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CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

David A. Frenz, MD
Editor-in-Chief

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Learning objectives for this issue:
1. Summarize how clinicians can use *The ASAM Criteria*.
2. Describe the FDA's risk mitigation program for extended-release and long-acting opioid analgesic medications. **3.** Detail the changes in the newest edition of *The ASAM Criteria*. **4.** Evaluate some of the current research regarding addiction.

How to Use The ASAM Criteria in Your Practice

David A. Frenz, MD
Medical Director, Mental Health & Addiction Care, HealthEast Care System, St. Paul, MN

Dr. Frenz has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

The ASAM Criteria—the American Society of Addiction Medicine's guidelines for addiction treatment—are not just a tool for program administrators and insurance bureaucrats. They provide a useful conceptual framework for thinking about your patients and what kind of care they need. In addition, insurance companies and government agencies often require you to document your patient's clinical status in ASAM format before they will authorize payment for certain services.

In this article, we'll provide you with the basics that you need to use

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Summary

- *The ASAM Criteria* can help you determine what kind of care your patients need
- You start by assessing your patient with ASAM's six dimensions
- You then assign risk ratings for each dimension and select an appropriate level of care

Q&A With the Expert

REMS: What It's All About

Edwin A. Salsitz, MD
Addiction Medicine Specialist
Mount Sinai, Beth Israel
New York, NY

Dr. Salsitz has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: We've been hearing about REMS and receiving big envelopes in the mail containing REMS materials. Please tell us about this program.
Dr. Salsitz: REMS stands for Risk Evaluation and Mitigation Strategies. It's a patient safety program for high-risk medications that was authorized by Congress in 2007.
CATR: What medications are covered?
Dr. Salsitz: There's quite a list—certain acne medications, anticoagulants, HIV medications, and so forth. And, of course, opioids, which is my involvement with the program.
CATR: What can you tell us about REMS and opioids?
Dr. Salsitz: REMS took a new direction in the face of the nationwide epidemic of opioid overdoses and deaths. The US Food and Drug Administration (FDA), which runs REMS, expanded the program to include extended-release and long-acting (ER/LA) opioid analgesic medications. Part of that initiative was education for prescribers about the use of these opioids, which resulted in the development of a continuing medical education (CME) course. The main objective is to help ensure that those who prescribe these ER/LA opioids for the treatment of chronic pain know how to do so effectively and safely.

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How to Use *The ASAM Criteria* in Your Practice

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the criteria. You might also want to get a copy of the entire book—a 460-page hardcover—as a desk reference for guidance on the finer points.

Case Example

To illustrate how to use the criteria, consider a hypothetical patient who is seeing me for a routine office visit for medication management. The young man has a history of heroin and cocaine addiction, along with comorbid bipolar disorder. He is being managed with Suboxone and was doing well when I last saw him. In the interim, however, he relapsed on crack cocaine and has been unable to control his use. He is becoming depressed and is worried that he will start using heroin again in order to cope with his depression.

In the resulting progress note at the end of this article, you can see how I have incorporated the ASAM criteria (see "Sample Outpatient Addiction Medicine Progress Note" on p. 4). I did this to comprehensively document his condition and to ensure that I had information necessary to justify the more intensive (and therefore more costly) level of treatment that he needed.

There are essentially three steps in using these criteria. Step 1 is recording the diagnosis in ASAM's six dimensions. Step 2 involves assigning a risk rating for each dimension. Finally, in Step 3, you bring all the data together to dial in the appropriate level of care.

Step 1: Diagnosis

You start by assessing the patient in six dimensions (**Table 1**). Dimension 1 is the core substance abuse issue—in this case opioid use disorder in remission, and active cocaine use disorder. Dimension 2 corresponds to past medical history (or Axis III in the old DSM), and Dimension 3 encompasses psychiatric disorders other than addiction—in this case, bipolar disorder. Dimension 4 reflects his motivation to seek treatment, which appears genuine; and Dimension 5 gauges the risk of continuing substance use, which I believe is significant. Finally, Dimension 6 assesses his current "recovery environment," meaning whether his current psychosocial situation is likely to help or hinder his recovery efforts. For this patient, this is problematic since his peers are substance abusers and he has stopped attending 12-step meetings.

Step 2: Severity

After populating the six dimensions with diagnoses and data, you then circle back to assign a risk rating for each dimension (**Table 2**). These range from zero ("non-issue or very low-risk issue") to four ("issues of the utmost severity"). Higher risk ratings involve something ASAM calls "imminent danger," which represents a high probability of "serious adverse consequences to the individual and/or others" in the next few hours to days. As you can see from the progress note, I assigned most of this patient's issues a risk rating of 2, meaning "moderate difficulty in functioning."

Step 3: Setting

The final step involves matching the patient to an appropriate level of care (**Table 3**). As a general rule, patients with low risk ratings (0s and 1s) require minimal clinical supervision, those with moderate risk ratings (2s) need services several days per week, and those with high risk ratings (3s and 4s) require some sort of 24-hour care. While I felt that this patient required more intensive treatment than the basic outpatient care he

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Table 1: ASAM's Six Dimensions

Patients are systematically evaluated in various domains. A risk rating (Table 2) is also assigned for each dimension.

Dimension	Definition	What to document
1	Acute intoxication and/or withdrawal potential	*DSM-5* substance-related disorders and severity
2	Biomedical conditions and complications	General medical conditions and severity
3	Emotional, behavioral, or cognitive conditions and complications	*DSM-5* non-addiction diagnoses and severity
4	Readiness to change	Number from 0 (complete readiness to change) to 4 (strong resistance to change)
5	Relapse, continued use, or continued problem potential	Number from 0 (low relapse potential) to 4 (high relapse potential)
6	Recovery/living environment	Number from 0 (good housing situation and recovery resources) to 4 (poor housing situation and recovery resources)

Source: Created with information from Mee-Lee D et al. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. Carson City, NV: The Change Companies; 2013.

EDITORIAL INFORMATION

Publisher: **Daniel Carlat, MD**

CEO: **Steve Zisson**

Executive Editor: **Joanne Finnegan**

Editor-in-Chief: **David A. Frenz, MD,** is medical director of mental health and addiction care at HealthEast Care System in St. Paul, MN.

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Steve Balt, MD, ABAM, is a psychiatrist in private practice and addiction psychiatry in the San Francisco Bay area. He is also the editor-in-chief of *The Carlat Psychiatry Report.*

Gantt P. Galloway, PharmD, is a senior scientist at the California Pacific Medical Center Research Institute in San Francisco, CA and executive and research director of New Leaf Treatment Center in Lafayette, CA.

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How to Use *The ASAM Criteria* in Your Practice

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was getting, I did not believe he needed either hospitalization or partial hospitalization. Therefore, I recommended intensive outpatient services, defined as nine or more hours of programming per week. My plan is to monitor his progress carefully in case his condition worsens, in which case he will likely need residential or inpatient care to stabilize. You can see the completed, sample progress note on p. 4.

Table 2: Risk Assessment

Risk in each ASAM dimension is assigned using the following five-point scale.

Risk Rating	Definition
0	Non-issue or very low-risk issue
1	Mildly difficult issue
2	Moderate difficulty in functioning
3	Serious issue or difficulty coping
4	Issues of utmost severity

Source: *The ASAM Criteria*.

Table 3: Levels of Care

The ASAM Criteria outline a seamless continuum of care for patients with addiction. Patients transition to more intense or less intense services depending on their clinical needs. There are currently 10 levels of care with discontinuous numbering (for example, there is no Level 2.2, 3.2, etc.).

Level of Care, Description, and Examples	
0.5	Early Intervention, for at-risk patients who do not meet criteria for addiction; eg, DUI/DWI programs
1	Outpatient Services, less than 9 hours of service per week; eg, medication management visits
2.1	Intensive Outpatient Services, 9 or more hours of service per week; eg, outpatient treatment programs
2.5	Partial Hospitalization Services, 20 or more hours of service per week but not requiring 24-hour care; eg, partial hospitalization programs
3.1	Clinically Managed Low-Intensity Residential Services, 24-hour structure with trained personnel available; eg, half-way houses
3.3	Clinically Managed Population-Specific High-Intensity Residential Services, 24-hour care with trained counselors with less intense milieu and group treatment; eg, residential treatment for patients with cognitive difficulties
3.5	Clinically Managed High-Intensity Residential Services, 24-hour care with trained counselors with more intense milieu and group treatment; eg, residential treatment for patients with normal cognitive abilities
3.7	Medically Monitored Intensive Inpatient Services, 24-hour nursing care with physicians available for significant problems; eg, residential treatment for patients with significant problems with addiction, mental health, and/or general medical conditions
4	Medically Managed Intensive Inpatient Services, 24-hour nursing care and daily physician care for severe, unstable problems; eg, hospital-based care
OTP	Opioid Treatment Program, administration of methadone or buprenorphine in conjunction with counseling for those with severe opioid addiction, eg, methadone clinic

Source: *The ASAM Criteria.*

Expert Interview: Dr. Salsitz

Continued from page 1

CATR: Can you tell us more about these courses?

Dr. Salsitz: These are CME courses that we deliver to various audiences. I teach under the auspices of the American Society of Addiction Medicine (ASAM) but other presenters are doing it through the pain societies and primary care organizations. The course itself is three hours long, free of charge, and offers CME credit to participants. The FDA initially hoped to make the education mandatory by tying it to a provider's Drug Enforcement Administration (DEA) registration, however, there was some resistance to that idea. So, for right now, REMS courses are voluntary.

REMS stands for Risk Evaluation and Mitigation Strategies. It's a patient safety program for high-risk medications.

Edwin A. Salsitz, MD

CATR: Who developed the content for these courses?

Dr. Salsitz: The FDA convened a panel of stakeholders in 2012 that included pain specialists, addiction specialists, primary care physicians, nurse practitioners, and others. They formed what is called the Collaborative for REMS Education, or CORE (www.core-rems.org). The FDA provided us with a blueprint of the topics that should be covered in the ER/LA opioid program and CORE used those guidelines to develop the actual course materials. The first such course was given in March 2013. While the pharmaceutical companies provide funding for the courses, they have absolutely no input into the content. The funding ensures the courses are free to participants and pays for the logistics of organizing the course, providing a venue, and advertising the courses.

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Sample Outpatient Addiction Medicine Progress Note

(See p. 2 for a walk-through of this progress note.)

Date of Service: 17 November, 2014

Current ASAM Level of Care: 1

Chief Complaint: Cocaine addiction

History of Present Illness: Patient continues to do well from an opioid standpoint. He last used heroin about nine months ago. He feels that his dose of Suboxone is adequate and he denied opioid cravings, withdrawal symptoms, and medication side effects. Unfortunately, the patient relapsed on crack cocaine about three weeks ago. He has been using every day for the past week and worries that he will eventually start mixing it with heroin again. Cocaine is taking up a lot of time, interfering with work, and making him feel depressed and mildly paranoid. He tried quitting a few times on his own but winds up using again within a day or two.

Dimension 1

- Cocaine use disorder, moderate
- Opioid use disorder, on maintenance therapy with buprenorphine, stable
- Risk Rating: 3
- Clinical Rationale: Cocaine use is interfering with function. Patient also has a prior history of cocaine-induced psychosis requiring hospitalization.

Dimension 2

- Moderate persistent asthma
- Risk Rating: 2
- Clinical Rationale: Albuterol use has increased in the past few weeks, probably due to cocaine use.

Dimension 3

- Bipolar I disorder, current episode depressed, moderate
- Risk Rating: 2
- Clinical Rationale: Cocaine use has destabilized his mood and placed him at risk for psychosis. PHQ-9 = 14, up from only 5 in September. No evidence of imminent danger.

Dimension 4

- Patient is highly motivated to re-establish abstinence from cocaine.
- Risk Rating: 0

Dimension 5

- Patient has been unable to re-establish abstinence on his own. Cocaine use will likely continue in the absence of more intensive intervention.
- Risk Rating: 2

Dimension 6

- Patient is not attending mutual help meetings and no longer sees his psychotherapist. His peers are substance abusers. He continues to have stable housing with his mother, who is aware of his cocaine use and remains supportive.
- Risk Rating: 2

Treatment Plan

1. For cocaine use disorder, a higher level of care is indicated. Based on *The ASAM Criteria*, we will ask his insurance company to fund a Level 2.1 intensive outpatient program though our healthcare system to address multidimensional instability. In my judgment, the patient does not require partial hospitalization or 24-hour supervision at this time.
2. For opioid use disorder, we will continue Suboxone without change.
3. For bipolar disorder, we will continue divalproex and quetiapine without change. We will consider obtaining a valproic acid level and possibly adjusting his medications should symptoms persist or worsen.
4. For asthma, we will add low-dose inhaled fluticasone as a controller medication. We will otherwise continue albuterol, as needed, for acute symptoms.
5. Patient was advised to return to clinic in one week for interval history, urine toxicology, and ongoing medication management.

David A. Frenz, MD

Q&A With the Expert

Understanding *The ASAM Criteria*

David Mee-Lee, MD

Chief Editor, The ASAM Criteria

Dr. Mee-Lee has disclosed that he is a consultant for The Change Companies, which publishes *The ASAM Criteria*. Dr. Frenz has reviewed this interview and found no evidence of bias in this educational activity.

CATR: What, exactly, are *The ASAM Criteria*?

Dr. Mee-Lee: *The ASAM Criteria* are the American Society of Addiction Medicine's guidelines for matching severity of illness and level of function with intensity of service in addiction treatment. The first edition was published in 2001 and a significant update appeared in 2013.

CATR: Why are *The ASAM Criteria* so important?

Dr. Mee-Lee: Well, for starters, they're pretty important for reimbursement. If your patient needs addiction treatment, the funder—a private commercial insurance company or government agency—is probably using *The ASAM Criteria* to respond to your request. It's a good idea for providers to understand them for that reason alone.

If your patient needs addiction treatment, the funder—a private commercial insurance company or government agency—is probably using *The ASAM Criteria* to respond to your request.

David Mee-Lee, MD

CATR: Are there other reasons?

Dr. Mee-Lee: Yes. In some states, *The ASAM Criteria,* or adaptations thereof, are used to license treatment programs. Also, a software version of *The ASAM Criteria* is coming out around January 2015. This will allow providers to use the criteria at the point of care for their patient encounters, regardless of setting. About 20 electronic health record vendors have already signed nondisclosure agreements to integrate *The ASAM Criteria* into their products.

CATR: What motivated the 2013 revision?

Dr. Mee-Lee: There were a number of reasons. DSM was being updated, and we wanted to make the diagnostic admission criteria compatible with *DSM-5*. In addition, over the years, many people had asked, "How does this apply to my particular population?" So we added four new sections on specific populations including: older adults; people in safety-sensitive occupations, such as doctors and pilots; parents whose children are with them during treatment; and people in criminal justice settings. Another big piece was adding new sections on working effectively with managed care and adapting to healthcare reform. We also included new sections on tobacco use disorder and gambling disorder—trying to elevate them to the level of substance-related disorders. And, finally, we wanted to update the language to make it more strength-based and recovery-oriented and to fit with ASAM's definition of addiction as a chronic disease.

CATR: How are *The ASAM Criteria* structured?

Dr. Mee-Lee: There are six dimensions that providers use to assess patients in various domains (see "Table 1: ASAM's Six Dimensions" on p. 2). There are also 10 levels of care ranging from outpatient services all the way up to hospitalization (see "Table 3: Levels of Care" on p. 3). A patient's profile in the six dimensions determines the most appropriate level of care at any given point in time.

CATR: How do the dimensions work?

Dr. Mee-Lee: These six dimensions create a comprehensive picture—not just of pathology and needs—but also of strengths, skills, and resources. They allow us to talk about what someone is doing well and not just how sick they are.

CATR: So when providers use these dimensions to structure their progress notes, what is the end result?

Dr. Mee-Lee: It's generally a combination of narrative material and a risk rating for each dimension. That risk-rating piece is really important because funders key in on those numbers—they are a very succinct way of describing the patient's current status.

CATR: Tell us more about those risk ratings.

Dr. Mee-Lee: Sure. Risk ratings range from zero to four (see "Table 2: Risk Assessment" on p. 3). We define zero as a non-issue or very low risk issue. Two is in the middle and represents moderate difficulty in functioning. And four indicates issues of utmost severity, something we call an "imminent danger" concern—strong probability of serious harm to self or others in the next few hours to days.

CATR: And providers come up with one number for each dimension?

Dr. Mee-Lee: Correct. And the overall picture—the six risk ratings taken together—justify your treatment plan. A lot of times the treatment plan is just fine, so the numbers support what you're already doing. In other cases, the patient is struggling, so you use the risk ratings to arrange the additional services that are needed. You send the numbers off to the funder—maybe it's an insurance company—to justify certain medications or a more intensive level of care.

CATR: This sounds like other areas of medicine where care is tailored to needs.

Dr. Mee-Lee: Absolutely. We talk about matching. You don't want to undermatch somebody—for example, treating them in your office when they need something more. That can lead to poor outcomes and ultimately increase healthcare utilization. But the opposite is also true. If you overmatch somebody—put them in a more intensive level of care than *The ASAM Criteria* suggest—that

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Research Updates

VIOLENCE

Substance Abuse Treatment Reduces Aggression

Addiction and violence are often linked. Despite this, few studies have looked at whether substance abuse treatment reduces aggressive behavior.

A prospective cohort study funded by the National Institute on Alcohol Abuse and Alcoholism followed 278 men and women with severe mental illness and addiction for six months. All of the patients were diagnosed with either schizophrenia spectrum or bipolar disorder and alcohol use disorder. Most (86%) also had other substance use disorders. On average, participants had received approximately 14 prior substance abuse treatments and eight episodes of psychiatric care.

Study participants received integrated dual disorders treatment at a community mental health center in Buffalo, New York. Individual and group therapy were provided. The average duration of treatment was about 15 weeks and 81% of patients were followed for the entire study period.

Researchers assessed patients on a monthly basis for substance use and aggressive behavior. Aggression was defined as problem behavior that occurred secondary to alcohol or drug use. Patients were specifically assessed for a history of arguments with family and friends, physical fights, arrests, injuring someone else, and property damage. Problem severity was rated from zero ("never") to three ("daily or almost daily").

Patients who attended more days of treatment had lower levels of substance use and aggression in follow-up. Statistical modeling found that substance use was an important mediating factor. Specifically, treatment reduced substance use, which, in turn, reduced aggressive behavior. Surprisingly, there was no relationship between the severity of psychiatric symptoms and violence (Zhuo Y et al, *J Subst Abuse Treat* 2014;47(5):353–361).

CATR's Take: This study, with a challenging patient population, found that substance abuse treatment reduced aggressive behavior. The hypothesized mechanism, which is intuitive, was a reduction in substance use. Providers can now add this benefit to the already long list of positive outcomes associated with addiction treatment.

Expert Interview: Dr. Salsitz

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CATR: What medications are addressed?

Dr. Salsitz: The course covers 30 different ER/LA opioids manufactured by 20 different companies. There is also a REMS for Suboxone (buprenorphine/naloxone), but that isn't part of this course. Our work deals exclusively with opioids prescribed for chronic pain. If new formulations of ER/LA opioids are approved by the FDA, these medications are added to the course. Recent examples include Zohydro, the long-acting hydrocodone product, and Targiniq, a new combination of oxycodone and naloxone.

CATR: What do providers learn about in the ER/LA opioids course?

Dr. Salsitz: The course is made up of six modules starting with one on assessment. During that module, we talk about some instruments that can be used to stratify patients in terms of their risk for medication misuse. One of these is the Opioid Risk Tool (ORT) (Webster LR & Webster RM, *Pain Med* 2005;6(6):432–442). Another is the Screener and Opioid Assessment for Patients with Pain (SOAPP) (Akbik H et al, *J Pain Symptom Manage* 2006;32(3):287–293).

CATR: How do these tools work?

Dr. Salsitz: ORT is a five-item instrument that puts patients into categories—low, moderate, and high risk for medication misuse—based on some simple historical factors. These are family history of addiction, personal history of addiction, personal history of mental illness, age, and personal history of child sexual abuse. Each item is weighted differently. Scoring is also different for men and women.

CATR: How about SOAPP?

Dr. Salsitz: That consists of 14 questions and is completed by the patient. For example, the first question is, "How often do you have mood swings?" Patients have five choices ranging from "never" to "very often." There are other questions about cigarette use, illegal drug use, and non-medical use of prescription medications. All of the responses are added up and the final score is interpreted as either positive or negative. A positive result means the patient is at higher risk for having problems with prescribed opioid medications.

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By the Numbers: Prescription Opioid Addiction

- Healthcare providers wrote 259 million prescriptions for opioid analgesic medications in 2012, enough for every American adult to have a bottle of pills
- Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month
- Hawaii had the lowest prescribing volume in the nation—52 prescriptions per 100 residents
- Ten of the highest prescribing states for painkillers are in the South
- Alabama and Tennessee had the highest prescribing volume—143 prescriptions per 100 residents
- Each day, 46 people in the US die from an overdose involving opioid analgesics
- Overdose deaths from opioid analgesics continue to rise—from 4,030 in 1999 to 16,651 deaths in 2010

Source: The US Centers for Disease Control and Prevention.

CE/CME Post-Test

To earn CE or CME credit, you must read the articles and log on to www.CarletAddictionTreatment.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by November 30, 2015. As a subscriber to *CATR,* you already have a username and password to log on www.CarlatAddictionTreatment.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

1. How many dimensions are addressed in *The ASAM Criteria* (Learning Objective #1)?
   [ ] a) Three [ ] b) Six [ ] c) Nine [ ] d) Twelve

2. For each dimension in *The ASAM Criteria*, clinicians assign a risk rating using a scale that ranges from___ (LO #1).
   [ ] a) Zero to five [ ] b) One to five [ ] c) Zero to four [ ] d) One to four

3. Which of the following is true of the FDA's Risk Evaluation and Mitigation Strategies (REMS) program for extended-release and long-acting opioid analgesic medications (LO #2)?
   [ ] a) It was developed as a response to the nationwide epidemic of opioid overdoses and deaths
   [ ] b) Clinicians are required to take a CME course to renew their DEA number
   [ ] c) Its main objective is to educate patients who take opioid analgesic medications
   [ ] d) Pharmaceutical companies developed the content for the CME course

4. *The ASAM Criteria* are guidelines that match severity of illness and level of function to the most appropriate services needed to treat addiction (LO #3).
   [ ] a) True [ ] b) False

5. A study that looked at whether substance abuse treatment reduces aggressive behavior found which of the following was true (LO #4)?
   [ ] a) Substance abuse treatment had no impact on violence
   [ ] b) Substance abuse treatment reduced aggressive behavior
   [ ] c) Violence was related to the severity of psychiatric symptoms
   [ ] d) There was no link between the number of days people attended substance abuse treatment and violence

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Expert Interview: Dr. Salsitz

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CATR: What other things do you cover in the ER/LA opioids course?

Dr. Salsitz: We address starting doses, titration guidelines, switching between medications, and how to deal with adverse effects. There is also material on monitoring, which gets into urine toxicology, prescription drug monitoring programs (PDMPs), and pill counts. The ASAM-sponsored REMS course includes a seventh module in which we review the evidence concerning the incidence of addiction and problematic behaviors in patients with chronic, non-cancer pain treated with chronic opioid therapy. Management of these patients is also discussed.

CATR: Tell us more about PDMPs.

Dr. Salsitz: Every state except Missouri has a PDMP (http://nyti.ms/1ugiTyX). These programs allow providers to use a web interface to review a patient's dispensing history for controlled substances. The reports tell you what medications they have received, dates, quantities, pharmacies, and, in some cases, prescriber names. PDMPs are designed to address "doctor shopping" and there is evidence from multiple sources that they are effective (http://bit.ly/1sIr4Qc).

CATR: Where can our readers learn more about the PDMPs in their states?

Dr. Salsitz: The DEA maintains a web page (http://1.usa.gov/1wXr3gv). They can also contact licensing boards such as the board of medicine or pharmacy.

CATR: How about pill counts?

Dr. Salsitz: This helps you assess for medication overuse and diversion. You contact patients—a random phone call is best—and have them bring their pill bottles to clinic. You then count pills and determine whether medication use is appropriate based on the dispensing dates and initial quantities.

CATR: Some of our readers will probably want to attend your course. Where can they get more information?

Dr. Salsitz: ASAM is a good place to start (http://bit.ly/1sIvlC7). There are also other accredited organizations offering this training (http://bit.ly/1yCBx33).

CATR: Thank you, Dr. Salsitz.

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This Month's Focus:
Risk and Reimbursement

Next month in *The Carlat Addiction Treatment Report:* Internet and Gambling Addictions

Expert Interview: Dr. Mee-Lee
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wastes resources and you don't necessarily get better outcomes. This is common sense, but there's a lot of evidence to back up our aims of increasing access to care and using resources more efficiently (Gastfriend DR & Mee-Lee D, *J Addict Dis* 2003;22(Suppl 1):1–8).

CATR: In Minnesota there's a joke: we have 10,000 lakes and also 10,000 treatment programs. Do you think *The ASAM Criteria* will lead to a change in that area?

Dr. Mee-Lee: Unfortunately, we're still very program driven in the public and private sectors. Addiction treatment is basically a sick care system and needs to move to a well care system. Also, there's still very much a belief in fixed lengths of stay and that patients should enter treatment at the residential level. This isn't true for any other chronic disease. We don't have fixed length-of-stay schizophrenia programs or residential diabetes programs. So, yes, in many ways *The ASAM Criteria* have totally changed our model to a seamless continuum of care for chronic disease management.

CATR: Thank you, Dr. Mee-Lee.

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