ASAM NEWS

American Society of Addiction Medicine

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Annual Meeting Washington, April 2-5

ASAM's 23rd annual medical-scientific meeting in Washington, DC, at the Ramada Renaissance Hotel, Techworld, will include 11 symposia, 6 courses, 8 workshops, 15 oral scientific papers, 18 scientific posters, one distinguished scientist lecture, 11 component sessions, an exhibit hall, committee meetings (last year there were 38 as well as two board meetings) and 2 daily onsite AA/mutual help meetings.

ASAM NEWS talked with program chair **Marc Galanter**, MD.

(continued on p. 3)

Inside

ASAM's Response to Managed Care:

FROM THE EXECUTIVE VICE PRESIDENT

An Update

by James F. Callahan, DPA

In future issues of *ASAM NEWS*, I will report on significant activities by ASAM that advance the field of addiction medicine and represent the interests of our members.

Managed care is the subject of this report.

After repeated requests from members for ASAM to respond to the problems created by managed care, ASAM took several significant steps over the past year and a half. The board approved and our office distributed a policy statement on "Managed Care and Addiction Medicine;" it will be published in the ASAM journal, Volume 11, Number 2. The Standards and Economics of Care Committee conducted a survey on members' problems with denial of treatment or with reimbursement. The board recommended that chapter presidents and state chairs notify their members about the model legislation on managed care developed by the Legal Action Center (New York, and Washington).

Patient Placement Criteria

Perhaps ASAM's most far-reaching action was the development of the *ASAM Criteria.* Denial of care, reimbursement refusal, and other problems caused by managed care were frequently the result of the lack of objective criteria on which to demonstrate medical necessity, or to appeal denials. These conditions still exist, but publishing the *ASAM Patient Placement Criteria* was a signal to those who would deny care or reimbursement that ASAM (in collaboration with other interested organizations) intends to establish a process for determining medical necessity, and will promote the adoption of equally objective and publicly available guidelines by third party payers and managed care companies.

Several steps have been taken to publicize the guidelines and promote their use. In March 1991, ASAM and NAATP co-sponsored a conference on the *Criteria* attended by about 175. In November, ASAM sponsored an Invitational Roundtable discussion in Washington, DC. Participants included third party payers, utilization review/managed care organizations, representatives of the corporate self-insured sector, government agencies, and physicians and other clinicians. *(cont. on p. 2)*

ASAM is a specialty society of 3,500 physicians who are concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

AMA NEWS

AMA House Approves Two Policies Introduced by ASAM

Jess Bromley, MD, ASAM delegate to the American Medical Association, attended the AMA House of Delegates Interim Meeting in Las Vegas in early December. Also present: ASAM executive vice president James F. Callahan, DPA. Dr. Bromley reported the following to *ASAM NEWS:*

Screening Trauma Patients

Last June, Dr. Bromley introduced a trauma resolution prepared by **Peter Rostenberg**, MD, co-chair of the ASAM Trauma Committee, to the AMA Board of Trustees. (See May-June *ASAM NEWS*, p. 4) The AMA House has approved it.

• The AMA encourages hospital medical staffs to promote the performance of blood alcohol concentration (BAC) tests and urine drug screens on hospitalized trauma patients.

• The AMA urges physicians responsible for the care of hospitalized trauma patients to implement appropriate evaluation and treatment when there is a positive BAC, other positive drug screen result, or other source of suspicion of a potential substance misuse disorder.

• The AMA encourages relevant physician organizations to develop practice parameters to assist physicians in the diagnosis and management of substance misuse disorders.

"While the recommendations are now AMA policy and will begin to influence trauma center practice, the development of a standard of care in collaboration with the AMA and other specialty societies will further regularize this process in all trauma centers across the nation," said Dr. Bromley.

Minimum Benefits Include Detox

The AMA now endorses the position that coverage for detoxification be included in any minimum health insurance benefits package. Last June, the AMA House had excluded detox in its Health Access America package for underinsured and uninsured. Dr. Bromley was deeply involved in effecting this change. And, due to efforts by **Sheila B. Blume**, MD, the New York Delegation introduced this resolution in Las Vegas. The American Psychiatric Association also spoke in favor. Dr. Blume had argued that excluding detoxification was not based on medical or scientific grounds, but rather on stigma: the attitude that alcoholics and addicts are not quite as worthy as other sick people. Potential negative repercussions, according to Dr. Blume, would have included: setting detox exclusion as the standard for health insurers; sending a message that detox is not part of the mainstream of acute medical care; deterring hospitals from establishing, or maintaining present, detox services; admitting alcoholics to hospitals under alternative diagnoses, which lessens opportunities for adequate follow-up care; represents a giant step backward in the effort to aid persons suffering from addictive disorders.

Methadone Treatment

New guidelines and regulations for methadone maintenance and treatment:

• The AMA supports the development of new methadone treatment guidelines and regulations with a shift of emphasis from administrative process to performance-based standards of care, with greater reliance on the physician's clinical judgment and scientific data in determining treatment.

• The AMA encourages the appropriate governmental agencies to provide the needed resources to allow the development of realistic methadone treatment outcome standards with provisions to allow for differences among methadone maintenance treatment program patient populations.

"This is a major policy position in ASAM's efforts to introduce the treatment of addictions into mainstream medicine, and 'remedicalize' all aspects of treatment for addictions," Dr. Bromley told *ASAM NEWS*. "The resolution was prepared by **J. Thomas Payte**, MD, chair of the Methadone Treatment Committee, and supports the efforts of **Vincent P. Dole**, MD, to 'medicalize' the methadone treatment of narcotic addicts."

Update

Proposed AMA national campaign against family violence now includes appropriate information detailing the important role of substance abuse, as does the report of the Council on Scientific Affairs on violence against women.

HIV Testing: existing AMA policy is expanded; recommend that physicians be able to test without explicit consent of hospitalized patients, and patients suspected of having HIV infection.

AMA budget priorities through 1994: AIDS and sexually transmitted diseases; alcohol and other drug abuse, especially tobacco; health and special populations with emphasis on women and minorities; family violence.

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New CPT Codes

by **Christine L. Kasser**, MD

As you probably know, timely implementation of the new Medicare Payment Schedule (MPS) requires important revisions to the AMA's Current Procedural Terminology (CPT). Key among the important revisions are changes to the CPT codes for evaluation and management services (i.e. visit codes). There is an entirely new section of CPT 1992 entitled "Evaluation and Management Services" which includes new codes and descriptors.

Key components of the new codes include the following:

• The incorporation of a "time factor."

• Usage of five levels of service in the office and hospital settings.

• More precise definitions of key terms.

• Separate and more precise descriptors for each class of service.

• Direct incorporation of the nature and complexity of patients' problems as a key element in the visit descriptors.

Hospitals, state medical societies, etc. should be providing training on how to use the new evaluation and management codes. Some specialty specific clinical examples are being developed, which should include a couple of examples for addiction medicine, which may be used to bill for addiction medicine services.

Further CPT questions or issues? Phone me (901) 227-4357, or FAX: 901-227-4087.

Dr. Kasser of Memphis is ASAM Representative to the AMA-CPT Advisory Committee

COMMITTEE UPDATE

Program Committee Plans Annual Medical-Scientific Meeting

Washington In April

Mission of ASAM's Program Committee: "To organize the scientific program for the annual medical-scientific conference and to collaborate with the executive committee on meeting arrangements."

ASAM's Annual Medical-Scientific Conference is not designed to replace the Review Course for ASAM certification exam candidates, but it does presuppose a level of knowledge and expertise with the field of addiction medicine. "However, people come who have never been to a previous addiction medicine conference, and we want to give them a sense of what the field is like, so it's a very diverse program," said psychiatrist **Marc Galanter**, MD, of New York City, who has chaired the Program Committee for about eight years.

Dr. Galanter told *ASAM NEWS* that "a typical conference registrant would be an ASAM member, in practice for some years, who is interested in the most recent information on scientific and therapeutic developments in the field. He or she has come to at least one or two annual conferences in the last four or five years, and we don't want to repeat what they've heard before."

ASAM members frequently ask how the contents of the program are chosen. "Any ASAM member is *welcome* to submit a research paper or workshop or course. Based on an objective scoring system, those that score highest are accepted and will be on the program," said Dr. Galanter.

A scientific paper will be presented in either an oral or a poster format. This year, 42 such abstracts were submitted; 15 were accepted for oral presentation, and 18 for poster sessions. Abstracts will be in ASAM's *Journal of Addictive Diseases*.

Twenty-three courses and workshops were submitted; 14 were accepted.

"The plenary sessions (symposia) are invited. We carefully select people who are known in the field for what they do, based on our assessment, and not just because someone might like to offer something," said Dr. Galanter.

Also invited was the second annual "distinguished scientist lecture," Avram Goldstein, MD, Addiction Research Professor, Emeritus, at Stanford University, whose awards include the Franklin Medal, the Nathan B. Eddy Award, the Sollmann Award, and the Pacesetter Award for Research (NIDA).

Dr. Galanter has organized one of the symposia, "Research on AA and Spirituality," which will "offer addiction specialists an introduction to current research on AA, how the Program achieves its effects, on whom these effects are wrought, and how it fits into the context of clinical care ... Presentations will be made by clinical researchers who have studied the interface between the experience of alcoholic people and the objective study of AA. Opportunity for discussion with the audience will be provided." Dr. Galanter told *ASAM NEWS*, "We hope this will enhance the clinician's capacity to work effectively in sending patients to AA. And provide information to those who do not have the acquaintance they should with AA, so they can view the fellowship as a more important part of any medical regimen for recovery."

How are Program Committee members (currently 24) chosen? "They're selected, and then approved by the ASAM Board, based on very active involvement in research and developing clinical programs," said Dr. Galanter. "Current members have had considerable research experience and academic work. Four or five people go off the committee each year."

Component workshops, which tell ASAM members what each committee is doing and what important information each believes is emerging in its area, are a recent development at this annual conference. Dr. Galanter and his committee hope they will foster a closer working relationship between ASAM committees and ASAM members." The eleven component workshops this year will be: Fellowship Committee, Section on Family Medicine, Section on Standards and Economics or Care, Section on Internal Medicine, Medical Review Officer Committee, Section on Pediatrics, Medical Care in Recovery Committee, Section on Psychiatry, The Family and Generational Issues Committee, Sub-Committee on Pain and Addictive Disease, AIDS Committee.

In addition, there will be a half-day workshop on AIDS.

Eleven years ago, fewer than 40 attended the annual one-day Special Course for Physicians., directed by **Maxwell N. Weisman**, MD. Renamed the Ruth Fox Course for Physicians in 1982, it now draws a crowd of at least 350. Directed again this year by **Lynn Hankes**, MD, and **Charles Whitfield**, MD, Dr. Hankes told *ASAM NEWS* that the presentations will offer "practical pearls of wisdom enabling immediate clinical implementation to assist in every day management of the CD patient, with broad-based appeal to all MD's." Two firsts this year: alcoholism and the surgical patient, and coping with the managed care monster from three perspectives. Dr. Galanter and his committee are not involved with the Ruth Fox Course. "It's operated separately with its own traditions for many years, and I feel my role has been to protect it from being disrupted," he told *ASAM NEWS*.

Dr. Galanter urged readers to register early for the conference, as capacity in some courses and workshops is reached quickly.

Dates: April 2-5, 1991
City: Washington, DC
Hotel: Ramada Renaissance Hotel, Techworld
More information: ASAM, 5225 Wisconsin Avenue NW, Suite 409, Washington, DC 20015
☎ (202) 244-8948. FAX: 202-537-7252
Conference Director: Virginia Watson Roberts
Program Coordinator: Louisa Macpherson

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REGIONAL MEETINGS

The First Georgia ASAM/aaPaa Joint Scientific Meeting

by **Paul H. Earley**, MD

Thirty-three Georgia physicians gathered on St. Simons Island, Oct. 4-6, 1991, for the first-ever joint ASAM/aaPaa (American Academy of Psychiatrists in Alcoholism & Addictions) Scientific Conference.

The conference served three purposes: 1) We realized that we share the common goal of treating the patient who is afflicted with addictive disease. In the spirit of education, physicians from both organizations learned together. 2) Members of aaPaa and of ASAM viewed their somewhat divergent political goals. Although no joint resolution came from this meeting, there was a spirit of cooperation, and at times, of hope. 3) Some bridges were built between our two organizations. During the business meeting, we resolved to have a member of Georgia ASAM visit all Georgia aaPaa meetings. And, a Georgia aaPaa member will be a non-voting member at all Georgia ASAM meetings. We have a shared purpose: the care we give our patients should not be destroyed by ignorance or politics.

Al J. Mooney, MD, who brought two physicians from Moscow on fellowships, described the history of addiction treatment, the interplay between the politics of medicine and addiction, and the profound wisdom about alcoholism of early physicians such as Benjamin Rush, MD. Prohibition signaled the start of a social and political drive to control addiction, which removed addiction treatment from medicine. Al then described the founding of AA and how the fellowship has dramatically shaped the treatment of addiction.

Thomas W. Hester, MD, said that with increasing pressures on interdiction rather than treatment, on managed care rather than patient-oriented care, addiction treatment is truly at a crossroads. He underlined industry's return to an emphasis on illegal drugs, while at the same time it tacitly condones alcohol and prescription drug dependence. Tom pointed out that physicians who are in addiction medicine need to define their involvement in addiction treatment and to develop leadership in the science of recovery. He challenged us to engage in political activities to further the cause of addiction. In the past, we have avoided documenting the quality of care and treatment outcome; he believes that we no longer have that luxury.

Anne Marie Riether, MD, next discussed the goals and direction of aaPaa. She pointed out that aaPaa's primary goal is education, a large portion of which is aimed at the American Psychiatric Association. There has been a dramatic increase in the number of fellowships in addictive disease in psychiatric residences in the United States; however, despite the increase in addiction education, the number of psychiatric residents who enter these programs does not match the slots allocated. aaPaa publishes a good new research journal *The American Journal on Addictions*. Anne Marie discussed the need for aaPaa to address the interface between addictive disease and psychiatric illnesses. The dual diagnosis patient is of prime concern to aaPaa. Who else is better suited to define the body of knowledge in dual diagnosis?

Your correspondent (**Paul H. Earley**, MD) challenged the audience to continue financial support of ASAM. The focus of my talk was on the issue of specialty status, at the center of controversy between psychiatrists in aaPaa and some ASAM members. Many in ASAM favor the development of a conjoint board (modified) for recognition of addiction medicine as a distinct specialty in medicine. Many psychiatrists would prefer an addiction certificate of added qualification (CAQ) in psychiatry. Some psychiatrists see addiction medicine as a subdivision of psychiatric care. Other specialties have various positions on the development of an addiction CAQ versus specialty status. The direction within ASAM appears to be the development of a conjoint board (modified) for a multidisciplinary addiction medicine specialty. *[See ASAM NEWS Nov.-Dec. issue, p. 1--Ed.]* I challenged the ASAM/aaPaa group at this conference to consider carefully the future of addiction medicine and to develop a unified front against the declining medical attention being paid to the importance of addictive disease.

The second day focused on treating addiction in special populations. **Tommie M. Richardson**, MD, pointed out ethnic and sociocultural issues that complicate treating addicted African-Americans. **Elizabeth F. Howell**, MD, chapter president, described the issues that arise from changing physiology and social position which often make treating addicted geriatric patients problematic. **Martha A. Morrison**, MD, said that societal pressures on women today make them challenges for recovery from addiction. Finally **Barry N. Jones**, MD, discussed the treatment of dual diagnosis patients.

Next year's annual meeting will again be in early October, date and place to be announced.

Paul H. Earley, MD, is immediate past president of Georgia ASAM and editor of the Georgia ASAM newsletter. He is director of Adult Addiction Medicine at Ridgeview Institute in Smyrna, GA. He has recently authored "The Cocaine Recovery Book" and a companion workbook titled "The Cocaine Recovery Workbook."

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CSAM State-of-the-Art Course

The west coast edition of the 1991 State-of-the-Art Course in Addiction Medicine drew 210 participants to San Diego Nov. 21-23. The conference focused heavily on research -- genetics and markers, promising new drugs, medications for treatment of nicotine dependence -- as well as on clinical topics such as cocaine-induced panic disorders, pregnancy and drug use, and assessing cognitive impairment.

Enoch Gordis, MD, reviewed recent advances in basic and clinical research from his vantage point as director of NIAAA, the federal institute that funds a great deal of the alcoholism research. He mentioned a tantalizing finding: the effects of self-administered alcohol in rats are different from those of experimenter-administered alcohol. A study showed that a rat which drinks ethanol freely over several weeks shows a reduction in threshold for electrical brain self-stimulation. Yet a "yoked" animal (a rat given alcohol by the experimenter

at the same time and in the same dose as that chosen by the freely-drinking animal) fails to show this effect. One hypotheses is that the freely-drinking animal imbibes in response to an internal signal not visible to the experimenter, while the yoked rat gets alcohol 'out of sync' with its own internal signals. Dr. Gordis said, "To understand what is going on here would undoubtedly be a profound insight."

Paul Berger, MD, who moved recently from NIMH Research Scientist to a position with the San Francisco VA Medical Center, reviewed new drugs under consideration which address cocaine craving. He said that, in his opinion, desipramine and imipramine will be shown to be mildly useful.

Kevin Olden, MD, reviewed liver disease as it appears clinically in chemically dependent patients, and emphasized the need for specific diagnostic studies. Dr. Olden said we now understand that addicts can suffer from a wide spectrum of liver disease: Wilson's disease, hemochromatosis, and hepatitis C infection can each mimic "alcoholic" liver disease. "Only by using the precise lab studies, sometimes coupled with liver biopsy, can the definitive diagnosis be made," he said.

Lynn Yonekura, MD, chief of obstetrics at Harbor General Hospital in Los Angeles, said that inpatient detoxification is recommended for pregnant women addicted to alcohol, barbiturates, and/or benzodiazepines. "Generalized seizures must be avoided," she said, "since they may precipitate fetal bradycardia. Moreover, withdrawal symptoms may provoke preterm labor and/or fetal distress."

Michael Gitlin, MD, Director of the Affective Disorders Program at UCLA, said that contrary to myth, he finds that bipolar patients use/abuse psychoactive drugs far more when manic than when depressed. "Many bipolar patients even decrease their alcohol intake when depressed," he said.

In a pre-conference workshop on managed care and addiction medicine, Peter Sterman, PhD, of Preferred Health Care, and William Goldman, MD, of Behavioral Health, discussed the role and the purpose of managed care companies. They said that, in the long run, the quality of patient care should be improved at the same time that costs are reduced, because managed care companies would identify and pay for effective care. Dr. Sterman said that payers and managed care companies will move toward "purchasing outcomes. There is the expectation that the treatment program bears some responsibility for the patient's progress." He said payers will want to purchase a full package of treatment, such as a one-year treatment program with a guarantee for readmission to higher levels of intensity if needed. "Clearly, the facility willing to embrace this crystal ball will have a competitive advantage."

The 217-page course syllabus, which includes materials from each of the 23 speakers, is available for $25 from the CSAM office at 3803 Broadway, Oakland, CA 94611.

Using a computer and printer set up in the registration area, a substance abuse librarian and information specialist, Andrea Mitchell, showed registrants how they can do literature searches from home computers.

Peter Banys, MD, was conference moderator and chair of the planning committee, which also included **William Brostoff**, MD, **Nicola Longmuir**, MD, **Richard Sandor**, MD, and **Karen Sees**, DO.

This State-of-the-Art Course was organized by the California Society of Addiction Medicine, in conjunction with CSAM's 19th Annual Meeting. Kevin Olden, MD, was installed as new president, taking over from **P. Joseph Frawley**, MD. Richard Sandor, MD, is new president-elect, William Brostoff, MD, new secretary-treasurer, and **Timmen Cermak**, MD, is now on the Executive Council ... *[Gail B.Jara]*

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Region III (Northeast) Annual Meeting

by **Hal Rosenblatt,** MD

About three dozen physicians gathered in Cambridge, MA, on Nov. 23 for Region III's annual meeting. Six physicians presented on topics in timely areas.

Peter Rostenberg, MD, talked about how trauma, the leading cause of death attributable to alcohol and other drug use, is the most important contributing factor to injuries seen in hospitalized trauma patients. These injuries represent both an enormous public health problem and an opportunity to provide appropriate medical care -- unfortunately, basically ignored. *(See report on the AMA on p. 2--Ed.]*

Alan A. Wartenberg, MD, discussed the patient's response to an HIV test result, and how it can affect his or her ability to benefit from, and to complete, a CD recovery program.

Alan Graham, MD, ASAM Region III director and our representative to the ASAM Board, gave an update on ASAM activities. **Michael R. Liepman,** MD, described the Co-Morbidities of Alcoholism, and reviewed patient characteristics in a research model among family practice residents. The presentation by **David Mee-Lee**, MD, was "Patient Placement Criteria, How, When, Where, and Why." He is chair of ASAM's Standards and Economics of Care Section.

Raymond Maciewics, MD, described the appropriate use of narcotics in chronic pain patients, clearly a high-risk group for addiction medicine specialists. He reviewed the definition of chronic pain, modalities that can be used in treating this group, and outcome data.

Next year's Region III meeting will be held in Connecticut, coordinated by Dr. Rostenberg.

Harold R. Rosenblatt, MD, is director of the Alcohol and Chemical Dependency Rehabilitation Program at Spaulding Rehabilitation Hospital in Boston.

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In Memoriam

William Bormes, MD, 65, of Aberdeen, SD, died Dec. 7 in Minneapolis as the result of a car crash near Aberdeen on Nov. 29. According to the *Aberdeen American News*, Dr. Bormes was a surgeon, and he was medical director of a local chemical dependency unit since its opening in 1958. He was certified by ASAM in 1990.

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*Names in **boldface** are first mentions of ASAM members.*

New Members

Joined ASAM Since Feb. 1991

Alabama

Dennis C. Chipman, MD - *Psychiatry*
Kishin M. Gehi, MD - *Family Practice*
Harrison M. Goodall, MD - *ADM*
Lloyd A. Manchiles, MD - *Anesthes.*
Carl W. Martens, MD - *Fam. Prac.*
Florinio S. Samson, MD - *Psychiatry*
Howard M. Sanford, Jr, MD - *Fam Prac.*

Arkansas

Brian H. Hardin, MD - *Pediatrics*
Judson H. Hout, MD - *Fam. Prac.*
Patrick J. Savage, MD - *Internal Med.*

Arizona

Karen A. Benner, MD - *Fam. Prac.*
Susan L. Brallier, DO
David P. Epphehimer, MD - *Int. Med.*
Mitchell E. Gibson, MD - *Psych.*
Eileen J. Lourie, MD - *Public Health*
William T. Meshier, MD - *Anesthes.*
D. Leonard Minisee, MD - *Int. Med.*
Roger L. Osterholtz, MD - *Int. Med.*
Theodore J. Radomski, MD - *Psych.*
Bruce A. Roberts, MD - *Fam. Prac.*
Houshang Semino, MD - *Psych.*

California

William M. Barnard, MD - *Psych.*
Eugene F. Bartlett, MD - *Gen. Surg'y*
Barbara Bennett, MD - *Gen'l Prac.*
Alan L. Berkowitz, MD - *Psych.*
Donald E. Branson, MD - *Gen'l Prac.*
Stephan J. Brown, MD - *Psych.*
Duane E. Carmalt, MD - *Int. Med.*
Thomas M. Cliff, MD - *Psych.*
Straehley J. Clifford III, MD - *Fam Prac*
Mark Colon - *Student*
Lawrence A. Denny, MD - *Psych.*
Anthony J. Errichetti, MD - *Psych.*
Isaac B. Freeman, MD - *Fam. Pract.*
Raymond C. Herold, MD - *Psych.*
Michael J. Horne, MD - *Psych.*
Maxine B. Ingham, MD - *Gen'l Prev. Med.*
Martin H. Karasch, MD -
Steven B. Karch, MD - *Emerg. Med.*
Howard G. Kornfeld, MD - *Emerg. Med.*
Edmund H. Lew, MD - *Fam. Prac.*
Susan McCau, MD - *Gen'l Prev. Med.*
Henry G. Moeller, MD - *Psych.*
Michael T. Mumford, MD - *Int. Med.*
Danielle Onstot - *Student*
Crescenzo Pisano, MD - *Int. Med.*
Jerry N. Rand, MD - *Gen. Prac.*
Roanald T. Silverstein, MD - *Psych.*
Mark A. Souza, MD - *Int. Med.*
Frank E. Staggers Jr., MD - *ADM*
Randell Stenson, MD - *Psych.*
Maureen Strohm, MD - *Faml Prac.*
G. D. Strother, MD - *Fam. Prac.*
Mercedita T. Timtiman, MD - *Gen'l Prac.*
Douglas E. Tucker, MD - *Psych.*
Peter A. WisseLink, MD - *Fam. Prac.*

Colorado

George E. Kalousek, MD - *Psych.*
Carol E. Trant, MD - *Psych.*

Connecticut

Edward S. Breakrell, MD - *A/C Pathology*
Lawrence A. Kilga, MD - *Anesthes.*
Edgardo D. Lorenzo, MD - *Psych.*
John G. Martina, MD - *Int. Med.*

DC (Washington)

Marc Hertzman, MD -*Psych.*
Chike Onyejekwe, MD - *Int. Med.*

Florida

Christina B. Ballester, MD - *Child Psych*
Kutty K. Chandran, MD - *Int. Med.*
Michael A. Cromer, MD - *Fam. Prac.*
Thomas A. Dennison, MD - *Psych.*
John E. Doyle III, MD - *Psych.*
Amy R. Fendrich, MD - *Int. Med.*
Louis B. Fowler, MD - *Fam. Prac.*
M. Calanthe Hamer, MD - *Fam. Prac.*
Speros G. Hampilos, DO
James S. Harding, MD - *Anesthes.*
Martin T. Harland, DO -*Fam. Prac.*
Richard W. Keesal, MD - *ADM*
Theodore E. Lefton, MD - *Fam. Prac.*
James G. Leker, MD - *Gen'l Surgery*
William A. McDonald, MD - *Psych.*
Albert M. Menduni, MD - *Int. Med.*
Kenneth C. Miller, MD - *Int. Med.*
Roger J. Miller, MD - *Fam. Prac.*
Louis J. Perrillo, MD - *Psych.*
William S. Rea, MD - *Psych.*
Richard B. Seely, MD - *Psych.*
Marc H. Sencer, MD - *Psych.*

Georgia

Robert A. Blackwood, MD - *Psych.*
William E. Coleman, MD - *Psych.*
Albert V. Dixon, MD - *Psych.*
Dean U. Harrell, MD - *Psych.*
John T. Hopkins, MD, MPH - *Psych.*
Craig G. Johnson, MD - *Psych.*
Barry N. Jones, MD - *Psych.*
Patrick T. Malone, MD - *Psych.*
James E. Massman, MD - *Radiology*
James E. McClendon, MD - *Psych.*
James C. Peden, MD - *Int. Med.*
Christopher S. Randolph, MD - *Psych.*
MaryAnne H. Schlosser, MD - *Fellow*
Cassandra L. Wanzo, MD - *Psych.*
Marlene J. Zetar, MD - *Psych.*

Hawaii

John McClure, MD - *Psych.*

Illinois

John J. Ambre, MD, PhD - *Int. Med.*
Charles W. Clemens III, MD - *Fam. Prac.*
Charles P. Connor, MD - *Psych.*
Timothy M. Cullinane, MD - *Psych.*
James C. Daniels, MD - *Neurology*
Robert S. Easton Jr, MD - *ADM*
Paul K. Feldman, MD - *Fam. Prac.*
Kathleen L. Geary, MD - *Psych.*
Suhail E. Ghattas, MD - *Psych.*
Frederick Horrath, MD
Paul S. Killion, MD - *Psych.*
Thomas E. Kirts, MD - *Psych.*
Carolyn S. Kraus, MD - *Fam. Prac.*
George L. Lagorio, MD - *Fam. Prac.*
Michael P. Notorangelo, DO - *Psych.*
Kathleen E. Pearson, DO - *Fam. Prac.*
Andrew B. Pundy, MD - *Psych.*
Robert G. Slack, MD - *Psych.*
Robert S. Small, MD - *Anesthes.*
Paul M. Stromberg, MD - *Int. Med.*
Mary S. Wenzel, MD - *Int. Med.*

Indiana

Gregory P. Barclay, MD - *Psych.*
Paul L. Hannah, MD - *Child Psych.*
Rod S. Kubley, MD - *Fam. Prac.*
Gerald P. Myers, MD - *Fam. Prac.*
K. J. Shaffer, MD - *Neurology*
Thomas L. Shumann, MD - *Fam. Prac.*

Iowa

Timothy L. Fischer, DO - *Fam. Prac.*

Kansas

Patricia N. Harper, MD - *Psych.*
Haydn M. Thomas, MD - *Psych.*

Kentucky

Braford C. Roberg, MD
Sheila L. Roberts, MD - *Psych.*
Barbara H. Smith, MD - *Psych.*
Vilma C. Witten, MD - *Fam. Prac.*

Massachusetts

Yousuf J. Allalawala, MD - *Psych.*
James B. Broadhurst, MD - *Fam. Prac.*
William Caruso, MD - *Int. Med.*
James M. Ellison, MD - *Psych.*
Joseph F. Gerstein, MD - *Int. Med.*
Paul Griffel, MD - *Int. Med.*
Inna Lamport, MD - *ADM*
Michael D. McGee, MD - *Psych.*
Debora M. Moran, MD - *Psych.*
Melvin B. Nemkov, MD - *Int. Med.*
Nancy C. Nitenson, MD - *Psych.*
Michael A. Taylor, MD - *Int. Med.*

Maryland

Hoover Adger Jr., MD, MPH - *Pediatr.*
Charles Beattie, MD - *Anesthes.*
Gacen F. Brooks, MD - *Int. Med.*
B. Rodrigs Cabanilla - *Fellow*
Carmen S. Freitas, MD - *DND*
Christopher S. Holland, MD - Occ. Med.
Robert W. Lange, MD - *Int. Med.*
Kofi E. Shaw-Taylor, MD - *Urology*
John D. Stafford, MD - *Gen'l Prev. Med.*
John T. Turski III, DO - *Fam. Prac.*

Maine

Steven A. Sokol, MD - *Int. Med.*
Joseph H. Walsh, DO - *Gen'l Prac.*

Michigan

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CONFERENCE DIGEST

How an AA Trustee Educates CD Physicians

"If you're going to adequately manage your patients, you have to know what goes on in an AA Program," declared psychiatrist **John N. Chappel**, MD, of the University of Nevada School of Medicine. He is a Class A (nonalcoholic) trustee for the General Service Board of Alcoholics Anonymous, and talked about "What the Health Professional Needs to Know About the 12 Steps" at SECAD-91, the Southeastern Conference on Alcohol and Drug Abuse, December 5 in Atlanta.

"Close to three-quarters of people who start in AA at the beginning of the year are not around at the end of that year," a statistic that has not changed since the late 1970s and is "of great concern to the General Service Board of AA." Dr. Chappel believes that all physicians who work with alcoholic patients must be as knowledgeable as possible about the fellowship in order to help turn this attrition rate around. He recommends the following education process, based on several years of experience with medical students in their clinical training.[1]

For Physicians

• Call the local AA office [the number is in the telephone book] and ask to talk to someone on the CPC committee [CPC stands for Cooperation with the Professional Community]. CPC members help health professionals become more knowledgeable about AA.

• Identify yourself as a physician who wants to learn more about the 12-Step programs. Ask for an AA recovery guide who will act as an instructor for you, preferably somebody who has completed working the 12 Steps and has an active recovery program. A recovery guide should also be willing to share his or her recovery with you.

• Meet at least four times with your recovery guide. The first encounter should include an AA meeting, and your guide's story. Go over the schedule of local meetings to select others that meet your interests or needs. These may include Al-Anon, Alateen, NA, or other 12-Step meetings. Plan to attend at least four. You may also have other special interests such as cocaine, marijuana, or heroin addiction; overdoses; prison experiences, etc. Your recovery guide can help you to meet recovering people with experience in those areas. Discuss all these experiences with your recovery guide during at least three more meetings.

For Recovery Guides

At the University of Nevada School of Medicine, Dr. Chappel suggests the following to AA recovery guides who work with physicians:

• Keep information basic and simple. Don't assume the physician to be knowledgeable about alcoholism, or even to know what questions to ask.

• Recommend that the physician visit the local AA central office. Suggest one or two basic AA brochures or brief sections of books -- *do not* recommend reading all of the 'Big Book' or the '12 and 12.'

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AA Trustee *(continued from p. 9)*

• Describe the common problems people have working a 12-Step recovery program. Be willing to discuss personal experiences or those of others, while preserving anonymity. Encourage questions. Describe behaviors that the physician can recognize in patients, both actively using and recovering.

• Introduce the physician to other recovering people whose experiences might interest him or her. The goal is for the physician to be comfortable with 12-Step programs and recovering people. This, in turn, will help him or her to aid alcoholic and other addicted patients to recover.

"I prefer teaching medical students through required time rather than elective time," Dr. Chappel concluded. "I have a set of questions about AA that our students have to pass to get out of their clerkship in psychiatry, or they don't get an MD."

[1]Adapted from a chapter by Dr. Chappel in *Comprehensive Handbook of Drug and Alcohol Addiction*, **Norman S. Miller**, MD, editor; Marcel Dekker, Inc., 1991, p. 1087.

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Hospital Interventions Conference

by **Allan Graham**, MD

Fifty-four participants from six countries and 14 states brought a rich variety of expertise and viewpoints to this international workshop on brief interventions for alcoholism and problem drinking. The disciplines included physicians, psychologists, nurses, alcohol counselors, and administrators; their respective nations: Australia, Brazil, Canada, Scotland, Sweden, and the United States. The Oct. 17-20 conference in the mountains of Stowe, Vermont, had financial assistance from three private treatment programs, the NIAAA, and the State of Vermont, and offered CME's through ASAM.

A dozen half-hour keynote lectures provided the conference data base. Prominent investigators Tom F. Babor, PhD, Jonathan Chick, MD, Martha Sanchez-Craig, PhD, Harvey A. Skinner, PhD, and George E. Vaillant, MD, shared their work. Clinically focused talks were given by Michele Seefeld, RN, CD, and Sheila M. Dunne, MS, RN, and by ASAM physicians **Martin C. Doot**, MD, **Valery W. Yandow**, MD, and your correspondent. Half the conference time was spent in five task groups; each presented at the closing session.

After **William D. Clark**, MD, and **Theodore V. Parran, Jr.**, MD, helped us brainstorm topics of interest and areas of concern, we chose task groups of individual interest. The products of these groups, which we shared in written, visual, and theatrical formats, dealt with: change within hospital institutional systems; layers of adaptation affecting women's recoveries; emergency department interventions; dealing with denial; and brief interventions in primary care. I personally learned that patience, acceptance, and persistence are important allies in bringing about institutional change.

A big "thank you" to ASAM for helping us with mailing lists, CME sponsorship, and being an organization dedicated to educating physicians and other professionals in addiction medicine. We plan to repeat the conference in two years.

Dr. Graham, of St. Johnsbury, Vermont, is Region III representative to the ASAM Board.

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*Names in **boldface** are first mentions of ASAM members.*

ASAM's Response to Managed Care:

FROM THE EXECUTIVE VICE PRESIDENT

(continued from p. 1)

The Roundtable's first goal was to generate comments on the *ASAM Criteria* and on ASAM's plans to implement and evaluate them. The second goal was to initiate a dialogue on the desirability and steps necessary to develop national guidelines that could be used by all concerned.

The 36 participants were from organizations and interest groups which have heretofore rarely met. They held surprisingly candid discussions on such issues as admission, continued stay, and discharge criteria; definitions of medical necessity; the public/private interface; and payment and cost. While not all participants were prepared to accept or to endorse the *ASAM Criteria*, there was praise for ASAM publishing the work, and acknowledgement that a desirable goal is to develop one national set of criteria that could be accepted by employers, purchasers, and providers of treatment. Barriers to developing a national consensus document were identified. Strategies were discussed to move all "stakeholders" toward a criteria development process that is inclusive, research-based, and field data-based.

ASAM now plans to follow two lines of action to promote the *ASAM Criteria* and continue discussion about a single national set of criteria. First, we will continue to promote the implementation and systematic evaluation of the *ASAM Criteria*. A conference on implementing the *Criteria* will be held in San Diego January 22-25. Several U.S. government agencies (National Institute on Drug Abuse, Office of Treatment Improvement, Department of Veterans Affairs) have expressed interest in using the *ASAM Criteria* in national treatment programs, or in other studies. We are considering a research protocol to study the *Criteria*, and seek foundation support to underwrite this research and evaluation. Our goal is to have the *Criteria* used as widely, and in as many different settings (both public and private), as possible, so that the data gathered will provide useful information for future editions.

The second line of action is to continue the Washington Roundtable dialogue on the development of a single national set of criteria. There was general agreement at the Washington meeting that national consensus guidelines should be the basis for appropriate patient assessment, serve as a guide to resource planning and management, simplify treatment planning, define the research agenda, facilitate reimbursement, and serve as a basis for patient tracking, procedural coding, and outcome determination. A second invitational Roundtable meeting will be held in mid-1992.

The ASAM members who developed the "Managed Care and Addiction Medicine" public policy statement (Drs. **David Mee-Lee, Sheila B. Blume,** and the members of the Public Policy Committee) and the members who contributed to the *ASAM Patient Placement Criteria* or who worked on previous documents from which the *Criteria* drew (Drs. **P. Joseph Frawley, James A. Halikas**, David Mee-Lee, **Martha A. Morrison, Daniel A. Nauts, Peter D. Rogers,** and **Jeremy A. Stowell**) deserve the recognition and thanks of all their ASAM colleagues. Also, Drs. **Christine L. Kasser** (Chair, Standards of Care Committee) and **Michael M.Miller** (Chair, Reimbursement Committee) deserve recognition for co-chairing the January 1992 conference in San Diego, and for participating in promoting the *Criteria's* implementation and evaluation. Finally, the ASAM Board of Directors deserves the members' recognition for taking such clear and decisive action on the issue of managed care. ASAM has received compliments from all sides for the work we have done in this area.

One advantage of ASAM's headquarters being in Washington is expeditious communication with federal agencies, other national medical specialty societies, and national CD organizations. We will continue to promote your interests with these groups in the managed care and other areas, and report to you in later articles on any significant happenings.

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Errata in Membership Dues Mailing

The annual cost for ASAM members to subscribe to *Alcoholism & Drug Abuse Weekly* is $266, not $78 as listed. The publisher, Manisses, will contact anyone who sent a check for $78 ... *[JmS]*

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BOOK EXCERPT

Guidelines for Facilities Treating Chemically Dependent Patients at Risk for AIDS or Infected by HIV

Prepared by the American Society of Addiction Medicine, Revised April 1991, Published November 1991.

This 34-page booklet was revised by ASAM's 13-member AIDS and Chemical Dependency Committee, chaired at the time by ***Larry Siegel, MD****. Current chair* ***Mel Pohl, MD****, suggested that ASAM NEWS excerpt the following material.*

Purpose

ASAM prepared the guidelines to help staff members working in chemical dependency treatment programs to respond effectively, safely, and humanely to the needs of patients who have AIDS, HIV-infection (regardless of whether they are experiencing symptoms), or are at high risk for HIV-infection. ASAM believes it is vitally important for members of the chemical dependency treatment community to respond in this manner because:

- It is medically imperative for people at risk for or already diagnosed with AIDS to stop using chemicals that can affect the immune system and impair judgment (such as alcohol, nicotine, and other drugs).
- There is great potential for limiting the occurrence of opportunistic infections and the progression of HIV-disease if early medical intervention is instituted.
- It is important to limit the spread of HIV-infection by helping patients reduce high-risk behavior.
- There is a need to improve the biopsychosocial quality of life of people with AIDS and HIV-illness.

The patient who is HIV-positive or has AIDS should not be treated any differently than someone who has pneumonia, cancer, or another serious illness. As long as these patients can benefit from continued participation in a chemical-dependency program--and their behavior does not disrupt its efficient operation--there is no reason to exclude them.

Rationale for Addictions Treatment in HIV-Infected Patients

Treating for addictions is important in improving the quality of life for HIV-infected individuals. When AIDS patients at Baker Place in San Francisco were asked why they wanted treatment for chemical dependence, they gave the following responses: "to complete something in my life;" "to find a purpose in my life;" "to plan the things I want to do with the rest of my life;" "to make peace with my family;" and "to get my life together (with respect to wills, custody of children, and the disposition of one's own body.)"

Drugs short-circuit the process of social interaction. Addictions treatment is necessary to reestablish healthier interpersonal relationships. With social supports restored, these patients incur less expense for care, partly by diminishing their length of stay in institutions. Treatment for chemical dependence also helps improve a person's sense of well-being.

A controlled study has not yet shown that people who continue to use drugs have a more rapid progression of HIV-infection. However, drug abusers are at an increased risk for

AIDS Guidelines *(continued)*

acquiring and transmitting the infection, and for experiencing a rapid progression of HIV-illness to AIDS and death for the following reasons:

• Alcohol and other drugs reduce inhibitions and predispose users to unsafe needle and sexual practices, thus increasing exposure of the user and others to the virus.

• Alcohol, cocaine, nicotine, and other drugs can alter the immune state, thereby diminishing natural killer-cell activity and affecting T4-cell function. They can also cause defects in other humoral mechanisms, and are associated with increased carcinogenesis and mutagenesis.

• Chemically dependent people have increased rates of infections other than HIV, including sexually transmitted diseases, infections associated with intravenously injecting adulterants (such as endocarditis and hepatitis), and infections associated with poor living conditions (such as pneumonia and tuberculosis).

• People addicted to drugs are often in poor health due to a lack of self-care, poor nutrition, and a stressful life-style.

• Alcoholics and drug abusers, including those persons with psychiatric comorbidity, frequently delay seeking medical care and have diminished compliance with medical regimens. The rejection of timely medical care is becoming increasingly detrimental to these persons as zidovudine (AZT) and other effective therapies for HIV-illnesses become available.

HIV Testing: An Individual Decision

Testing for HIV antibody involves benefits and risks. It requires careful thought. Following are some of the advantages and disadvantages of testing, as compiled by members of ASAM's AIDS and Chemical Dependency Committee.

Advantages

Medical --To guide therapeutic interventions.

• *Diagnostic Significance:* HIV testing has diagnostic significance in a patient at risk in the differential diagnosis of unusual illnesses.

• *Treatment:* Infections may be approached differently in an HIV-positive patient. TB, pneumonia, hepatitis B, delta infection, bacterial endocarditis, sexually transmitted diseases, and risk of gynecologic cancers may require closer observation and more aggressive treatment in an HIV-positive patient.

• *Intervention:* Rigorous assessment and early intervention may prevent or improve the prognosis for many HIV-related conditions; treatments are available which may prevent or delay seropositive individuals from developing progressive HIV-illness; knowledge of HIV status may enable access to current research protocols; immunosuppressive therapy for another disease may not be indicated for an HIV-positive patient.

• *Prevention:* Knowledge of HIV status enables better-informed health decision regarding pregnancy; if a vaccine becomes available, it may be offered to uninfected persons to prevent them from becoming infected with the virus.

Psychologic

• An HIV-negative result may relieve anxiety.

• An HIV-positive result may encourage changes to make remaining life more meaningful. **Economic**

• Knowledge of status may encourage organization of personal affairs, wills, finances.

Public Health

• Knowledge of status may increase measures to protect oneself or others.

Disadvantages

Chemical Dependency

• Knowledge of positive test may induce relapse or termination of treatment.

Social

• Ostracism from family, friends, and society is possible. Some HIV-positive individuals may lose support of others when they most need it. Lack of confidentiality and anti-discrimination policies intensify that risk.

Psychologic

• Potential for depression, stress, anxiety, and suicide.

• Reactions to results may be erratic, even dangerous. A positive test may result in pessimism, hopelessness, and self-destructive behaviors, including drug or alcohol abuse or unsafe sex practices.

Economic

• Potential for job loss. Exorbitant fees and/or disqualification for health and life insurance is likely. Again, lack of confidentiality and anti-discrimination policies intensify this risk.

Public Health

• A negative test may discourage modification of risk behavior. A positive test may encourage vindictive or retaliatory behavior, leading to further infection.

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The booklet is available at ASAM headquarters, $3.75 for members, $4.50 for nonmembers, postpaid, prepaid.

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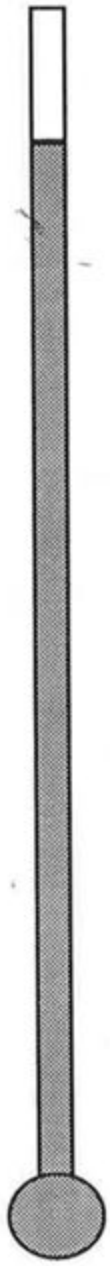

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ASAM CALENDAR

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❑ **ASAM 23rd Annual Medical-Scientific Conference:**
Washington DC, April 3-5
Ruth Fox Course for Physicians: April 2
Board Meeting: April 1
Ramada Renaissance Hotel, Techworld

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❑ **Chemical Dependency in Depth:**
Cayman Brac, BWI, Apr. 18-25
Hub Concepts in Medical Education,
Attn: Bruce E. Bassett, PhD, 11550 IH-10 West, S/185,
San Antonio, TX 78230
☎ 1-800-547-3747

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❑ **Co-Dependency Training for Physicians:**
Rapid City, SD, May 8-14
ONSITE, 2820 W. Main St, Rapid City, SD 57702
☎ (605) 341-7432

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❑ **ASAM 2nd National Conference on Adolescent Addiction, San Antonio, June 25-28**
Palacio Del Rio Hilton

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❑ **ASAM 5th National Conference on Nicotine Dependence, Seattle, Sept. 17-20** *Seattle Sheraton*

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❑ **ASAM Review Course in Addiction Medicine,**
Chicago, Oct. 8-10 *O'Hare Marriott*
Atlanta, Oct. 22-24 *Marriott Marquis (downtown)*

◆

❑ **ASAM/CSAM Review Course in Addiction Medicine,**
Los Angeles, Nov. 5-7

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❑ **ASAM Certification Examination:**
Atlanta, Chicago, Los Angeles, Dec. 5, 1992
(Deadline for applications was Jan. 15, 1992)

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