ASAM NEWS

Volume IX, No. 1 | January-February 1994 | Published Bimonthly

ASAM 25th Annual
Medical-Scientific Conference
New York City
April 14-17
see p. 4

Health Care Reform Alert

States Take Action

ASAM members are reminded that health care reform will occur as the result of a two-tiered process. While states enact reform legislation, the Congress will debate the issues and prepare draft versions of health care reform bills. ASAM members must take action, therefore, at both state and Congressional levels. Previous issues of *Health Care Reform Alert* contained updates on Congressional actions that will potentially affect the future shape and scope of addictions treatment benefits. In this issue of *Health Care Reform Alert* we discuss some of the major state initiatives.

Impatient with the pace of federal health reform efforts, a growing number of states are moving toward implementing their own programs of health care reform. As these state-level plans are being crafted, a small cadre of lawmakers and advocates have argued the necessity of coverage for addictive disorders. Of the more than 70 major reform bills considered in 45 states during 1993, two-thirds contained some benefits for alcohol and drug treatment.

In the eight states—Colorado, Florida, Minnesota, Montana, Oregon, Texas, Vermont and Washington—that have taken the lead on reform, the debate over addictions coverage provides a preview of what to expect as a national plan is crafted.

Colorado offers three types of coverage, to be delivered by HMOs, PPOs and indemnity plans to members of regional purchasing pools. All three plans include benefits for alcohol and drug treatment (see the chart that follows.)

In designing the coverage, state health department officials insisted that alcohol and drug services be treated separately from the mental health benefit. They also argued against detoxification in acute care settings on the grounds that it is costly and often unnecessary, urging instead that non-hospital residential services be used unless a more intensive setting is medically required. Health staff also favor a flat rate for the outpatient co-payment, maintaining that the rising copayament in the original plan would discourage patients from continuing care.

Florida's "Healthy Homes Act," signed into law in April, mimics the Clinton plan in its emphasis on Health Purchasing Alliances to provide members with insurance purchasing services.

(continued on page 2)

Inside

ASAM
American Society of Addiction Medicine

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

Health Care Reform Alert

A REPORT FROM THE EXECUTIVE VICE PRESIDENT

Dr. Callahan is executive vice president of the American Society of Addiction Medicine.

(continued from p. 1) *by James F. Callahan, DPA*

A precise benefit structure is to be developed by the state's Agency for Health Care Administration, although each purchasing alliance will be permitted to supplement the core benefit with specialized services. The Agency will hold public hearings early in 1994 to solicit input on the scope of benefits to be offered.

Minnesota's legislature enhanced addiction coverage in the state's 1992 health plan for low-income residents—called *MinnesotaCare*—by adopting amendments that (1) clarify that the $10,000 inpatient benefit applies to treatment for addictive disorders and mental illness, (2) add medication management by a physician to the list of covered services, and (3) expand the outpatient benefit by adding day treatment and partial hospitalization and removing the 10-hour limit on outpatient treatment for alcohol and drug problems.

Montana's legislature directs a Health Care Authority to present a single-payer and multiple-payer plans to the legislature by October 1, 1994. Addictions advocates have submitted a proposal to the Health Plan Benefit Committee for review.

Oregon—with federal permission to "prioritize" Medicaid services—enacted legislation in August to implement the proposed reforms and to fund expanded coverage to all low-income residents through an increase in the cigarette tax. Under the new law, all outpatient addiction treatment services currently reimbursed by Medicaid will be offered statewide as of January 1, 1995. A state health plan administrator will define the basic benefit package.

Texas' omnibus insurance reform incorporates a "managed competition" model by creating two types of purchasing pools through which smaller firms may purchase coverage for employees. Two of three basic plans being offered must include alcohol and drug benefits, with the most generous of the three—the *Standard Plan*—offering addiction benefits equal to those provided for any other illness

Vermont's Health Care Authority has given the legislature two options—a single-payer model and a multiple-payer plan—to consider in the 1994 session. An advisory group to the Authority has recommended that any proposal treat substance abuse, mental health and health services alike.

Washington legislators in 1993 adopted a version of "managed competition" that will guarantee all residents access to health insurance coverage by July 1, 1999. A newly established commission is to develop the benefits package, which must include coverage of "...case-managed services for chemical dependency and mental illness...to the extent that such services reduce inappropriate utilization of more intensive or less effective medical services."

Addiction Coverage in Eight State Programs

State	Inpatient Coverage	Outpatient Coverage	Other Features
Colorado (ColoradoCare Plans)	*Plan A:* up to 20 inpatient/40 partial hospital days per year.	*Plan A:* up to 20 visits per year. Visits 1-6: patient pays $15; visits 7-20: patient pays 50%.	Detoxification *Plan A:* Patient pays 50% of detox costs (no co-pay for patients below 100% of poverty line)
	Plan B: up to 40 inpatient/80 partial hosp. days per year.	*Plan B:* up to 30 visits per year. Visits 1-6: patient pays $10 or 10%; visits 7-20: patient pays 20%; visits 21-30: patient pays 30%.	*Plan B:* Acute detoxification limited to 2 episodes per year/4 lifetime. Patient pays 10%.
	Plan C: up to 40 inpatient/80 partial hosp./120 residential days per year. Each episode has a deductible equal to full cost of the first day. After deductible is met, no co-pay for the first 5 days, 10% thereafter.	*Plan C:* up to 30 visits per year. Visits 1-6: patient pays greater of $5 or 5%; visits 7-20: patient pays 15%; visits 21-30: patient pays 25%.	*Plan C:* Acute detoxification limited to 2 episodes per year/4 lifetime. Patient pays 5%
Florida	To be determined by Community Health Purchasing Alliances.	To be determined by Community Health Purchasing Alliances.	To be determined by Community Health Purchasing Alliances.
Minnesota (Employees Insurance Program)	*Medica Premier:* up to 73 days per year; 20% co-pay up to $250.	*Medica Premier:* up to 40 hours per year; $10 per hour co-pay for individual therapy; $5 per hour of group therapy.	
	Fortis/Preferred: up to 73 days per year; 10% co-pay.	*Fortis/Preferred:* up to 130 hours; 10% co-pay.	
	Group Health: up to 73 days per year; 10% co-pay.	*Group Health:* up to 40 hours per year; $10 per hour co-pay.	
	Blue Plus: up to 73 days per year; 10% co-pay.	*Blue Plus:* up to 40 hours; 10% co-pay.	
Montana (as recommended to the Health Benefit Plan Committee)	*Inpatient:* up to $7,000 per year benefit. *Partial hospitalization treatment:* up to $4,000 per year. *Transitional living facility:* up to $4,000 per year.	*Routine outpatient:* up to $1,000 per year. *Intensive outpatient:* up to $2,000 per year.	Deductible of $250 per person/$500 per family per year. 20% co-pay. Maximum of $11,000 per year/$22,000 lifetime.
Oregon	Same as Medicaid.	Same as Medicaid.	Same as Medicaid.
Texas (Small business coverage)	*Preventive and Primary Care Plan:* up to 5 days/per year inpatient care.	*Preventive and Primary Care Plan:* up to 40 outpatient visits.	*Preventive and Primary Care Plan:* $15,000 annual cap on benefits.
	In-Hospital Health Benefit Plan: provides coverage with no special limits for addictions.	*In-Hospital Benefit Plan:* outpatient visits as needed for up to 90 days after hospitalization.	*In-Hospital Benefit Plan:* $100,000 annual benefit cap; $1 million lifetime maximum.
	Standard Health Benefit Plan: medical treatment and referral services must be offered.		
Vermont (as recommended to the Health Care Authority)	*Integrated System of Care (ISC):* 100% coverage for inpatient residential and detoxification services.	*Integrated System of Care (ISC):* $5 per visit co-pay; including intensive outpatient and intermediate services.	
	Non-ISC: After deductible, plan pays 70% of charges.		
Washington	To be defined by commission.	To be defined by commission.	To be defined by commission.

News About Members

Two ASAM members recently won annual awards from NCADD (National Council on Alcoholism and Drug Dependence, Inc.). **Enoch Gordis**, MD, director of NIAAA since 1986, won the 1993 Gold Key Award for outstanding contribution to the field on a national level. **Max A. Schneider**, MD, received the Silver Key Award.

David E. Smith, MD, president-elect of ASAM, won this year's SECAD award, given during the annual Southeastern Conference on Alcohol and Drug Abuse in Atlanta.

Two ASAM members were involved in their organizations acquiring sizable federal government grants. Gosnold, in Falmouth, Cape Cod, MA, received a $4.5 million HHS/CSAT grant over five years for pregnant or postpartum addicted women in a rural setting. Medical Director is **Kevin O'Brien**, MD. **Marc Galanter**, MD, Program Chair of the Annual Medical-Scientific Conference, received a $1.5 million grant from NIDA for research and training on substance abuse treatment as described in his book "Network Therapy for Alcohol and Drug Abuse."

William T. Clements, MD, is the new medical director for the Caron Foundation in Wernersville, PA.

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ASAM NEWS Wins Markie Award

ASAM NEWS has won "first place: volunteer newsletter" for material produced in 1992 in the 11th Annual Markie Awards competition. Given yearly since 1983 by the National Foundation for Alcoholism & Addiction Communications, this competition in the addiction field includes entries from journalism, public information, advertising, and marketing—in print, film, TV and radio. The awards ceremony took place in December at the SECAD conference. **Elizabeth Howell**, MD, past president of GASAM, the Georgia chapter of ASAM, accepted on behalf of *ASAM NEWS*.

Newsletter Review Board members are **LeClair Bissell**, MD, **Sheila B. Blume**, MD, **Allan Graham**, MD, and **Max A. Schneider**, MD.

Founder-editor is Lucy Barry Robe; the first issue was published in Oct. 1985.

ASAM staffer Linda Fernandez (L) and Dr. Howell (C), accept Markie Award from Jerry Miller (R)

ASAM Annual Meeting

In keeping with the 40th anniversary spirit, the theme of ASAM's 25th Annual Medical-Scientific Conference is "Addiction Medicine—Our History, Our Future."

At the annual awards luncheon, a few long-term members will talk briefly about ASAM's history, landmarks, and accomplishments by decades—the 50s, 60s, 70s and 80s—and a closing speaker will describe ASAM's vision of the 90s.

Also at the luncheon, as previously announced in ASAM *NEWS* , ASAM Annual Awards will be given to **Jasper Chen See**, MD and Henri **Begleiter**, MD, and the Distinguished Scientist Award to Samuel Guze, MD, who will give the annual Distinguished Scientist Lecture. Join us to celebrate this occasion, April 14-17, 1994, at the Marriott Marquis Hotel in Times Square, New York City!

Wanted: Historic Photos

ASAM needs photos (donations or loans) that commemorate historic occasions in the addiction medicine field. These would be used in a display at the annual luncheon in New York City, and/or for an article in the newsletter. If anyone has historic photos that include ASAM members, please call Claire Osman in the New York Office (☎ 212-206-6770) or Lucy Barry Robe in the *ASAM NEWS* office (☎ 407-627-6815; FAX 407-627-4181).

Job Mart

Final call for a possible job mart: this could be an informal meeting of physicians who are interested in exploring job opportunities, organizations that are or might be looking for physicians in addiction medicine, and recruiters.

If interested, please contact Louis Macpherson, 1013 Rivage Promenade, Wilmington, NC 28412. (☎ 919-452-4920, FAX 919-452-4919). If there is enough interest, details will be in the final conference program.

Ruth Fox Course for Physicians

The annual Ruth Fox Course for Physicians, named in honor of ASAM's founder, will be offered Thurs. April 14 in New York City. A faculty of 11 nationally known doctors will cover HIV and addiction, pharmacotherapy and opioid dependence, neuropharmacology of craving, ethics, literature review, medical marriage in crisis, misconceptions in the medical management of alcoholism, and patient-centered addiction encounters.

Faculty are **LeClair Bissell**, MD, **William D. Clark**, MD, **Carlton D. Erickson**, PhD, **Robert B. Millman**, MD, **Robert M. Morse**, MD, **J. Thomas Payte**, MD, **Mel Pohl**, MD, **Donald E. Rosen**, MD, and **Maxwell N. Weisman** MD, course director emeritus.

Course director is **Lynn Hankes**, MD; co-director is **Charles L. Whitfield**, MD.

Conference Information

Registration material, hotel and travel information were mailed to ASAM members in January. Nonmembers can contact Sandy Schmedtje, ASAM, 5225 Wisconsin Ave. NW, Suite 409, Washington, DC 20015.

☎ 202-244-8948; FAX 202-537-7252.

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Committee on Practice Guidelines Survey

Introduction

The ASAM Committee on Practice Guidelines is developing a series of practice guidelines in the area of addiction medicine. We want to select topics which have the most potential for positive impact on health care delivery for addictions.

The National Academy of Sciences (NAS) has established seven criteria for selection of the topics. They are:

- prevalence of clinical condition
- burden of illness associated with clinical condition
- cost of health practices commonly used to manage the condition
- variation in health practices used to manage the condition
- potential to change health outcomes
- potential to change costs
- potential to affect ethical, legal or social issues

Please consider each of these NAS criteria, then indicate what topics ASAM should develop into practice guidelines for our field.

Instructions

Consider each of the 7 NAS criteria, then select the five most important topics; mark them with a number "1."

Then find the five you think are the next most important; mark them with a number "2."

In the space provided, write in topics which you think are of high priority ("1") or intermediate priority ("2") and should be considered by the committee now. Leave the rest blank.

Comments and questions are most welcome; write them on a separate sheet and enclose them with the survey.

Please return this form by April 1, 1994.

Mail it to:

ASAM Committee on Practice Guidelines
c/o CSAM, 3803 Broadway, Oakland, CA 94611.
Or FAX it to: 510/653-7052.

Thank you! We appreciate your help.

Potential Topic	
1. Screening in primary care	____
2. Screening in pregnancy	____
3. Screening in trauma patients	____
4. Screening in the workplace	____
5. Screening in hospitalized patients	____
6. Brief intervention in primary care	____
7. Brief intervention in hospitalized patients	____
8. Appropriate history, physical exam, and laboratory work for patients presenting for alcohol withdrawal	____
9. Pharmacological management of alcohol withdrawal	____
10. Indications for inpatient and outpatient treatment of alcohol withdrawal	____
11. Prophylaxis against alcohol withdrawal seizures	____
12. Management of patient presenting with an alcohol withdrawal seizure	____
13. Management of alcohol withdrawal delirium	____
14. Appropriate history, physical examination, laboratory work for patients presenting for opiate withdrawal	____
15. Management of opiate withdrawal	____
16. Appropriate history, physical examination, laboratory work for patients presenting for withdrawal from cocaine	____
17. Management of sedative-hypnotic withdrawal	____
18. Management of nicotine dependence	____
19. Multidisciplinary psychosocial assessment in substance abuse treatment	____
20. Antabuse therapy	____
21. Methadone maintenance therapy	____
22. Self-help groups in recovery	____
23. Management of pain in the recovering patient	____
24. Management of psychiatric disorders in the recovering patient	____
25. Management of addiction in HIV-positive patient	____
26. Write your suggested topic here:	

AMA Delegates Meet by James F. Callahan, DPA

Several issues of interest and concern to ASAM members were debated and acted upon at the 1993 Interim Meeting of the AMA House of Delegates held in New Orleans in December. The 435-member house is the policy-making body of the 295,000-member American Medical Association.

ASAM has one delegate, **Jess W. Bromley,** MD, and one alternate, **David E. Smith**, MD. ADM is the AMA code for addiction medicine. The following are now AMA policy:

AMA Policies

Recognition

- The AMA encourages all physicians, particularly those in primary care fields, to undertake education in treatment of substance abuse.
- The AMA directs its representatives to appropriate Residency Review Committees to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance abuse. Those RRCs that already require such instruction should consider greater emphasis for this subject.
- The AMA encourages treatment of substance abuse as a subject for continuing medical education, and
- The AMA affirms that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation.

These actions are in response to a resolution that ASAM presented to the AMA House of Delegates at the June 1993 meeting, asking the AMA to urge managed care companies, health insurers and utilization review organizations to acknowledge that all physicians who have the appropriate medical background, training and skills be recognized to practice addiction medicine, and that the recognition not be limited to any particular one of the 24 specialties recognized by the American Board of Medical Specialties.

Self-incrimination / Discrimination

At last year's December 1992 meeting, ASAM and the Medical Society of the State of New York introduced resolutions concerning questions that physicians applying for licensure (in some states) or seeking board certification (in certain specialties) are required to answer about past treatment or referral for substance abuse land psychiatric problems. The resolutions opposed such questions, and proposed asking physicians for self-reports of any conditions that might affect their *current* ability to practice. The House of Delegates has enacted the following policies in this regard:

- The AMA reaffirms its policy that licensing boards take steps to ensure the confidentiality of sensitive information contained on applications for licensure and re-registration.
- The AMA urges licensing boards to require that reports concerning physician competence or professional misconduct be made at the time of application for or re-registration only for causes that may reasonably be related to the licensees' *current* competency to practice medicine.
- The AMA encourages the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings, to better facilitate the sharing of information.
- The AMA will seek clarification of the application; of the Americans with Disabilities Act (ADA) to the actions of medical licensing and medical specialty boards, and
- Until the applicability and scope of the ADA are clarified, the AMA will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, re-registration and certification processes when such questions are asked.

Managed Care, Insurers

In related action, the AMA House of Delegates adopted several policies aimed at curbing any practice that might exist by insurance companies of excluding participation by physicians in managed care plans or other provider plans, based solely on a history of substance abuse:

- The AMA reaffirms its policies against discrimination against physicians and others with a history of substance abuse. The AMA is to develop draft federal and model state legislation requiring managed care plans and third-party payers to disclose to physicians and the public the selection criteria used to select, retain, or exclude a physician for managed care of other provider plans.
- The AMA is to request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans.
- The AMA is to encourage state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be unfairly treated by managed care plans, particularly with respect to the selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse, and
- The AMA is to urge managed care plans and third-party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.

Addictions Treatment in Health Care Reform

The AMA proposal for addictions treatment under health-care reform legislation is contained in the AMA Required Benefits Package. It covers unlimited outpatient visits with physicians for individual or group therapy, including day-night hospital services for mental conditions/substance abuse.

ASAM has been told by AMA staff to the Council of Medical Services that detoxification is covered as a medical benefit. We are not yet certain that this is so, and are seeking confirmation in writing. The AMA inpatient benefit is limited to "one 28-day treatment program up to $3,000 per lifetime."

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AMA Delegates

ASAM contested this benefit at the June 1992 AMA meeting by introducing a resolution that treatment provided for addictive disorders should be covered like treatment for any chronic disease, on a nondiscriminatory basis. ASAM then submitted a report to the AMA providing the data on treatment effectiveness, treatment costs and cost benefit.

In September 1993, the AMA replied in writing that the ASAM data did not justify a more generous benefit than the AMA 28-day lifetime/$3,000 cap. The AMA challenged ASAM to provide actuarial data that would justify a more generous benefit.

The ASAM Healthcare Reform Task Force will meet to discuss obtaining appropriate actuarial data from the US Department of Health and Human Services, the Congressional Budget Office and other sources, and will submit a formal report to the AMA. ASAM has asked the American Psychiatric Association to collaborate in computing the data. In the meantime, the Resident Physicians Section of the AMA (**Stuart Gitlow**, MD, ASAM Delegate) has submitted a resolution asking that the AMA "direct its Washington office to lobby Congress that treatment for all chronic diseases be available in a nondiscriminatory manner." The AMA has reaffirmed its policy supporting an increase in federal excise taxes for tobacco and alcohol, which would be allocated to healthcare needs and health education.

Tobacco

The House of Delegates passed several measures related to tobacco:

- The report on "Environmental Tobacco Smoke: Health Effects and Prevention Policies" reviews the scientific and public policy issues surrounding ETS for physicians and their patients.
- The House received the results of an AMA review of hotel and locale regulation of environmental tobacco smoke, as criteria for AMA meetings and locations.
- The House also received the AMA's Annual Report on Tobacco and Health.
- The AMA is to petition the Occupational Safety and Health Administration to adopt regulations prohibiting smoking in the work place.
- The AMA is to encourage federal lawmakers to introduce legislation that would ban smoking on passenger trains.
- Given recent allegations about tobacco industry strategies, the AMA is to urge state and county medical societies and local health professionals along with their allies to support efforts to strengthen state and local laws that require public disclosure of direct and indirect expenditures to influence legislation or ordinances, and
- The AMA is to urge state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking ordinance is introduced, and to become directly involved in community tobacco control activities.

HIV

The house adopted or reaffirmed several policies regarding HIV:

- The AMA supports the enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649), and
- The AMA affirms existing policy that supports prohibiting HIV-infected foreign nationals from settling permanently in the US.
- The AMA is to encourage the AMA Physicians Health Foundation to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities.
- The Liaison Committee on Medical Education Annual Medical School Questionnaire should continue to collect information on the prevalence of HIV infection and other blood-borne diseases among medical students, taking all necessary precautions to protect their confidentiality with reports to the House of Delegates on an as-needed basis.
- The AMA supports voluntary, routine HIV-antibody testing of the newborn in areas with a high prevalence of HIV infection, observing strict confidentiality of test results.
- The AMA advocates development of optimal care programs for HIV-positive and AIDS-symptomatic infants and their families. Such programs should include support systems to help parents care for these infants and simplified foster care arrangements for children whose parents are unable to provide such care.
- The AMA advocates continued development and evaluation of better diagnostic tests for HIV infection in newborns and supports their widespread use in early diagnosis, and
- The AMA urges all insurance companies ordering HIV testing on insurance applicants to use the AMA modified informed consent form and all applicable guidelines for pre-test and post-test counseling.

Alcohol

The House adopted the report of the Council on Scientific Affairs on "Alcoholism in the Elderly" which states that:

- The AMA should work with others to develop new guidelines for physicians concerning the prevention, diagnosis and treatment of alcoholism in the elderly, with suggestions on how to overcome diagnostic and treatment barriers. These guidelines should be disseminated widely among primary care practitioners.
- The AMA is to encourage medical educators to consider expanding instructional material on alcohol and aging at all levels of medical education, particularly in residency and/or post-graduate training.
- The AMA is to urge relevant foundations, universities and government agencies to sponsor clinical studies on alcoholism in the elderly. (The report identifies a number of issues in need of study.)
- The AMA is to cooperate with other groups, such as the American Association of Retired Persons and appropriate government agencies in public education *(continued on p. 13)*

Left to Right: Jess W. Bromley, MD, Kevin Olden, MD, Richard Sandor, MD, Gail B. Jara, Garrett O'Connor, MD, Anthony B. Radcliffe, MD, Max A. Schneider, MD.

CSAM Awards Dinner

California Society of Addiction Medicine Annual Meeting

CSAM held its its 20th annual meeting at a dinner in San Diego on Nov. 19, 1993. "There were really two ongoing forces pushing us to get organized," reminisced Jess W. Bromley, MD, who received the CSAM Founder's Award. "The need to get the treatment of addiction into the medical mainstream, and the need to change the outdated laws which kept us from doing that."

Gail B. Jara, who has been of CSAM's exeucutive director since its inception, received the society's Community Service Award.

CSAM is a state chapter of ASAM. Drs. Radcliffe and Schneider are past ASAM presidents; Dr. Bromley is past ASAM secretary.

Richard Sandor, MD, is CSAM president; Kevin Olden, MD, is immed. past president.

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ASAM NEWS is published bimonthly. January-**February**, March-**April**, May-**June**,July--**August**, September-**October**, November-**December**.
Subscriptions: ASAM NEWS is sent free to members. Nonmembers may subscribe for $25 per year. Call/write/FAX Washington headquarters.
Advertising Rates: Start at $60. Call/write/FAX editor, or ASAM headquarters.

ISSN # 0889-9215

ASAM Certificate for MROs by David E. Smith, MD

ASAM has taken a leadership role in regard to Medical Review Officers (MROs). The result is greatly increased expertise for treating employees who test positive in the work place for the NIDA-5 (cocaine, amphetamine, opiates, PCP and/or marijuana). In many large companies the MRO not only fulfills the regulatory requirement of determining if there is a medical reason why the urine screen is positive, but also evaluates, prescribes, and monitors treatment for the drug-involved employee, based on severity of the problem, levels of treatment needed, and using *ASAM Patient Placement Criteria.*

The ASAM-MRO courses led by **Donald Ian Macdonald**, MD, provide excellent MRO training combined with how to evaluate addiction treatment. These sessions are consistent with the body of knowledge contained in the field of addiction medicine.

ASAM has influenced other medical specialties, such as occupational medicine, to broaden their perspectives to include addiction medicine treatment in their MRO training and approval.

Our society also has influenced public policy. For example, Dr. Donna Smith of the Dept. of Transportation (DOT), who teaches MRO, publicly credited ASAM with influencing DOT policy of using a substance abuse professional for treatment evaluation in new DOT alcohol testing regulations.

We have much to be proud of in the MRO area. We have broadened the traditional role of the MRO, from its original limited role of drug testing to test evaluation, intervention, treatment, and work in re-entry monitoring.

New Certificate: ASAM MRO

In acknowledgement, in 1994 ASAM will offer for the first time a separate certificate to physicians who have been certified by ASAM in addiction medicine, and who have also attended the MRO training course. This certificate will attest to the physician's certification in addiction medicine, and to the fact that he or she has received training appropriate to carrying out the work of an MRO. The 1994 ASAM Certification Exam will also test for knowledge of MRO issues.

An ASAM certified MRO has knowledge of the broad field of addiction medicine as certified by examination, and also has specific training in the skills required to be a Medical Review Officer.

Although the MRO was created originally as part of the random drug testing in the Drug Free Workplace Act, the concept of the MRO has gone far beyond its original limits. Random drug testing and the Medical Review Officer are not synonymous. An ASAM-certified MRO is a major force in providing treatment for drug involved employees and can be a credit to both our society and the field of addiction medicine.

Dr. Smith is president-elect of ASAM. He is founder-medical director of the Haight-Ashbury Free Medical Clinic in San Francisco, and has taught in MRO courses all over the country.

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Guidelines Revised for Granting CMEs

The Accreditation Council for Continuing Medical Education (ACCME) has adopted a number of new guidelines for sponsorship of educational activities which offer Category I AMA Physician Recognition Award credits.

According to **James A. Halikas**, MD, chair of the ASAM Continuing Medical Education Committee, the new ACCME guidelines "are very specific about the responsibility of the accrediting organization" (in this case ASAM) to provide "supervision for all phases of any proposed educational activity. ASAM will be required to demonstrate its involvement in all aspects of a CME program from the beginning." This includes the educational needs, goals and objectives of the proposed activity, and far closer involvement in program development than in the past.

Commercial Support

From now on, any commercial or industrial relationship between any individual or organizational participant, and any corporate participant, *must* be disclosed *in writing in advance* of the conference for all attendees to evaluate. All conference corporate financial support must be handled through pre-approved standard written contracts by ASAM.

Publicity

All announcements must include: learning objectives, the accreditation statement, and acknowledgment of all financial support ("support for this conference is provided through an unrestricted educational grant from _____ [company name])." Corporate financial support must also be indicated on all brochures and in all publicity.

Conflict of Interest

Each speaker must complete a conflict of interest form, and the information conveyed to the audience before a presentation begins (usually done with a faculty addendum sheet).

Outside Support

Outside support must be acknowledged in all publicity. Companies providing support may not exhibit in the meeting room. Meeting materials, including slides, may not contain promotions for their products. ASAM must have a written signed agreement with any industrial sponsor articulating ASAM's independence in the planning of the conference. A written agreement with each sponsor is necessary.

Reaccreditation

ASAM was notified in December that the society "was reaccredited by the Accreditation Council for Continuing Medical Education (ACCME) for the next two years as a sponsor of continuing medical education for physicians. ACCME organizations include the AMA, ABMS, AHA, Association for Hospital Medical Association, Association of American Medical Colleges, Council of Medical Specialty Societies, and Federation of State Medical Boards of the US."

For More Information

ASAM staff contact for CME information is Claire Osman, ASAM, 12 West 21 Street, New York, NY 10010. Phone: (212) 206-6770. FAX: 212-627-9540.

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The Section for Psychiatric and Substance Abuse Services
of the
AMERICAN HOSPITAL ASSOCIATION
will present its annual conference
From Vision to Action: Forming Community Partnerships in Behavioral Health
June 23-25, 1994
Stouffer Mayflower Hotel
Washington, DC

Workshop topics include:

- national health care reform
- integrated network development
- capitated payment arrangements
- hospital/physician relationships
- treatment outcome measures
- treatment programs for special populations
- partial hospitalization
- intensive outpatient services...

and more!

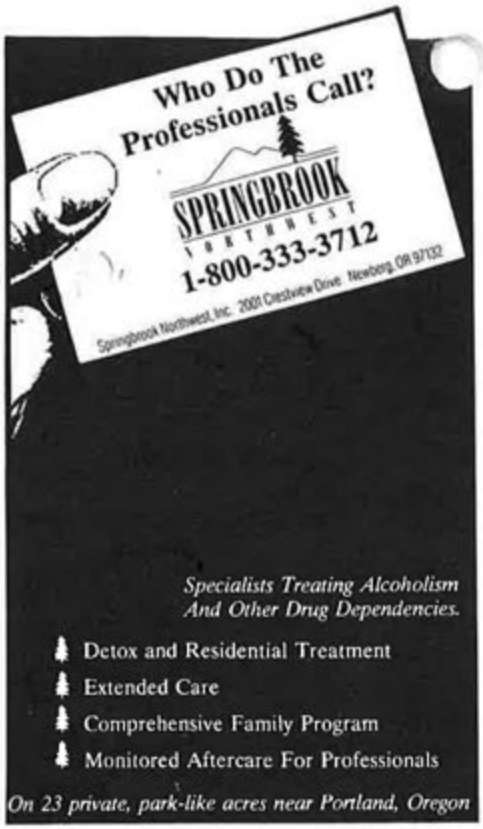
For further information and a complete-brochure,please contact: 312/280-6451

ADDICTION MEDICAL DIRECTOR

Pittsburgh, PA

Large JCAHO certified comprehensive chemical dependency center seeks an experienced, appropriately Board Certified Addictionologist to be its Medical Director. A complete continuum of care is provided to 700+ patients/day. Programs emphasize innovative quality treatment, prevention, research, and education. 278-acute psychiatric/addiction beds (part of 750 bed medical center with ACGME accredited Psychiatric Residency Program). Leadership and supervisory skills a must.

Contact: Joy Harris, Division of Medical Administration, Daniel Stern and Associates, Pittsburgh, PA; 800-438-2476.



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addictions '94

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Lorie Dwinell, MSW, Seattle, Washington *"Parents and Parenting in Recovering Families"*

Barbara Brennan, Ph.D., M.D., FRCSC *"Addiction in Pregnancy - Effects on the Fetus and New Born Infants"*

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Fax 519-767-1114

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MEDICAL DIRECTOR
MacNeal Hospital
Dependency Treatment Center

MacNeal Hospital, a teaching facility located in the western suburbs of Chicago, seeks a demanding and dynamic leader to become Medical Director of our rapidly-growing Dependency Treatment program. The physician must be board-certified in Family Practice or Internal Medicine and must also be certified by the American Society of Addictions Medicine. MacNeal's program is founded strictly in accordance with ASAM guidelines for treatment. Services include inpatient detoxification, residential rehabilitation, dual-diagnosis treatment and a variety of outpatient programming including child and family therapy. In addition to clinical responsibilities, the Medical Director must be an active educator for residents in MacNeal's Family Practice Training Program. The Medical Director will be responsible for driving continued growth of MacNeal's Dependency Treatment program and for assuring high-quality, service-oriented care. Candidates must have strong program development ability and excellent medical credentials. A constructive and collaborative approach to working with managed care organizations is essential. Please send your CV to: **Jeanette Simons, Physician Affairs, 3249 S. Oak Park Ave., Berwyn, IL 60402.**

MacNeal Hospital

Should ASAM Accept Non-physicians as Associate Members?

The ASAM board of directors has been asked to consider a new membership category: associate membership for non physicians.

The Board wants your opinion on this important issue.

Two ASAM members discuss the "pro" and the "con" of this issue.

Membership Committee Chair is **Ken Roy**, MD.

Point

by **David E. Smith**, MD

I advocate extending associate membership in ASAM to non-physician health professionals in the addiction field. Such a move is not new for specialty medical societies in the AMA. For example, diagnostic radiology and medical genetics, both represented in the AMA, accept PhD's as members. This has not compromised their standings as specialty societies. The ASAM leadership has determined that such an associate membership expansion will *not* compromise our progress toward ABMS specialty status.

Expansion of associate membership in ASAM would not be foreign to the addiction field, for we have been the leaders in using the health care team approach to the treatment of this chronic, relapsing disease. Some of the leading professionals in addiction research, prevention and treatment, are PhD's, pharmacists, and nurses who specialize in chemical dependency. Many of these fine people already attend our scientific meetings and are known to the ASAM membership.

Finally, a broad based health professional coalition will strengthen our advocacy for including substance abuse benefits in health care reform. As many ASAM state chapters have found, a unified health professional field speaks with a stronger voice than does a divided field.

Counterpoint

by **Nicholas Pace**, MD

I do not advocate extending associate membership in ASAM to non-physician health professionals in the addiction field. As physician addictionists, we in ASAM are still working hard to gain acceptance in the mainstream of medicine as well as with the public at large.

I believe that associate membership will not only compromise our progress towards ABMS specialty status, but also will further interfere with our ability to gain respect among our colleagues for addiction as a disease. It will impede the concept that the physician addictionist should be the captain of the treatment team for the addicted patient. The next time a PhD social worker speaks to you about your patient being a "client," ask yourself, "Would having non-physician members help ASAM establish itself as a legitimate medical subspecialty?"

Not advocating extending associate membership in ASAM to non-physician health care professionals in the addiction field in no way should suggest that we are demeaning their importance in the field. Some of the most important work in research, prevention, and treatment has been done by non-physician PhD's, pharmacists, and nurses who specialize in chemical dependency and these professionals should be encouraged to attend our scientific meetings and join with us in advocacy support of substance abuse benefits in the health care system.

Please take a moment now to complete the three questions below and return them to ASAM headquarters. Clip out the page and mail to: Membership Department, ASAM, Suite 5225 Wisconsin Avenue NW, Suite 409, Washington, DC 20015. Thank you.

This page has been designed as a self-mailer if you prefer. Please fold

1. **Should ASAM accept non-physician associate members? YES NO** *(circle one)*

2. **If YES, who should be eligible** for associate membership?
   (choose one)
   A. Doctorate level - health care only
   B. Doctorate level - any discipline
   C. Masters level and above - health care only
   D. Masters level and above - any discipline.

3. If non-physician associate members are accepted as ASAM members, should they be eligible to **vote and hold office?**
   YES NO *(circle one)*

Comments:

ASAM Members 1993

fold here, staple or tape at bottom *fold here*

First Class Postage Here

Membership Department
ASAM Suite 409
5225 Wisconsin Avenue N.W.
Washington, DC 20015

AA in Treatment Centers

Learning to stay sober through the AA Program is an integral part of treatment in most chemical dependency facilities.

It may be helpful for ASAM members to read the AA guidelines for its members who conduct meetings in these facilities. Published in AA World Services newsletter 'Box 459' Oct.-Nov. 1992, p. 9, they are reprinted here with permission .

'Within the Traditions'

The unity of an AA meeting within a treatment facility is essential for carrying the AA message.

• AA members who carry the message into treatment facilities, like all AA's, are but trusted servants. They do not power-drive an AA meeting in a treatment facility. They allow the Higher Power to govern the meeting.

• Patients who are dually addicted may attend AA meetings as long as one of their problems is alcohol. Only the patient may decide whether he or she has a desire to stop drinking.

• Tradition Five is really what Twelve Stepping in treatment facilities is all about; to carry its message to the alcoholic who still suffers. This is what AA's do best, share their experience, strength and hope with the suffering alcoholics, especially those in treatment facilities. There can be no more important commitment for an AA member than to carry the message.

• We cooperate but we do not affiliate. We wish to work with treatment facility program administrators and staff but we do not wish to be merged with them in the minds of administrators, patients, staff or the public. AA is available to the treatment facilities but public linking of the AA name can give the impression of affiliation. Therefore, an AA meeting or group that meets in a treatment facility should not bear the name of the facility.

• When AA's are invited into a facility to conduct a meeting for patients only, no contribution is required as this meeting is not an AA group.

• AA's carry the AA message because it helps them stay sober.

• AA ought to abide by the rules and regulations of a treatment facility, even though they may disagree with its policies. Although AA's may disagree with the methods used by some treatment facilities they learn to "walk the walk," and simply carry the AA message. AA's who do Twelfth Step work in treatment facilities should not be diverted from their primary purpose.

• AA's who carry the message into treatment facilities represent AA itself to facility personnel. Those who engage in this work should remember that they are the "attraction" to AA, not only for the patients but also for all staff members of a facility.

• Placing principles before personalities enables AA's who carry the message into treatment facilities to keep their primary purpose first. Let us always remember that anonymity—not taking credit for our own or others' recovery—is humility at work.

• Let us stop being concerned about how a treatment facility or professional does their work for the alcoholic. Let us be concerned with one thing—let us carry the message of AA to the suffering alcoholic. Let us try.

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Did You Know That...

When AA co-founders Dr. Bob S. and Bill W. worked with their first alcoholics in Akron, Ohio, in 1935, initial detoxification was "paraldehyde and one shot of whiskey. This knocked them out for 24 to 36 hours. When they woke up, their diet was canned tomatoes, sauerkraut, and karo syrup."

Why the sauerkraut? "Bill took it for his ulcer; he thought it would be good for drunks!"

Bob S., son of Dr. Bob
North Palm Beach, FL, Oct. 9, 1993

Letters

To the Editor:

Regarding Dr. Paul Earley's editorial, "What to Do About it" in *ASAM NEWS* (Sept.-Oct. p. 4), like every other doctor (not just addictions, for I have run a hospital UR program for the past decade!), the experience which he described so clearly makes me feel the depths of inner conflict. These MCO (managed care organization) actions are immoral, unethical, and constitute breach-of-contract, really, based on the original promise of care by the insurer.

Dr. Earley puts his finger on the central issue: reaching a conclusion about the correct diagnosis and/or correct treatment of *any* patient is a complex task which *constitutes the practice-of-medicine*. Any person who does that should be properly credentialed within that *state*, and within that *field*. Further, anyone rendering such conclusions should be required to make a written entry of them into the patient's chart.

The organizing principle here is obvious: the *privilege* of evaluation/treatment must be tightly tied to responsibility for outcome. A state license (probably with insurance requirement) and written chart entry could put, I suggest, some measure of "turgor" in these chart entries

Mr. Clinton, Mr. Magaziner, and Congress can pass whatever they like in a reform mode, but if this legislation does not demand responsibility from MCO personnel, then what is given will be taken back by the pirate ship, flying not the jolly roger but "medical necessity."

I think a sample bill, for submission to each state legislature—if not to Congress itself—is an appropriate and timely objective of ASAM.

Dan H. McDougal, MD
Baltimore, MD

Dr. McDougal is an internist who joins Kaiser Permanente in January.

ASAM NEWS welcomes letters from readers. We sometimes have to edit material for space reasons.

Please send letters to editor Lucy Barry Robe, 303-D Sea Oats Drive, Juno Beach, FL 33408.

First Meeting of Coalition for National Clinical Criteria

by **David Mee-Lee**, MD

The Coalition for National Clinical Criteria on Addiction Treatment, which grew out of the first two Roundtable Discussion Conferences on the ASAM Patient Placement Criteria, met Nov. 17-18 in Bethesda, MD. Over 50 people representing professional organizations, managed care, industry, providers, government agencies, unions, and researchers, planned for the goal of national criteria for placement and treatment of patients who suffer from addiction to alcohol and other drugs.

Two themes guided the plenary and breakout group discussions: 1) national healthcare reform with particular attention to the just-announced further cutbacks in substance abuse provisions of the Health Security Act, and 2) expansion and further development of the *ASAM Patient Placement Criteria* to address field comments and concerns, especially from the public sector and managed care organizations.

Task Forces from 1992 Roundtable

Retaining the four working task forces established at the 1992 Roundtable Conference, the Coalition developed plans to inform and influence both national and state legislators about the need to ensure coverage for addiction treatment within a continuum of care guided by national clinical criteria.

Subcommittees of the Criteria Improvement Task Force were also formed to offer eventually, in an appendix to the *ASAM Criteria,* refinements and implementation guidelines addressing certain field concerns. Such areas are: (a) expansion of the continuum of care into primary prevention and early brief intervention, Chair: Julia Griffith; (b) greater specificity to distinguish intensive outpatient from partial hospitalization in Level II, chair Jack R. Leggett, Jr., PhD; (c) clarification of the kinds of settings in Level III e.g. therapeutic communities, psychosocial residential care, halfway houses and group living settings, chair Gerald D. Shulman, MA; (d) examination of Dimension I criteria in light of new data on ambulatory detoxification, chair **P. Joseph Frawley**, MD; (e) the place of methadone maintenance as Level II service, chair Robert Lubran; and (f) further conceptual development to articulate new models of placement and clinical criteria, chair **David Mee-Lee**, MD.

While the Coalition for National Clinical Criteria does not seek to develop another bureaucracy and duplicate the efforts of other organization, considerable discussion focused on a plan to secure more ongoing funding to sustain and advance the energetic momentum generated at this meeting. It became clear that funding for the activities planned could no longer be ASAM's sole responsibility. ASAM continues to be willing to provide leadership and to administrate funds generated for the coalition's activities, and will be accountable and responsive to the Coalition's constituencies.

2nd Meeting in March

A second meeting of the Coalition is planned for Mar. 2, 1994, in Washington, DC, to receive update reports on the progress of the work planned.

Steering Committee

Steering Committee: *Criteria Improvement Task Force*, chair: Gerald D. Shulman, MA, David Mee-Lee, MD, ASAM Criteria Cmte chair. *Research Evaluation Task Force* chairs: Jeffrey T. Kramer, Gil Hill, PhD; ASAM Treatment Outcome Research Cmte chair: **David R. Gastfriend**, MD. *Criteria Implementation Task Force* chair: Mona L. Sumner, MHA; ASAM Standards of Care Cmte Liaison, David Mee-Lee, MD. *Treatment Access and Reimbursement Task Force* chair Stephen Moss, PhD; ASAM Reimbursement Cmte chair: **Michael M. Miller**, MD.

Joint Legislative Conference

The Coalition meeting will follow another meeting Feb. 27 - March 1 organized by NAADAC, NAATP, NASADAD, NCADD, TCA, and The Legal Action Center, to discuss the implications of the Health Security Act of 1993 on the effective treatment of alcoholic and drug dependent Americans. Key administration officials and members of Congress will speak to attendees at that joint meeting, at which Dr. Miller will represent ASAM.

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AMA Delegates

(continued from p. 7)

programs for the elderly, concerning alcohol-related problems.

Family Violence

In December 1992, the AMA released a report on Family Violence from its Council on Scientific Affairs. The report failed to adequately acknowledge the role of alcohol and other drug use in promoting and perpetuating family violence. In June 1992 the council's revised report drew attention to this association. At the just concluded AMA meeting, the house of delegates reaffirmed its policy concerning the association between family violence and the use of alcohol and other drugs.

Other Matters

On the issue of the problem related to production quotas and distribution of Methylphenidate Hydrochloride, the House adopted the policy that the AMA is to evaluate the process by which the Drug Enforcement Administration and the Food and Drug Administration determine the manufacturing limits (quotas) for Schedule II drugs, so that variability in the availability of such drugs does not compromise the quality of patient care. ASAM testified to the abuse potential of this drug, and counseled that it should be maintained under Schedule II.

The AMA is to support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs.

Dr. Callahan is executive vice president of ASAM.

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

Ruth Fox Memorial Endowment Fund

ASAM expresses its appreciation to Yasuda Trust & Banking Co. for its generous contribution to the Ruth Fox Memorial Endowment Fund. We are grateful for their continued support.

We also thank you, our members, for continuing to send in contributions and pledges. Our goal is to reach $2 million by the end of 1994. P{lease help us to make this happen. If you have not already made a pledge/contribution, we ask you to do so now.

Perhaps you would like to consider a planned giving gift (bequest).

For more information about making a pledge/contribution, planned giving gift, or upgrading your current pledge, please contact Claire Osman at at ASAM, 12 W. 21 St., New York, NY 10010. Or telephone her at (212) 206-6770. FAX: 212-627-

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ASAM Calendar

Information about ASAM conferences is available at Washington headquarters: Sandy Schmedtje, 5225 Wisconsin Avenue NW., Ste.. 409, Washington, DC 20015.
☎ (202) 244-8948. FAX: 202-537-7252.

1994

- **Mar. 11-13: ASAM MRO Training Course**
  Marina Del Rey, CA *Ritz Carlton Hotel*
- **Mar. 2-6: Second Annual EuroCAD/94**
  London, England *Gloucester Hotel*
  Tom Claunch, PO Box 40259, San Diego, CA 92164
  1-800-882-3303 or (619) 295-5377
  FAX: 619-295-3030
- **Mar. 25: Texas Medical Professional Group**
  Spring Regional Meeting - CME Program
  San Antonio, TX *Hyatt Regency Hotel*
  12603 Morgans Ridge, San Antonio, TX 78230
  ☎ (210) 493-7055
- **April 15-17: ASAM Annual Meeting & 25th Annual Medical Scientific Conference**
  New York City *Marriott Marquis Hotel*
  Apr. 13: ASAM Board Meeting
  Apr. 14: Ruth Fox Course for Physicians
  Marriott Marquis Hotel
- **Aug. 26-28: ASAM MRO Training Course**
  Arlington, VA *Crystal Gateway Marriott*
- **Sep. 30-Oct. 2: ASAM Board Meeting**
  San Diego, CA Marriott Marina & Tower
- **Oct. 27-30: ASAM 1994 Review Course**
  Chicago *O'Hare Marriott Hotel*
- **Dec. 3: ASAM 1994 Certification/ Recertification Examination**
  Atlanta** and **Los Angeles
  (Application deadline was Jan. 10, 1994)

1995

- **April 17-21: ASAM Annual Meeting & 26th Annual Medical-Scientific Conference**
  Chicago *Marriott Downtown*

1996

- **April: ASAM Annual Meeting & 27th Annual Medical-Scientific Conference**
  Atlanta

Calendar includes only meetings that are sponsored or jointly sponsored (CME credits) by ASAM: one time listing for jointly sponsored conferences. For inclusion in this calendar, please send information directly to Lucy B. Robe, Editor, at least three months in advance.

ASAM staff contact for CME information is Claire Osman, ASAM, 12 W. 21 St., New York, NY 10010.
☎ (212) 206-6770. FAX: 212-627-9540.

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