# Medicine Responds to Addiction: Implementing Physician Training

**January 30, 2018**


**sponsored by**

**The Addiction Medicine Foundation**

**in partnership with**

**National Institute on Alcohol Abuse and Alcoholism,**
**National Institute on Drug Abuse,**
**Substance Abuse and Mental Health Services Administration**

# Proceedings

## Welcome and Overview

**Tim Brennan, M.D., M.P.H., and Anna Lembke, M.D.**

Dr. Brennan opened the symposium at 8:00 a.m. He thanked the Office of National Drug Control Policy, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the Substance Abuse and Mental Health Services Administration, the Accreditation Council for Graduate Medical Education, the Translation Research Initiative planning group, and all speakers and participants.

Dr. Lembke discussed the logistical details of the symposium. A recording of the entire meeting would be on the website of The Addiction Medicine Foundation (TAMF).

Dr. Brennan detailed the growth in addiction medicine (ADM) fellowship from 2012 to 2018. In 2012, the first ten ADM fellowship training programs were established. By 2018, there were 52 current and 19 emerging fellowships. The goal is to have 125 by 2025.

## Responding to Drug Use, Addiction, and the Opioid Crisis: Administration Priorities and the Need for a Trained Workforce

**June Sivilli, M.A., Division Chief, Public Health and Public Safety, Office of National Drug Control Policy**

Ms. Sivilli assured attendees that the Office of National Drug Control Policy (ONDCP) had done what it could over the years to advance addiction medicine. In 2015-16, it co-hosted two symposia at the White House. She promised that ONDCP would work to establish more addiction medicine fellowships and expand the addiction medicine and addiction psychiatry workforce. Over 63,000 Americans died from accidental drug poisoning in 2016, and initial 2017 data do not suggest a downturn in the rate of overdose deaths. The administration is undertaking a multipronged strategy to respond to the opioid crisis. The National Survey on Drug Use and Health (NSDUH) indicates that only about ten percent of people with substance use disorders actually receive specialty treatment. Among individuals with an opioid use disorder, approximately 20 percent access treatment. The administration is working to improve screening for substance use and addiction, and to create more pathways to addiction treatment. It allocated more than $800 million in the past year for prevention, treatment, first responders, prescription drug monitoring programs, and recovery services. The president has created an Opioid Commission. The Department of Health and Human Services has established a Pain Coordinating Committee.

## Translating Science to Physician Training and Practice

**George Koob, Ph.D., Director, National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health (NIH)**

**Key Points of Presentation:**

- Alcohol is the third leading preventable cause of death in the U.S.
- 15.1 million adults have alcohol use disorder (AUD).

- There has been an increase in emergency department visits and hospitalizations related to alcohol in the last 10 years.
- Decades of research shows that addiction is a chronic brain disease.
- AUD frequently co-occurs with other mental health conditions.
- Less than ten percent of people with AUD get any treatment.
- Less than four percent of patients with AUD use a Food and Drug Administration (FDA)-approved medication to treat their disorder.
- NIAAA-funded researchers developed 3-D photography and image analysis techniques to enhance detection of alcohol-induced facial features in children prenatally exposed to alcohol. The new technique will help identify individuals within the fetal alcohol disorder spectrum with facial features too subtle for detection by the human eye.
- There are evidence-based interventions for preventing and treating AUD:
    - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
    - Minimum legal drinking age of 21
    - Professionally led behavioral interventions
    - FDA-approved medications
    - Mutual support groups, such as Alcoholics Anonymous
- Alcohol Screening and Brief Intervention (SBI) in primary care reduces alcohol misuse among adults; recommended by the U.S. Preventive Services Task Force.
- Effective prevention interventions of alcohol misuse and harm include:
    - Individually oriented (Screening and Brief Intervention (SBI))
    - Family
    - School
    - Web-based
    - Environmental
    - Policies (e.g. taxes, outlet density, driving while intoxicated laws, and minimum legal drinking age laws)
    - Multi-component community interventions
- Effective professionally led behavioral interventions include:
    - Cognitive-behavioral therapy: to change the thought processes that lead to alcohol misuse and develop skills to cope with situations that trigger problem drinking
    - Motivational enhancement therapy: to enhance motivation to change drinking behavior with life goals
    - Community reinforcement: to facilitate changes in a person's life to make abstinence more rewarding than drinking
    - Marital and family counseling: incorporates family into treatment to help repair and improve family relationships
- There are three FDA-approved medications for the treatment of AUD:
    - Disulfiram blocks the breakdown, or metabolism, of alcohol by the body, increasing acetaldehyde, and causing unpleasant symptoms such as nausea and flushing of the skin.
    - Naltrexone diminishes the rewarding effects of alcohol to help people reduce heavy drinking.

    - Acamprosate reduces the negative emotional state associated with protracted abstinence from alcohol and may also reduce craving, make it easier to maintain abstinence
- To assist people in finding AUD treatment, NIAAA has developed the NIAAA Alcohol Treatment Navigator, which outlines the features of evidence-based AUD treatment, describes the varied routes to recovery, and provides a strategy for locating qualified treatment specialists.
- NIAAA sponsored the Wearable Alcohol Biosensor Challenge.
- A second challenge recently closed. The object was to design a wearable sensor using technologies that detect alcohol non-invasively in blood or interstitial fluid.
- A study of 54 primary care clinics found 88 percent had no policies or requirements to ask patients about alcohol use, and those with policies had no consistent evidence-based methods for screening or referral.
- NIAAA seeks to grow the addiction medicine workforce by:
    - Improving physician training in substance use prevention and treatment at all levels
    - Integrating prevention, early intervention, and treatment into routine medical care
- NIAAA, the National Institute on Drug Abuse (NIDA), and other federal agencies engaged with the White House on a national effort to grow the addiction medicine workforce.
- Next steps include identifying medical school curriculum needs and enhancing addiction medicine questions on medical board exams.

## Nora Volkow, M.D., Director, NIDA, NIH

**Key Points of Presentation:**

- Overdose death rates increased tremendously in all parts of the country between 1999 and 2016.
- Opioid prescriptions steadily increased from 1991 to 2011.
- Opioid morphine milligram equivalents (MME) dispensed fell by over 15 percent from 2010 to 2015.
- Fentanyl-related deaths surpassed deaths from heroin or prescription opioids in 2016.
- Medication-assisted treatment (MAT) decreases opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission, and increases social functioning and retention in treatment, but it is highly underutilized, and relapse rates are very high.
- Integrating buprenorphine treatment (BT) into a large Federally Qualified Health Center (FQHC) network increased retention rates to levels similar to those reported by clinical trials. Prescription of psychiatric medicine and on-site substance abuse counseling improved retention whereas cocaine use decreased it.
- Integrating BT into primary care settings could also improve co-morbid disease diagnosis and management of chronic diseases.

- In 2016, an estimated 20.1 million Americans 12 or older were dependent on any illicit drugs or alcohol, but only 3.8 million, or 19 percent, of these individuals had received some type of treatment in the past year and very few involved health care systems.
- We need physicians to be our partners in better integrating drug abuse screening, prevention, and treatment into the healthcare system. To make this happen, we need physicians to be provided with more education and training.

## Anita Everett, M.D., Chief Medical Officer, Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services (HHS)

**Key Points of Presentation:**

- The 2016 NSDUH found that 7.5 percent of people aged 12 or older had a substance use disorder; 18.3 percent of people aged 18 or older had a mental illness; and 3.4 percent of people aged 18 or older had both substance use and a mental disorder.
- Among those with a substance use disorder, about 33 percent struggled with illicit drugs, 75 percent with alcohol use, and 11 percent with both.
- Among those with a mental illness, about 25 percent had a serious mental illness.
- Over two million Americans have an opioid use disorder (OUD); of those, only one in five receive specialty treatment for illicit drug use.
- There were over 64,070 drug overdose deaths in 2016, 75 percent of which were from opioids.
- Among 28 states with available data, neonatal abstinence syndrome (NAS) increased 300 percent from 1999 to 2013.
- HHS has a five point opioid strategy
    - Strengthening public health surveillance
    - Advancing the practice of pain management
    - Improving access to treatment and recovery services
    - Targeting availability and distribution of overdose-reversing drugs
    - Supporting cutting-edge research
- Examples of public health surveillance include:
    - National Survey on Drug Use and Health
    - Treatment Episode Data Set
    - National Survey of Substance Abuse Treatment Services
    - Collaboration with the Centers for Disease Control and Prevention (CDC) on Prescription Drug Monitoring Program (PDMP) implementation
- SAMHSA plans to address the opioid crisis through support for evidence-based prevention, treatment, and recovery services for opioid use disorder. This includes:
    - State-Targeted Response (STR) grants to states
    - Block grants to states
    - Refocusing technical assistance
    - Naloxone access/first responders/peers
    - Pregnant/postpartum women/NAS
    - Criminal justice programs with MAT

    - Recovery coaches
    - Public outreach: prevention
    - Health Insurance Portability and Accountability Act (HIPAA)/42 Code of Federal Regulations (CFR): family inclusion in medical emergencies: overdose
- Education of our workforce is a critical foundation for the change we all need to see.

## Physician Training Resources: Science Informing Physician Training and Practice

**<u>Alcohol</u>: Margaret (Peggy) Murray, Ph.D., Director, Global Alcohol Research Program, Office of the Director, NIAAA, NIH**

**Key Points of Presentation:**

- Medical education is part of NIAAA's mission. NIAAA provides leadership in the national effort to reduce alcohol-related problems by translating and disseminating research findings to health care providers, researchers, policymakers, and the public.
- Dissemination science is part of the NIH mission. Dissemination is the targeted distribution of information to a specific public health or clinical practice audience. The intent is to spread knowledge and the associated evidence-based intervention.
- The search for alcohol treatment can feel overwhelming. NIAAA's Alcohol Treatment Navigator will help you focus your search to find options that increase the chance for success. It has no commercial ties, an emphasis on evidence-based approaches, and a goal to educate.
- Next steps include:
    - Studies of education interventions that broaden the focus of physician education beyond Screening and Brief Intervention to include neurobiology of addiction and effective treatments (i.e. medications)
    - Improve alcohol content questions on medical student and licensing exams
    - Ensure the expectations of alcohol/addiction identification and treatment as quality care
    - Requirements will drive the education quality
    - Use of technological advances in skill development
- From 2002 to the present, NIAAA has funded Alcohol Education Project Grants, an R25 grant program for projects designed to support the science of dissemination of new knowledge acquired through alcohol research to a wide array of health professionals. Grantees receive $250,000 per year for two to three years.
- The five signs of higher quality care:
    - Credentials
    - Comprehensive assessment
    - Customized, responsive treatment plan
    - Evidence-based therapies
    - Continuing recovery support

## NIDA Portfolio: Michelle Corbin, MBA, Public Health Analyst, NIDAMED, NIDA, NIH

**Key Points of Presentation:**

- NIDAMED's mission is to develop and disseminate science-based resources on opioids and SUD that educate health professionals and those in training about screening, addressing, and treating SUD; and enhancing their awareness of addiction as a treatable brain disorder.
- NIDAMED is accomplishing its mission through partnerships, developing content that is usable and easily digestible.
- Top NIDAMED products:
    - Screening, assessment, and drug testing resources
    - Screening tools chart
    - Opioid-specific content, including: prescribing guidance, OUD treatment information, and content for special populations
    - Continuing education courses that focus on general substance abuse, adolescent substance use (SU), opioid prescribing and pain, opioids, and opioid overdose
    - SU treatment
    - Patient resources
    - Curriculum resources
    - ADM content
- Created in collaboration with The Addiction Medicine Foundation, the new ADM Fellow Toolkit serves as an introduction for new ADM fellows before entering their fellowship programs. The resources in the toolkit can help prepare fellows on their journey to becoming ADM-certified.
- EXPLORE provides ADM fellows with accessible and practical information on the following topics:
    - Addiction science
    - Opioid information and prescribing
    - Pain management
    - Substance use treatment
- BOOKMARK suggests up-to-date information and webpages that the fellows can frequently refer back to during and after their journey to become ADM-certified.
- LEARN provides the ADM fellows with continuing medical education (CME) and modules in order to review and further expand their knowledge base on substance use and addiction. These resources can serve as booster training materials in addition to what they have learned in the classroom or in their practice or clinic.
- WATCH provides ADM fellows with the opportunity to learn from experts in the substance use and addiction fields through an extensive library of videos.

## <u>Tobacco</u>: Doug Tipperman, M.S.W., Tobacco Policy Liaison, Office of Policy, Planning, and Innovation, SAMHSA, HHS

**Key Points of Presentation:**

- Smoking remains the leading cause of preventable disease and death in the United States. It is responsible for over 480,000 deaths per year.
- Tobacco-related diseases are the leading cause of death in patients previously treated for alcoholism and other SUDs.
- SAMHSA's National Survey on Drug Use and Health (NSDUH) found that 48.3 percent of adults with an SUD in the past year smoked, as opposed to 18.6 percent without an SUD.
- Smoking prevalence for those 12 and older who received substance use treatment was 74 percent.
- A 2017 nationally representative, prospective longitudinal study of long-term outcomes for SUD found that continued smoking and smoking initiation among nonsmokers were associated with significantly greater odds of SUD relapse.
- A 2004 meta-analysis of 19 studies found that smoking cessation interventions provided during addictions treatment were associated with a 25 percent increased likelihood of long-term abstinence from alcohol and illicit drugs.
- A 2014 meta-analysis of 26 studies found that smoking cessation is associated with decreased depression, anxiety, and stress, and improved positive mood and quality of life compared with continuing to smoke.
- Based on this research, the Substance Abuse and Mental Health Services Administration recommends the adoption of tobacco-free facility/grounds policies and the integration of tobacco treatment into behavioral healthcare.
- Routinely screening patients for tobacco use and encouraging every smoking patient willing to make a quit attempt to use evidence-based cessation counseling treatments and medications is effective.
- Counseling and medication are effective when used by themselves for treating tobacco dependence. The combinational counseling and medication, however, is more effective.
- Many may benefit from additional counseling and longer use of cessation medications as well as combination use of medications.
- Adopting and implementing a tobacco-free facility/grounds policy is effective.
- The U.S. Public Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence, 2008 update, reflects the distillation of a literature base of more than 8,700 research articles, and provides detailed recommendations about clinical interventions for tobacco cessation and found that tobacco dependence treatments are effective across a broad range of populations.
- The U.S. Department of Health and Human Services (HHS) launched Million Hearts in 2012 to reduce cardiovascular events. Million Hearts has evidence-based tools and resources for tobacco cessation interventions.

**<u>Opioids</u>: Christina A. Mikosz, M.D., M.P.H., Medical Officer, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, HHS**

- Almost 310,000 people have died from an opioid overdose since 1999. T
- In the first wave, over 183,000 people have died from prescription opioids since 1999. The natural and semi-synthetic opioid death rate increased four-fold from 1999 to 2011. The methadone death rate increased six-fold from 1999 to 2007.
- CDC published its Guideline for Prescribing Opioids for Chronic Pain in 2016. The guideline groups 12 recommendations into three conceptual areas:
    - Determining when to initiate or continue opioids for chronic pain
    - Opioid selection, dosage, duration, follow-up, and discontinuation
    - Assessing risk and addressing harms of opioid use
- CDC focuses on four priority areas to maximize the uptake and use of the opioid prescribing guideline for chronic pain outside of active cancer, palliative, and end-of-life care:
    - Translation and communication: develop tools and resources about the guidelines for a variety of audiences, including providers, health systems, and the general public
    - Clinical training: educate providers through medical schools and ongoing continuing medical education (CME) activities
    - Health system implementation: educate providers, integrate into electronic health records (EHRs) and other clinical decision support tools, adopt and use quality metrics, and leverage within broader coordinated care activities
    - Insurer/pharmacy benefit manager information: proactive use of claims information and improvement in coverage and service delivery payment models, including reimbursement for clinician counseling, coverage for non-pharmacological treatments, and drug utilization review or prior authorization

## Fellowships Drive Competency Adoption Across Medical Training and Practice

**Patrick G. O'Connor, M.D., M.P.H., Yale School of Medicine**

**Key Points of Presentation:**

- In May 2015, Dr. O'Connor and his colleagues at Yale received an invitation to provide consultation on Vietnam's ADM curriculum.
- Their goals were to propose a design and infrastructure for training in addiction medicine in Vietnam, and develop and implement core concepts for training in addiction medicine at Vietnamese medical schools.
- If Vietnam can do this, why not us?
- The American Board of Medical Specialties (ABMS) recognized addiction medicine as a subspecialty in 2016.

- The Accreditation Council for Graduate Medical Education (ACGME) developed program requirements, with input from ADM fellowship directors. A final vote is set for February 2, 2018.
- ACGME accreditation applications for ADM fellowships should be available in the first quarter of 2018.
- ACGME fellowships impact training and practice
    - Produce clinical experts, faculty and teachers, researchers, and change agents
    - Drive knowledge, skills, and other competencies
    - Provide institutional leadership on addiction prevention and treatment
    - Advance community and population health
- Yale's addiction medicine fellowship, directed by Dr. Jeanette Tetrault, sponsors one to two fellows per year for one to two years. It has graduated three fellows; a fourth fellow is currently in training. ADM fellowship at Yale drives educational initiatives
    - Undergraduate medical education
    - Graduate medical education addiction recovery clinic (ARC)
    - Interdisciplinary training (SBIRT)
    - CME and community relations
    - Advanced training
- Yale School of Medicine has created an addiction medicine curriculum, with eight master courses, three longitudinal courses, and nine longitudinal threads, including addiction.
- Overall, the ARC rotation has been highly regarded. Common themes:
    - Appreciated role-modeling by faculty
    - Emphasized utility of pre-clinic teaching on ADM topics
    - Importance of continuity of care from week to week
- 28 percent of trainees and 45 percent of faculty have registered for or completed buprenorphine training.
- Programs Yale sponsors
    - Research in Addiction Medicine Scholars (RAMS), a NIDA R25 grant
    - Drug use, Addiction, and HIV Research Scholars, a NIDA K12
- Fellowships supporting medical student education
    - University of Florida College of Medicine: mandatory two-week rotation for all students
    - Stanford University: fellows involved in medical school teaching as part of a new addiction medicine curriculum
    - University of Wisconsin: four-week elective offered in the fourth year of medical school; public health with focus on addressing a substance-related harm at the population level
    - University of California, San Francisco (UCSF): panel of guests in recovery, clinical microsystems clerkship with projects on opioid safety, clerkship narrative reflection exercise on talking about addiction
- Fellowships supporting resident education
    - University of Buffalo: mandatory rotation for all family medicine residents with focus on combatting the opioid epidemic

    - University of Wisconsin: two eight-hour days of didactics focused on ADM in family medicine program; addiction medicine track in primary care internal medicine program
    - UCSF: SBIRT curriculum for all residents
- Boston University's Chief Resident Immersion Training (CRIT) is a four-day program to improve chief residents' substance use knowledge, clinical practice, and teaching skills.
- Fellowships supporting clinical leader education
    - UCSF SHOUT Project: designed by ADM Fellow Hannah Snyder
    - Mt. Sinai School of Medicine: fellows involved in buprenorphine training of attending physicians in an effort to initiate buprenorphine prior to hospital discharge
- Like other medical specialties, addiction medicine fellowships and programs should drive addiction patient care, education, and research throughout their institutions.

## The VA and Addiction Medicine Training and Funding

### Anthony Albanese, M.D., Affiliations Officer, Department of Veterans Affairs (VA) Office of Academic Affiliations, Clinical Professor of Medicine and Psychiatry, University of California (UC) Davis School of Medicine

**Key Points of Presentation:**

- VA has the largest integrated health care system in the U.S., serving more than 8.5 million Veterans each year.
- The VA health care system has a budget of about $59 billion per year. It spends $1 billion for health stipends and $630 million on research.
- VA has affiliations with 144 of 149 allopathic medical schools, 34 of 34 osteopathic medical schools, 1,800+ colleges and universities, 7,200+ program agreements. It sponsors training in over forty health professions.
- The Office of Academic Affiliations (OAA) provides GME support to 11,000 positions and over 43,000 individual residents. Twenty-four thousand medical students receive clinical training in the VA each year.
- In 2016, VA trained 59 physicians, 20 psychologists, 8 social workers, 3 pharmacists, and 1 chaplain in substance abuse treatment.
- The goal of the Veterans Access Choice and Accountability Act of 2014 (VACAA) was to reduce wait times and improve access to care for Veterans. The act included funding for 1,500 additional trainees in primary care, mental health, and scarce specialties. It provided a new method for Veterans living more than 40 miles from a VA facility, those waiting over 30 days for an appointment, and those requiring services not available in the VA to get treatment in the community. Public Law 114-315, passed in 2016, expanded the timeline of the act to 2024.
- VACAA has resulted in the approval of 773.45 positions through 2017.
- Steps to obtain VA funding:
    - Go to www.va.gov
    - Connect with the Designated Education Officer (DEO)

- Complete standardized affiliation agreement and disbursement agreements
- Work with the DEO to determine the desired and available clinical rotations and select VA site directors
- The DEO will request from the OAA the full-time equivalents (FTEs) the applicant agrees to send. Temporary positions are in extremely short supply this year, but may be available if rotations can begin before the next funding cycle.
- Infrastructure funds may be available the year after fellows begin rotating at the VA. VA will notify DEOs if they can apply for these funds.

## The ACGME Accreditation Process for Addiction Medicine Fellowships

**Mary W. Lieh-Lai, M.D., Senior Vice President, Medical Accreditation, ACGME**

**Key Points of Presentation:**

- Accreditation is not certification. Programs receive accreditation from ACGME. Individuals receive certification from certifying boards.
- GME programs received accreditation when judged to be in substantial compliance with the Essentials of Accredited Residencies in Graduate Medical Education.
- ACGME's mission is to improve health care and population health by assessing and advancing the quality of resident physicians' education through accreditation.
- The Board of Directors
  - Sets policy and direction
  - Is responsible for accreditation
  - Delegates authority to accredit programs and institutions to its review committees
  - Monitors review committees
  - Sets budget and fees
- ACGME has 29 review committees.
- Applicants should pay attention to details, including closing dates, ask if they do not understand, and submit an application that really shows what their program is all about.
- Possible accreditation status
  - Initial accreditation (typically lasting two years)
  - Continued accreditation
  - Continued accreditation without outcomes
  - Continued accreditation with warning
  - Probationary accreditation
  - Withdrawal accreditation
  - Administrative withdrawal (rare)
  - Egregious violation (rare)

## Navigating the ACGME Addiction Medicine Application and Review

**Jerry Vasilias, Ph.D., Executive Director, Review Committee for Internal Medicine**

## William Hart, Associate Executive Director, Review Committee for Internal Medicine

**Key Points of Presentation:**

- All review committee (RC) members are volunteers. The number of voting members (7-24) varies by RC. Physician members are nominated by
    - American Medical Association
    - ABMS specialty board
    - Specialty academy/college
    - Each RC has at least one resident physician member
    - Most RCs have at least one American Osteopathic Association-nominated physician
- Most RCs have a non-physician public member with a vote.
- Each nominating organization may appoint an ex-officio member without a vote.
- RC responsibilities
    - Accredit new GME programs
    - Review established programs
    - Confer an accreditation status for each program annually
    - Prepare and maintain program requirements
    - Initiate discussion and recommend changes in GME policies
- RCs meet regularly to conduct business. Frequency depends on workload. They must function in a manner consistent with ACGME policies:
- ADM is a multidisciplinary subspecialty, so multiple RCs are involved. However, each RC has the same Program Requirements (PRs), application form, application process, and objective review process to determine compliance with PRs.
- There are three different types of reviews
    - Applications/new programs
    - Annual data reviews of established programs
    - Self-study reviews of established programs
- The Designated Institutional Official (DIO) needs to initiate the application process in ACGME's Accreditation Data System (ADS).
- The application is three parts:
    - 1. General application for all programs-online data entry
    - 2. Specialty-specific application-word-processing document to be completed and uploaded
    - 3. Other attachments
        - Policies
        - Evaluation tools
        - Block diagram
        - Goals and objectives
- Check agenda closing dates on the website.
    - Core specialty applications need a site visit.
    - Subspecialty applications do not need a site visit.

    - Addiction medicine is a subspecialty.
- The RC reviews applications and programs to determine substantial compliance with minimum PRs, not total compliance with every PR.
- The application success rate is 95 percent. Typically, an application does not receive initial accreditation because of a combination of many things. You can achieve substantial compliance even with a few areas of non-compliance.
- Citations identify areas of non-compliance linked to specific PRs, and require a response in ADS. Areas for improvement can represent general concerns, but are usually tied to PRs, and do not require response in ADS.
- Citations associated with not receiving initial accreditation include:
    - Inaccurate or incomplete information in the application
    - Minimum required number of certified faculty
    - Block diagram doesn't document required educational experiences
    - No evidence of scholarly activity
- General tips:
    - Be honest and accurate
    - Be concise but complete
    - Be internally consistent
    - When necessary, change verb tense
    - Start early when possible, but keep information up to date
    - Spelling, grammar, and neatness count
    - Translate local jargon
    - Don't include unsolicited information
    - Write with PRs in mind and in hand
    - Ask yourself, why are they asking?
- The program director (PD) and DIO will receive an email with the RC's accreditation decision within five business days of the RC meeting.
- A letter of notification follows six to eight weeks later that will detail any noted areas of non-compliance.
- ACGME uses these data for annual review
    - Resident/fellow survey
    - Clinical experience
    - Certification exam pass rate
    - Faculty survey
    - Scholarly activity
    - Attrition/changes/ratio
    - Subspecialty performance
    - Omission of data
- A program with a warning or probation will receive further review. A program with no warning, probation, citations, or annual data issues will pass with continued accreditation.
- In addition to annual review, every ten years programs undergo a self-study and a full accreditation site visit.

## Next Steps, Adjourn

**Tim Brennan, M.D., M.P.H., and Anna Lembke, M.D.**

Dr. Brennan encouraged attendees to think about where the field has been and where it is heading. He thanked the staff from NIDA, NIAAA, SAMHSA, and TAMF for helping to put together the symposium.

Dr. Lembke reminded participants that the Addiction Medicine Fellowship Directors Association was meeting on Wednesday, April 11 in San Diego, the day before the American Society of Addiction Medicine (ASAM) meeting. Each program was eligible for $750 of travel funding. Agenda items included revisiting the ACGME discussion.

Dr. Lembke adjourned the meeting at 2:32 p.m.

# Appendix A: Participant List

**ACADEMIC INSTITUTIONS**

**CURRENT ADDICTION MEDICINE FELLOWSHIPS**

**Addiction Institute of New York Addiction Medicine Fellowships**
Icahn School of Medicine at Mount Sinai
New York, NY

*Tim Brennan*, M.D., M.P.H.
Program Director
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*Benjamin Shuham*, MS4
Icahn School of Medicine at Mount Sinai
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**Addiction Medicine Fellowship at Kaiser Permanente Northern California**
Kaiser Permanente Northern California
Union City, CA

*Martha J. Wunsch*, M.D.
Program Director
Director, The Addiction Medicine Foundation
Martha.J.Wunsch@kp.org

**Addiction Medicine Fellowship at Saint Joseph's Medical Center (NY Medical College)**
St. Joseph's Medical Center/NY Medical College
Yonkers, NY

*Maria Rita Aszalos*, M.D.
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**Addiction Medicine Fellowship Program at NYU School of Medicine**
New York University School of Medicine
New York, NY

*Joshua D. Lee*, M.D., M.Sc.
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**Betty Ford Center Addiction Medicine Fellowship**
Hazelden Betty Ford
Rancho Mirage, CA

*Joseph Skrajewski*, M.A.
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**Boston Children's Hospital Pediatric Addiction Medicine Fellowship**
Boston Children's Hospital
Boston, MA

*Julie Lunstead*, M.P.H.
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**Boston University Addiction Medicine Fellowship**
Boston University School of Medicine
Boston, MA

*Alexander Y. Walley*, M.D., M.Sc.
Program Director
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**Caron-Reading Health System Addiction Fellowship**
Caron Treatment Centers/Reading Health System
Wernersville, PA

*Joseph M. Garbely*, D.O.
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**Community Bridges/Honor Health Integrated Addiction Medicine Foundation**

Community Bridges/HonorHealth
Mesa, AZ

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**David C. Lewis, M.D., Fellowship in Addiction Medicine at Rhode Island Hospital**
Rhode Island Hospital/Brown-Alpert Medical School
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*Susan E. Ramsey*, Ph.D.
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**UCLA-David Geffen School of Medicine Addiction Medicine Fellowship**
David Geffen School of Medicine at UCLA
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*Patrick T. Dowling*, M.D.
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**Geisinger Addiction Medicine Fellowship at Marworth**
Geisinger-Marworth
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*Robert Z. Friedman*, M.D.
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**Howard University Addiction Medicine**
Howard University College of Medicine
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*Denise M. Scott*, Ph.D.
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**Johns Hopkins University Addiction Medicine Fellowship**
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# Appendix B: Agenda

**8 AM** **Welcome and Overview**

*Tim Brennan*, M.D., M.P.H., and *Anna Lembke*, M.D.

**Responding to Drug Use, Addiction, and the Opioid Crisis: Administration Priorities and the Need for a Trained Workforce**

*June Sivilli*, M.A., Division Chief, Public Health and Public Safety, Office of National Drug Control Policy

**8:15 AM** **Translating Science to Physician Training and Practice:**

*George Koob*, Ph.D., Director, NIAAA, NIH

*Nora Volkow*, M.D., Director, NIDA, NIH

*Anita Everett*, M.D., Chief Medical Officer, SAMHSA, HHS

**9:15 AM** **Physician Training Resources: Science Informing Physician Training and Practice**

Alcohol: *Margaret (Peggy) Murray*, Ph.D. Director, Global Alcohol Research Program Office of the Director NIAAA, NIH

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Opioids: *Christina A. Mikosz*, M.D., M.P.H., Medical Officer, Division of Unintentional Injury Prevention, National Center for Injury Prevention, Centers for Disease Control and Prevention, HHS

**10:00 AM** **Break**

**10:15 AM** **Fellowships Drive Competency Adoption Across Medical Training and Practice**

*Patrick G. O'Connor*, M.D., M.P.H., Yale School of Medicine

**10:40 AM** **The VA and Addiction Medicine Training and Funding**

| | |
|---|---|
| | *Anthony Albanese*, M.D., Affiliations Officer, VA Office of Academic Affiliations, Clinical Professor of Medicine and Psychiatry , UC Davis School of Medicine |
| **11:00 AM** | **The ACGME Accreditation Process for Addiction Medicine Fellowships** |
| | Mary W. Lieh-Lai, M.D., Senior Vice President, Medical Accreditation, ACGME |
| **Noon** | **Networking Lunch (in room)** |
| **12:30 PM** | **Navigating the ACGME Addiction Medicine Application and Review** |
| | *Jerry Vasilias*, Ph.D., Executive Director, Review Committee for Internal Medicine |
| | *William Hart*, Associate Executive Director, Review Committee for Internal Medicine |
| **2:30-3:00 PM** | **Next Steps, Adjourn** |
| | *Tim Brennan*, M.D., M.P.H., and *Anna Lembke*, M.D. |