, the disease of alcohol dependence proceeds on a faster course in women, requiring medical treatment four years sooner, on average, than for male problem drinkers.

The Affordable Care Act One Year Later: Lessons for Addiction Medicine

H. Westley Clark, MD, JD, MPH

Dr. Clark served for 16 years as the Director of the Center for Substance Abuse Treatment (CSAT) tackling important issues such as getting treatment to pregnant and postpartum women, reducing recidivism among individuals in the criminal justice system, and increasing choice of treatment options - including recovery support services - for individuals with substance use disorders.



Not So "Smart" Drugs: Stimulants and Academic Performance

Amelia Arria, PhD

Dr. Arria is currently the Director of the Center on Young Adult Health and Development at the University of Maryland School of Public Health and an Associate Professor with the Department of Behavioral and Community Health.

Pre-Conference Workshops

WEDNESDAY, OCTOBER 21

From X to Rx: Confronting Real World Obstacles to Buprenorphine Prescribing
(see page 13)

Patient-Centered Urine Drug Testing
Urine drug testing (UDT) is playing an increasing role in the management of risk in clinical care. Unfortunately, drug testing can suffer from several shortcomings, especially when called upon to identify problematic use of controlled substances. Still, UDT can be an important part of patient-centered care. This interactive, case-based workshop will explore difficult clinical issues in the identification, treatment, and monitoring of patients while providing objective data for risk evaluation and minimization strategies necessary for responsible clinical care.

Spirituality in Recovery: Insights from Non-Christian Perspectives
What is spirituality? What is the role of spirituality when treating substance use disorders? Can 12-Step programs, which are rooted in Christian beliefs, be relevant to other cultural and religious traditions? This interactive workshop features discussion of three of the many spiritual approaches to recovery: Judaic, Buddhist and Native American.

Prescription Drug Abuse: From Gabapentin to Buprenorphine and (Almost) Everything in Between
A case-based approach to the problem of prescription drug abuse, with a focus on medications not commonly addressed. Also, the workshop will present the latest evidence on tapering patients down and off of benzodiazepines.

Managing Challenges in the Assessment and Treatment of Cannabis Use Disorders
(see page 15)

Motivational Interviewing for Busy Clinicians
This workshop will review and teach motivational interviewing (MI) tools for treating unhealthy alcohol and drug use as well as for promoting behavior change in primary care and other specialties. Emphasis will be on mentored small group learning, clinical skills acquisition and practice. All participants will develop continuing learning plans to increase proficiency.

Other Topics

CHRONIC PAIN AND ADDICTION

Chronic Pain and Addiction: The Compassionate Doctor, the Narcissistic Injury, and the Primitive Defense
Anna Lembke, MD, Director, Stanford Addiction Medicine Program and Chief, Stanford Addiction Medicine Clinic, Stanford University School of Medicine

Bupe in New Places: Perioperative Care and Novel Uses in Pain Treatment
Andrea Rubinstein, MD, Chief, Department of Chronic Pain, Kaiser Permanente Santa Rosa Medical Center

Medical Update: Neurobiology of Pain
Jodie Trafton, PhD, Assistant Professor, Stanford University School of Medicine

CARE Oregon: How a State Addressed Primary Care Opioid Over-Prescribing
Amit Shah, MD, Medical Director, Care Oregon, Portland

INTEGRATING WHOLE HEALTH INTO ADDICTION MEDICINE

Integrative Addiction Medicine: What is it? What is the Evidence?
Sharone Abramowitz, MD, Director, Behavioral and Addiction Medicine, Internal Medicine Residency, Division of Primary Care, Alameda Health System

Neurobiology of Food Addiction
Eric Zorrilla, PhD, Associate Professor, The Scripps Research Institute; Associate Adjunct Professor, Department of Neurosciences, UC San Diego

Physician Resilience: What Have We Learned?
Karen Miotto, MD, Director of UCLA Addiction Medicine Service; Associate Professor, David Geffen School of Medicine, UCLA

Credit

Up to 26 AMA PRA Category 1 Credits™ (19 for the Thursday-Saturday Conference and 7 for the pre-conference workshops on Wednesday). ■

For more information or to register visit to csam-asam.org

CSAM Recognizes Outstanding Leadership & Service

Annually CSAM presents its Vernelle Fox and Community Service Awards. In 2015 these awards will be presented on October 23 as part of the Addiction Medicine State of the Art Conference, at the Hyatt Regency Burlingame, CA.

Karen Miotto, MD
Vernelle Fox Award

Karen Miotto, MD is a Clinical Professor in the Department of Psychiatry and Bio-behavioral Sciences at the UCLA David Geffen School of Medicine and the Director of the UCLA Alcoholism and Addiction Medicine Service. She is the recipient of a career development award from the National Institute on Drug Abuse to study treatment for GHB withdrawal.

She is the chair of the UCLA Medical Staff Health Committee and active in projects promoting physician health and wellbeing. She serves on the board of California Public Protection & Physician Health (CPPPH) and chairs its Quality Improvement Committee and leads the CPPPH Group of Chairs of Physician Health Committees in California's Academic Health Centers. She also serves as Chair of the CSAM Physician Well-Being Committee and is a member of the CSAM Executive Council. She has chaired the State of the Art Conference and has been a frequent contributor to CSAM as speaker and course coordinator.

Welcome New CSAM Members

Aungkhin Aungkhin, MD, *Anaheim*
Aron Bick, MD, *Canoga Park*
Ekram Elzik, MD, *San Clemente*
Michael Farrell, DO, MBA, *Laguna Hills*
Zhila Haghbin , MD, *Yuba City*
Jason Hott, MD, *Daly City*
Meredith Kelly, MD, *Redwood City*
Alok Krishna, MD, *Sacramento*
Harvey Latourette, MD, *Los Angeles*
Jaspreet Mann, MD, *Sacramento*
James Massman, MD, *Fallbrook*
George Rivera, *Pico Rivera*
Shira Shavit, MD, *San Francisco*
James Shaw, MD, *Carmel*
Zamida Tayyib, MD, *Mountain View*
Duraiyah Thangathurai, MD, *Pasadena*

Shannon Smith-Bernardin, PhD
Community Service Award

Shannon Smith-Bernardin, PhD, is Deputy Director for the San Francisco Medical Respite and Sobering Center, a specialized shelter offering a diversion from hospital admission for persons picked up by police, EMTs, or homeless outreach due to alcohol use. The Center provides a cot to sleep it off, round the clock nursing, a chance to launder clothes, a hot meal, and even beginning detoxification in-house pending a bed in residential detox. Since July 2003, the program has provided care for 10,000 individuals for a total of 38,000 encounters. Over 90% of clients were homeless at the time of service. ■

Task Force on Cannabis Policy

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2. CSAM supports access to evidence-based treatment for all individuals who suffer from Cannabis Use Disorder, and a public health approach to prevent or reduce cannabis related harms among at-risk populations, particularly youth, persons with psychotic disorders, and pregnant women.
3. Policy changes that increase access to cannabis should establish adequate regulations to protect the public health.
4. Any policy change that generates tax revenues from use of an addictive substance such as cannabis should also ensure that sufficient tax revenue is committed upfront to fully fund prevention, intervention and treatment programs for vulnerable populations such as youth.

RECOMMENDATIONS:

1. Prevent or reduce use of cannabis by youth and mitigate harm to youth from cannabis use.
2. If cannabis is legalized for adults, a regulatory structure overseeing sales and distribution should be established.
3. Measures to prevent or reduce accidental ingestions and overdoses, particularly among vulnerable populations.
4. The California Department of Public Health should take a prominent role in establishing and overseeing regulations and resources to reduce public health harms related to cannabis use.
5. If cannabis is legalized for adults, provide $10 million in stable funding with annual COLAs to California-based academic and research institutes for public health outcomes research to guide revisions to the law.

The full document with expanded recommendations is online at csam-asam.org.

Newly Formed CSAM Committee to Focus on Integration and Access to Systems of Care


Sharone Abramowitz, MD

Patients with Substance Use Disorders (SUDs) are seen in several types of systems of care. Most often, they are first seen or only seen in primary care or health systems other than specialized addiction treatment settings. This will increase in coming years as the Affordable Care Act allows more patients to access primary care services. However, the number of primary care providers prepared to treat them is still stagnant.

In order to address this need CSAM's Executive Council has formed a new Committee: The Integration and Access to Systems of Care Committee chaired by Sharone Abramowitz, MD. Its focus is on addressing access and integration between primary care, mental health systems, and specialized addiction treatment systems, based on evidence-based treatment and best system practices for patients who have SUDs. Additionally, the Committee will address parity implementation, coverage expansion, and meeting the needs of underserved populations and regions.

For more details on the goals of this committee see the section on CSAM's Leadership Development Retreat. ■

President's Message: How Do We Measure Up?

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outcomes is a good thing. We went into this field to make a difference, to serve, and with our high-achieving personalities we tend to welcome the opportunity to demonstrate how we excel at that. But it's a different story when we factor cost into the equation (with 'value' usually defined as a quality outcome divided by its cost). Furthermore, there can be tradeoffs and unintended distortions implicit in specific measures.

What is clear is that this is a conversation in which it is paramount for us to participate. Either we set our measures, or someone else will set them for us. And setting measures means not just selecting them, but persuading the many stakeholders who touch our work to adopt these measures as well.

This past July, CSAM held its 5th biennial Leadership Development Retreat. This is a weekend-long event attended by thirty or so members who have a demonstrated or expressed interest in being leaders at CSAM and ASAM. The meeting was co-chaired by CSAM President-elect Monika Koch, MD and myself. We were delighted to be joined by ASAM President Jeff Goldsmith, MD and President-elect Kelly Clark, MD. The retreat featured several activities related to the issue of "measurement" in addiction medicine.

There was an open session during which participants wrestled with the question of whether "recovery" is measurable. The consensus that emerged is that while no single measure may encapsulate recovery, a triad of measures addressing symptoms, function, and wellbeing may be suitable.

We also held the inaugural meeting for a newly formed CSAM committee led by Sharone Abramowitz, MD: the Committee on Integration and Access to Systems of Care. This committee plans to influence access to patient-centered, evidence-based, treatment for all patients at risk for Substance Use Disorders (SUDs), including a focus on access to treatment for the historically underserved. The Committee will promote the following:

- Integration of evidence-based addiction treatment with primary care and other systems of care based on best systems practices;
- Adoption of health system performance standards related to SUDs;
- SUD education and training standards for physicians;
- Elimination of barriers that prevent quality addiction treatment for all, including financial, geographic, treatment 'silos', and cultural biases.

As such, a significant component of the Committee's focus is likely to be measurement. Specifically, the committee will advocate for the adoption of patient-centered measures that drive quality of care as opposed to quantity of care. The Committee will assertively weigh in on appropriate performance measures for treating Substance Use Disorder (SUD) in California, rather than simply responding to measures demanded by private or public sector health plans.

"Performance measures" may not be the most alluring topic in the addiction field. It is hard to imagine clambering to find a seat for a lecture entitled "the assessment of processes and outcomes in addiction medicine." But because of rising costs and affordable healthcare, we are forced to evaluate our efficacy and efficiency. This is not a bad thing, but left in the wrong hands it may be an inaccurate appraisal and in fact make practice more onerous. In order to have true meaning and create improvement we have to take performance measures into our own hands. At CSAM, we are strategizing ways to make performance measure meaningful. But we also need our constituents in CSAM to become active and involved. Our imperative is to participate in this process and ensure that the standards that get set, implemented, and adopted, are an accurate reflection of the ethics and personal values for which we chose to go into the field of addiction medicine.

We strongly believe that through this effort, CSAM can impact the practice of addiction medicine and improve patient care in California. ■

A Focus of CSAM's Public Policy Committee

Access to Physician Care at Alcohol and Drug Treatment Facilities

Since 2009, CSAM has been supporting and sponsoring legislation that would allow for alcohol and drug treatment facilities licensed by the Department of Health Care Services (DHCS) to provide onsite incidental medical services. Existing law prohibits any facility that provides 24-hour residential treatment and detoxification services, defined as recovery services, from providing onsite medical services.

Four prior attempts at legislation to fix this fell short of getting to the Governor's desk in order to be signed into law. In 2015, CSAM co-sponsored AB 848 in its latest attempt at legislation to allow for medical services to be provided on premises by a physician or surgeon or other health care practitioner who is knowledgeable about addiction medicine. AB 848, by Assembly Member Mark Stone, was introduced to address the need for patients at residential treatment facilities to have their physical and mental health needs met onsite at these facilities, rather than being transported to a physician's office or health care facility to receive care, which is not only disruptive and dangerous for the patient, but also more costly than onsite care. CSAM is co-sponsoring AB 848 with Elements Behavioral Health/Promises Treatment Centers and Janus of Santa Cruz. Also in support of the bill are the California Narcotic Officers' Association, the County Behavioral Health Directors Association of California, and the San Francisco Department of Public Health. There is no known opposition at this time.

As of Septmeber 3, 2015, AB 848 passed the Floors of the Assembly and Senate. It is anticipated that by the close of this legislative session in September, the bill will make it to the Governor's desk and CSAM members will be alerted by email on the bill's progress. ■

Form a Community Consult Group in Your Area

What is it?

A group of addiction medicine physicians in an area who meet regularly at an informal location to discuss clinical issues collectively.

- Network with your colleagues
- Earn CME Credit
- Keep up to date with your clinical skills
- Share knowledge across specialties and practice settings
- Have fun!

Find out more at http://csam-asam.org/TripleC

Judith Martin, MD

"We have had a CSAM Community group in the East Bay for a few years now, meeting quarterly in my home. We compare notes about our practice protocols, do curbside consults while we load our plates with food — I guess that's called a plate-side consult — and pretty much don't stop talking. Someone brings a case on a pre-set topic, presents it to get help from the group, and then at future meetings we hear how it went, what worked and what didn't. There is a little bit of paperwork for CME, signing in, answering a survey once a year, and generating our topics of interest once a year. After each meeting we circulate a paragraph summary, so everyone including the CSAM staff knows what we did for CME documentation. In our group we always meet at the same place and always on Thursdays. We usually send a journal article or two around before the meeting. Our group is diverse with members coming from a variety of clinical settings; some work in the county public health system, others teach residents, some are psychiatrists and others from primary care backgrounds. This brings richness to the discussion." — **Judith Martin, MD (*East Bay Addiction Medicine Community Consult Group*)**

Introducing CURES 2.0

Currently, CURES provides prescribers and dispensers with vital patient information, including personal information and detailed historical prescription data (e.g. drug names, strength, and quantity) and is an important tool to address drug abuse and diversion.

CURES 2.0 is launching in the next 60 days and will provide faster, more reliable service accommodating all prescribers and dispensers in the State.

Security standards for CURES 2.0 will require Internet Explorer 11 or newer, Firefox, Chrome, or Safari browsers. Earlier Internet Explorer versions are not sufficiently compliant with CURES 2.0 security standards.

CURES 2.0 will continue to run in parallel with CURES 1.0 until December 31 to ensure ongoing clinician access to the prescription drug monitoring data while facilities update their browser capability for CURES 2.0 connectivity.

In addition to increased performance and responsiveness, some of the new functionality of CURES 2.0 will include:

Delegation: Will allow prescriber and dispenser registrants to designate delegates authorized to make Patient Activity Report requests on their behalf.

Compacts: Will allow prescribers to specify patients with whom they have treatment exclusivity compacts/agreements to warn other providers that additional prescribing to these patients can be potentially counter-productive to their existing treatment regimen.

Peer-to-Peer Communication: Will provide the ability for clinicians to launch collaboration seeking personal messages across the encrypted, HIPAA-compliant CURES 2.0 environment to fellow practitioners.

Pro-Active Patient Reports: Will push pro-active patient reports to the prescribers' dashboards on patients whose prescriptions reach thresholds known to be associated with a risk of adverse outcome. Because multiple prescribers can be involved, the pro-active patient report affords the prescriber an important opportunity to evaluate a respective Patient Activity Report and determine whether his/her patient's overall prescription therapy agrees with his/her own medical judgment. ■

CSAM Reports on Minimum Insurance Benefits for Medically-Assisted Treatment of Opioid Dependence

CSAM's Consumer Guide and Scorecard's rating of Covered California health plans on coverage for addiction treatments, published last year, disclosed that not a single health plan offered the minimum health insurance coverage for medically-assisted treatment of opioid dependence.

In most plans physicians were not allowed to choose the appropriate medication, with plans offering either methadone OR buprenorphine. Many plans also required physicians to provide extensive paperwork every month for ongoing treatment.

CSAM's Committee on Opioids will be advocating that ALL insurance plans meet these standards by meeting with insurance regulators and insurance companies. As part of this Committee, members Tauheed Zaman, MD and Joan Striebel, MD, drafted a report that describes the minimum benefits insurance companies should provide to meet standards of evidence-based practice. ■

The report, as well as the *Consumer Guide and Scorecard*, can be accessed on the CSAM website csam-asam.org.

Medi-Cal No Longer Requires Prior Authorization for Buprenorphine

In an important change that began on June 1, 2015, Medi-Cal no longer requires a Treatment Authorization Request (TAR) for most buprenorphine products. This will make it much easier for patients to get prescriptions filled in a timely manner. All that is required is a DEA waiver and a diagnosis of opioid addiction (304.00, ICD 9). There is a maximum of 120 units and a 30-day supply. Zubsolv (manufactured by Orexo) is not included in the new formulary. ■

Workshop at the CSAM State of the Art Conference

Wednesday, October 21

From X to Rx: Confronting Real World Obstacles to Buprenorphine Prescribing

This workshop is designed for ALL advocates of buprenorphine treatment. It will review the challenges of managing patients on buprenorphine in different practice settings, and experts in the field will discuss successfully navigating DEA visits, obtaining reimbursement, managing inductions, performing urine drug testing, and preventing diversion. Participants will be provided with a toolkit which they can begin to use immediately to jumpstart their own buprenorphine practice.

Policy Perspective on Marijuana Legalization

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out of proportion.

In America we've had a war on marijuana for over eighty years, and we lump it in with much more dangerous drugs. For decades, we have demonized marijuana as if it were as dangerous as methamphetamine, cocaine, or heroin. It's not and the voters know it. Continuing this demonization doesn't make any further sense — we should be focusing police enforcement on "hard" drugs. I make a distinction between hard and soft drugs because I think it's a practical necessity. They do this in Europe, but America can't seem to get its head around this concept.

Criminal prosecution of marijuana possession and use has its own harmful effects on young people. An arrest record or conviction can lead to so many problems downstream — it can interfere with federal student loans, they may have to disclose the arrest or conviction on a job application, it can interfere with their ability to maintain custody of their children, and it can affect applications for naturalization.

The criminalization of marijuana is also found in schools that have adopted a zero tolerance policy. Zero tolerance policies were originally developed to deal with violence in schools in the 1990's, but were later co-opted to deal with drugs. Data show that zero tolerance has not made an impact on reducing marijuana use among young people, and the suspensions and expulsions it produces are associated with poor educational outcomes. Zero-tolerance policies as well as random drug testing in schools have been opposed by the American Academy of Pediatrics and the National Institute on Drug Abuse. Student assistance programs, analogous to adult employee assistance programs, are a much more effective model than threat-based or punishment-based models for helping teens who experiment with, use, or abuse drugs.

For minors caught with marijuana, what would an alternative to the juvenile justice system response look like?

Outside of schools, consequences and some forms of leverage are still appropriate for teens caught with marijuana. An infraction system with fix-it tickets for juveniles would be a compassionate and effective consequence. Teens can be required to go to drug education and student assistance program counseling to work off the $100 fine. A system like this would neither criminalize nor pathologize marijuana possession or use by teens — it's not harsh nor overly punitive. It gives authorities some leverage to educate kids on why using marijuana may not be their safest choice and why delaying or reducing use are scientifically sound policies for young brains.

Inside of schools, we should replace the current zero tolerance model with student assistance programs (SAPs). A student assistance program would offer counseling, intervention, and peer and family support. Additionally, we should do away with random drug testing in schools. It's a violation of the privacy and dignity of young adults, and there is no evidence that it works as a deterrent to student drug use.

How do we keep kids from abusing drugs and alcohol? Are there specific education and treatment models that have been shown to be effective for this problem?

In the United States, we've had an all or none approach for too long — we put too much emphasis on "prevention," meaning total abstinence from drugs and alcohol. These just-say-no, scare-them-straight, and DARE-type programs have mostly failed. Data in California show that a huge proportion of kids in high school have personal experience with marijuana and, as an example, 8% of 11th graders in California are already heavy users, using more than 20 days each month. It's just not working. And this is before any legalization initiative.

It's time for a new approach, one that emphasizes delay and reduced usage, and backs up its program with good, science-based education. Student assistance programs can do this. It is problematic for high school students to use marijuana, especially if they are using very frequently. It can have long term effects because it impacts their ability to learn and pay attention in school, and this can have lasting effects on work success. A student assistance program would be able to intervene with heavy users, who are the most likely to be working at a reduced learning capacity. I believe that the risks to education are greater than the risks of addiction.

With regard to marijuana use among adults, are there problems that are associated with more regular (or heavy) use, vs. occasional use? What are the risks with each?

People who wait until they are adults to try marijuana have a very low incidence of developing an addiction to it. In fact, most adults who use marijuana regularly do not meet addiction criteria. On balance, the risks of marijuana to the adult population don't require extraordinary public health efforts, apart from sensible regulatory controls. I don't think we need to put tax revenue into remediating adult use — it's the kids I'm worried about, and who we need to focus our funding on.

It's possible, however, that the increase in potency of refined products will lead to an increase in adult vulnerability. Potency won't go down once marijuana is legal, so we need to be thoughtful about how we regulate marijuana products. The Netherlands is considering a 15% cap on THC content in their brown cafes, and it seems that Colorado and Washington, where recreational use is now legal, are considering similar potency limits.

Policy Perspective on Marijuana Legalization

What do you think is the most important issue that the public and policy makers need to think about before legalizing marijuana in California?

If we decide to legalize marijuana for recreational purposes in California, we need to be very careful and thoughtful about the way we regulate cannabis products. Any initiative put forward to voters should specifically address the problem of marijuana use among young people, how to fund programs for them, and how to leverage them when they break the rules.

This is the time to rethink how we look at drug use among young people and adults and how we reduce harm. We can't double down on the "Just Say No" model - it doesn't work. When about 50% of the population in California has experience with marijuana, we know that the total abstinence message does not work.

We can borrow from the medical meaning of "prevention," which is to take all steps necessary to prevent an undesired diagnosis. This doesn't mean "preventing all use" - it means keeping people safe if and when they use problematically. With young people, we could fund student assistance programs that would counsel and intervene with teens, keeping them safe and in school. We should also fund long-term outcomes studies on the effectiveness of these programs, so that we can evaluate and change them.

Finally, we need to specify very clear parameters for drug use and possession among minors within a scheme where marijuana is legal for adults. What is charged as an infraction, as a misdemeanor, as a felony? What is the penalty for each? Is it commensurate with the harm or potential harm? Can we eliminate misdemeanor charges for juveniles in favor of infractions, fix-it tickets, and education? Moreover, can we anonymize low-level arrest databases so that individual names don't pop up on computerized searches? Questions like this need to be addressed before we decide that legalizing marijuana is a "no-brainer."

In 2010, a marijuana legalization initiative in California failed, in part, because its regulatory controls were widely and correctly understood as insufficient to the task at hand.

In 2016, the voters at the ballot box must ask two questions, not just one. First, do I want to legalize marijuana in California? Second, and equally important, are there regulatory controls, student assistance programs, and long-term outcomes studies effectively designed and stably funded? ■

Cannabis Topics to be Presented at the Addiction Medicine State of the Art Conference

WORKSHOP - WEDNESDAY, OCTOBER 21

MANAGING CHALLENGES IN THE ASSESSMENT AND TREATMENT OF CANNABIS USE DISORDERS

This interactive and case-based workshop will address the diagnosis of cannabis use disorder, implications of co-occurring disorders, evidence-based treatment options and strategies for engaging and treating youth.

PLENARY - FRIDAY, OCTOBER 23

MARIJUANA LEGALIZATION: LESSONS FROM COLORADO

Tista Ghosh, MD, Deputy Chief Medical Officer, Colorado Department of Public Health and Environment

MARIJUANA: NEW FORMULATIONS

Ingeborg Schafhalter-Zoppoth, MD, Internal Medicine, California Pacific Medical Center, San Francisco

MARIJUANA LEGALIZATION: THE VIEW FROM THE E.R.

Kennon Heard, MD, PhD, Associate Professor of Emergency Medicine, University of Colorado School of Medicine

EVIDENCE-BASED USES OF MEDICAL MARIJUANA

Tauheed Zaman, MD, Clinical Fellow, UCSF School of Medicine

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

Addiction Medicine State of the Art 2015

October 21-24, 2015 • Hyatt Regency, San Francisco Airport

Annual Meeting of the Membership
Friday, October 23 at 12:40 pm

CONFERENCE HIGHLIGHTS

How Does Science Inform Alcoholism Treatment | *George Koob, PhD*

Implications of Gender Differences in Addiction | *Shelly Greenfield, MD*

Novel Uses of Buprenorphine in Pain Treatment | *Andrea Rubinstein, MD*

The Affordable Care Act: One Year Later | *H. Westley Clark, MD, JD, MPH*

Marijuana Legalization: Lessons from Colorado | *Tista Ghosh, MD*

Not So 'Smart' Drugs: Stimulants and Academic Performance | *Amelia Arria, PhD*