1. NAME OF THE PROPOSED CERTIFICATION

Addiction Medicine

2. PURPOSE OF THE NEW SUBSPECIALTY CERTIFICATION IN ONE PARAGRAPH OR LESS

Addiction Medicine is the prevention, evaluation, diagnosis and treatment for persons with addiction, for individuals with substance-related health conditions, for persons who manifest unhealthy substance use, and for family members whose health and functioning are affected by another’s substance use or addiction. The purpose of the new subspecialty is to establish the certification and training of an expanding number of physicians - across medical specialties and practice environments - in the prevention, diagnosis, treatment, and management of addiction involving nicotine, alcohol, controlled prescriptions and other licit and illicit drugs. This subspecialty is necessary to help address the enormous medical and public health burden presented by risky substance use and addiction, which constitute America’s largest preventable health problem. Sixteen percent of the non-institutionalized U.S population age 12 and over meet clinical criteria for addiction – more than those with cancer, diabetes or heart disease. Only ten percent of these individuals with addiction, however, receive any form of treatment. Of those who do receive treatment, most do not receive evidence-based care. Risky substance use and untreated addiction account for one-third of inpatient hospital costs and 20 percent of all deaths in the United States each year, and cause or contribute to more than 100 other conditions requiring medical care, as well as vehicular crashes, other fatal and non-fatal injuries, overdose deaths, suicides, homicides, domestic discord, the highest incarceration rate in the world and many other costly social consequences.
3. DOCUMENTATION OF THE PROFESSIONAL AND SCIENTIFIC STATUS OF THE SUBSPECIALTY

a. In the space provided, please describe how the existence of a body of scientific medical knowledge underlying the proposed new or modified subspecialty area is in large part distinct from, or more detailed than, that of other areas in which certification is offered:

Addiction medicine has been shown to be a very distinct area of medicine, distinguishable from other areas of certification and medical practice. While physicians in all specialties, including Preventive Medicine, are called upon to evaluate and treat patients with addiction related disorders, they are often not prepared for the specialty care involved with the treatment of these patients. Addiction involving nicotine, alcohol and other drugs is now understood to be a brain disease, often chronic in nature, with genetic, environmental, and socioeconomic underpinnings. Health, economic and social ramifications from risky substance use and addiction cost the U.S. an estimated $539 billion each year. The scientific understanding of the underlying mechanisms of addictive disorders has grown as has the ability to offer effective pharmacologic and behavioral treatment options to those who suffer a disorder. New understanding of the brain’s addiction pathways, molecular mechanisms, and neuroadaptive and neuropharmacological effects have galvanized further research for targeted chemical and behavioral therapies.

The Center for Substance Abuse Prevention (CSAP), a part of the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute on Alcohol Abuse and Alcoholism’s (NIAAA) Division of Epidemiology and Prevention Research (DEPR) have both led the development of evidence-based models for the prevention of risky substance use and addictive disease. Prevention strategies have been implemented at multiple levels, from at-risk individuals, to targeted cohorts, to environmental approaches that affect the population at large.

The recognition of the distinctive medical practice of Addiction Medicine is seen in the robust educational resources available and utilized by physicians. In 2015, the largest specialty society in Addiction Medicine, the American Society of Addiction Medicine (ASAM), offered more than 600 CME credit hours through its live and online programs, including an annual conference attended by more than 1,400 clinicians participating in symposia, workshops, posters and pre-conferences. The Journal of Addiction Medicine is a peer reviewed journal and widely used by physicians in multiple specialties. In addition to the Journal, the reference textbook published by ASAM, Principles of Addiction Medicine, is an over 1700 page resource providing core knowledge of scientific principles and practical essentials of clinical Addiction Medicine.

How Addiction Medicine is in large part distinct from, or more detailed than, that of other areas in which certification is offered

A seminal consensus report from the fields of Addiction Psychiatry and Addiction Medicine was crafted in 2010 and clearly articulated the issue: the need for a broadened workforce of trained and qualified providers to attend to the needs of persons with substance use...
disorders. The consensus group, composed of the leadership of Addiction Psychiatry and Addiction Medicine, stated that “Patients’ needs far exceed the current and forecast supply of qualified physicians.” They also stated that, “Other than Addiction Psychiatry, Addiction Medicine is the only medical specialty focusing directly on this population.” They noted that while there is a “pressing need to enhance the knowledge and skills of current primary care practitioners, there is an equally compelling need to assure the long-term supply of qualified addiction physician specialists necessary to train them, and to be available as referral or treatment resources.” And that “…establishing Addiction Medicine residencies will produce a sufficient workforce of academic faculty, clinical mentors, and specialty consultants to teach and support non-addiction-specialist providers.” (Joining Forces with HRSA. American Academy of Addiction Psychiatry, American Board of Addiction Medicine, The ABAM Foundation, American Society of Addiction Medicine, and the Association for Medical Education and Research in Substance Abuse. September 27, 2010)

The untapped opportunity of American medicine to effectively respond to dangerous substance use and addiction as an enormous health and social issue has been attributed by Wood, et. al. to insufficient attention by medical education systems to the training of physicians in Addiction Medicine. Their opinion also notes that the process of establishing Addiction Medicine fellowships is a process that “will enable physicians completing their specialty training in a spectrum of disciplines (e.g., Internal Medicine, Family Medicine, Pediatrics) to pursue further standardized training to gain expertise to treat and prevent the spectrum of medical problems associated with substance use disorders.” (Physician Education in Addiction Medicine. E. Wood, J.H. Samet, N.D. Volkow. JAMA, Volume 310, Number 16, October 23/30, 2013)

A current certification program in Addiction Psychiatry has been in place for 22 years. Of the many distinguishing features of these two disciplines, one is significant: Addiction Psychiatry is focused on the practice of psychiatric conditions related to addictions. The Addiction Medicine subspecialty is for those physicians practicing addiction related medicine with the practice content of the non-psychiatrist.

Importantly, most patients who suffer from substance use disorders are seen in the practices of physicians who work in primary care or in other medical disciplines. Therefore, a major reason to have an Addiction Medicine subspecialty certification is to support development of a cadre of subspecialists—in both clinical practice and in medical education—who are in the disciplines in which patients with addiction currently present for acute and chronic care.

b. Explain how this proposed new or modified subspecialty addresses a distinct and definable patient population, a definable type of care need or unique care principles solely to meet the needs of that patient population:

**Distinct and definable patient populations**

The substance using and addicted population has behaviors, actions and attitudes that perplex non-substance-abusing individuals, including physicians. As a group, these patients
are often ostracized from routine participation in family, social and medical care environments. And, secondary to their dysfunctional neurocircuitry, when they do engage with medical care providers, they are often unable to comprehend and respond to care recommendations in a manner that is the norm for patients with other illnesses.

Unhealthy substance use can be prevented, and addiction can be treated. American physicians are unsurpassed in caring for the complications of addiction, such as cardiovascular, hepatic, pancreatic and other gastrointestinal disease, as well as cancer and trauma, yet the Institute of Medicine (IOM) noted that one reason the United States rates 16\textsuperscript{th} of 17 when compared with peer countries is the burden caused by drugs and alcohol, both directly by drug-related deaths and by the casually connected use of alcohol and drugs in persons with multiple medical conditions. (\textit{U.S. Health in International Perspective. Shorter Lives, Poorer Health}. Institute of Medicine, January 2013)

The populations of persons with substance use problems and addiction are also distinct in their lack of access to prevention and treatment in mainstream, integrated medical settings.

For instance, addiction-focused interventions may not be available in a setting of screening, monitoring and care for substance using pregnant women. The current epidemic of the neonatal abstinence syndrome stemming from a mother’s opioid dependence is one indication of this lack of adequate care, and now crosses groups always viewed as vulnerable as well as newer cohorts of substance using mothers. The prenatal tobacco smoking rate of 11.5\% is associated with pre-term deliveries, low birth weights, pre-term related deaths and SIDS. Prenatal smoking is one of the most preventable causes of infant morbidity and mortality in the U.S. (\textit{Infant Morbidity Attributable to Prenatal Smoking in the U.S.} P.P. Dioetz, L.J. England, C.K. Shapiro-Mendoza, V.T. Tong, S.L. Farr, W.M. Callahan. American Journal of Preventive Medicine Vol. 39, Issue 1, July, 2010)

Our active military and veteran populations are also uniquely impacted by insufficient attention to substance use and addiction. Active members of the military and veterans who may have multiple non-psychiatric medical co-morbidities and substance use issues, and who traditionally do not view themselves as in need of, or accepting of, psychiatric care, often do not have access to addiction evaluation and treatment by their primary care providers. In fact, two reports made sweeping recommendations for improvement in the Veterans Administration (VA) and Department of Defense (DOD) systems for addressing alcohol and drug problems. The IOM found that although the VA and DOD seek to understand the scope of these problems, “at many times their response is dwarfed by the magnitude of the problems.” (\textit{Substance Use in the Armed Forces}. Institute of Medicine, September, 2012; \textit{Returning Home from Iraq and Afghanistan. Assessment of Readjustment Needs of Veterans, Service Members, and Their Families}. Institute of Medicine, March 2013)

Populations in need of specialized attention to the prevention and treatment of substance use and addiction span all ages. The IOM has noted that nearly two thirds of the burden of disability in young adults is associated with either mental health or substance use disorders. Young adults have the highest rates of death and injury from motor vehicle crashes, homicides and substance abuse. Young adults ages 18-25 have the highest rates of abuse of
prescription opioids, ADHD stimulants, and anti-anxiety drugs. Adolescents and young adults also have transition problems in receiving targeted prevention and treatment for substance use disorders and addiction. Providers often lack current young adult-specific knowledge and the skills needed to work effectively with this age group (*Investing in the Health and Well-Being of Young Adults*. Institute of Medicine. February, 2015). The IOM also found that the mental health and substance use workforce for older adults is inadequate. One in five older adults (65 and older) has one or more mental health or substance use issues. The IOM found that across the health care workforce, there is little if any training in geriatric substance use. The need for training across the primary care specialties was noted. (*The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Institute of Medicine, July 2012).

More distinct populations have been identified. They include: women in primary care settings; children, racial and ethnic minorities; individuals with minority sexual orientations; individuals involved in the justice system, etc. The care that these populations may need related to substance use issues is understood by them and their providers to be “special,” and this care is generally not available. The Addiction Medicine specialist can and should be available in these population settings.

**Definable type of care and unique care principles**

Dangerous substance use and addiction are conditions demanding a unique set of care competencies from the physician. These include care based on a detailed knowledge of the physiology and neurophysiology of the addicted brain, interpersonal skills to reach alienated and disenfranchised patients, special assessment and diagnostic skills, motivational interviewing techniques, expertise in pharmacological therapies for addiction, family counseling, chronic disease management, and an understanding of health systems by which he or she must find a path for continued comprehensive care for patients with addiction.

The Educational Objectives for Addiction Medicine Fellowship Training (see Appendix VIII) outline the unique competencies of Addiction Medicine physicians, formatted in a manner consistent with the ABMS Core Competency outline. As in other specialized areas of medical practice, physicians must possess unique knowledge and skills, and tailor services to specific patient needs.

c. To provide COCERT with information about the group of physicians concentrating their practice in the proposed new or modified subspecialty area, please indicate the following:

i. The current number of such physicians

There are a significant number of physicians who spend a sizeable portion of their practice time treating addiction. The American Board of Addiction Medicine (ABAM) currently recognizes 3,363 ABAM-certified Addiction Medicine physicians practicing in the U.S. and Canada (see chart below). Another group of physicians who devote some portion of their practice to Addiction Medicine can be identified through the federally administered Drug Addiction Treatment Act (DATA) waiver program. There are over 25,000 physicians who treat opioid dependence with schedules III-V controlled medications approved by the Food
and Drug Administration (FDA) for this indication. This evidence-based, medication-assisted treatment for opioid and opiate dependence is of importance because of the increasing mortality caused by prescription opioids, as well as from heroin. These “DATA waived” physicians may treat up to 100 patients at any one time. The American Society of Addiction Medicine (ASAM) has 3,117 members. As the chart below highlights, nearly half of their membership reports spending more than 50% of their time practicing Addiction Medicine.

### American Society of Addiction Medicine Members

**% of Practice that is Addiction Medicine**

**2014**

(Excludes Students & Associate Members)

![Bar Chart](chart.png)

ii. The annual rate of increase of such physicians in the past decade (along with the source(s) of the data):

**Historical Growth**

As shown in the two charts below, ABAM and ASAM have experienced steady upward growth with an increasing number of new physicians entering addiction medicine.
Annual Number of New ABAM Certificants
1986 - 2014

ASAM Historical Membership
2010 - 2014
iii. The current geographic distribution of this group of physicians, its projected spread in the next five (5) years.

**Current Distribution**

Addiction Medicine physicians are currently distributed throughout the United States. As an example, below is a table of ABAM certificants.

**ABAM Certificants by U.S. State or Territory**

<table>
<thead>
<tr>
<th>State</th>
<th>Certificants</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>4</td>
</tr>
<tr>
<td>AL</td>
<td>25</td>
</tr>
<tr>
<td>AR</td>
<td>9</td>
</tr>
<tr>
<td>AZ</td>
<td>50</td>
</tr>
<tr>
<td>CA</td>
<td>426</td>
</tr>
<tr>
<td>CO</td>
<td>43</td>
</tr>
<tr>
<td>CT</td>
<td>67</td>
</tr>
<tr>
<td>DC</td>
<td>10</td>
</tr>
<tr>
<td>DE</td>
<td>7</td>
</tr>
<tr>
<td>FL</td>
<td>214</td>
</tr>
<tr>
<td>GA</td>
<td>73</td>
</tr>
<tr>
<td>HI</td>
<td>26</td>
</tr>
<tr>
<td>IA</td>
<td>9</td>
</tr>
<tr>
<td>ID</td>
<td>11</td>
</tr>
<tr>
<td>IL</td>
<td>105</td>
</tr>
<tr>
<td>IN</td>
<td>35</td>
</tr>
<tr>
<td>KS</td>
<td>15</td>
</tr>
<tr>
<td>KY</td>
<td>53</td>
</tr>
<tr>
<td>LA</td>
<td>51</td>
</tr>
<tr>
<td>MA</td>
<td>117</td>
</tr>
<tr>
<td>MD</td>
<td>96</td>
</tr>
<tr>
<td>ME</td>
<td>26</td>
</tr>
<tr>
<td>MI</td>
<td>120</td>
</tr>
<tr>
<td>MN</td>
<td>44</td>
</tr>
<tr>
<td>MO</td>
<td>31</td>
</tr>
<tr>
<td>MS</td>
<td>28</td>
</tr>
<tr>
<td>MT</td>
<td>10</td>
</tr>
<tr>
<td>NC</td>
<td>93</td>
</tr>
<tr>
<td>ND</td>
<td>4</td>
</tr>
<tr>
<td>NE</td>
<td>11</td>
</tr>
<tr>
<td>NH</td>
<td>8</td>
</tr>
<tr>
<td>NJ</td>
<td>144</td>
</tr>
<tr>
<td>NM</td>
<td>23</td>
</tr>
<tr>
<td>NV</td>
<td>21</td>
</tr>
<tr>
<td>NY</td>
<td>275</td>
</tr>
<tr>
<td>OH</td>
<td>96</td>
</tr>
<tr>
<td>OK</td>
<td>28</td>
</tr>
<tr>
<td>OR</td>
<td>58</td>
</tr>
<tr>
<td>PA</td>
<td>137</td>
</tr>
<tr>
<td>PR</td>
<td>1</td>
</tr>
<tr>
<td>RI</td>
<td>24</td>
</tr>
<tr>
<td>SC</td>
<td>36</td>
</tr>
<tr>
<td>SD</td>
<td>5</td>
</tr>
<tr>
<td>TN</td>
<td>83</td>
</tr>
<tr>
<td>TX</td>
<td>121</td>
</tr>
<tr>
<td>UT</td>
<td>30</td>
</tr>
<tr>
<td>VA</td>
<td>77</td>
</tr>
<tr>
<td>VT</td>
<td>15</td>
</tr>
<tr>
<td>WA</td>
<td>61</td>
</tr>
<tr>
<td>WI</td>
<td>67</td>
</tr>
<tr>
<td>WV</td>
<td>21</td>
</tr>
<tr>
<td>WY</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>3,363</strong></td>
</tr>
</tbody>
</table>
It is anticipated that most new physicians practicing addiction medicine will derive from a similar distribution based on historical data, and that there will be an increase in the number of Addiction Medicine physicians in states with fellowship programs. As noted elsewhere, the number of fellowship programs is expected to continue to expand.

a. Identify the existing national societies, the principal interest of which is in the proposed new or modified subspecialty area. Indicate the existing national societies’ size and scope, along with the source(s) of the data; the distribution of academic degrees held by their members, along with the source(s) of the data; and the relationship of the national societies’ membership with the proposed new subspecialty area:

The American Society of Addiction Medicine is the key national society of physicians in the field of Addiction Medicine.

**American Society of Addiction Medicine (ASAM)**

Founded in 1954, ASAM is a professional medical society dedicated to increasing access and improving the quality of addiction treatment, educating health care professionals and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction. ASAM’s mission also includes establishing Addiction Medicine as a widely recognized medical specialty among health care professionals, organizations, government and the public.

ASAM has been an Accreditation Council for Continuing Medical Education (ACCME) - accredited provider of continuing medical education since 1977. ASAM is a recognized leader in the planning and presentation of educational events in the addiction field. ASAM’s educational programs prepare physicians to translate the power of science into high-quality services for patients, their families, and communities. Through its publications, textbooks, journal, and educational programs, ASAM addresses the most fundamental questions about alcohol, tobacco, opiate addiction, and other substance use disorders, ranging from helping providers understand how drugs act on the brain; fostering the dissemination and adoption of new treatment interventions; and responding to emerging problems such as the abuse of prescription drugs.

ASAM is engaged in numerous activities to improve resources for physicians to deliver quality addiction treatment. In 2015 ASAM released *Standards of Care: For the Addiction Specialist Physician*. These standards address the unique responsibilities borne by a physician who manages or oversees the care of a patient with addiction and addiction-related disorders, and apply to any physician assuming this responsibility. The Society has identified performance measures linked to these standards and will be specifying and testing a subset of these measures over the coming year.

**Size and Scope of ASAM**

The Society has more than 3,000 physician members and has recently expanded to include a non-physician membership category. Currently, fewer than 100 associated professional
members, such as nurse practitioners, physician assistants, Master’s trained counselors, and PhD clinicians and researchers belong to this membership category. In addition to its national office, ASAM has 39 active chapters covering 41 states as well as the District of Columbia.

**Distribution of Academic Degrees**

98% of the current ASAM membership holds either an MD or DO degree.

![Physician Members by License Type](chart.png)

**ASAM Members’ Relationship with Addiction Medicine**

ASAM is recognized as being the primary medical association for physicians with a focus on the disease of addiction.

b. For the entities described below, please provide the number of those who have a primary educational effort devoted to the proposed new or modified subspecialty area, along with their geographic locations and the source(s) of the data:

i. Medical schools
ii. Hospital departments
iii. Divisions
iv. Other (please specify)

There are currently 27 Addiction Medicine fellowship training programs accredited through a system instituted by The American Board of Addiction Medicine Foundation (ABAMF) and modeled on that of the Accreditation Council for Graduate Medical Education (ACGME). All ABAMF accredited fellowship programs are based in medical schools. A complete list of these programs is shown in the chart in section 4.

At the present time there is no definitive list of medical school departments, sections and divisions of Addiction Medicine; however a growing number exist. Examples include the Harvard Division of Addictions; the University of California, Division of Substance Addiction...
and Addiction Medicine; The Johns Hopkins University, Center for Substance Addiction, Treatment and Research; the University of Pennsylvania, Center for Studies of Addiction; and The University of Washington, Alcohol and Drug Addiction Institute.

The natural evolution of Addiction Medicine, after approval by the American Board of Medical Specialties (ABMS) and with training accredited by the ACGME, would be the creation of additional divisions or sections of medical school departments. This will occur as the number of programs continues to grow and the size and impact of fellows and faculty increases.

There are a number of Addiction Medicine departments and services in hospitals throughout the United States. These services are based on the clinical needs of each hospital within their own communities and the size and impact of the clinicians in the service environment. These types of hospital services would be expected to grow substantially as the number of physicians trained and certified in Addiction Medicine increases.
4. NUMBER AND NAMES OF INSTITUTIONS PROVIDING RESIDENCY AND OTHER ACCEPTABLE EDUCATIONAL PROGRAMS IN THE PROPOSED NEW SUBSPECIALTY

a. Indicate the total number of trainee positions available currently (along with the source(s) of the data), and b. Provide the number of trainees completing the training annually (along with the source(s) of the data):

As of March, 2015, ABPM has identified 27 Addiction Medicine training programs based in institutions with a medical school affiliation. There are 58 total trainee positions, 43 graduates and 32 current fellows. Information about each program’s location, affiliation, length and number of fellows is shown in the chart below; also see Appendix XI for more detailed program information.

<p>| Fellowship                                      | City                  | Sponsoring Institution | Medical School                                      | Primary Clinical Site                                      | Length of Training | Fellow Max | Graduates | Current Fellows |
|-------------------------------------------------|-----------------------|------------------------|----------------------------------------------------|------------------------------------------------------------|-------------------|------------|-----------|----------------|----------------|
| St. Paul’s Hospital Goldcorp Fellowship in Addiction Medicine | Vancouver, British Columbia | University of British Columbia Faculty of Medicine | University of British Columbia Faculty of Medicine | St. Paul’s Hospital | 1 Year     | 5          | 4          | 4              |
| Betty Ford Center Addiction Medicine Fellowship | Rancho Mirage, CA     | Eisenhower Medical Center | Keck School of Medicine of the University of Southern California &amp; Loma Linda University Medical Center | Betty Ford Center | 1 Year     | 1          | 0          | 1              |
| Stanford Addiction Medicine Program             | Stanford, CA          | Stanford Hospital &amp; Clinics | Stanford University School of Medicine | Stanford Hospital &amp; Clinics | 1 Year     | 2          | 1          | 1              |
| University of Colorado Addiction Medicine Fellowship | Aurora, CO           | University of Colorado School of Medicine | University of Colorado School of Medicine | Center for Dependency, Addiction and Rehabilitation (CeDAR)/University of Colorado Hospital | 1 Year     | 1          | 0          | 1              |
| Rushford Addiction Medicine Residency/ Fellowship Program | Middletown, CT      | Hartford Hospital       | University of Connecticut School of Medicine | Rushford Center | 1 Year     | 1          | 0          | 1              |
| Yale University Addiction Medicine Fellowship   | New Haven, CT         | Yale-New Haven Hospital | Yale School of Medicine | APT Foundation Central Medical Unit | 1 or 2 Years | 2          | 0          | 2              |
| University of Florida Addiction Medicine Program | Gainesville, FL      | University of Florida College of Medicine | University of Florida College of Medicine | Shands Hospital at the University of Florida | 1 or 2 Years | 6          | 12         | 5              |</p>
<table>
<thead>
<tr>
<th>Fellowship</th>
<th>City</th>
<th>Sponsoring Institution</th>
<th>Medical School</th>
<th>Primary Clinical Site</th>
<th>Length of Training</th>
<th>Fellow Max</th>
<th>Current Fellows</th>
<th>Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loyola University Medical Center Addiction Medicine Fellowship</td>
<td>Maywood, IL</td>
<td>Loyola University Medical Center</td>
<td>Loyola University Chicago Stritch School of Medicine</td>
<td>Edward Hines Jr VA Hospital</td>
<td>1 Year</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>University of Kentucky Addiction Medicine Fellowship Program</td>
<td>Lexington, KY</td>
<td>University of Kentucky College of Medicine</td>
<td>University of Kentucky College of Medicine</td>
<td>University of Kentucky Dept of Psychiatry</td>
<td>1 Year</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Boston University Addiction Medicine Fellowship</td>
<td>Boston, MA</td>
<td>Boston University Medical Center</td>
<td>Boston University School of Medicine</td>
<td>Boston Medical Center</td>
<td>1 or 2 Years</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>University of Maryland- Sheppard Pratt Training Program</td>
<td>Baltimore, MD</td>
<td>University of Maryland Medical Center</td>
<td>University of Maryland School of Medicine</td>
<td>University of Maryland Medical System</td>
<td>1 Year</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>St. Joseph Mercy Hospital Ann Arbor Addiction Medicine Fellowship</td>
<td>Ypsilanti, MI</td>
<td>St. Joseph Mercy Hospital Ann Arbor</td>
<td>Wayne State University School of Medicine; University of Michigan Medical School; Michigan State University College of Osteopathic Medicine; University of Toledo College of Medicine</td>
<td>St. Joseph Mercy Hospital Ann Arbor</td>
<td>1 Year</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Minnesota Addiction Medicine Residency Program: UM-HCMC-VA</td>
<td>Minneapolis, MN</td>
<td>University of Minnesota Medical School</td>
<td>University of Minnesota Medical School</td>
<td>University of Minnesota Division, Fairview</td>
<td>2 Years</td>
<td>4</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Addiction Institute of New York Fellowship in Addiction Medicine</td>
<td>New York, NY</td>
<td>University at Buffalo School of Medicine and Biomedical Sciences</td>
<td>Icahn School of Medicine at Mount Sinai</td>
<td>Roosevelt Hospital</td>
<td>1 Year</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Addiction Medicine Fellowship Program at NYU School of Medicine</td>
<td>New York, NY</td>
<td>Icahn School of Medicine at Mount Sinai</td>
<td>New York University School of Medicine</td>
<td>Bellevue Hospital Center</td>
<td>1 or 2 Years</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>University at Buffalo Addiction Medicine Fellowship</td>
<td>Buffalo, NY</td>
<td>New York University School of Medicine</td>
<td>University at Buffalo School of Medicine and Biomedical Sciences</td>
<td>Erie County Medical Center</td>
<td>1 or 2 Years</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Fellowship</td>
<td>City</td>
<td>Sponsoring Institution</td>
<td>Medical School</td>
<td>Primary Clinical Site</td>
<td>Length of Training</td>
<td>Fellow Max</td>
<td>Fellow Graduates</td>
<td>Current Fellows</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------</td>
<td>------------------------</td>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Cincinnati Addiction Medicine Research Fellowship</td>
<td>Cincinnati, OH</td>
<td>University of Cincinnati Medical Center Inc.</td>
<td>University of Cincinnati College of Medicine</td>
<td>VA Medical Center - Cincinnati</td>
<td>2 Years</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>St. Vincent Charity Medical Center Addiction Medicine Fellowship</td>
<td>Cleveland, OH</td>
<td>St. Vincent Charity Medical Center</td>
<td>Northeast Ohio Medical University; Case Western Reserve University School of Medicine</td>
<td>St. Vincent Charity Medical Center</td>
<td>1 or 2 Years</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Summa Addiction Medicine Fellowship</td>
<td>Akron, OH</td>
<td>Summa Health System</td>
<td>Northeast Ohio Medical University</td>
<td>St. Thomas Hospital</td>
<td>1 Year</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>University of Oklahoma School of Community Medicine, at Tulsa, Addiction Medicine Program</td>
<td>Tulsa, OK</td>
<td>University of Oklahoma-Tulsa School of Community Medicine</td>
<td>University of Oklahoma College of Medicine</td>
<td>12 &amp; 12 Inc. (treatment center)</td>
<td>1 Year</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Centre for Addiction and Mental Health Addiction Medicine Fellowship</td>
<td>Toronto, Ontario</td>
<td>University of Toronto Faculty of Medicine</td>
<td>University of Toronto Faculty of Medicine</td>
<td>Centre for Addiction and Mental Health</td>
<td>1 Year</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Oregon Health &amp; Science University Addiction Medicine Fellowship</td>
<td>Portland, OR</td>
<td>Oregon Health &amp; Science University Hospital</td>
<td>Oregon Health &amp; Science University School of Medicine</td>
<td>Oregon Health &amp; Science University Hospital</td>
<td>1 or 2 Years</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Geisinger Addiction Medicine Residency at Marworth</td>
<td>Waverly, PA</td>
<td>Geisinger Health System</td>
<td>Temple University School of Medicine &amp; Philadelphia College of Osteopathic Medicine</td>
<td>Marworth Treatment Center</td>
<td>1 Year</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Caron-Reading Medical Center Fellowship Program</td>
<td>Wernersville PA</td>
<td>Reading Hospital</td>
<td>Jefferson Medical College</td>
<td>Caron Treatment Centers, Wernersville</td>
<td>1 Year</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rhode Island Hospital Addiction Medicine Fellowship</td>
<td>Providence, RI</td>
<td>Brown University / Rhode Island Hospital-Lifespan</td>
<td>Warren Alpert Medical School of Brown University</td>
<td>Rhode Island Hospital</td>
<td>1 or 2 Years</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Swedish Addiction Medicine Fellowship</td>
<td>Seattle, WA</td>
<td>Swedish Medical Center</td>
<td>University of Washington School of Medicine</td>
<td>Swedish Medical Center</td>
<td>1 Year</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
b. Describe how the numbers of training programs and trainees are adequate to:

i. Sustain the area of subspecialization:

As noted in the table above, there are currently a significant number of fellowships in addiction medicine. We project that the number of ACGME accredited programs will have grown to 50 with an annual graduation of 125 new fellows by the end of the practice pathway five years post subspecialty approval.

The subspecialty will be sustained by the major impact on patient care from the development of ACGME training programs in medical schools and teaching hospitals. As these programs evolve the faculty will grow in size and experience, and that growth will support the development of formal academic departmental units such as sections.

ii. Allow for a sustained critical mass of trainees necessary for trainee testing validity and training program accreditation:

The current number of fellowship programs and fellows in training provides a solid base of graduates. This will be augmented by a significant number of training programs scheduled to come on-line in the first five years of accreditation. Additional details about the program development plan are located in Section 5 of this application.

As noted above, at the conclusion of the certification five-year practice pathway, it is projected that the number of ACGME accredited programs will have grown to 50 with an average of 125 graduates per year. This fellowship growth will provide an adequate number of candidates to support the requirements for a valid trainee examination process and allow for continued program accreditation.
5. NUMBER AND TYPE OF ADDITIONAL EDUCATIONAL PROGRAMS THAT MAY BE DEVELOPED BASED ON THIS NEW SUBSPECIALITY AREA. PLEASE INDICATE HOW YOU ARRIVED AT THAT NUMBER.

In January 2014, the National Center for Physician Training in Addiction Medicine (NCPTAM), operated by The American Board of Addiction Medicine Foundation, finalized an Addiction Medicine Fellowship Expansion Plan. The long-term objective is to create Addiction Medicine fellowship training programs or dedicated training capacity in Addiction Medicine at every medical school in the U.S.

The NCPTAM has developed a four-part strategy to achieve its fellowship expansion and sustainability objectives. The strategy includes: expanding the number of training slots in existing fellowship programs; focused outreach to high probability candidates to create new programs; general outreach to open the pipeline for identifying future candidates for fellowship training programs; and support to all fellowships to assure their continuation.

The NCPTAM fellowship expansion plan has a goal of increasing the number of fellowship training programs to 65 by 2020 and 125 by 2025. This is based on the addition of an average of 7-8 programs per year between now and 2020, and an average of 12 a year between 2020 and 2025. There has been an addition of eight in the past year without an aggressive plan so these targets are reasonable goals. Once Addiction Medicine has been recognized as a subspecialty, and ACGME accreditation is available for Addiction Medicine training, we believe the doors to programs through the VA - where the need is high - and to the availability of some limited GME funding to support the fellowships will open.

6. PROVIDE RESPONSES TO (a) THROUGH (d) REGARDING THE DURATION AND CURRICULUM OF EXISTING PROGRAMS

Please see Appendices VII, VIII, IX and X for these related documents that are in use by current Addiction Medicine training programs:

- Core Content for the Subspecialty of Addiction Medicine
- Educational Objectives for Addiction Medicine Fellowship Training
- Template for a Typical 12-Month Addiction Medicine Fellowship
- Program Requirements for Fellowship Education in the Subspecialty of Addiction Medicine

a. The goals and objectives of the existing programs:

The goal of existing programs is to produce a physician workforce with the expertise in the prevention and treatment of addiction to serve patients, families, communities and the health care system. The primary objective of Addiction Medicine training programs is to provide physicians with a structured educational experience that will enable them to care for patients with substance use disorders and for family members of persons with substance use disorders. Training also provides experiences for physicians to become faculty, administrators and community change agents in the prevention and treatment of addiction. Existing programs teach a comprehensive body of knowledge and skills, including a thorough understanding of the biomedical sciences (e.g. molecular biology, genetics, anatomy, physiology, pharmacology, neurology and pathology) the clinical sciences (e.g. patient interviewing, physical diagnosis and laboratory testing, diagnostic reasoning, clinical epidemiology, pharmacological management of disease and psychosocial counseling), and the latest approaches and strategies for preventing addiction, particularly in adolescents and young adults.

b. The expected competencies that will distinguish this subspecialist from other subspecialists in the areas of cognitive knowledge, clinical and interpersonal skills, professional attitudes and practical experience:

**Cognitive Knowledge**

In the area of cognitive knowledge, the Addiction Medicine subspecialist brings to patient and family encounters, and to other physicians and health care professionals, the unique addiction medicine knowledge base that includes: specific genetic factors and predictors of treatment response; epigenetic phenomena related to addiction; principles of reinforcement, tolerance, cross-tolerance, and sensitization; the unique epidemiology of addiction and substance use; epidemiological trends; Medical Review Officer responsibilities and authority; the pharmacokinetics and pharmacodynamics of drugs of abuse and dependence as well as of medications used in addiction treatment; the basic science of each drug class; primary, secondary and tertiary prevention for substance use disorders; teaching skills in screening, brief intervention and referral to treatment; community and public policy
approaches to prevention and treatment; special populations considerations, including correctional health; linking addiction treatment with other medical and psychiatric treatment; non-substance addictions (involving gambling, sex, food, et. al.); hospital and outpatient addiction management; behavioral interventions; community-based interventions and support systems; co-occurring disorders often associated with addiction; co-occurring psychiatric disorders; pain and addiction; and social-legal concepts.

A review of the currently used core content and educational objectives of the field of Addiction Medicine can be found in Appendix VII and VIII.

Clinical and Interpersonal Skills

As noted previously, the Addiction Medicine physician brings a unique set of clinical skills to the care of patients with substance use disorders and addiction. Notable examples are the expertise acquired in the safe detoxification of patients with polydrug and polypharmacy disorders, the use of motivational interviewing skills, addiction chronic disease monitoring, long-term management of patients on pharmacotherapy, as well as family therapies, interventions, assessment and diagnostic skills across a wide range of patients with addictive disorders.

The interpersonal skills of Addiction Medicine physicians include a non-judgmental stance when confronted with behaviors and patient attitudes that are often noxious and repulsive, encouraging perseverance by the family, society and/or other health care providers, the engendering of optimism for patients who have been unsuccessful in previous attempts to address their illness, and the ability to frame addiction as an often chronic disease for which both the patient and physician can work together successfully. The Addiction Medicine physician is also adept at managing patient manipulation, denial, blame, rationalization and resistance to engagement.

Professional Attitudes

Addiction Medicine physicians have a professional presence that instills confidence in both patients and medical colleagues that risky and harmful substance use and addiction can be treated like other diseases and conditions. The Addiction Medicine physician brings the patient with an addictive disorder into the health system to receive comprehensive care and reduce the chances for future medical-surgical complications.

Practical Experience

Addiction Medicine physicians have primary specialty training and practice experience across the breadth of medical specialties and are then additionally trained in a wide range of addiction prevention, evaluation and treatment modalities. They learn to address substance use and addiction in population-specific ambulatory care settings, acute care and long-term care facilities, mental health settings, and residential facilities, as well as in Occupational Medicine settings and in Federally Qualified Community Health Clinics.
c. The scope of practice:

Addiction Medicine physicians focus on prevention, early intervention, evaluation and diagnosis, treatment and disease management for patients including those who have co-occurring general medical and psychiatric conditions in a wide variety of medical and treatment settings, and in collaboration with other physicians and health care specialists. Addiction Medicine physicians work in clinical medicine, public health, educational, and research settings to advance the prevention and treatment of addiction and substance-related health conditions and to improve the health and functioning of persons with unhealthy substance use or who are affected family members of unhealthy substance users. *(Scope of Practice of Addiction Medicine, March 6, 2012, The ABAM Foundation)*

d. The body of knowledge and clinical skills required and whether it is broad enough to require at least 12 months of training:

There are currently 27 Addiction Medicine training programs. The large pool of experience since the first program came on line in 2011 provides evidence that the curriculum is broad enough to require at least twelve months of training. The current Core Content for the Subspecialty of Addiction Medicine, the Educational Objectives for Addiction Medicine Fellowship Training, the Program Requirements for Fellowship Training in Addiction Medicine, and a Template for a Typical 12 Month Addiction Medicine Fellowship Program are consistent with and outline a twelve-month curriculum to prepare physicians for practice in Addiction Medicine (see Appendices VII, VIII, IX and X). A 12-month Addiction Medicine curriculum is the minimum necessary to accommodate the clinical and didactic activity required to produce a subspecialist prepared to apply this knowledge and skill set.
7. PROVIDE A PROJECTION (AND THE METHODOLOGY USED) OF THE ANNUAL COST OF THE REQUIRED SPECIAL TRAINING

The total annual program cost per fellow is approximately $100,000 - 125,000. These costs are comparable to ACGME subspecialty graduate medical education programs at the PGY IV or V level.

When approved by the ABMS and operating under the accreditation standards of the ACGME, Addiction Medicine programs could be eligible to receive funding through their sponsoring institution. Although no GME funding is guaranteed, these programs should be internally competitive and it is reasonable to believe that some GME funding will shift to support this training. The current non-ACGME Addiction Medicine fellowship programs use a variety of funding sources that are common to subspecialty programs in other specialties. These include grants from business and philanthropic individuals and organizations and fellowship awards from organizations such as The American Board of Addiction Medicine Foundation. The programs also garner significant institutional support from medical school departments and hospitals, including fellow and faculty support, in-kind contributions and shared administrative support. There is also potential for utilizing primary specialty clinical service revenue provided by fellows outside of their educational responsibilities.

a. As the sponsoring Member Board, do you have, or have access to, the resources to conduct a regular certification and MOC program in this specialty?

ABPM administers regular certification and MOC programs in the specialties of Aerospace Medicine, Occupational Medicine, and Public Health and General Preventive Medicine as well as the subspecialties of Clinical Informatics and Undersea and Hyperbaric Medicine, and participates in the subspecialty of Medical Toxicology. ABPM is the administering board for all 24 member Boards both for Clinical Informatics and for Undersea and Hyperbaric Medicine. ABPM has the resources to support the development and will dedicate all necessary resources to Addiction Medicine’s certification and MOC programs.

b. Do you plan to ask for ACGME accreditation for this new program?

Yes.

c. If these programs are not accredited by the ACGME, please document the accrediting body for this program and whether you have the resources to review these programs in a fashion comparable to ACGME.

Not Applicable.
8. OUTLINE THE QUALIFICATIONS REQUIRED OF APPLICANTS FOR CERTIFICATION IN THE PROPOSED NEW SUBSPECIALITY AS IT PERTAINS TO THE FOLLOWING:

a. Possession of an appropriate medical degree or its equivalent:
   An applicant must have graduated from a medical school in the United States which at the time of the applicant’s graduation was accredited by the Liaison Committee on Medical Education, a school of osteopathic medicine approved by the American Osteopathic Association, an accredited medical school in Canada, or from a medical school located outside the United States and Canada that is deemed satisfactory to the Board. In evaluating the suitability of medical schools located outside the United States and Canada, the Board will apply the same criteria it uses when considering applications for other ABPM certificates.

b. General certification by an approved primary specialty Board:
   An applicant must hold current certification by at least one ABMS Member Board.
   i. Will Diplomates from other ABMS Member Boards be allowed to apply for this subspecialty certificate?
      Yes.
   ii. If “yes,” but only specific ABMS Member Board Diplomates would be allowed to apply for this subspecialty certificate, please list those Member Boards:
       All ABMS Member Board Diplomates will be allowed to apply.
   iii. If “yes,” would you require Diplomates to maintain their primary certificate?
       Yes.

c. Completion of specified education and training or experience in the subspecialty field:
   Completion of one of the following pathways is required for access to the certification examination in Addiction Medicine:

   1. Accreditation Council for Graduate Medical Education (ACGME) Accredited Fellowship Training Pathway
      A physician must successfully complete a minimum of 12 months in an ACGME-accredited Addiction Medicine fellowship program. If the program is longer than 12 months, the physician must successfully complete all years of training for which the program is accredited in order to meet the eligibility criteria for certification.
2. Practice Pathway

Two tracks are available in the Practice Pathway.

A. Time in Practice: For a period of five years from the date when the American Board of Preventive Medicine begins receiving applications for certification in Addiction Medicine an applicant may submit documentation of a minimum of 1,920 hours over at least 24 of the previous 60 months engaged in the practice of Addiction Medicine at the subspecialty level. Practice time need not be continuous. However, all practice time must have occurred in the five-year interval immediately preceding application for certification.

Practice must consist of broad-based professional activity with significant Addiction Medicine responsibility. Documentation of Addiction Medicine teaching, research and administration activities, as well as clinical care or prevention of, or treatment of, individuals who are at risk for or have a substance use disorder may be considered.

B. Non-Accredited Fellowship Training: Credit for training in a non-ACGME accredited fellowship program may be applied toward the practice pathway. The applicant must have successfully completed an Addiction Medicine fellowship of at least 12 months that is acceptable to the American Board of Preventive Medicine. The fellowship training curriculum as well as a description of the actual training experience must also be submitted. Fellowship training of less than 12 months may be applied towards the hour requirements of the practice pathway. The training received in the non-accredited fellowship must have been substantially equivalent to, or exceed, the training that would be expected in ACGME accredited fellowships.

d. Additional qualifications:

Medical Licensure

An unrestricted and currently valid license to practice medicine in a state, the District of Columbia, a territory, commonwealth, or possession of the United States or in a province of Canada is required. No license may be restricted, revoked, or suspended or currently under such notice.

The licenses of all applicants are verified and confirmed, and licensure may be investigated. Exceptions for licensure restrictions will be evaluated on a case by case basis by ABPM for possible approval.
Evaluation of candidates for the certificate in Addiction Medicine will occur by means of a secure written cognitive examination administered by computer-based testing or paper and pencil or both, depending on the demand for the certificate. The examination will consist of single best answer multiple-choice questions linked to the Core Content topic areas listed in Appendix VII.

Content validity will be established through an examination committee, composed of experienced Addiction Medicine physicians in the United States, who are working in various practice settings in Addiction Medicine. By this method, the practice of Addiction Medicine will be incorporated into the test items for the cognitive examination. Passing scores will be determined by the same standard setting process, using the Rasch model, currently used for the other criterion-referenced testing, under the direction of a psychometrician, offered by the American Board of Preventive Medicine.
10. FOR (a) THROUGH (d) BELOW, PROJECT THE NEED FOR AND THE EFFECT OF THE PROPOSED NEW SUBSPECIALITY CERTIFICATION ON THE EXISTING PATTERNS OF SUBSPECIALTY PRACTICE. INDICATE HOW YOU ARRIVED AT YOUR RESPONSE.

a. How the Member Board will evaluate the impact of the proposed new or modified subspecialty certificate:

i. On its own primary and subspecialty training and practice:

The new subspecialty is not expected to negatively impact the specialties or subspecialties of Preventive Medicine. The potential impact will be evaluated by the number of current ABPM diplomates who certify in Addiction Medicine and from which specialty (Aerospace Medicine, Occupational Medicine, or Public Health and General Preventive Medicine), the number of ABPM diplomates who complete Addiction Medicine fellowships, the number of new ACGME fellowships with ABPM physician leadership, and the number of Addiction Medicine fellowships sponsored by existing preventive medicine residencies.

ii. On the primary training and practice of other Member Boards:

The new subspecialty is not expected to negatively impact the training and practice of other Member Boards. The one Member Board with a related subspecialty has endorsed the ABPM application (see Appendix V). Diplomates in the new subspecialty will be required to maintain their primary board certification through recertification.

b. The value of the proposed new or modified subspecialty certification on practice, both existing and long-term (in health care, value is typically defined as quality divided by cost), specifically:

i. Access to care:

Access to care will be increased with the certification and training of subspecialists in Addiction Medicine providing high quality, focused care. The increase in access will occur as a result of:

- Additional physicians – certification and standardization of training programs will attract more medical students and residents to the field.
- Improved ability for patients to find trained physicians - currently patients and other health care providers have no reliable way to locate and evaluate Addiction Medicine physicians; certification would eliminate this barrier.
- Increased numbers of training programs – with ACGME accreditation of programs there will be a concurrent increase in medical school faculty and hospital departments, which will in turn lead to more opportunities for interaction with, and ability to inform, other specialties.
ii. Quality and coordination of care:

The subspecialty of Addiction Medicine will improve quality and coordination of care by having higher standards which demand professional excellence through continual learning. Such learning promotes quality improvement which reflects higher standards that leads to better care.

The outcomes expected from higher standards, advanced training and better care include those listed in the next section: benefits to the public, i.e., reduction in morbidity, mortality, and hospital cost; an increase in worker productivity; decreased criminal justice system expense; decreased social service agency costs; and family and community spending on unaddressed substance use and its sequelae. Additional benefits accrue from evidenced-based substance use prevention, where multiple studies find that for every $1 spent, $7-12 is saved in medical, social, productivity, and other costs.

Coordination of care in the prevention and treatment of primary substance use disorders and the medical and psychiatric complications of these disorders is an addressed goal. In most instances, when a patient presents with a substance use disorder, the attending physician is uncertain of how to treat or where to refer. An Addiction Medicine subspecialty, over time will increase knowledge in medical students, residents, and practicing physicians of prevention and treatment and to whom to consult or to refer when needed in their own practices. Physicians who are Addiction Medicine experts will serve as leaders in bridging to other health professionals who also are engaged with the care of patients with these disorders.

iii. Benefits to the public:

The public benefits of an Addiction Medicine certification are many and include:

**Access to Care**

As discussed above, an increase in the number of Addiction Medicine physicians along with easier sources of information to help patients find trained physicians will greatly improve access to care.

**Standardization of Physician Training**

Training programs will be accredited by the ACGME, which will ensure that high and uniform standards for all programs will be maintained. ACGME oversight guarantees a level of objectivity and credibility both to medical students and residents who are contemplating training, as well as to the public. The creation of the subspecialty will help to standardize key elements of Addiction Medicine training so that practitioners share a common foundational knowledge and skill set when they emerge from training.
Reduction in Economic Costs & Increase in Worker Productivity

Referring just to alcohol, the estimated economic costs of excessive drinking was $223.5 billion in 2006, of which 72% was from lost productivity, 11% from health care costs, 9% from criminal justice cost, with total cost being $1.90 per alcoholic drink. (Economic Costs of Excessive Alcohol Consumption in the U.S., 2006. E.E. Bouchery, H.T. Harwood, J.J. Sacks, C.J. Simon, R.D. Brewer. American Journal of Preventive Medicine Vol. 41, Issue 5, November 2011)

Treatment substantially reduces drinking among people with alcohol use disorders, and 40 to 60% of those treated alcohol and drug problems remain abstinent after a year. Because 85% of heavy drinkers work, employers who aggressively address this problem can improve their employees’ health while enhancing company performance. By providing comprehensive health benefits that cover treatment for alcohol use disorders, employers can reduce their health care and personnel costs as well as contribute to employees' well-being and productivity. (Impact of Alcoholism and Alcohol Induced Disease and Disorders on America, Research Society on Alcoholism, 2015)

The patterns of cost for nicotine and other drugs are also well documented to impose a huge burden both financially, and on workforce productivity. Federal, state and local governments alone spend close to half a trillion dollars annually on this problem at a cost of approximately $1,500 for each person in the United States.

The health care costs associated with addiction also stem from the impact that addiction has on the ability to treat other diseases, but these costs are rarely recognized and instead are attributed to treating the co-occurring medical illness. Persons with untreated addiction have higher health care utilization rates and more frequent hospital stays, generating billions of dollars in largely avoidable health care charges.

Reduction in Morbidity, Mortality and Hospital Costs

When the subspecialty of Addiction Medicine is recognized, public benefit can accrue by reduction in the one-third of inpatient hospital costs and 20% of all deaths each year related to risky substance use and addiction. The sequelae of substance use disorders will have the full benefit of medicine’s investigation and prevention, and there would be a greater opportunity to assist in the decrease of vehicle crashes, other fatal and non-fatal injuries, overdose deaths, suicides, homicides, domestic discord, our nation’s high incarceration rate and other medical sequelae and costly social consequences.
c. Please explain the effects of the proposed new or modified subspecialty certification on:

i. Immediate costs and their relationship to the probable benefits:

Initially there will be increase costs relative to savings, as training and education programs are established and as teams and departments are organized to accommodate a new system focus on substance use disorders, as well as payment to a new group of physician experts. Yet, the additional cost of addressing substance use disorders in a manner similar to that for addressing other medical conditions will, based on all existing evidence, result in early decreases in morbidity, mortality and cost. There is good evidence for this from the literature on nicotine and alcohol medical interventions. The quality of life for many patients, families and communities will be immediately improved. And screening and early intervention results in immediate cost savings related to reduced injuries, trauma, and unplanned pregnancies, and other health consequences of risky substance use.

ii. Long-term costs and their relationship to the probable benefits:

The long term costs of the new specialty will include that of training programs, faculty, systems development throughout health care as well as direct payments to physicians, hospitals, clinics, and others. These costs will be greatly offset by savings noted in this application. Since Addiction Medicine is not procedure oriented and will be available across medical specialties, and because the patients and families treated will lead others to seek medical assistance or apply prevention principles, significant benefits will accrue. Subspecialty certification will improve the availability and quality of patient care, which will continue to reduce the significant health care costs as well as social costs associated with risky substance use and addiction.

d. Please explain the effects if this subspecialty certification is not approved:

Without this new subspecialty, medicine and all of health care will not garner the potential benefit of an expanded, dedicated and focused physician workforce needed to help address the enormous medical and public health burden presented by risky substance use and addiction. Attention to risky drug use and addiction would lack the full force of medical science and excellence that characterizes the prevention and treatment of other medical diseases. There could be little expectation that the meager rates of treatment for those in need (now at 10%) of available evidenced based care would improve. It could be expected that without this new subspecialty, medicine and health care will have fewer options in addressing one-third of inpatient hospital costs and 20 percent of all deaths each year related to risky substance use and addiction. The sequelae of substance use disorders would not have the full benefit of medicine’s investigation and prevention, and there would be a missed opportunity to assist in the decrease of vehicle crashes, other fatal and non-fatal injuries, overdose deaths, suicides, homicides, domestic discord, our nation’s high incarceration rate and many other costly social consequences.
In the absence of an ABMS recognized subspecialty of Addiction Medicine, patients, their families and even medical colleagues would not reliably know how to find, nor access care through the existing medical and health care infrastructure, a physician who has expert knowledge and skills in the prevention of risky substance use and in the evaluation, treatment and management of addictive disorders. As it stands today, only a relatively few hospital medical staffs and academic medical centers have official departments or divisions of Addiction Medicine. Managed care panels often do not include such specialists to care for members who have addictive disorders, do not reimburse for such care at rates comparable to those for other specialized care, and do not involve Addiction Medicine physicians in their utilization review panels. Without ABMS recognition, this situation would continue at the expense of those in need. In addition, the many physicians who have committed a significant investment of time and resources so they may better prevent and treat addiction, and physicians who may be encouraged to join in this work, will have their endeavors viewed as less than legitimate by their colleagues and the family of medicine. The active interest of the broad community of medicine would be discouraged, as it is now, from addressing this illness.
11. **INDICATE HOW THE PROPOSED NEW SUBSPECIALTY WILL BE REASSESSED PERIODICALLY (e.g., every five years) TO ASSURE THAT THE AREA OF CLINICAL PRACTICE REMAINS A VIABLE AREA OF CERTIFICATION**

Periodic reassessment every five years will determine the subspecialty remains viable for the near term and likely the longer term. The assessment may include the following:

1. The number of physicians entering the field as determined by new diplomates and by physician membership in the key specialty society (ASAM).
2. The amount of Addiction Medicine practice time and the physician compensation will be requested to be surveyed, if not already, by the key specialty society (ASAM).
3. The cost and success of fellowship programs will be tracked (including number of fellows graduating and number taking and passing the Addiction Medicine certification exam).
4. The determination of the number of new diplomates and fellows needed to keep the examination and training programs economically sound.
5. The payment structure for physicians and institutions relative to Addiction Medicine care.
6. The integration of Addiction Medicine into other specialties will be assessed by identifying the number of diplomates by primary specialty.

Some measures may be available from the key specialty society or from government agencies such as the number of diplomates and the number of members of the key specialty society who are employed by public and private employers. The diplomates may also be tracked by specialty and surveyed for their practice patterns.
12. LIST KEY EXTERNAL PUBLIC STAKEHOLDERS THAT COCERT MAY SOLICIT FOR POSSIBLE PUBLIC COMMENT ON THE PROPOSED NEW SUBSPECIALTY

The key public stakeholders have been engaged with the Addiction Medicine community for some time and willingly provided support letters and are included in Appendix I. These key stakeholders may be contacted to provide additional comment.

American Society of Addiction Medicine (ASAM)  
www.asam.org
Jeffrey Goldsmith, M.D., President

Association for Medical Education and Research in Substance Abuse (AMERSA)  
http://www.amersa.org
Daniel Alford, M.D., M.P.H., President

Centers for Disease Control and Prevention (CDC)  
www.cdc.gov
Tom Frieden, M.D., M.P.H., Director

Conrad Hilton Foundation  
http://www.hiltonfoundation.org/substance-use-prevention
Alexa Eggleston, J.D., Senior Program Director, Domestic Programs

National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health  
www.niaaa.nih.gov
George F. Koob, Ph.D., Director

National Institute on Drug Abuse (NIDA), National Institutes of Health  
www.nida.nih.gov
Nora D. Volkow, M.D., Director

White House Office of National Drug Control Policy (ONDCP)  
www.whitehousedrugpolicy.gov
Michael Botticelli, Director
PLEAS ATTACH THE FOLLOWING ADDITIONAL ITEMS

1. **Copy of proposed application form for the candidates for certification**

   The proposed application is included as Appendix IV.

2. **A written statement indicating concurrence or specific grounds for objection from each Primary and Conjoint Board having expressed related interests in certifying in the same field.**

   A current certification program in Addiction Psychiatry through the American Board of Psychiatry and Neurology has been in place for 22 years. Dr. Larry Faulkner, President and CEO, has provided a letter of support (Appendix V) for this subspecialty in Addiction Medicine.

3. **Written comments on the proposed new or modified subspecialty area from at least two (2) external public stakeholders**

   See Appendix I for letters of support from the following stakeholders:
   - American Society of Addiction Medicine (ASAM)
   - Association for Medical Education and Research in Substance Abuse (AMERSA)
   - Centers for Disease Control and Prevention (CDC)
   - Conrad N. Hilton Foundation
   - National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health
   - National Institute on Drug Abuse (NIDA), National Institutes of Health
   - White House Office of National Drug Control Policy (ONDCP)

4. **A copy of the proposed certificate for ABMS records**

   See Appendix VI.
INDEX OF APPENDICES

APPENDIX I  WRITTEN COMMENTS FROM PUBLIC STAKEHOLDERS
APPENDIX II  LETTERS FROM INSTITUTIONS INTERESTED IN FELLOWSHIP DEVELOPMENT WHEN ADDICTION MEDICINE BECOMES RECOGNIZED
APPENDIX III  ABAM CERTIFICANTS DISTRIBUTION OF SPECIALTIES
APPENDIX IV  PROPOSED APPLICATION FORM
APPENDIX V  STATEMENT FROM THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
APPENDIX VI  PROPOSED CERTIFICATE
APPENDIX VII  CORE CONTENT FOR THE SUBSPECIALTY OF ADDICTION MEDICINE
APPENDIX VIII  EDUCATIONAL OBJECTIVES FOR ADDICTION MEDICINE FELLOWSHIP TRAINING
APPENDIX IX  TEMPLATE FOR A TYPICAL 12-MONTH ADDICTION MEDICINE FELLOWSHIP PROGRAM
APPENDIX X  PROGRAM REQUIREMENTS FOR FELLOWSHIP EDUCATION IN THE SUBSPECIALTY OF ADDICTION MEDICINE
APPENDIX XI  ADDICTION MEDICINE TRAINING PROGRAMS
APPENDIX XII  KEY REFERENCES IN ADDICTION MEDICINE
APPENDIX XIII  ADDICTION DEFINED
APPENDIX I
WRITTEN COMMENTS FROM PUBLIC STAKEHOLDERS

Beginning on the next page are letters of support from leaders of the following organizations:

- American Society of Addiction Medicine (ASAM)
- Association for Medical Education and Research in Substance Abuse (AMERSA)
- Centers for Disease Control and Prevention (CDC)
- Conrad N. Hilton Foundation
- National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health
- National Institute on Drug Abuse (NIDA), National Institutes of Health
- White House Office of National Drug Control Policy (ONDCP)
April 13, 2015

William Greaves, MD, MPH
Executive Director
American Board of Preventive Medicine
111 West Jackson Boulevard, Suite 1340
Chicago, IL 60604

Dear Dr. Greaves:

The American Society of Addiction Medicine (ASAM) is a professional medical society dedicated to increasing access and improving the quality of addiction treatment, educating healthcare professionals and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

Founded in 1954, ASAM is the oldest and largest national professional society representing over 3,200 addiction specialist physicians and associated health professionals. ASAM’s mission also includes establishing addiction medicine as a widely-recognized medical specialty among healthcare professionals, organizations, government and the public and ABMS recognition is critical to ASAM’s mission.

ASAM strongly supports the application by the American Board of Preventive Medicine (ABPM) to the American Board of Medical Specialties (ABMS) for the establishment of a subspecialty certificate in Addiction Medicine.

There is a great public health burden presented by addiction involving nicotine, alcohol, prescriptions for controlled substances and illicit drugs, and a great public health need for more physicians to be trained in addiction prevention and treatment. The absence of recognition of the specialty of addiction medicine has contributed to a significant lack of access to important prevention and treatments options.

ASAM believes that ABMS certification will pave the way for improved quality of care for patients diagnosed with the disease of addiction. This will in turn have a significant impact in reducing overall health care costs in the United States and in improving the lives of families affected by the disease of addiction.

Please feel free to contact me, if there is any further information we can provide or, if there are any questions I can answer for you about this very important development.
Respectfully,

Stuart Gitlow, MD, MPH, MBA
President

Cc: Penny S. Mills, ASAM Executive Vice President
March 27, 2015

Dear Dr. Greaves:

As President of The Association for Medical Education and Research in Substance Abuse (AMERSA), I am writing to enthusiastically support the application by the American Board of Preventive Medicine (ABPM) to the American Board of Medical Specialties (ABMS) for the establishment of a subspecialty certificate in Addiction Medicine. AMERSA is a multidisciplinary and multispecialty national organization dedicated to education and research in substance abuse. It is also the sole national organization with a major focus on health professional faculty development related to substance use and addiction. We fully recognize the need to support the development of a well-trained physician workforce in order to promote the wellbeing of our patients and the health of the nation.

There is a great public health burden presented by addiction involving nicotine, alcohol, controlled prescriptions and illicit drugs, and a great public health need for more physicians to be trained in addiction prevention and treatment. The absence of recognition of this specialty has led to unfortunate lack of access to important prevention and treatments options. We believe that ABMS certification will pave the way for improved quality of care for these patients.

We believe that the faculty development that will occur with the ACGME approval of new fellowship training programs will support and encourage the expansion of high quality research and professional education across all medical specialties. This will in turn have a major impact on the care of patients and families impacted by substance abuse in the United States.

In summary, AMERSA is most pleased to support the establishment of Addiction Medicine as an ABMS subspecialty through the ABPM. This will represent a significant positive step forward for our patients and for our field.

Respectfully,

Daniel P. Alford, MD, MPH
President - AMERSA
William Greaves, MD, MSPH  
American Board of Preventive Medicine  
111 West Jackson Boulevard, Suite 1340  
Chicago, Illinois 60604  

Dear Dr. Greaves:

As the nation’s public health agency, the Centers for Disease Control and Prevention (CDC) is committed to protecting the health of all Americans. The sharp rise in prescription opioid abuse, addiction, and overdose over the last 15 years is a national epidemic and a top priority for our agency. The severity and persistence of this epidemic, which is now contributing to an increase in heroin use and overdose, call for the United States to redouble its efforts to improve and expand treatment for substance use disorders. To that end, CDC supports the American Board of Preventive Medicine’s (ABPM) application to the American Board of Medical Specialties (ABMS) to create a subspecialty certification in Addiction Medicine.

Prescription opioid overdoses killed more than 16,200 people in 2013 and more than 145,000 people in the last 10 years. This staggering loss of life represents only the starkest outcome of a much larger epidemic of abuse and addiction. Based on 2011 data, for every one prescription opioid overdose death there were 12 treatment admissions for prescription opioids, 25 emergency department visits, 105 people who abused or were dependent on prescription opioids, and 659 people who used prescription opioids non-medically. With heroin-related overdose death rates nearly tripling within the last three years, the urgency of a cogent national response to addiction and overdose is more apparent than ever.

A national effort to reverse this epidemic must approach the problem from multiple fronts. We must address the inappropriate opioid prescribing that created and continues to fuel the epidemic. This includes promoting safe opioid prescribing practices and a better appreciation of opioids’ risks for abuse and addiction. We also must assist patients who are already dependent on opioids and provide effective, accessible treatment for people with substance use disorders.

An ABMS-recognized certification process in Addiction Medicine available to diplomates of multiple ABMS boards would be a major step forward in building a modern, effective medical workforce prepared for the challenges of treating and preventing addiction in the 21st Century. ABPM’s application has all the essential components to establish an effective subspecialty for this chronic disease and to build a deeper bench of physicians who can address the substantial need for effective, accessible treatment.

Establishing an ABMS-recognized Addiction Medicine subspecialty could not come at a more critical time for the nation’s public health. Not only will such a step help combat the prescription
opioid and heroin epidemics, it will also help with the ongoing need to treat addiction to alcohol, nicotine, and other substances.

We are grateful for ABPM’s efforts to establish this important subspecialty and for its steadfast commitment to disease prevention and public health.

Sincerely,

Thomas R. Frieden, MD, MPH
Director, CDC
Dear Dr. Greaves:

The Conrad N. Hilton Foundation is pleased to submit the following letter of support for the American Board of Preventive Medicine's recognition of Addiction Medicine as a physician subspecialty across medicine. As the leading philanthropic funder in the substance use prevention field, it has been a pleasure to partner with the American Board of Addiction Medicine (ABAM) Foundation to advance the education of physicians in addiction medicine. The Foundation recognizes that risky drug use and addiction is a leading cause of lost opportunities and lost lives for America's youth, and a major driver of many of our nation's medical, social, and economic problems. That is why the Foundation launched a five-year $50 million strategic initiative in 2013 to advance innovative approaches to prevent and intervene early to address adolescent substance use. Through this initiative we are partnering with several leading medical organizations including the ABAM Foundation, the American Academy of Pediatrics, and Boston Children's Hospital to develop new approaches to advance Screening, Brief Intervention and Referral to Treatment (SBIRT) for youth.

Previous studies have shown that people who start drinking before the age of 15 are four times more likely to meet the criteria for alcohol dependence at some point in their lives, and young people consume more than 90 percent of their alcohol by binge drinking. Given the link between early use and addiction, it is our view and the view of most experts that the best approach is prevention and early intervention. The Foundation supports the efforts of the field of Addiction Medicine to include a focus on youth prevention. We believe that recognition by the American Board of Medical Specialties for the field of Addiction Medicine will have a major positive impact on the quality of evidenced-based prevention and treatment services America's youth receive. Physicians have the capacity to translate science to practice. Trained physician specialists in Addiction Medicine are an essential component of the national effort to attenuate and reverse substance related morbidity and mortality in America.

We are pleased that the certification proposed will be open to diplomates of all ABMS boards. Physicians from many fields encounter addiction in their practices and have interest in the specialized training this new certification will allow. The Foundation strongly offers its support for the application by the American Board of Preventive Medicine (ABPM) to the American Board of Medical Specialties (ABMS) for the establishment of a subspecialty certificate in Addiction Medicine.

Respectfully,

Alexa Eggleston, J.D.
Senior Program Officer, Conrad N. Hilton Foundation
April 6, 2015

William Greaves, MD, MPH
Executive Director
American Board of Preventive Medicine
111 West Jackson Boulevard, Suite 1340
Chicago, IL 60604

Dear Dr. Greaves:

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of the 27 Institutes and Centers of the National Institutes of Health. As the Director of NIAAA and a former Editor-in-Chief of the Journal of Addiction Medicine, I strongly support the application by the American Board of Preventive Medicine (ABPM) to the American Board of Medical Specialties (ABMS) to establish a subspecialty certificate in Addiction Medicine.

Since its founding more than 40 years ago, NIAAA has led the effort to reframe Alcohol Use Disorder as a medical—rather than a moral—problem. The NIAAA and its grantees rigorously investigate issues relating to alcohol and health and disseminate research that supports evidence-based treatment of affected individuals. Recognition of Addiction Medicine as an ABMS subspecialty will augment these efforts.

Alcohol addiction and alcohol misuse have profound effects on individuals, families, and communities. According to the 2013 National Survey on Drug Use and Health, 16.6 million American adults have an alcohol use disorder (AUD), and the Centers for Disease Control and Prevention estimates that excessive alcohol consumption cost the U.S. $224 billion in 2006. The public health need for more physicians trained in addiction prevention, treatment and research is clear. NIAAA endorses an ABMS certificate in the subspecialty of Addiction Medicine to address this need.

The recognition of Addiction Medicine as an ABMS subspecialty will establish faculty with expertise in addiction medicine within medical schools and teaching programs and expand the development of accredited fellowship programs. Training programs, in turn, will energize further development of evidence-based research into the epidemiology, etiology, prevention, diagnosis, and treatment of addictive disorders.

In summary, an ABMS credentialed subspecialty of Addiction Medicine will help ensure that there are sufficient physicians with specialty training to intervene with those whose lives could be vastly improved by treatment.

Respectfully,

George F. Koob, Ph.D.
Director
National Institute on
Alcohol Abuse and Alcoholism
March 30, 2015

William Greaves, M.D., MPH
Executive Director
American Board of Preventive Medicine
111 West Jackson Boulevard, Suite 1340
Chicago, IL 60604

Dear Dr. Greaves:

The National Institute on Drug Abuse (NIDA) is a component of the National Institutes of Health, a part of the U.S. Department of Health and Human Services. Our mission is to bring the power of science to bear on drug abuse and addiction—major health problems that deserve more attention from medical practitioners and medical educators. The charge of our Institute has two critical components. The first is the strategic support and conduct of research across a broad range of disciplines. The second is to ensuring the rapid and effective dissemination and use of the results of that research to significantly improve prevention, treatment, and policy as it relates to drug abuse and addiction.

Drug addiction is a ubiquitous, complex, and urgent challenge that affects us all. The challenge includes the persistence of chronic drug use in a considerable number of teens and the high rates of prescription drug abuse among both adolescents and adults. This trend has contributed to a near-doubling of drug overdose deaths nationwide from 1999 through 2013, mainly from pharmaceuticals, 71% of which involved opioid analgesics.

Trained physician specialists in Addiction Medicine are an essential component of the national effort to attenuate and reverse substance related morbidity and mortality in America. Physicians have the capacity to translate science to practice. NIDA believes that certification for the field of Addiction Medicine by the American Board of Medical Specialties (ABMS) will have a major positive impact on the quality of medical care for patients at risk for and with substance use disorders as well as a significant impact on the epidemiological, biomedical, clinical, and health services research necessary to better understand and address these important issues.

We have long admired the work of the leaders of the American Board of Addiction Medicine (ABAM) to certify physicians, and of the leaders of the ABAM Foundation to develop and accredit graduate medical education training programs in addiction for physicians from all specialties. Now that the American Board of Preventive Medicine (ABPM) has stated its intention to make a formal application to the full ABMS that will result in the establishment of a certification program for physicians in Addiction Medicine within the ABMS umbrella, we are pleased to have the opportunity to offer our support. We are especially pleased that the
envisioned certification program will be open to Diplomates of all of the 24 ABMS boards. Physicians from many fields encounter addiction in their practices and have interest in the specialized training this new certification will promote.

As the Director of NIDA, I unequivocally offer my support for the application ABPM to ABMS for the establishment of a subspecialty certificate in Addiction Medicine.

Respectfully,

[Signature]

Nora D. Volkow, M.D.
Director
April 22, 2015

William Greaves, MD, MPH
Executive Director
American Board of Preventive Medicine
111 West Jackson Boulevard, Suite 1340
Chicago, IL 60604

Dear Dr. Greaves:

As Director of National Drug Control Policy, I write regarding the American Board of Preventive Medicine’s (ABPM) proposal to the American Board of Medical Specialties (ABMS) to establish a subspecialty certificate in Addiction Medicine. Expanding the Addiction Medicine workforce through a subspecialty certificate would provide an opportunity for physicians across a range of medical specialties to identify patients at risk of developing a substance use disorder and to treat those with an existing disorder. Such a certificate also would be consistent with the policies and priorities of the Office of National Drug Control Policy (ONDCP).

A component of the Executive Office of the President, ONDCP was created by the Anti-Drug Abuse Act of 1988. The agency advises the President on drug-control issues, coordinates drug-control activities and related funding across the Federal government, and produces the annual National Drug Control Strategy, which outlines Administration efforts to reduce illicit drug use, manufacturing and trafficking, drug-related crime and violence, and drug-related health consequences. The Strategy establishes a balanced approach to drug policy guided by three concepts: a substance use disorder is a brain disease that is preventable and treatable; people with this disease can recover; and innovative reforms more widely implemented can help stop the criminal justice system’s revolving door.

ONDCP plays a major role in coordinating activities to reduce the demand for drug use through addiction prevention, addiction treatment, and the coordination of health services and medical education activities related to the healthcare of persons with substance use disorders. Accordingly, ONDCP encourages the development of initiatives and programs to expand substance use and recovery education because of the significant and urgent national need.

Illicit drug use and its consequences challenge our shared dream of building a country that is healthier, safer, and more prosperous for our children. Furthermore, illicit drug use is associated with lower academic performance among our young people and contributes to crime, injury, and serious dangers on the Nation's roadways. Drug use and its consequences jeopardize the progress we have made as a Nation, contributing to unemployment, impeding re-employment, and costing our economy billions of dollars in lost productivity.

ONDCP recognizes the vital role of physicians trained to extend high-quality care to patients and their families impacted by substance use disorders. We are grateful for ABPM's
work to create a subspecialty certificate in Addiction Medicine and for its continued work to improve the care and treatment of people with the disease of addiction.

Sincerely,

Michael P. Botticelli
Director
APPENDIX II

LETTERS FROM INSTITUTIONS INTERESTED IN FELLOWSHIP DEVELOPMENT IF ADDICTION MEDICINE BECOMES RECOGNIZED
April 15, 2015

Patrick O’Connor, MD
President, American Board of Addiction Medicine
4300 Montgomery Ave, Ste. 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship Program Application “Letter of Interest”

Dear Dr. O’Connor:

We understand that Addiction Medicine is on the threshold of becoming an ABMS-recognized subspecialty. Our institution is very interested in establishing an addiction medicine fellowship training program.

Harvard Medical School and Boston Children’s Hospital have the clinical and research capacity to provide fellowship education. It is our intention to apply for accreditation pending hiring an additional faculty member and identifying financial support to cover the expenses associated with fellow’s education. We anticipate that the program would be based in the Division of Developmental Medicine, and we are in the process of hiring an individual certified by the American Board of Addiction Medicine (ABAM) to take the lead in this project.

Sincerely,

Sharon Levy, MD, MPH

Medical Director, Adolescent Substance Abuse Program
Division of Developmental Medicine
Boston Children’s Hospital

Assistant Professor of Pediatrics
Harvard Medical School
April 2, 2015

Patrick O’Connor, MD
President, American Board of Addiction Medicine
4300 Montgomery Ave, Ste. 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship Program Application Letter of Interest

Dear Dr. O’Connor,

I am certified by the American Board of Addiction Medicine (ABAM) and will become the medical director of the Fairbanks Addiction Treatment Center in Indianapolis, Indiana in August. Within a couple of blocks there is Community Hospital East with its Family Medicine Residency Program. These two institutions have all the appropriate resources to train addiction medicine fellows. I am extremely interested in establishing an addiction medicine fellowship in Indianapolis and anticipate that ACGME approval of addiction medicine fellowship programs will facilitate the development of such a program in Indianapolis. I am willing to support your efforts with the ABAM application to ABMS and ACGME in any way that I can.

Sincerely,

Darrin Mangiacarne, DO, MPH, CPE
Future Medical Director
Fairbanks
Apr. 1, 2015

Patrick O’Connor, MD
President, American Board of Addiction Medicine
4300 Montgomery Ave. Suite 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship Program Application Letter of Interest

Dear Dr. O’Connor,

We have the appropriate resources to train addiction medicine fellows and are committed to establishing a new addiction fellowship training program at our institution. We have begun the process that will lead to the submission of an accreditation application to the American Osteopathic Association for the program. We have also identified individuals who are certified by the American Board of Addiction Medicine (including myself) and we plan to submit a program accreditation application to the ABAM-Foundation as soon as this is possible.

Sincerely,

William Murphy D.O., FASAM, Diplomate ABAM
Residency Director, Family Practice, Largo Medical Center
Medical Director, Family Care of Walsingham
April 13, 2015

Patrick O'Connor, M.D.
President, American Board of Addiction Medicine
4300 Montgomery Ave, Ste. 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship Program Application “Letter of Interest”

Dear Dr. O’Connor,

Our institution has the appropriate resources to train addiction medicine fellows. We are committed to establishing the first addiction medicine fellowship training program in Washington DC and have begun the process of applying for accreditation from the ABAM-Foundation. ABMS recognition of the subspecialty of addiction medicine and ACGME approval of addiction medicine fellowship programs will facilitate the development of such a program at Howard University.

Sincerely,

[Signature]

Robert E. Taylor, M.D., Ph.D., FACP
Professor of Pharmacology, Medicine and Psychiatry
Chair, Department of Pharmacology
Dean Emeritus (2005-2011)
Howard University College of Medicine
April 10, 2015

Patrick O'Connor, MD
President, American Board of Addiction Medicine
4300 Montgomery Ave, Ste. 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship Program Application Letter of Intent

Dear Dr. O'Connor,

Our institution has the appropriate resources to train addiction medicine fellows, and we are committed to establishing an addiction medicine fellowship training program. We anticipate that the program would be based in the Department of Pediatrics and that training would occur within our existing adolescent medicine fellowship. We have identified pediatricians who are certified by the American Board of Addiction Medicine (ABAM) and addiction psychiatrists who will spearhead this initiative. We have begun the process of applying for accreditation by the ABAM-Foundation.

Sincerely,

Hoover Adger, Jr., MD, MPH, MBA
Professor of Pediatrics
Director, Adolescent Medicine & LEAH Program
April 25, 2015

Patrick O'Connor, MD
President, American Board of Addiction Medicine
4300 Montgomery Ave, Ste. 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship Program Application Letter of Intent

Dear Dr. O'Connor,

I am writing to notify you of the intent to develop an Addiction Medicine Fellowship Program in the Northern California Region of Kaiser Permanente Foundation Hospitals and Clinics. I have meet with my Chief of Service, Dr. Adam Travis, and the Graduate Medicine Education leadership. We have determined we have the appropriate resources to train addiction medicine fellows, and we are committed to establishing a new addiction medicine fellowship training program at Kaiser Permanente. I am Fellowship Trained Addiction Medicine specialist, certified by the American Board of Addiction Medicine and have academic teaching and research experience.

We have begun the process that will lead to the submission of an accreditation application to the American Board of Addiction Medicine. We have also identified individuals who are certified by the American Board of Addiction Medicine (ABAM) and we plan to submit a program accreditation application to the ABAM-Foundation as soon as this is possible.

Sincerely,

[Signature]

Martha J Wunsch MD
Diplomate, American Board of Addiction Medicine

Cc: Adam Travis MD, Chief of Psychiatry
    The Permanente Medical Group
March 27, 2015

Patrick O’Connor, MD
President
American Board of Addiction Medicine
4300 Montgomery Ave, Ste. 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship

Dear Dr. O’Connor,

Our institution would be extremely interested in establishing an addiction medicine fellowship training program once approval is obtained from the Accreditation Council for Graduate Medical Education (ACGME).

We have been committed to establishing an addiction medicine fellowship training program in Las Vegas, but at the present time our small institution does not have the resources to absorb the full costs of a fellowship that is not-ACGME approved. In the near future, a new medical school will open in Las Vegas, and when that occurs we will revisit the feasibility of working together with officials from the school to establish an addiction medicine fellowship training program in Las Vegas. There are physicians in Las Vegas who are certified by the American Board of Addiction Medicine (ABAM) and who are willing to help.

Sincerely,

[Signature]
Mei Pohl, MD
Medical Director

via email:

Patrick.oconnor@yale.edu
kkunz@abam.net.
April 3, 2015

Patrick O’Connor, MD
President
American Board of Addiction Medicine
4300 Montgomery Ave, Ste 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship

Dear Dr. O’Connor,

Our institution is extremely interested in establishing an addiction medicine fellowship training program within the next 1-2 years. We have the appropriate resources to implement the addiction medicine fellowship training curriculum. We have identified an individual who is certified by the American Board of Addiction Medicine (ABAM) and who could begin the process establishing an addiction medicine fellowship training program at the appropriate time. This process would be accelerated once approval is obtained from the Accreditation Council for Graduate Medical Education (ACGME).

Sincerely,

[Signature]

Daniel H. Angres M.D.
Medical Director, Positive Sobriety Institute
Chief Medical Officer, RiverMend Health
Adjunct Associate Professor of Psychiatry,
Northwestern Feinberg School of Medicine
April 10, 2015

Patrick O’Connor, MD  
President, American Board of Addiction Medicine  
4300 Montgomery Ave, Ste. 206  
Bethesda, MD 20814

Re: Addiction Medicine Fellowship Program Application Letter of Interest

Dear Dr. O’Connor,

I am certified by the American Board of Addiction Medicine (ABAM) and my institution has the appropriate resources to train addiction medicine fellows. We are committed to establishing an addiction medicine fellowship training program, and we anticipate that the program would be based in the Department of Family Medicine. We have begun the process of applying for accreditation by the ABAM-Foundation. The recognition of addiction medicine by the American Board of Medical Specialties (ABMS) and the approval by the Accreditation Council for Graduate Medical Education (ACGME) would greatly facilitate our progress.

Sincerely,

[Signature]

Rita Aszalos, MD  
Faculty, St. Joseph’s Department of Family Medicine  
Assistant Professor, New York Medical College
Monday, April 28, 2015

William Greaves, MD, MPH
Executive Director
American Board of Preventive Medicine
111 West Jackson Boulevard, Suite 1340
Chicago, IL 60604

Dear Dr. Greaves:

I have received a request from Dr. Kevin Kunz, Executive Director of the American Board of Addiction Medicine Foundation (ABAMF), that I provide a letter of support on behalf of my residency training program.

The University of Hawaii John A. Burns School of Medicine Department of Psychiatry was pleased to support for six years an addiction medicine fellowship (PGY5), which was managed in conjunction with the existing addiction psychiatry residency training program. This program was quite successful, and had the additional advantage of co-educating trainees from two or more different specialties, such that they were able to mutually educate one another. It was only placed on hiatus as a result of diminished funding within the State of Hawaii, the result of the recent economic recession. We anticipate applying once again to establish a fellowship program, predicated on many of the same principles that we had advanced in creating a model curriculum for the current ABAMF training programs.

On this limited notice, I may truly represent only myself as a residency program training director, without purporting to represent the medical school or the University of Hawaii. However, our previous record of successful support, and the State’s continued acknowledgment of a need for doctoral level providers for substance use disorders, assure me that we may expect the sustainment needed for an ABMS-specialty affiliated fellowship training program once such status is conferred. It is clear that ABMS and ACGME approvals of the field are essential to the success of any fellowship training endeavor.

William F. Haning, III, M.D., FASAM, DFAPA
Professor and Associate Chair for Education
Haning@hawaii.edu, (808) 556-7436
April 10, 2015

Patrick O' Connor, MD
President
American Board of Addiction Medicine
4300 Montgomery Ave, Ste 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship

Dear Dr. O' Connor,

I am certified by the American Board of Addiction Medicine (ABAM) and serve as the program
director for the University of Utah Addiction Psychiatry fellowship training program, which is
accredited by the Accreditation Council for Graduate Medical Education (ACGME).

The University of Utah Department of Psychiatry has considered developing an Addiction
Medicine fellowship program in the past, but our leadership determined that it was not feasible
at that time. However, the Addiction Psychiatry fellowship faculty members are very interested
in starting an Addiction Medicine fellowship once approval for Addiction Medicine fellowships is
obtained from the ACGME, and plan to advocate for this with our department leadership. Four
of our fellowship faculty members are ABAM-certified and another is seeking ABAM
certification. We are actively recruiting additional faculty members who specialize in addiction,
and have a new Department Chairman who is active in addiction research. We have the
appropriate clinical and educational resources to add an Addiction Medicine fellowship program
to our department's educational mission.

Please do not hesitate to call if you have questions or need further information.

Sincerely,

[Signature]

Elizabeth Howell, MD, DFAPA, FASAM
Training Director, Addiction Psychiatry Fellowship Program
University of Utah Department of Psychiatry
April 9, 2015

Patrick O’Connor, MD
President, American Board of Addiction Medicine
4300 Montgomery Ave, Ste. 206
Bethesda, MD 20814

Re: Addiction Medicine Fellowship Program Application Letter of Intent

Dear Dr. O’Connor,

I am certified by the American Board of Addiction Medicine (ABAM), based at Willingway Hospital and have been in contact with officials from a local medical school. Our institutions have the appropriate resources to train addiction medicine fellows. We are committed to establishing an addiction medicine fellowship training program in our area and have begun the process of applying for accreditation by the ABAM-Foundation. ACGME approval of addiction medicine fellowship programs will facilitate the development of such a program at our institutions.

Sincerely,

Shawn Williams, M.D.
Willingway Hospital
311 Jones Mill Road
Statesboro GA 30458
Certificates From ABMS Member Boards Held by ABAM Certificants*
April 2015

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Certificants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy &amp; Immunology</td>
<td>1</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>173</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1</td>
</tr>
<tr>
<td>Colon and Rectal Surgery</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>76</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>420</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>520</td>
</tr>
<tr>
<td>Neurological Surgery</td>
<td>3</td>
</tr>
<tr>
<td>Neurology</td>
<td>15</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>3</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynecology</td>
<td>41</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>2</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>5</td>
</tr>
<tr>
<td>Pathology</td>
<td>8</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>47</td>
</tr>
<tr>
<td>Physical Medicine &amp; Rehabilitation</td>
<td>23</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>2</td>
</tr>
<tr>
<td>Preventive Medicine</td>
<td>50</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1,159</td>
</tr>
<tr>
<td>Radiology</td>
<td>16</td>
</tr>
<tr>
<td>Surgery</td>
<td>20</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>2</td>
</tr>
<tr>
<td>Urology</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,598</strong></td>
</tr>
</tbody>
</table>

* Some ABAM Certificants hold certificates from more than one board.
APPLICATION FOR ADMISSION TO THE CERTIFYING EXAMINATION

AMERICAN BOARD OF PREVENTIVE MEDICINE®

111 West Jackson, Suite 1340
Chicago, Illinois 60604

Phone (312) 939-2276 [ABPM] Fax (312) 939-2218
E-Mail: abpm@theabpm.org Website: www.theabpm.org

Addiction Medicine APPLICATION PACKET

APPLICATION DEADLINE IS JUNE 1
INSTRUCTIONS FOR COMPLETING THE APPLICATION

DEADLINES

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>JUNE 1</td>
<td>Deadline for applications and application and examination fees. Applications received after this date will be held for future review.</td>
</tr>
<tr>
<td>AUGUST 1</td>
<td>Deadline for receipt of additional information not included with the application.</td>
</tr>
<tr>
<td>AUGUST 1</td>
<td>Deadline for completion of requirements to sit for the October examination.</td>
</tr>
</tbody>
</table>

COMPLETING THE APPLICATION

1. The Board stresses careful and complete preparation of the application. Applications must be legibly printed or typewritten. Incomplete applications may result in an additional fee or possible disqualification.
2. Return all numbered pages of the application along with supporting documentation. Reference all enclosures by application item number.
3. You must use the application form for the current year.

CHECKLIST OF DOCUMENTATION

<table>
<thead>
<tr>
<th>Item</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Application and Appropriate Fees</td>
<td><strong>Must be received by June 1</strong></td>
</tr>
<tr>
<td>2. Photocopy of other ABMS Board certificate (if other than ABPM)</td>
<td></td>
</tr>
<tr>
<td>3. Photocopy of certificate of completion of medical school (diploma)</td>
<td></td>
</tr>
<tr>
<td>4. Photocopy of all current medical license(s) and license renewal(s)</td>
<td>showing expiration date(s)</td>
</tr>
<tr>
<td>5. <em>Fellowship training pathways</em>: Documentation of completion of an approved fellowship. (Letter from program director required).</td>
<td></td>
</tr>
<tr>
<td>6. <em>Practice pathway</em>: Documentation of 1,920 practice hours which must have been completed over at least two years within the five years preceding application to be considered</td>
<td></td>
</tr>
<tr>
<td>7. Three current letters of reference from physicians (at least one of which must be certified by one of the ABMS Member Boards) verifying training or content and percent time of Addiction Medicine training/practice.</td>
<td></td>
</tr>
<tr>
<td>8. Curriculum vitae</td>
<td></td>
</tr>
</tbody>
</table>
NON-REFUNDABLE APPLICATION FEE
Fellowship pathway ........................................ $385.00*
Practice pathway ........................................ $555.00*

NON-REFUNDABLE RE-REVIEW FEE for Applicants not approved who wish to document fulfillment of outstanding requirements within two years of the original application date ........ $190.00*

EXAMINATION FEE is due with the application and is non-refundable if registration for the exam is canceled less than 48 hours prior to the exam. If your application is not approved, the examination fee will be refunded .................. $1,750.00*

FEE PAYMENT: Fees may be paid by credit card by completing the information below and submitting it with the application to the ABPM Board office. Personal checks and money orders are also accepted for fees. There is a $25.00 charge for bank-returned checks. Only U.S. dollars may be used; no foreign currencies are acceptable. Make check/money order payable to: The American Board of Preventive Medicine.

* All fees are reviewed annually and subject to change at the direction of the Board.

CREDIT CARD INFORMATION
Name (as it appears on credit card): _______________________________________________________
Billing Address: _______________________________________________________________________

Select type of credit card:

Credit Card Number:

Security Code: ___ Expiration Date: __________ Amount: $____

Signature: ___________________________ Date: __________________

Email Address: _________________________

The Security Code is the 3 or 4 digit code found on the back (or front for American Express) of your credit card. All fees are in US dollars.
Three current letters of reference are required from physicians who know of your experience in Addiction Medicine. At least one of the physicians must be certified by a medical specialty board under the American Board of Medical Specialties. In addition, at least one letter must have been written by a physician who is familiar with your professional work activities within five years of the date of application for examination.

Please insure that all physicians from whom you request a letter receive these Instructions and Template for Letters of Reference. All letters must address all areas noted below to be considered complete.

Letters should comment on:

1. The length of time you have known the applicant and in what capacity.
2. The most recent period of time in which you have had direct contact with the applicant.
3. The performance of the applicant, including clinical abilities.
4. The professional conduct and ethics of the applicant.
5. The amount of time the applicant spends in practice/training in Addiction Medicine.
6. Information on where you can be contacted if necessary.

A reference letter template can be downloaded from the ABPM web site www.theabpm.org
In making this application and in consideration of its acceptance by the ABPM, I hereby agree to accept and be bound by the terms and conditions governing certification as a Diplomate of the ABPM as set forth in the Articles of Incorporation, Bylaws, and Policies and Procedures of the ABPM, as they now exist and as they may be amended from time to time in the future.

In further consideration of my acceptance by ABPM for examination, I hereby further agree:

1. To indemnify and hold harmless the ABPM and each of its members, trustees, officers, agents, employees and examiners, individually and collectively, from and against any claim or liability arising out of any act or omission related to or arising out of (a) the processing of this application, (b) the examination or the grading of it, or (c) the granting or failure to grant certification or Diplomate status;

2. That any certificate of Diplomate status issued to me shall be and shall remain the property of the ABPM and that I shall promptly return the certificate to the ABPM in the event my status as a Diplomate is terminated, either voluntarily or by action of ABPM;

3. That the application fee which accompanies this application for examination is not refundable;

4. That if my application for examination is accepted, but I do not register for the examination in 2010 my examination fee will be applied to a future examination. If my application is not approved the examination fee will be refunded;

5. That I am obligated to inform the ABPM immediately of any change in my status as described in this application occurring after its submission, and I understand that my failure to so inform the Board is grounds for my disqualification as a candidate for examination or as a Diplomate, if I am certified;

6. That the names of all physicians certified as Diplomates of the American Board of Preventive Medicine are published in The Official ABMS Directory of Board Certified Medical Specialists which is available to the public. In the event I become a Diplomate of the ABPM, I will be consulted concerning the form and content of my listing and any special limitations I might identify;

7. That I have been provided with a copy of the ABPM Cheating Policy and agree to refrain from any activities that are prohibited in the Cheating Policy.

I CERTIFY that all statements and representations made as part of the application are true and accurate and I FULLY ACKNOWLEDGE AND ACCEPT the foregoing terms and conditions of my application for admission to the examination.

SIGNATURE DATE

In further consideration of my acceptance for examination by the ABPM, I hereby authorize the ABPM to request information from any of the persons or organizations to which I have referred in this application and to take such further action as it deems necessary, in its absolute discretion, to verify that I possess the training, experience, and medical licensure required to be admitted for the examination.

SIGNATURE DATE
1. GENERAL CONSIDERATIONS

The American Board of Preventive Medicine (ABPM) expects that all candidates will refrain from cheating, the appearance of cheating, or enabling another candidate to cheat. All examinations will be openly and visibly proctored. The testing center facilities will be arranged in a manner that minimizes the opportunity to cheat.

The ABPM also expects that all candidates will refrain from any communication, written or spoken, with other examinees concerning the content of the examination for the entire duration of the examination offering.

2. RESPONSIBILITY

Any candidate observing cheating behavior must bring it to the attention of the testing center proctor.

3. CANDIDATE MONITORING

The testing centers will proctor the examinations through video and direct surveillance and will capture testing events via audio and video recording. Video and audio tapes of testing sessions will be retained at the testing centers for thirty (30) days. At least one certified proctor shall maintain direct line-of-sight monitoring at all times during the examination administration.

4. COUNSELING AND CONDITIONS OF TERMINATION

If the testing center proctor observes or becomes aware of candidate behavior that in any way suggests inappropriate activity or cheating, the proctor shall counsel the candidate and may separate the candidate into a separate testing area. The proctor may allow the candidate to complete the test but will generate a detailed irregularity report immediately upon awareness of the irregularity. The testing center will make available to the Board this report as well as video and/or audio tapes of the activity in question.

5. REMOVAL FROM EXAMINATION

The testing center proctor has the option of removing a candidate from the examination if such candidate does not cooperate with the steps taken to assure examination and site security, candidate verification, and candidate monitoring. For reasons of privacy and protection from disruption, the Board and the testing center reserve the prerogative not to remove a candidate showing irregular behavior from the examination or to relocate the candidate. The Board also reserves the right subsequently to invalidate the examination of the candidate or of those candidates judged to be involved in cheating.

6. ACTIONS

Upon confirmation of observed cheating behavior, the candidate will be disqualified. The disqualified candidate will be so notified and the respective score(s) dropped from aggregate scoring. Readmission for examination will be considered after a period of three years contingent upon Board review of credentials using criteria for admission applicable at the time of review, including current letters of reference.
Select the pathway through which you are applying and enclose the appropriate fee with your completed application.

___ $2135* ($385 application fee + $1750 examination fee) - Fellowship Pathways (ACGME-Accredited or Non-accredited)
___ $2305* ($555 application fee + $1750 examination fee) - Practice Pathway

LAST NAME
FIRST NAME
MIDDLE NAME

NAME, INCLUDING DEGREES IF DESIRED, EXACTLY AS IT SHOULD APPEAR ON THE CERTIFICATE

Date of Birth: __________ Soc. Sec. #: __________ Place of Birth: __________

Home Address: ____________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Home Phone: ______________

Work Address: _____________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Work Phone: _______________ Fax: _______________

E-mail address: _____________________________________________________________

Correspondence should be mailed to: ___ Home  or  ___ Work

HAVE YOU PREVIOUSLY SUBMITTED AN APPLICATION TO THE ABPM?

___ YES, complete information below.  ___ NO

Date(s) submitted: ___________ Specialty as previously applied for: ___________

Name under which submitted, if different: _______________________________________
## SECTION A. MEDICAL DEGREE

**Requirement:**
Graduation from a medical school in the United States which at the time of the applicant's graduation was accredited by the Liaison Committee on Medical Education, a school of osteopathic medicine approved by the American Osteopathic Association, an accredited medical school in Canada, or from a medical school located outside the United States and Canada that is deemed satisfactory to the Board.

**Instruction:**
Send photocopy of certificate of completion of medical school (diploma) with this application.

___ M.D. ___ D.O. Year Graduated:
Medical School:
Location:

---

## SECTION B. MEDICAL LICENSE

**Have you ever had a medical license revoked, suspended, restricted, or under disciplinary action?**

___ YES, Please Explain
___ NO

**Requirement:**
An unrestricted and currently valid license(s) to practice medicine in a State, the District of Columbia, a Territory, Commonwealth, or possession of the United States or in a Province of Canada is required. No license may be restricted, revoked, or suspended or currently under such notice.

*All current licenses must be listed. All such licenses must be unrestricted.* Use additional sheet if needed.

**Instruction:**
Send photocopy of all current medical license(s), and license renewal(s) showing expiration dates, with this application.

State/Province: License Number:
State/Province: License Number:
State/Province: License Number:

---

## SECTION C. SPECIALTY BOARD CERTIFICATION

Name the American Board of Medical Specialties Member Board by which you are currently certified.

Specialty Board_______________________Cert No. and Date_____________________
Specialty Board_______________________Cert No. and Date_____________________
Specialty Board_______________________Cert No. and Date_____________________

Please submit copy of your certificate if certification or recertification is from an ABMS Member Board other than ABPM. *Please note: This certification must be current.*
Requirements for Fellowship Pathways:
AGCME-Accredited Fellowship
The applicant must have successfully completed a minimum of 12 months in an ACGME-accredited Addiction Medicine fellowship program. If the program is longer than 12 months, the applicant must successfully complete all years of training for which the program is accredited in order to meet the Board's eligibility criteria for certification. A verification form must be completed by the program director stating satisfactory completion of the required training.

Or
Non-ACGME Accredited Fellowship
The applicant must have successfully completed an Addiction Medicine fellowship of at least 12 months that is acceptable to the American Board of Preventive Medicine. The fellowship training curriculum as well as a description of the actual training experience must also be submitted. For each applicant a verification form must be completed by the program director stating satisfactory completion of the required training.

List fellowship, hospital, other institution, and dates of training.

<table>
<thead>
<tr>
<th>Hospital or other institution:</th>
<th>Director of Training:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone number:</td>
<td></td>
</tr>
</tbody>
</table>

Start date: _End date: _

Include a concise statement describing this training [use additional sheet if necessary]:


**Practice Pathway Requirements:** Documentation of 1,920 practice hours which must have been completed within the five years preceding application to be considered. **Note:** Practice time must have occurred in the United States, its territories, or in Canada. Practices occurring outside of these locations will not be accepted. Practice time need not be continuous. However, all practice time must have occurred in the five-year interval immediately preceding application for certification.

Include a current curriculum vitae with this application. Photocopy this page for each additional position held.

<table>
<thead>
<tr>
<th>Dates: from [MO/YR] to [MO/YR]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Title/Position:</td>
</tr>
<tr>
<td>Average number of hours per week in Addiction Medicine:</td>
</tr>
</tbody>
</table>

Present a detailed description of this practice below:
APPENDIX V
STATEMENT OF CONCURRENCE FROM THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
April 13, 2015

William W. Greaves, M.D., M.S.P.H.
Executive Director
American Board of Preventive Medicine
111 West Jackson Blvd., Suite 1340
Chicago, IL 60604

Dear Dr. Greaves-

In response to your request of April 8, 2015, I am pleased to inform you that the American Board of Psychiatry and Neurology (ABPN) strongly supports your application for a new subspecialty in Addiction Medicine. As you well know, addictions and their sequelae continue to be significant public health concerns, and the ABPN is pleased that the ABPM is taking steps to address these problems by seeking to add the subspecialty of Addiction Medicine to our own subspecialty of Addiction Psychiatry. If we can be of additional help in that regard, please let me know.

Sincerely-

[Signature]

Larry R. Faulkner, M.D.
President and CEO
ABPN

LRF/atk
APPENDIX VI
PROPOSED CERTIFICATE

The American Board of Preventive Medicine

Organized to Encourage the Study, Improve the Practice
and Advance the Cause of Preventive Medicine

John Sample Doe, MD
Has demonstrated to the satisfaction of this Board possession of
special knowledge and is therefore certified in the subspecialty of
Addiction Medicine

Certification Date: January 1, 2028
Expiration Date: January 31, 2028
Certificate No. 00000

Chair
Secretary

A Member Board of the American Board of Medical Specialties
APPENDIX VII
CORE CONTENT FOR THE SUBSPECIALTY OF ADDICTION MEDICINE

Core Content represents the areas of knowledge of a specialist in Addiction Medicine. This content was approved by The American Board of Addiction Medicine Foundation March 11, 2010.

Definitions and Basic Science Concepts

1.0 Definitions
1.1 Addiction
1.2 Addiction Medicine
1.3 Unhealthy use
1.4 Dependence
1.5 Withdrawal
1.6 Detoxification
1.7 Substance Related Disorders
1.8 ICD10 Diagnostic Categories

2.0 Basic Science
2.1 Genetics
2.1.1 Heritability of risk for addiction
2.1.2 Epigenetic phenomena related to addiction
2.1.3 Genetic predictors of treatment response
2.2 Pharmacokinetic and Pharmacodynamic Principles
2.2.1 Drug Metabolism and Principles of Drug Interactions (including the impact of addictive drug use on the metabolism of common therapeutic medications)
2.2.2 Reinforcement
2.2.3 Tolerance
2.2.4 Cross-tolerance.
2.2.5 Physical dependence
2.2.6 Conditioning
2.2.7 Sensitization
2.2.8 Impact of route of drug administration (oral, sublingual, intravenous, inhalation, intramuscular, etc.)
2.3 Pharmacology
2.3.1 Alcohol
2.3.2 Benzodiazepines, benzodiazepine receptor agonists, barbiturates and other sedative-hypnotics.
2.3.3 Opioids (opium, heroin, prescription opioids)
2.3.4 Cocaine, amphetamine and other stimulants.
2.3.5 Nicotine and tobacco.
2.3.6 Cannabinoids.
2.3.7 Hallucinogens (LSD, mescaline, psilocybin, and other hallucinogens.)
2.3.8 Dissociatives (phencyclidine, ketamine, dextromethorphan and other dissociatives).
2.3.9 Inhalants (nitrous oxide, hydrocarbons, and other inhalants)
2.3.10 Anabolic Steroids
2.3.11 Club Drugs (MDMA, GHB, and other club drugs)
2.4 Neurobiology of Addiction
2.4.1 Animal models of addiction
2.4.2 Neuropharmacology
2.4.2.1 Acetylcholine
2.4.1.2 Norepinephrine
2.4.2.3 Dopamine
2.4.2.4 Serotonin
2.4.2.5 Gamma-aminobutyric acid (GABA)
2.4.2.6 Glutamate and NMDA receptors
2.4.2.7 Other amino acids and peptides
2.4.2.8 Endogenous Opioids
2.4.2.9 Endocannabinoids
2.4.3 Cellular and molecular mechanism in addiction (including neuro-adaptation, epigenetic phenomena, etc.)
2.4.4 Neuro-imaging of addiction and related phenomena (craving, relapse, recovery, etc.)

Epidemiology and Prevention Concepts

3.0 Epidemiological Concepts
3.1 Epidemiologic associations and interpretation
3.2 Biostatistics

4.0 Epidemiological Trends of Substance Use Disorders
4.1 Incidence, Prevalence and Initiation
4.2 Special Populations
4.2.1 Injury/Trauma
4.2.2 The Elderly
4.2.3 Women
4.2.4 Pregnant Women and Newborns
4.2.5 Adolescents and Young Adults
4.2.6 Families with Alcohol and Other Drug Using Members (including children at risk)
4.3 Alcohol and Drug Use in the Workplace
4.3.1 General Trends and Operational Definitions of Use/Dependence in the Workplace
4.3.2 Adverse Effects
4.3.2.1 Absenteeism
4.3.2.2 Injury: Occupational and Non-occupational
4.3.2.3 Implications for Health Care Utilization
4.3.3 Employee Assistance and Prevention Programs
4.3.4 Clinical and Legal Considerations in Drug Testing
4.3.4.1 Workplace Drug Testing
4.3.4.2 Medical Review Officer (MRO) Responsibilities and Authority
4.3.5  Fitness for duty evaluations
4.3.6  Substance Use Disorders in Health Professionals
   4.3.6.1  Epidemiology
   4.3.6.2  Intervention, Treatment, and Monitoring

5.0 Prevention
   5.1  Primary Prevention
   5.2  Secondary Prevention
   5.3  Tertiary prevention
   5.4  Environmental Interventions to Reduce Alcohol, Tobacco and other Drug Use
   5.5  Prevention Programs
   5.5.1  High Risk Populations
   5.4.2  Educational Approaches
   5.5.3  Community Organizational Approaches
   5.5.4  Public Policy Approaches
   5.5.4.1  Regulation of Supply
   5.5.4.2  Demand Reduction

Clinical Concepts

6.0 Screening, Assessment and Brief Intervention
   6.1  Screening
   6.1.1  Laboratory Tests
   6.1.1.1  Clinical Drug Testing
   6.1.2  Standard Questionnaires
   6.1.2.1  Adults
   6.1.2.2  Adolescents
   6.1.2.3  Pregnant Women
   6.2  Assessment
   6.3  Brief Intervention
   6.3.1  Ambulatory Care Settings
   6.3.1.1  Pregnant Outpatients
   6.3.1.2  Adolescent Outpatients
   6.3.2  Emergency Departments
   6.3.3  Hospital Inpatient Settings

7.0 Overview of Addiction Treatment
   7.1  History of Addiction Medicine
   7.2  Treatment of Alcohol Use Disorders
   7.3  Treatment of Drug Use Disorders
   7.4  Linking Addiction Treatment with Other Medical and Psychiatric Treatment
   7.5  Alternative Therapies for Alcohol and Drug Addiction
   7.6  Non-substance Addictions: Gambling, Sex, Food
   7.7  Treatment Needs of Children and Adolescents
7.8 Treatment Needs of Seniors
7.9 Quality Management in Addiction Treatment
7.9.1 Outcome Measurement
7.9.2 Satisfaction Measurement
7.9.3 Performance Evaluation

8.0 Management of Inpatient and Outpatient Intoxication and Withdrawal
8.1 General Principles in Management of Intoxication and Withdrawal
8.2 Management of Alcohol Intoxication and Withdrawal
8.3 Management of Sedative-hypnotic Intoxication and Withdrawal
8.4 Management of Opioid Intoxication and Withdrawal
8.5 Management of Other Drug Intoxication and Withdrawal (e.g., cocaine, stimulants, nicotine, phencyclidine, cannabinoids, hallucinogens, dissociatives, inhalants, steroids, club drugs, etc.)
8.6 Pharmacologic and non-pharmacologic intervention for Neonatal Intoxication and withdrawal for opioids and sedatives
8.7 Management of adverse impact and long term consequences of alcohol on fetus
8.8 Management of Alcohol/Drug Withdrawal Among Those Hospitalized for an Acute Co-morbid Condition (including Critical Care Detoxification)

9.0 Pharmacologic Interventions for Addictions
9.1 Pharmacological Interventions for Opioid Dependence
9.2 Pharmacological Interventions for Alcohol Dependence
9.3 Pharmacological Interventions for Tobacco Dependence
9.4 Pharmacologic Interventions for Other Drug Dependence
9.5 Pharmacologic and Non-pharmacologic Interventions for Neonatal Intoxication and Withdrawal for Opioids and Sedatives
9.6 Pharmacological Interventions for Non Substance Related Addictions

10.0 Behavioral Interventions
10.1 Psychological aspects of alcohol and drug use, intoxication and addiction (including “set and setting,” placebo, and expectation)
10.2 Patient Engagement and Securing Treatment Entry
10.3 Motivating Patients to Change
10.4 Individual Psychotherapy
10.5 Cognitive Behavioral Therapy
10.5.1 Relapse Prevention
10.5.2 Community Reinforcement and Vouchers
10.5.3 Contingency Management
10.5.4 Matrix Model
10.6 Group Therapy
10.7 Self Help Groups
10.7.1 Twelve Step Programs and 12-Step Facilitation Therapies
10.7.2 Other Self Help Programs
10.8 Couples and Family Counseling, Therapies, and Interventions
10.9 Adolescent Relapse Prevention
10.10 Residential Treatment and Therapeutic Communities
10.11 Treatment Retention and Chronic Disease Management
10.12 Comprehensive Case Management (use of integrated medical care and supplemental services for persons with chronic, persistent addiction)
10.13 Translating Research to Practice
10.14 Principles of Integrating Behavioral and Pharmacological Treatment
10.15 ASAM Patient Placement Criteria and Appropriate Use of Levels of Care.

11.0 Co-Occurring and Medical Disorders among Patients with Alcohol and Other Drug Use and Addiction
11.1 General Medical Evaluation and Management
11.2 General Medical and Surgical Complications
11.2.1 Cardiovascular Consequences
11.2.2 Hepatic Disorders
11.2.3 Other Gastrointestinal Disorders
11.2.4 Renal and Metabolic Disorders
11.2.5 Respiratory Disorders
11.2.6 Neurological Disorders
11.2.7 Infectious Diseases (HIV, TB, Sexually transmitted infections, and Others)
11.2.8 Hematologic Disorders
11.2.9 Sleep Disorders
11.2.10 Acute Traumatic Injuries
11.2.11 Rehabilitation from Traumatic Brain Injuries and Spinal Cord Injuries
11.2.12 Terminal Illness, Palliative Medicine, and End-of-Life Issues
11.2.13 Endocrine and Reproductive Disorders
11.3 Obstetrical Complications and Pregnancy Related Disorders and Complications
11.4 Fetal Drug Exposure, Including Fetal Alcohol Spectrum Disorders

12.0 Co-Occurring Psychiatric Disorders among Patients with Alcohol and Other Drug Use and Addiction
12.1 Neuropsychological Dysfunction (Problems with attention, memory, learning, executive function)
12.2 Substance Induced Mental Disorders
12.3 Affective Disorders
12.4 Posttraumatic Stress Disorder
12.5 Other Anxiety Disorders
12.6 Psychotic Disorders
12.7 Attention Deficit/Hyperactivity Disorder
12.8 Eating Disorders
12.9 Personality Disorders
12.10 Cognitive and Behavioral Diagnoses Secondary to in- utero Alcohol and Drug Exposure
13.0 Pain and Addiction
13.1 Musculoskeletal and Orthopedic Problems
13.2 Chronic Non-cancer Pain and Addiction
13.3 Psychological Issues in the Management of Pain
13.4 Non-Opioid Treatments in Management of Pain
13.5 Opioid Treatments in Management of Pain
13.6 Legal and Regulatory Considerations in Pain Management

Social-Legal Concepts

14.0 Ethical, Legal and Liability Issues in Addiction Practice
14.1 Ethical Issues in Addiction Practice
14.2 Informed Consent and Confidentiality in Clinical Practice and Clinical Research
14.3 Clinical and Legal Considerations in Prescribing Drugs for Treatment of Addiction
14.4 Clinical and Legal Considerations in the Treatment of Minors
14.4.1 Adolescent School-based Drug Testing
14.5 Drug Courts and the Treatment of Incarcerated Populations
14.6 Licensing and Credentialing Issues for Health Professionals
14.7 Forensic Addiction Medicine: Expert Witness and Civil Commitment
14.8 Competency and the Assessment of Competence
14.9 Environmental tobacco smoke
14.10 Disability and Substance Use
14.11 Americans with Disabilities Act
14.12 Medical Futility and End-stage Addiction
14.12.1 Therapeutic Pessimism/Nihilism and Pseudo-futility
14.13 Addiction Services Administration

Adapted from: ASAM Content of Addiction Medicine (9/13/06), and Core Content of Addiction Medicine (9/9/09); Principles of Addiction Medicine, Fourth Edition (2009)
EDUCATIONAL OBJECTIVES FOR ADDICTION MEDICINE FELLOWSHIP TRAINING


The ABAM Foundation’s Compendium of Educational Objectives for Addiction Medicine Fellowship Training was developed to provide training program directors and faculty with an inventory of specialty-defining skills and knowledge for use in curriculum design. The Compendium is organized according to the ACGME core competencies of Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interprofessional and Communication Skills, Professionalism, and Systems-based Practice. It also presents the objectives by 15 major categories of Addiction Medicine practice. One-hundred-and-eighty (180) objectives are required for all fellowships and another 251 are optional, thus promoting national consistency in Addiction Medicine while providing for flexibility and innovation among training programs. Of the optional objectives, 203 are labeled as “should” elements (recommended but not required) and 48 as “could” elements (worthy of consideration). There is a certain amount of overlap, with similar objectives sometimes listed under multiple competencies and categories, where they alternately appear as “must” or “should” elements, depending on the context. The full list of educational objectives, therefore, requires a 48-page Compendium of Educational Objectives (http://www.abam.net/publications).

To convey the key educational elements of Addiction Medicine more succinctly, the table below presents only the required objectives, organized by ACGME Competency (the last column) and the 15 ABAM Foundation categories (second column). The third column shows whether the objectives are to be met in specific rotations or longitudinally.

<table>
<thead>
<tr>
<th>Objective</th>
<th>ABAMF Category</th>
<th>Longitudinal Rotation (L), Specific Rotation (S), or either (SL)</th>
<th>ACGME Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA1. Perform a general, preventive and public health history and physical examination in any of multiple venues, including emergency departments, trauma units, intensive care units, general medical and specialty hospitals wards, outpatient and community clinics, occupational health programs, private offices, jails and prisons, and mental health programs.</td>
<td>Prevention, Public Health and Administration</td>
<td>L</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IA2. Retrieve essential and accurate information encompassing the usual medical history, as well as public health data unique to the patient’s bio-psycho-social and geographic background, as these relate to patient attitudes, practices and consequences of alcohol or drug use, or risk of use, as well as relevance to community planning and intervention strategies.</td>
<td>Prevention, Public Health and Administration</td>
<td>L</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IA3. Interpret and formulate diagnoses, plan additional appropriate testing, and outline initial treatment interventions, based on the result of the history and physical, and with consideration of patient preferences and the available resources available in the family, available healthcare milieu, and the community.</td>
<td>Prevention, Public Health and Administration</td>
<td>L</td>
<td>Patient Care</td>
</tr>
<tr>
<td>Objective</td>
<td>The Addiction Medicine fellow must be able to:</td>
<td>ABAMF Objective Category</td>
<td>Longitudinal Rotation (L), Specific Rotation (S), or either (SL)</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>IA4.</td>
<td>Work in a cohesive manner with a multi-disciplinary team that includes medical specialists or sub-specialists, and other health care professionals and lay persons, including nurses, psychologists, counselors, pharmacists, educators, employers, criminal justice system staff, family members, and persons in the faith-based and mutual-support communities.</td>
<td>Prevention, Public Health and Administration</td>
<td>L</td>
</tr>
<tr>
<td>IB1.</td>
<td>Provide patient care that is compassionate, appropriate and effective. Establish a style and physician-patient relationship sufficient to obtain a history and physical exam from patients who may be unaware that they have, or have a risk for, a substance use disorder; who have or have the risk of developing consequences and complications thereof; or who may be under the influence of a chemical or in acute withdrawal at the time of the assessment.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB2.</td>
<td>Obtain a clinical history and perform a physical exam that evaluates the patient’s general medical status and the patient’s specific substance use problems, including addiction, if present.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB3.</td>
<td>Obtain a clinical history and perform a physical exam for patients for whom the primary concern is not their primary substance use issue, but medical, psychiatric or social consequences related to substance use.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB4.</td>
<td>Perform a physical exam that can identify the general medical consequences of substance use, and the physical findings of secondary conditions and common co-occurring or complicating medical disorders.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB5.</td>
<td>Assess the presence of non-addictive but unhealthy alcohol and other drug use in order to initiate brief intervention and motivational enhancement activities or, as indicated, refer to another member of the healthcare team to provide brief intervention, Motivational Enhancement Therapy (MET), or referral to other addiction care.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB6.</td>
<td>When indicated, provide a brief intervention for alcohol and/or other drug use that may include brief advice and/or motivational interviewing.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB7.</td>
<td>Competently initiate treatment and referral to the appropriate level of outpatient or inpatient care, as indicated.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB8.</td>
<td>Form a relationship with the patient that includes unconditional acceptance of the patient, regardless of the severity of his or her primary disease or its complications, and which may include the patient’s inability to adhere to recommendations regarding abstinence from alcohol or drug use.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB9.</td>
<td>Proficiently devise a message and a manner of message delivery, which the patient and family can reasonably integrate, based on their unique socio-cultural identifiers, and the unique obstacles existent in patients and families dealing with substance use disorders.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB10.</td>
<td>Use laboratory tests, including urine drug testing, and other diagnostic procedures and consultations, to appropriately provide ongoing monitoring of the patient's addictive disease and/or general medical complications and/or general psychiatric complications of chronic drug/alcohol use/addiction.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
<tr>
<td>IB11.</td>
<td>Show proficiency in assessment of severity of use and complications of use, using the Assessment dimensions of the Addiction Severity Index.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>L</td>
</tr>
</tbody>
</table>


**Objective**
*The Addiction Medicine fellow must be able to:*

<table>
<thead>
<tr>
<th>Objective</th>
<th>ABAMF Objective Category</th>
<th>ACGME Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB12. Integrate other sources of data into one’s diagnostic assessments, including (a) review of medical records of previous health care encounters, and interviews of family members and other relevant collaterals, to confirm or refute patient self-reports and come to the most accurate diagnosis, and (b) utilization of psychometric instruments that complement the clinical assessment, for example: screening instruments (Alcohol Use Disorder Identification Test [AUDIT], or CAGE Questionnaire); diagnostic instruments for addiction disorders (Addiction Severity Index [ASI]; and other instruments used for psychosocial evaluations (Beck Depression Inventory [BDI]).</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IB13. Assess and manage withdrawal syndromes as they appear in medically/surgically/obstetrically hospitalized inpatients that require chronic alcohol and other drug exposure of addiction.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IB14. Use rating scales for the assessment of withdrawal syndromes (e.g., Clinical Institute Withdrawal Assessment for Alcohol-revised [CIWA-Ar]; and the Clinical Opioid Withdrawal Scale [COWS]).</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IB15. Conduct appropriate risk assessment of the patient, including suicide and self harm risk and risk of harm to others.</td>
<td>Assessment, Screening and Brief Intervention</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IC1. Complete a comprehensive addiction assessment addressing the six assessment dimensions of the ASAM Patient Placement Criteria (PPC) and to make an appropriate diagnosis of all substance use disorders present (as well as 'pertinent negatives' regarding addiction to various classes of drugs).</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IC2. Assess the presence of non-addictive but unhealthy alcohol and other drug use in order to initiate brief intervention and motivational enhancement activities or, as indicated, refer to another member of the healthcare team to provide brief intervention, MET, or referral to other addiction care.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IC3. Perform a physical exam that evaluates the patient's general medical status as well as signs/symptoms of withdrawal, or to review recent H&amp;P data submitted by the patient's primary care provider or from a recent hospitalization, emergency room encounter, urgent care center encounter, or Level IV, III or II detox encounter.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IC4. Perform a mental status exam and collect a psychiatric review of systems to rule out or rule in the presence of significant co-morbid psychiatric conditions that should be addressed along the individual’s substance use disorder; this includes assessment of self-harm, suicide, and harm-to-other risk.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IC5. Use laboratory tests, including urine drug testing, and other diagnostic procedures and consultations to appropriately provide ongoing monitoring of the patient’s addictive disease and/or general medical complications of chronic drug/alcohol use/addiction.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IC6. Use rating scales (CAGE, AUDIT, etc.) to assist in the formulation of a diagnosis.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IC7. Integrate other sources of data into diagnostic assessment, including review of medical records of previous health care encounters, and interviews of family members and other relevant collaterals to confirm or refute patient self-reports and come to the most accurate diagnosis.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>Objective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Addiction Medicine fellow must be able to:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
<th>ABAMF Objective Category</th>
<th>Longitudinal Rotation (L), Specific Rotation (S), or either (SL)</th>
<th>ACGME Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC8.</td>
<td>Perform a history and physical exam to identify the presence/absence of intoxication/withdrawal at admission to Outpatient Care or any time subsequently during Outpatient Care, as indicated.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC9.</td>
<td>Demonstrate competence in assessing and managing withdrawal syndromes as they appear in the ambulatory setting.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC10.</td>
<td>Form a relationship with the patient that includes unconditional acceptance of the patient, regardless of the severity of his or her primary disease or its complications, and which may include the patient’s inability to adhere to recommendations regarding abstinence from alcohol or drug use.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC11.</td>
<td>Engage the patient and secure their agreement to remain involved with general outpatient ADM care, as indicated.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC12.</td>
<td>Initiate, continue, and discontinue addiction pharmacotherapies, as indicated, as a component of general outpatient Addiction Medicine services.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC13.</td>
<td>Identify proper patient candidates for office-based opioid treatment, to perform outpatient inductions onto buprenorphine maintenance treatment, to utilize buprenorphine appropriately as an opioid withdrawal management medication, and to manage patients over time via buprenorphine maintenance.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC14.</td>
<td>Determine appropriateness for discontinuation of buprenorphine maintenance and to manage patients during buprenorphine discontinuation.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC15.</td>
<td>Develop and execute written treatment plans for addiction medicine outpatients and, as indicated by accreditation and licensure bodies, to participate in multidisciplinary team review of treatment plans and discharge plans.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC16.</td>
<td>Appropriately consult physicians from other specialties and other health care professionals as indicated during general outpatient Addiction Medicine care.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC17.</td>
<td>Demonstrate familiarity with the ASAM Patient Placement Criteria, offering continuing care in Level 0.5 or Level I as indicated, and either discharging patients or referring them to more intensive levels of addiction care when their severity of illness improves or worsens, accordingly.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>IC18.</td>
<td>Maintain appropriate medical records of physician services provided to patients and family members when offering general outpatient Addiction Medicine services.</td>
<td>Outpatient Addiction and Substance Use Care</td>
<td>S</td>
</tr>
<tr>
<td>ID1.</td>
<td>Monitor and lead a multidisciplinary clinical team offering patient care that is safe, effective, compassionate, and appropriate within a structured program of psychosocial treatment, psycho-educational experiences, and pharmacotherapy services, as indicated, that involves several hours per day, several days per week of patient involvement.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td>S</td>
</tr>
<tr>
<td>Objective</td>
<td>The Addiction Medicine fellow must be able to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID2. Form a relationship with the patient that includes unconditional acceptance, regardless of the severity of his or her primary disease or its complications, and which may include the patient’s inability to adhere to recommendations regarding abstinence from alcohol or drug use.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID3. Perform a physical exam that evaluates the patient’s general medical status at admission to the IOP/PH, or to review recent H&amp;P data submitted by the patient’s primary care provider or from a recent hospitalization, emergency room encounter, urgent care center encounter, or Level IV, III or II detox encounter.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID4. Complete a comprehensive addiction assessment addressing the six assessment dimensions of the ASAM Patient Placement Criteria (PPC) and to make an appropriate diagnosis of all substance use disorders present (as well as ‘pertinent negatives’ regarding addiction to various classes of drugs).</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID5. Use rating scales (CAGE, AUDIT, etc.) to assist in the formulation of a diagnosis.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID6. Integrate other sources of data into diagnostic assessment, including review of medical records of previous health care encounters, and interviews of family members and other relevant collaterals to confirm or refute patient self-reports and come to the most accurate diagnosis.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID7. Conduct appropriate risk assessment of the patient, including suicide and self harm risk and risk of harm to others.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID8. Perform a history and physical exam to identify the presence/absence of intoxication/withdrawal at admission to the IOP/PH, or subsequently during IOP/PH treatment, as indicated.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID9. Use laboratory tests, including urine drug testing, and other diagnostic procedures and consultations to appropriately provide ongoing monitoring of the patient's addictive disease and/or general medical complications of chronic drug/alcohol use/addiction.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID10. Work with non-physician personnel in the use and interpretation of standardized withdrawal rating scales, when the IOP or PH program is structured to offer detox services. In addition, in this setting the resident should demonstrate the ability to:</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Use appropriate clinical judgment in the requesting of consultation from dieticians, as indicated, to address nutritional deficits that may be present.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Classify the Stage of Alcohol Withdrawal (Stage I, II, III, and IV) and refer the patient to higher levels of detox care, as indicated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Use appropriate pharmacotherapy to manage withdrawal syndromes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID11. Work collaboratively with the attending addiction medicine physician in chairing treatment planning meetings of the multidisciplinary clinical team, reviewing continuing care and discharge criteria per the ASAM PPC and recommending post-IOP care plans for ongoing addiction care.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Objective**

*The Addiction Medicine fellow must be able to:*

<table>
<thead>
<tr>
<th>ID12. Make appropriate recommendations for the initiation or continuation of addiction pharmacotherapies during the IOP/PH encounter.</th>
<th>Intensive Outpatient and Partial Hospitalization Addiction Treatment</th>
<th>S</th>
<th>Patient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID13. Make appropriate recommendations for the initiation or continuation of methadone or buprenorphine in an Opioid Treatment Program (often referred to as a methadone maintenance clinic).</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>ID14. Maintain appropriate medical records of physician services provided to patients and family members during the IOP/PH encounter.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE1. Monitor and lead a multidisciplinary clinical team offering patient care that is safe, effective, compassionate, and appropriate within a structured program of psychosocial treatment, psycho-educational experiences, and pharmacotherapy services, as indicated, that involves several hours per day, several days per week of patient involvement.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE2. Form a relationship with the patient that includes unconditional acceptance, regardless of the severity of his or her primary disease or its complications, and which may include the patient’s inability to adhere to recommendations regarding abstinence from alcohol or drug use.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE3. Perform a physical examination to evaluate the patient’s general health status with special attention to physical manifestations of substance use disorders, including intoxication and withdrawal.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE4. Integrate multiple sources of data into a diagnostic assessment.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE5. Interview family members and other relevant collateral sources for diagnostic assessment and treatment planning.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE6. Complete a comprehensive addiction assessment, and make a complete diagnosis of all substance use disorders present, and note pertinent negatives.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE7. Work collaboratively with the attending Addiction Medicine physician in chairing treatment planning meetings of the multidisciplinary clinical team, reviewing continuing care and discharge criteria per the ASAM PPC and recommending post-inpatient/residential care plans for ongoing addiction care.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE8. Make appropriate recommendations for the initiation or continuation of addiction pharmacotherapies during the inpatient/residential encounter.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE9. Conduct an appropriate risk management assessment of each patient, including suicide and self-harm risk and risk to others, and refer to a higher level of care if indicated.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>Objective</td>
<td>Category</td>
<td>Rotation</td>
<td>Competency</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>IE10. Assess and medically manage withdrawal from alcohol and other drugs, appropriate to the level of care provided, or refer for a higher level of care if indicated by appropriately using and interpreting standard withdrawal assessment scales.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IE11. Maintain appropriate medical records of physician services.</td>
<td>Inpatient/Residential Addiction Treatment</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF1. Perform a physical exam that documents physiological disturbances due to acute withdrawal from alcohol, sedatives, opioids or other classes of drugs.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF2. Perform a mental status exam that documents perceptual, cognitive, emotional and behavioral disturbances due to acute withdrawal from alcohol, sedatives, opioids or other classes of drugs.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF3. Complete a comprehensive addiction assessment addressing the six assessment dimensions of the ASAM Patient Placement Criteria (PPC) and to make an appropriate diagnosis of all substance use disorders present (as well as 'pertinent negatives' regarding addiction to various classes of drugs).</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF4. Document findings from the patient examination and treatment recommendations, as well as the patient's response to those recommendations.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF5. Integrate multiple sources of data into a diagnostic assessment.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF6. Make a complete diagnosis of all substance use disorders present, and note pertinent negatives.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF7. Use appropriate pharmacotherapy to manage withdrawal syndromes.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF8. Conduct appropriate risk assessment of the patient during withdrawal, including suicide and self harm risk, aggression risk, elopement risk, and fall risk.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF9. Provide patient care that is safe, effective, compassionate, and appropriate with regard to acute withdrawal syndromes that require inpatient or residential level of care, minimizing, during withdrawal through his/her own actions or the involvement of consultants) medical complications such as aspiration or other swallowing or ventilation deficits.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF10. Demonstrate the ability to recommend the appropriate level of addiction services, which could be in accord with the ASAM PPC, for addiction treatment services to follow the detox encounter.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF18. Manifest skill in conducting follow-up patient interviews for diagnostic and treatment recommendation purposes when the initial examination was conducted during a state of intoxication or withdrawal or otherwise altered mental status that could have affected the validity of the patient's responses.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF19. Appropriately assess the patient's motivational level/stage of change and treatment readiness for psychosocial or other ongoing services, using rating scales if necessary.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
<tr>
<td>IF20. Make appropriate recommendations for the initiation or continuation of addiction pharmacotherapies during/at the end of the detox encounter.</td>
<td>Medically Managed Withdrawal</td>
<td>S</td>
<td>Patient Care</td>
</tr>
</tbody>
</table>
**Objective**
The Addiction Medicine fellow must be able to:

| IG1. Completion of a comprehensive addiction assessment, with focus on opioids, alcohol and nicotine. | Pharmacologic Therapies | SL | Patient Care |
| IG2. Assess and medically manage withdrawal from opioids, alcohol and nicotine, appropriate to the level of care provided, or refer for a higher level of care if indicated, using and appropriately interpreting standardized screening and assessment tools and standard withdrawal assessment scales. | Pharmacologic Therapies | SL | Patient Care |
| IG3. Provide outpatient stabilization and pharmacotherapy for opioid addiction, utilizing pharmacotherapies appropriate to clinical needs of the patient, including opioid antagonist or agonist therapy such as naltrexone, buprenorphine and methadone. | Pharmacologic Therapies | SL | Patient Care |
| IG4. Provide outpatient stabilization and pharmacotherapy for alcohol addiction, using pharmacotherapies appropriate to the clinical needs of the patient. | Pharmacologic Therapies | SL | Patient Care |
| IG5. Provide outpatient stabilization and pharmacotherapy for nicotine addiction, using pharmacotherapies appropriate to the clinical needs of the patient. | Pharmacologic Therapies | SL | Patient Care |
| IG6. Integrate the use of pharmacological treatment with psychosocial treatments in the management of individuals with addictive disorders. | Pharmacologic Therapies | SL | Patient Care |
| IH1. Use patient assessment, along with consultation with members of the treatment team and other treatment professionals, to devise an individualized plan for optimal psychosocial treatment for individual patients. | Psychosocial Therapies | SL | Patient Care |
| IH2. Match the level of psychosocial treatment to the treatment needs of individual patients. | Psychosocial Therapies | SL | Patient Care |
| IH3. Integrate the use of pharmacological treatment with psychosocial treatments in the management of individuals with addictive disorders. | Psychosocial Therapies | SL | Patient Care |
| II1. Recognize common medical conditions as they occur among patients with substance use conditions, and know when to seek appropriate medical consultation. | Medical Comorbidities and Complications | SL | Patient Care |
| II2. Recognize the relationship between the medical diagnosis and the substance use condition. | Medical Comorbidities and Complications | SL | Patient Care |
| II3. Recognize and treat substance use conditions (e.g. intoxication, withdrawal, use disorders) in the setting of acute and chronic medical conditions. | Medical Comorbidities and Complications | SL | Patient Care |
| IJ1. Recognize common psychiatric conditions as they occur among patients with substance use conditions, and know when to seek appropriate psychiatric consultation. | Psychiatric Comorbidities and Complications | SL | Patient Care |
| IJ2. Recognize the relationship between the psychiatric diagnosis and the substance use condition. | Psychiatric Comorbidities and Complications | SL | Patient Care |
| IJ3. Recognize and treat substance use conditions (e.g. intoxication, withdrawal, use disorders) in the setting of acute and chronic psychiatric conditions. | Psychiatric Comorbidities and Complications | SL | Patient Care |
Objective
The Addiction Medicine fellow must be able to:

<table>
<thead>
<tr>
<th>Objective</th>
<th>ABAMF Objective Category</th>
<th>Longitudinal Rotation (L), Specific Rotation (S), or either (SL)</th>
<th>ACGME Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM1. Manage withdrawal from alcohol, sedatives, and opioids, in consultation with a maternal fetal medicine specialist. Specifically, he/she should be familiar with the indications for and the use of: Methadone • Buprenorphine • Benzodiazepine substitution (lorazepam, diazepam, chlordiazepoxide) • Phenobarbital substitution • Antihypertensives in the treatment of stimulant intoxication (including the avoidance of beta blockade) • Antiepileptic drugs in the management of alcohol and sedative withdrawal, including education of women of childbearing age regarding risks of use of such agents.</td>
<td>Women, Pregnancy and Addiction SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IM2. Manage addiction to alcohol and other drugs in women, making appropriate adjustments to pharmacotherapy choice and dosing during pregnancy, and utilizing gender-specific primary treatment and continuing care as indicated.</td>
<td>Women, Pregnancy and Addiction SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IM3. Determine the indications for referral to specialized intensive outpatient or residential services that offer concurrent comprehensive services to pregnant and non-pregnant women with addiction and their children, including family therapy, parenting training, and other services.</td>
<td>Women, Pregnancy and Addiction SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN1. Provide anticipatory guidance about the impact of and the effects of psychoactive drug use, abuse and addictions to children, adolescents and their families.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN2. Guide the child, adolescent and family throughout the treatment process of either the pediatric patient and/or their family member.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN3. Identify, for the pediatric patient in addiction treatment, developmentally appropriate treatment goals, potential factors contributing to relapse, and identify strategies to prevent or minimize relapse, and, finally, identify appropriate referrals to or provide to treatment after discharge from treatment.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN4. Evaluate the newborn for the effects of substance exposure.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN5. Assist the child health specialist in developing an appropriate treatment plan for the newborn exposed to any psychoactive substances (licit or illicit) during gestation.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN6. Evaluate and develop a treatment plan for the newborn infant with intoxication and/or potential withdrawal from psychoactive substances (alcohol, sedative hypnotic medications, illicit and licit opioids, illicit and licit stimulants, and nicotine) in the newborn care unit.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN7. Use and interpret standardized neonatal abstinence scoring scales for physician and non-physician staff in a newborn care unit.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN8. Order and then interpret the results of urine and meconium testing for psychoactive substances in mother and neonate.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN9. Utilize non-pharmacological and pharmacological interventions for the treatment of neonatal intoxication and withdrawal from psychoactive substances including initial stabilization and tapering regimens.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>ABAMF Objective Category</td>
<td>Longitudinal Rotation (L), Specific Rotation (SL), or either (SL)</td>
<td>ACGME Competency</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>IN10. Assess the mother for substance use disorders when a newborn has potentially been exposed to psychoactive substances during gestation.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN11. Demonstrate an understanding of resources for evaluation of the toddler, child, and adolescent exposed to substances during gestation, specifically Fetal Alcohol Spectrum Disorders.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN12. Recognize the effects of parental substance abuse and addiction upon the child and adolescent and identify resources available in the community for children of parents with substance-use disorders.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN13. Evaluate and manage the child or adolescent who is intoxicated or withdrawing from psychoactive substances and provide non-pharmacological and pharmacological interventions to stabilize the patient.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN15. Communicate with and engage the family of the child and adolescent with substance abuse and addiction during assessment and treatment.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN16. Evaluate the effect of child and adolescent developmental status and problems upon the diagnosis of and management of adolescent abuse and addiction.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IN17. Effectively employ substance use screening tools applicable to the child and adolescent; teach physicians and non-physicians how to utilize screening tools.</td>
<td>Pediatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IO1. Recognize the relationship between aging and substance use conditions.</td>
<td>Geriatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IO2. Recognize and treat substance use conditions (e.g. intoxication, withdrawal, use disorders) in aging patients, taking account of the status of multiple chronic medical illnesses that may be present.</td>
<td>Geriatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IO3. Understand all of the patient's medications, prescribed and OTC, and the drug-drug interactions possible among alcohol, prescription opioids and sedatives, and other agents.</td>
<td>Geriatrics SL</td>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>IIB1. Knowledge of the diagnostic criteria for substance use disorders and various intoxication and withdrawal states according to the current standard of care (e.g., Diagnostic and Statistical Manual of Mental Diseases or “DSM,” the International Classification of Diseases or “ICD” codes).</td>
<td>Assessment, Screening and Brief Intervention SL</td>
<td>Medical Knowledge</td>
<td></td>
</tr>
<tr>
<td>IIB2. Knowledge of the broad range of medical, mental health and social conditions that can co-occur with substance use disorders, or are directly caused or exacerbated by substance use and demonstrate the ability to assess patients with addiction disorders who also have co-occurring medical, surgical, obstetrical or psychiatric conditions.</td>
<td>Assessment, Screening and Brief Intervention SL</td>
<td>Medical Knowledge</td>
<td></td>
</tr>
<tr>
<td>IIB3. Knowledge of how to assess a patient’s motivational level and readiness to initiate behavioral change.</td>
<td>Assessment, Screening and Brief Intervention SL</td>
<td>Medical Knowledge</td>
<td></td>
</tr>
<tr>
<td>IIB4. Knowledge of how to assess the behavioral, environmental, psychological, and physical dependence aspects of a patient’s nicotine addiction.</td>
<td>Assessment, Screening and Brief Intervention SL</td>
<td>Medical Knowledge</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Addiction Medicine fellow must be able to:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective Category</th>
<th>Longitudinal Rotation (LR)</th>
<th>Specific Rotation (SL)</th>
<th>ACGME Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIC1. The diagnostic criteria for substance use disorders and various intoxication and withdrawal states per the most recent edition of the DSM.</td>
<td>Outpatient Treatment (Level I)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIC2. The pharmacology of pharmacotherapeutic agents for alcohol, nicotine and opioid addiction, proper dosing, and ongoing management using them.</td>
<td>Outpatient Treatment (Level I)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIC3. The pharmacology of pharmacotherapeutic agents for alcohol and other drug withdrawal management.</td>
<td>Outpatient Treatment (Level I)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIC4. The theory and practice of office based opioid treatment using buprenorphine and how to integrate that into outpatient treatment of addiction.</td>
<td>Outpatient Treatment (Level I)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IID1. The diagnostic criteria for substance use disorders and various intoxication and withdrawal states per the most recent edition of the DSM.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment (Level II)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IID2. The pharmacology of pharmacotherapeutic agents for alcohol, nicotine and opioid addiction, proper dosing, and ongoing management using them.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment (Level II)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IID3. The theory and practice of office based opioid treatment using buprenorphine and how to integrate that into IOP care.</td>
<td>Intensive Outpatient and Partial Hospitalization Addiction Treatment (Level II)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIE1. The currently accepted diagnostic criteria for substance use disorders, including abuse, dependence, and other disorders caused by substances.</td>
<td>Inpatient/Residential Addiction Treatment (Level III)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIE2. The mechanisms of alcohol, sedatives, opioid and other drug withdrawal syndromes and the pharmacologic principles and mechanisms of medications used to treat different types of withdrawal.</td>
<td>Inpatient/Residential Addiction Treatment (Level III)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIE3. How to classify patients according to level of motivation and stage of change.</td>
<td>Inpatient/Residential Addiction Treatment (Level III)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIF1. The signs and symptoms of alcohol, sedative, opioid, and other drug withdrawal syndromes, as well as their neurobiology and pathophysiology.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIF2. Spontaneous and precipitated withdrawal and the actions of pharmacological antagonists in circumstances of intoxication or withdrawal.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIF3. &quot;Symptom-triggered detox&quot; as a treatment approach for alcohol withdrawal management.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIF4. Sedative tapers, with and without augmentation with anticonvulsants, for benzodiazepine detoxification.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIF5. Key features of management of alcohol/sedative withdrawal delirium.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>Objective</td>
<td>ABAMF Objective Category</td>
<td>Longitudinal Rotation (L), Specific Rotation (S), or either (SL)</td>
<td>ACGME Competency</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------</td>
<td>-------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>IIF6. The use of methadone and buprenorphine in the management of opioid withdrawal—clinical, legal and regulatory aspects.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIF7. The use of nicotine replacement therapies and other approaches in the management of nicotine withdrawal.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIF8. Definitions of a “standard drink” when calculating a patient's quantity/frequency of consumption and trying to determine the level of tolerance of the likelihood of developing alcohol withdrawal.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIF9. The diagnostic criteria for substance use disorders and various intoxication and withdrawal states per the most recent edition of the DSM.</td>
<td>Medically-managed Withdrawal (Detoxification)</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIIG1. Summarize current understanding of the pharmacology of alcohol, opioids, and nicotine.</td>
<td>Pharmacologic Therapies</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIIG2. Specify the currently-accepted diagnostic criteria for alcohol, opioid, and nicotine disorders, including abuse, dependence, and other disorders caused by these substances.</td>
<td>Pharmacologic Therapies</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIIG3. Synthesize the pharmacologic principles and mechanisms of medications used to treat withdrawal and craving for alcohol, opioids, and nicotine and prevent relapse to alcohol, opioid, and nicotine use.</td>
<td>Pharmacologic Therapies</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIIG4. Understand the need for psychosocial/behavioral treatment in conjunction with pharmacological treatment.</td>
<td>Pharmacologic Therapies</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIH1. The theory, principles and practice involved in psychosocial treatments for individuals with addictions and their families, including CBT, MET, family therapy, group therapy, contingency management, intensive case management, and other psychosocial addiction treatments.</td>
<td>Psychosocial Therapies</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IIH2. The principles and practice of 12-Step programs and other mutual help programs.</td>
<td>Psychosocial Therapies</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>III1. Understand the epidemiology of co-occurring medical and substance use conditions.</td>
<td>Medical Comorbidities and Complications</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>III2. Demonstrate an understanding of the differential diagnosis of medical symptoms in the setting of ongoing substance use, including the effects of substance use to mimic medical conditions.</td>
<td>Medical Comorbidities and Complications</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IJ1. Understand the epidemiology of co-occurring psychiatric and substance use conditions.</td>
<td>Psychiatric Comorbidities and Complications</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IK2. The pharmacology of medications used to treat acute and chronic pain.</td>
<td>Pain Medicine</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IK3. The potential for the development of addiction when pain medications are used in various patient populations.</td>
<td>Pain Medicine</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>Objective</td>
<td>ABAMF Objective Category</td>
<td>Longitudinal Rotation</td>
<td>ACME Competency</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------</td>
<td>-----------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>The Addiction Medicine fellow must be able to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IK4. Approaches to prevention and mitigation of risk relative to diversion and unauthorized use of pain medications.</td>
<td>Pain Medicine</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IK5. Knowledge of the use of methadone and buprenorphine as pain management modalities as well as addiction management modalities.</td>
<td>Pain Medicine</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IK6. Knowledge of the use of urine drug testing to assist in the monitoring of the patient treated with opioids for chronic non-cancer pain, both in cases of co-occurring addiction and in cases where there is no confirmed co-occurring addiction.</td>
<td>Pain Medicine</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IK7. Potential interactions between pain medication and medication used to treat addictive disorders.</td>
<td>Pain Medicine</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IL1. The effect of the individual’s substance use disorder on the family and the importance of the family as a major part of prevention, intervention, treatment and recovery.</td>
<td>Family Aspects and Impacts of Substance Use and Addiction</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IL2. The role of the family, environment and community in prevention and treatment, and have an ability to work with the family as an important part of prevention, intervention, treatment and recovery.</td>
<td>Family Aspects and Impacts of Substance Use and Addiction</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IL3 Addiction disorders as overwhelmingly familial in origin, with salient genetic and environmental influences, and that they heavily cluster in certain families.</td>
<td>Family Aspects and Impacts of Substance Use and Addiction</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IM1. Knowledge of the scope of substance use during pregnancy: tobacco, alcohol, opioids and opiates, stimulants, sedatives and hallucinogens.</td>
<td>Women, Pregnancy and Addiction</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>IM2. Knowledge of the effects of drugs on the fetus:</td>
<td>Women, Pregnancy and Addiction</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>• fetal alcohol syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• intrauterine growth restriction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• spontaneous abortion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• potential teratogenesis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• low birth weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• intrauterine fetal death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• sudden infant death syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• non-reassuring fetal status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• neonatal withdrawal syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• placental abruption</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• preterm labor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• withdrawal syndromes (opioids, alcohol, sedatives)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• intoxication syndromes (stimulants, opioids, sedatives)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IM4. Knowledge of the special risks of intoxication and withdrawal in the pregnant patient, including seizure, placental abruption, fetal distress and fetal death, specifically:</td>
<td>Women, Pregnancy and Addiction</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>• Increased risk of withdrawal from alcohol and benzodiazepines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increased risk of withdrawal from opioids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increased risk of intoxication with stimulants (cocaine, amphetamines, MDMA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IM5. Knowledge of the spectrum of fetal alcohol disorders, including fetal alcohol syndrome.</td>
<td>Women, Pregnancy and Addiction</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>Objective</td>
<td>ABAMF Objective Category</td>
<td>Longitudinal Rotation (L), Specific Rotation (SR), or either (SL)</td>
<td>ACGME Competency</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>IM6.</strong> Knowledge of models of treatment for pregnant and non-pregnant women that incorporate multiple modalities of supplemental services (including parenting classes and vocational counseling) into the treatment of the woman with addiction, and that involve the woman and her children concurrently in intensive outpatient or residential addiction treatment.</td>
<td>Women, Pregnancy and Addiction</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN1.</strong> The normal growth and development stages, including physical and psycho-social developmental stages, of the child and adolescent.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN2.</strong> The effect of substance abuse and addiction upon achievement of these milestones.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN3.</strong> The effects on the adult, the child and the adolescent of pre-natal and environmental exposure to alcohol, sedative hypnotics, opioids, stimulants, tobacco, marijuana and hallucinogens.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN4.</strong> The rapid progression of addiction in the child and adolescent.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN5.</strong> The pharmacologic agents prescribed for the treatment of all neonatal intoxication and withdrawal diagnoses, including specifically opioid and sedative hypnotic withdrawal.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN6.</strong> The pharmacologic agents used in the treatment of child and adolescent addiction including the treatment of intoxication and withdrawal.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN7.</strong> The pharmacology of commonly abused drugs, including stimulants, depressants, opioids, inhalants, hallucinogens, and cannabinoids, and the non-therapeutic use of non-prescribed and prescribed medications among children, and adolescents.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN8.</strong> The effect of psychoactive drugs including: intoxication, acute and chronic adverse reactions and withdrawal syndromes, common behavioral and physiological effects and side effects, and the half-life and duration of action.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN9.</strong> The incidence, prevalence, morbidity, and mortality associated with use, abuse and addiction to psychoactive drugs of abuse, including neonatal drug exposure related problems.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN10.</strong> The predominant patterns of drug use, abuse and dependence for children and adolescents.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN11.</strong> The socioeconomic costs of substance use disorders specific to children and their families.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN12.</strong> The applicable state laws, including ethical and confidentiality requirements of addiction treatment and legal notification and involvement of parents, as they relate to physician-patient communications and prescribing practices for children and adolescents.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>IN13.</strong> The diagnosis of Fetal Alcohol Syndrome, and those problems and diagnoses included in the non-diagnostic umbrella term Fetal Alcohol Spectrum Disorders.</td>
<td>Pediatrics</td>
<td>SL</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td><strong>III1.</strong> Appraise and assimilate scientific evidence.</td>
<td></td>
<td></td>
<td>Practice-Based Learning &amp; Improvement</td>
</tr>
<tr>
<td>Objective</td>
<td>ABA/MF Objective Category</td>
<td>Longitudinal Rotation (L), Specific Rotation (S), or either (SL)</td>
<td>ACGME Competency</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>III2. Investigate and evaluate his or her care of patients.</td>
<td></td>
<td>SL</td>
<td>Practice-Based Learning &amp; Improvement</td>
</tr>
<tr>
<td>III3. Continuously improve patient care based on constant self-evaluation and life-long learning.</td>
<td></td>
<td>SL</td>
<td>Practice-Based Learning &amp; Improvement</td>
</tr>
<tr>
<td>III4. Identify strengths, deficiencies, and limits in one’s knowledge and expertise.</td>
<td></td>
<td>SL</td>
<td>Practice-Based Learning &amp; Improvement</td>
</tr>
<tr>
<td>IV1. Demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.</td>
<td></td>
<td>SL</td>
<td>Interpersonal &amp; Communication Skills</td>
</tr>
<tr>
<td>V1. Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.</td>
<td></td>
<td>SL</td>
<td>Professionalism</td>
</tr>
</tbody>
</table>
## APPENDIX IX
### TEMPLATE FOR A TYPICAL 12-MONTH ADDICTION MEDICINE FELLOWSHIP PROGRAM

<table>
<thead>
<tr>
<th>Block Rotations</th>
<th>Longitudinal Experiences</th>
<th>Scholarly Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient chemical dependency ¹</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Outpatient chemical dependency ¹</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Outpatient chemical dependency ¹</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Inpatient chemical dependency ²</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Inpatient chemical dependency ²</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Inpatient consultation service</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Program-required rotation ³</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Program-required rotation ³</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Program-required rotation ³</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Fellow elective rotation ⁴</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Fellow elective rotation ⁴</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Fellow elective rotation ⁴</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Vacation/CME</td>
<td>4 weeks</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** rotations can be blended; e.g. fellows may spend the morning in one program and the afternoon in another, or one day a week in each.

¹ **Outpatient Chemical Dependency Rotations**
Intake, assessment, diagnostic and treatment planning setting; Intensive Outpatient Treatment Program; medication assisted treatment program; outpatient detoxification program; day hospital program; adolescent and young adult program; women’s program; infectious disease outpatient program; correctional health clinic, correctional health setting; veterans setting; emergency departments; triage settings, etc.
2 Inpatient Chemical Dependency Rotations
Inpatient detoxification service; medically managed 28 day residential treatment program; medically supervised residential treatment program; consult services – dedicated substance use consult service (Internal Medicine, Pediatrics, Obstetrics/Gynecology, etc.) consult liaison with Psychiatry or other department, etc.

3 Program Required Rotations
Varies with the opportunities and strengths of a particular program, but could include: Pain clinic; infectious disease clinic; dual diagnosis setting; women’s health; adolescent and youth programs; correctional health; pre-natal and NAS settings; geriatric addiction setting; veterans pain and addiction setting; medication assisted treatment, community based care; public health clinical practice or administrative setting, etc.

4 Fellow Elective Rotations
To address increasing strengths in weak areas, or encouraging the fellow’s special interest in other areas; For example more time with Psychiatry and inpatient settings for a fellow from Pediatrics; more time in Infectious Disease and Adolescent CD for a psychiatrist, etc. And more specific assignments based on rounding out the training of the fellow.
APPENDIX X
PROGRAM REQUIREMENTS FOR FELLOWSHIP EDUCATION IN THE SUBSPECIALTY OF ADDICTION MEDICINE

Definition and Description of the Subspecialty

The Addiction Medicine physician provides medical care within the bio-psycho-social framework for persons with addiction, for the individual with substance-related health conditions, for persons who manifest unhealthy substance use, and for family members whose health and functioning are affected by another’s substance use or addiction.

The Addiction Medicine physician is specifically trained in a wide range of prevention, evaluation and treatment modalities addressing substance use and addiction in ambulatory care settings, acute care and long-term care facilities, psychiatric settings, and residential facilities. Addiction Medicine specialists often offer treatment for patients with addiction or unhealthy substance use who have co-occurring general medical and psychiatric conditions.

The Addiction Medicine physician is a key member of the health care team and is trained to collaborate, coordinate and provide consultation services for other physicians and to use community resources when appropriate. Some Addiction Medicine physicians limit their practice to patients with addiction or other patterns of unhealthy substance use. Others focus their practice on patients within their initial medical specialty who have substance-related health conditions. Addiction Medicine physicians work in clinical medicine, public health, educational, and research settings to advance the prevention and treatment of addiction and substance-related health conditions and to improve the health and functioning of persons with unhealthy substance use or who are affected family members of unhealthy substance users.

The purpose of post graduate medical education (GME) fellowship training in Addiction Medicine (ADM) is to provide physicians with a structured educational experience that will enable them to care for patients with substance use disorders, and for family members of persons with substance use disorders, as described in the Scope of Practice of ADM.

Physicians who wish to pursue fellowship training in ADM must be certified by a member specialty board of the American Board of Medical Specialties (ABMS) or have successfully completed all the training requirements and are eligible for board certification from an ABMS Member Board.

Fellowship training in ADM is one year, and must be sponsored by an educational institution approved by the Accreditation Council for Graduate Medical Education (ACGME) to offer fellowship education. The Year One requirements may be fulfilled on a 12-month full-time equivalent basis or on a part-time basis over two years.
Program Requirements \textit{(Common Program Requirements are in bold)}

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to Fellow assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

1.A.1 The addiction medicine fellowship training program must be sponsored by an educational institution approved by the Accreditation Council for Graduate Medical Education (ACGME) to offer Fellowship education.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for Fellows;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of Fellows, as specified later in this document;

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern Fellow education during the assignment.

I.B.2. The Program Director must submit any additions or deletions of participating sites that routinely provide an educational experience, which is required for all Fellows in the program, whenever such experiences are of one month full time equivalent (FTE).

1.B.3. Participating sites may not be at such distance from the primary teaching sites that it would fragment the educational experience.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single Program Director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in Program Director. After approval, the Program Director must submit this change to the RRC.
II.A.2. The Program Director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

II.A.3. Qualifications of the Program Director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the RRC;

II.A.3.b) current certification in the specialty of Addiction Medicine, or specialty qualifications that are acceptable to the RRC;

II.A.3.c) current medical licensure and appropriate medical staff appointment; and

II.A.4. The Program Director must administer and maintain an educational environment conducive to educating the Fellows in each of the ACGME competency areas. The Program Director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

II.A.4.b) approve a local director at each participating site who is accountable for Fellow education;

II.A.4.c) approve the selection of program faculty as appropriate;

II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

II.A.4.e) monitor Fellow supervision at all participating sites;

II.A.4.f) prepare and submit all information required and requested by the RRC, including but not limited to the Program Accreditation Applications Forms and annual program Fellow updates, and ensure that the information submitted is accurate and complete;

II.A.4.g) provide each Fellow with documented semiannual evaluation of performance with feedback;

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

II.A.4.i) provide verification of Fellowship education for all Fellows, including those who leave the program prior to completion;

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for Fellow duty hours and the working environment, including moonlighting, and, to that end, must:

II.A.4.j.(1) distribute these policies and procedures to the Fellows and faculty;
II.A.4.j).(2) monitor Fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of Fellows, disciplinary action, and supervision of Fellows;

II.A.4.m) be familiar with and comply with ACGME and RRC policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.4.n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the RRC information or requests for the following:

II.A.4.n).(1) changes in Fellow complement;

II.A.4.n).(2) major changes in program structure or length of training;

II.A.4.n).(3) progress reports requested by the RRC;

II.A.4.n).(4) responses to all proposed adverse actions;

II.A.4.n).(5) requests for increases or any change to Fellow duty hours;

II.A.4.n).(6) voluntary withdrawals of ACGME-accredited programs by the Sponsoring Institution;

II.A.4.n).(7) requests for appeal of an adverse action; and

II.A.4.n).(8) appeal presentations to a Board of Appeal or the RRC.

II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

II.A.4.o).(1) program citations, and/or

II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.
II.A.4.p) The Program Director must devote sufficient time to the Fellowship program (i.e., at least 0.25 FTE per year) spent in Fellow administration, Fellow teaching, Fellow precepting and attending duties, and exclusive of time spent in direct patient care without the presence of Fellows.

II.A.5. An acting or interim director must possess the qualifications listed in Section II.A.a-d, unless a specific waiver of this requirement is granted by the RRC.

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all Fellows at that location.

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of Fellows, and

II.B.1.b) administer and maintain an educational environment conducive to educating Fellows in each of the ACGME competency areas.

II.B.2. The physician faculty must have current certification in the subspecialty of Addiction Medicine, or possess qualifications acceptable to the RRC.

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.4. The non-physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding;

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

II.B.5.b).(4) participation in national committees or educational organizations.
II.B.5.c) Faculty should encourage and support Fellows in scholarly activities.

II.B.6. Faculty/Fellow Ratio

In addition to the Program Director there must be at least a .25 FTE Addiction Medicine physician for each additional Fellow in the program.

II.B.7. Faculty Role Modeling

As is expected of the Program Director, the physician faculty should have a specific time commitment to patient care to maintain clinical skills.

II.B.8. Faculty Development

There must be a structured program of faculty development that involves regularly scheduled faculty development activities.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.C.1. Additional teaching staff will be needed to provide training in curricula areas in which the Addiction Medicine faculty are not trained or experienced.

II.C.2. Addiction Medicine Fellows should be engaged in cross-disciplinary training as part of the addiction treatment team composed of addiction counselors, nurses, psychologists and members of other health care disciplines. Because addiction medicine engages physicians from several medical specialties, Fellows should also train in settings where there is meaningful clinical interaction, collaboration and consultation with other Fellows (e.g., Emergency Medicine, Family Medicine, Geriatrics, Internal Medicine, Obstetrics-Gynecology, Pain Medicine, Pediatrics and Adolescent Medicine, Psychiatry and Surgery).

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for Fellow education, as defined in these Program Requirements.

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Fellowship Appointments

III.A. Eligibility Criteria

The Program Director must comply with the criteria for fellowship eligibility as specified in the Institutional Requirements.
Applicants with one of the following qualifications, who are certified by a Member Board of the American Board of Medical Specialties (ABMS) or have successfully completed all training requirements for certification from an ABMS Board, are eligible for appointment to programs:

III.A.1.a) Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

III.A.1.b) Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).

III.A.1.c) Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:

III.A.1.c).(1) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or,

III.A.1.c).(2) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.

III.A.1.d) Graduates of medical schools outside the United States who have completed a Fifth Pathway** program provided by an LCME-accredited medical school.

III.B. Number of Fellows

The Program Director may not appoint more Fellows than approved by the RRC, unless otherwise stated in the specialty-specific requirements. The program’s educational resources must be adequate to support the number of Fellows appointed to the program.

III.B.1. Those accepted into the first year of training should have adequate funding available for 12 month equivalents of training (24 months for optional two year programs). Contracts may be renewed for each year of enrollment for 2 year programs.

III.C. Fellow Transfers

III.C.1. Before accepting a Fellow who is transferring from another program, the Program Director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring Fellow.

III.C.2. A Program Director must provide timely verification of Fellowship education and summative performance evaluations for Fellows who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, Fellows from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed Fellows’ education. The Program Director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.
IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must distribute to Fellows and faculty annually, in written or electronic form;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to Fellows and faculty annually, in either written or electronic form. These should be reviewed by the Fellow at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.3.a)(1) Year one training

The four main components of the year one structured clinical portion of ADM Fellowship training are: 1) structured blocks of 12 clinical rotations; 2) longitudinal outpatient continuity clinical experiences, 3) longitudinal didactic sessions and other learning experiences and 4) scholarly activities.

IV.A.3.a). (2) Approximately 4 hours per week, on average, must be devoted to longitudinal learning experiences such as didactic conferences, individual or small group tutoring sessions with program faculty, and mentored self-directed learning. These experiences must address the topics of the Core Curriculum of Addiction Medicine.

IV.A.3.a) (3). Conferences should reflect the needs of the program and the Fellows. At least one faculty should attend each conference given by Fellows.

IV.A.3.a).(4) Each program must have the following:

IV.A.3.a).(4).(a) An educational rationale for use of conferences for the program;

IV.A.3.a). (4).(b) A statement on how conferences are evaluated and how the resultant data are used by the program; and,

IV.A.3.a).(4).(c) An explanation of Fellow involvement in conference design and presentations.

IV.A.3.a).(5) The structured block clinical rotations and longitudinal clinical experiences are described in the ABAM Foundation’s Compendium of Educational Objectives for Addiction Medicine Fellowship Training, and the ADM Fellowship Training Core Curriculum with ACGME Competencies.

IV.A.3.a).(6) The clinical rotations consist of structured experiences over the Year One clinical training that can be scheduled either as traditional “block rotations” or longitudinally over several months.
IV.A.3.a). (7) The block rotations (or longitudinal clinical experiences) will consist of 12 four-week blocks (each equivalent to 160 hours or “one month”) and four weeks of vacation/continuity medical education (CME) activities:

- 480 hours (12 weeks or 3 months) of experience with outpatient chemical dependency treatment (a “core rotation”).
  For example: intensive outpatient treatment or “day treatment” programs, addiction medicine consult services, opioid replacement or maintenance programs (using buprenorphine or methadone), and other medical services where the Fellow is directly involved with patient assessment, counseling, treatment planning, and coordination with community based services;

- 320 hours (8 weeks or 2 months) of experience with inpatient chemical dependency treatment programs (a “core rotation”).
  For example: hospital-based rehabilitation programs or medically managed Fellowship programs where the Fellow is directly involved with patient assessment and treatment planning, which can include the management of withdrawal (i.e., “detoxification”).

- 160 hours (4 weeks or 1 month) of experience in an inpatient general medical facility (a “core rotation”).
  For example: Teaching hospitals (that include acute care beds, critical care units, emergency departments, etc.) where the Fellow provides consultation services to other physicians for patients admitted with a primary medical, surgical, obstetrical, or psychiatric diagnosis.

- 480 hours (12 weeks or 3 months) of program-specific requirements in addition to the 6 months of “core rotations” that serve to meet addiction medicine Fellowship program requirements.

- 480 hours (12 weeks or 3 months) Fellow electives to compliment the Fellow’s prior training and/or meet Fellowship program requirements.

- 160 hours (4 weeks or 1 month) Vacation /CME

Each 4 week rotation consists of approximately 160 hours of experience that could be completed as a traditional block rotation, a longitudinal clinical experience or a combination of the two.

IV.A.3.a). (8) Longitudinal outpatient continuity care experiences. At least one half-day per week for 12 months must be devoted to providing continuity care to a panel of patients who have an addiction disorder. The Fellow may serve as either a specialty consultative physician with care focused on the addiction disorder or may serve as a primary care physician who provides comprehensive care for the patient panel. This clinical experience must occur during at least 6 continuous months.

IV.A.3.b) Optional year two training

IV.A.3.b). (1) The optional year two is a one year “practicum.” The three main elements of the year two are experiences during which the Fellow will acquire: 1) Administrative skills related to patient care (i.e., “case
management”), 2) Teaching skills, and 3) Scholarly activities such as research relevant to the specialty of Addiction Medicine.

IV.A.3.b).(2) Examples of this practicum include: 1) A one year clinical experience in the practice of addiction medicine, 2) A one year experience as an addiction medicine faculty member at a medical school or at an Addiction Medicine training program, 3) A one-year structured research fellowship.

IV.A.3.b). (3) A combination of these experiences can be used to fulfill this requirement. An advanced academic degree (e.g., MPH) could also be used to fulfill all or a portion of the practicum requirement. The Fellow shall also prepare a thesis on a topic related to ADM in fulfillment of this requirement. The practicum and the thesis topic must be approved by the RRC.

IV.A.4. Delineation of Fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of Fellows over the continuum of the program; and,

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) Patient Care

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows:

IV.A.5.a).(1) The Program Director and faculty must develop a list of Patient Care competency educational objectives for each of the 15 rotations (12 block rotations and the 3 longitudinal experiences), and describe the clinical and didactic experiences where the competency will be acquired. The educational objectives should be tailored for each Fellow, taking into account the Fellow’s prior training and experience. The objectives should be taken from The ABAM Foundation’s Compendium of Competency Educational Objectives for Addiction Medicine Fellowship Training and the ADM Fellowship Core Curriculum with ACGME Competencies.

IV.A.5.a).(2) Continuity of care is a recognized core value of the specialty of addiction medicine and must be a priority in each program.

IV.A.5.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows:

IV.A.5.b).(1) The Program Director and faculty must develop a list of Medical Knowledge competency educational objectives for
each of the 15 rotations, and describe the clinical and didactic experiences where the competency will be acquired. The educational objectives should be tailored for each Fellow, taking into account the Fellow’s prior training and experience. The objectives should be taken from the ABAM Foundation’s *Compendium of Competency Educational Objectives for Addiction Medicine Fellowship Training*, and the *ADM Fellowship Core Curriculum with ACGME Competencies*.

IV.A.5.c) Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Fellows are expected to develop skills and habits to be able to meet the following goals:

**IV.A.5.c).(1)** identify strengths, deficiencies, and limits in one’s knowledge and expertise;

**IV.A.5.c).(2)** set learning and improvement goals;

**IV.A.5.c).(3)** identify and perform appropriate learning activities;

**IV.A.5.c).(4)** systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

**IV.A.5.c).(5)** incorporate formative evaluation feedback into daily practice;

**IV.A.5.c).(6)** locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;

**IV.A.5.c).(7)** use information technology to optimize learning; and,

**IV.A.5.c).(8)** participate in the education of patients, families, students, Fellows and other health professionals.

IV.A.5.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Fellows are expected to:

**IV.A.5.d).(1)** communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

**IV.A.5.d).(2)** communicate effectively with physicians, other health professionals, and health related agencies;

**IV.A.5.d).(3)** work effectively as a member or leader of a health care team or other professional group;
IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.

IV.A.5.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Fellows are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others;

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;

IV.A.5.e).(3) respect for patient privacy and autonomy;

IV.A.5.e).(4) accountability to patients, society and the profession; and,

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Fellows are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;

IV.A.5.f).(5) work in inter-professional teams to enhance patient safety and improve patient care quality; and,

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.

IV.A.5.f).(7) The Program Director and faculty must develop a list of Systems-based Practice competence educational objectives, and describe the clinical and didactic experiences where the
competence will be acquired objectives will be met. The educational objectives should be tailored for each Fellow, taking into account the Fellow’s prior training and experience. The objectives should be taken from the ABAM Foundation’s *Compendium of Competency Educational Objectives for Addiction Medicine Fellowship Training*, and the *ADM Fellowship Core Curriculum with ACGME Competencies*.

IV.B. Fellows’ Scholarly Activities

IV.B.1. The curriculum must advance Fellows’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2. Fellows should participate in scholarly activity.

IV.B.2.a) Each program must provide supervised experiences for all Fellows in scholarly activities such as research, presentations at national, regional, state, or local professional meetings, or presentation and/or publication of review articles and case presentations. Formal instruction and practical experience must ensure that each Fellow develops and demonstrates skills in locating sources of scientific data pertinent to the care of patients, analyzing the appropriateness of research design and statistical methods, obtaining information about diagnostic and therapeutic effectiveness, and applying evidence from pertinent clinical studies to patient care.

IV.B.2.b) The program must provide a supervised, ongoing forum in which Fellows explore and analyze emerging scientific evidence pertinent to the practice of medicine.

IV.B.2.c) Additionally, all Fellows must actively participate in scientific inquiry, either through direct participation in research, or undertaking scholarly projects that make use of the scientific methods noted above.

IV.B.2.d) Fellows must also have guided experiences in the application of emerging clinical knowledge applicable to their own patient panels. The training environment must be in compliance with accepted evidence-based practices.

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate Fellow involvement in scholarly activities.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate Fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:
V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

V.A.1.b).(3) document progressive Fellow performance improvement appropriate to educational level; and, provide each Fellow with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of Fellow performance must be accessible for review by the Fellow, in accordance with institutional policy.

V.A.2. Summative Evaluation

The Program Director must provide a summative evaluation for each Fellow upon completion of the program. This evaluation must become part of the Fellow’s permanent record maintained by the institution, and must be accessible for review by the Fellow in accordance with institutional policy. This evaluation must:

V.A.2.a) document the Fellow’s performance during the final period of education, and

V.A.2.b) verify that the Fellow has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.B.3. This evaluation must include at least annual written confidential evaluations by the Fellows.

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) Fellow performance;

V.C.1.b) faculty development;

V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,
V.C.1.d) program quality. Specifically:

V.C.1.d.(1) Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

V.C.1.d.(2) After each rotation, the Fellow will complete an anonymous evaluation of the rotation.

V.C.1.d.(3) The program must use the results of Fellows’ assessments of the program together with other program evaluation results to improve the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Principles

VI.A.1. The program must be committed to and be responsible for promoting patient safety and Fellow well-being and to providing a supportive educational environment.

VI.A.2. The learning objectives of the program must not be compromised by excessive reliance on Fellows to fulfill service obligations.

VI.A.3. Didactic and clinical education must have priority in the allotment of Fellows’ time and energy.

VI.A.4. Duty hour assignments must recognize that faculty and Fellows collectively have responsibility for the safety and welfare of patients.

VI.B. Supervision of Fellows

The program must ensure that qualified faculty provide appropriate supervision of Fellows in patient care activities.

VI.C. Fatigue

Faculty and Fellows must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the Program: i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
VI.D.1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

VI.D.2. Fellows must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

VI.D.3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

VI.E. On-call Activities

VI.E.1. In-house call must occur no more frequently than every third night, averaged over a four-week period.

VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Fellows may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

VI.E.3. No new patients may be accepted after 24 hours of continuous duty.

VI.E.4. At-home call (or pager call)

VI.E.4.a) The frequency of at-home call is not subject to the every-third night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each Fellow.

VI.E.4.b) Fellows taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

VI.E.4.c) When Fellows are called into the hospital from home, the hours Fellows spend in-house are counted toward the 80-hour limit.

VI.F. Moonlighting

VI.F.1. Moonlighting must not interfere with the ability of the Fellow to achieve the goals and objectives of the educational program.

VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

VI.G. Duty Hours Exceptions

The RRC may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1. In preparing a request for an exception the Program Director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
VI.G.2. Prior to submitting the request to the RRC, the Program Director must obtain approval of the institution’s GMEC and DIO.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the RRC. In preparing requests, the Program Director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once the RRC approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

***

Footnote for III.A.1.d

** A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).
Addiction Institute of New York Fellowship in Addiction Medicine

Sponsoring Institution: St. Luke’s and Roosevelt Hospitals
Location: New York, NY
Length of Training: 1 Year
Total ABAM Foundation Approved Positions: 2

Program Director: Abigail J. Herron, DO
The St. Luke’s and Roosevelt Hospitals
1000 Tenth Avenue
New York, NY 10019

Email: AHerron@chpnet.org
URL: www.AddictionInstituteNY.org

Program Description

The Addiction Institute of New York (AINY) Fellowship in Addiction Medicine in New York City is a one-year program that offers qualified physicians the unique opportunity to train in the evaluation and treatment of patients with substance use disorders, behavioral addictions, and co-occurring psychiatric disorders.

The Addiction Medicine fellow trains in behavior modification techniques, motivational interviewing, 12-step facilitation, and psychopharmacology specifically designed for this patient population. Furthermore, the fellow has full access to the entire range of AINY’s teaching services, which include inpatient facilities for detoxification and rehabilitation, outpatient programs, a residential house, an opioid treatment program, a buprenorphine induction center, a day program and school for addicted adolescents, and a consult service for patients in medical and surgical units.

There is no call but moonlighting is available if desired.

Program objectives are: 1) To provide an understanding of the nature of addiction on psychological, physiological, and social bases; 2) To train physicians in current pharmacological and psychosocial therapeutic modalities of addiction treatment; and 3) To provide opportunities for teaching and original research (optional).

The Addiction Institute is a world-renowned center for state-of-the-art addiction treatments, research, and education. It is the largest comprehensive treatment center in New York City specializing in the treatment of substance use and other co-occurring psychiatric disorders. Its history is rich in accomplishments and innovations in the development of the best treatments for people who struggle with alcohol, heroin, cocaine, nicotine and other addictions.
The Addiction Medicine Fellowship Program at NYU School of Medicine

Sponsoring Institution: New York University School of Medicine
Location: New York, NY
Length of Training: 1 or 2 Years
Total ABAM Foundation Approved Positions: 1

Program Director: Joshua D. Lee, MD MSc
Division of General Internal Medicine
NYU School of Medicine
550 First Ave., VZ30 622
New York, NY 10016

Email: joshua.lee@nyumc.org
URL: http://medicine.med.nyu.edu/dgim/

Program Description

This fellowship builds on our well-established and nationally recognized fellowship in Addiction Psychiatry at NYU School of Medicine. The fellow will train across a broad array of clinical and investigational settings on the NYULMC and Bellevue Hospital Center campuses, gaining exposure to traditional addiction specialty and related inpatient and outpatient programs (detoxification, dual diagnosis, consult and liaison psychiatry, emergency care, pain medicine, methadone maintenance, and intensive outpatient treatment). The core longitudinal clinical experience is an Addiction Medicine clinic within a primary care medical home setting at Bellevue Hospital.

Clinical research opportunities include ongoing NIH-funded clinical trials as well as extensive training opportunities in research methods through the NYU-HHC Clinical and Translational Science Institute. Mentorship and didactics are integrated with the Addiction Psychiatry Fellowship, preparing the fellow for the ABAM certification exam and a career in Addiction Medicine.
Betty Ford Center Addiction Medicine Fellowship

Sponsoring Institution: Eisenhower Medical Center
Location: Rancho Mirage, CA
Length of Training: 1 Year
Total ABAM Foundation-approved Positions: 1

Medical Education Coordinator: Joseph Skrajewski, MA
39000 Bob Hope Drive
Rancho Mirage, CA 92270
Email: jskrajewski@bettyfordinstitute.org
URL: www.bettyfordcenter.org / www.bettyfordinstitute.org

Program Description:

The Betty Ford Center Addiction Medicine Fellowship is a one-year program that offers a well-rounded, diverse, rich experience focusing on patient care. It is designed to equip physicians to be specialists in addiction and will focus on clinical rotations and practical clinical experiences. The end result will be to empower physicians to be capable in addressing all aspects of Addiction Medicine.

The non-profit Betty Ford Center is a licensed Chemical Dependency Recovery Hospital that provides effective alcohol and other drug dependency treatment services, including programs of education and research, to help women, men and families begin the process of recovery. The educational rationale is to provide an enriching experience that provides as much exposure as possible to patients and clinical supervision. It is designed to prepare physicians for the independent practice of Addiction Medicine and to expose them to the wide range of career opportunities available in academics, research, clinical practice and the various addiction medicine subspecialties.

Residents will rotate on the Betty Ford Center detoxification and inpatient units, making clinical rounds with the attending physician, and they will participate in a variety of specialty groups and small group settings. They will administer detoxification protocols and assess patients from the time of admission and throughout their treatment stay. In addition, residents will complete addiction-focused history and physical exams, pathophysiology, disease concept, relapse indicators, medical treatment, diagnostic criteria, family codependency dynamics, prevention/public health policy, evidence of mastering Addiction Medicine literature, interview skills, oral presentations, medical management (clinical judgment), counseling skills, patient education, and ability to function as a critical part of the multidisciplinary team.

Rotations through the Betty Ford Center Residential Day Treatment (RDT) Program, Pain Management Track (PMT), Family Program, Intensive Outpatient Program (IOP), Psychiatry experience, and Ranch Recovery Center round out this enriching experience.
Boston University Addiction Medicine Fellowship

Sponsoring Institution: Boston Medical Center
Location: Boston, MA
Length of Training: 1-2 Years
Total ABAM Foundation Approved Positions: 4

Program Director: Alexander Walley, MD
Boston Medical Center
801 Massachusetts Avenue
Boston, MA  02118

Email:  Alexander.Walley@bmc.org
URL:  http://www.bumc.bu.edu/amf/

Program Description

The Boston University Addiction Medicine Fellowship Program combines the resources of the BU School of Medicine and Public Health as well as local training institutions to offer a comprehensive training program that includes both clinical and research experience.

Fellows, all of whom have completed another clinical residency, can complete a single clinical training year or the two years of combined longitudinal research and clinical training. Experiences are tailored to the individual’s interests and fellows are guided by the interdisciplinary Boston University Addiction Medicine Fellowship faculty. The program faculty members draw from multiple relevant disciplines (Internal Medicine, Psychiatry, Emergency Medicine, Preventive Medicine, Obstetrical Medicine, Pediatrics) and have established relationships with relevant teaching sites. These include: Boston Medical Center (BMC), New England’s largest safety net hospital; Boston Public Health Commission, responsible for a wide range of preventive and treatment services; Boston Children’s Hospital Adolescent Addiction Program, one of the preeminent research and training sites for teen addiction nationally; and Faulkner Hospital Addiction Service, site of an inpatient medical detoxification and partial hospitalization unit.

The Boston University Addiction Medicine Program curriculum is organized around four areas: 1) Clinical Addiction Medicine; 2) Analytic and Research Skills on Addiction Epidemiology and Health Services Delivery; 3) Leadership, Teaching and Administrative Skills for Addiction Medicine; and 4) Identity as an Addiction Medicine Physician. A central focus on health disparities in urban, impoverished and minority populations infuses the entire curriculum.
Centre for Addiction and Mental Health Addiction Medicine Fellowship

Sponsoring Institution: Centre for Addiction and Mental Health
Location: Toronto, Ontario, Canada
Length of Training: 1 Year
Total ABAM Foundation-approved Positions: 3

Program Director: Lisa Lefebvre, MD
100 Stokes Street
Toronto, Ontario, Canada M6J 1H4

Email: lisa.lefebvre@camh.ca
URL: http://www.camh.ca

Program Description

The fellowship is part of an Addiction Medicine training program established in 1995 at the Centre for Addiction and Mental Health (CAMH), which is affiliated with the University of Toronto and is Canada’s largest mental health and addiction teaching hospital. Training is based in CAMH and at a general hospital where the fellow participates in an Addiction Medicine consultation service. The program’s 13 physician faculty represent Family Medicine, Psychiatry and Public Health, as well as Addiction Medicine. Four faculty hold MD/PhDs. Fellow experiences include outpatient consultation, inpatient and outpatient withdrawal management, motivational interviewing, inpatient consultation in the emergency department and intensive care unit, exposure to concurrent disorders, use of methadone and buprenorphine for co-occurring pain and addiction, as well as use of pharmacotherapies for nicotine and alcohol dependence. Electives include gambling and adolescent clinic, and training includes participation in interprofessional teams. Fellows conduct a quality improvement project and have opportunities to participate in research and teaching.
Cincinnati Addiction Medicine Fellowship

Sponsoring Institution: University Hospital, University of Cincinnati College of Medicine
Location: Cincinnati, OH
Length of Training: 2 Years
Total ABAM Foundation Approved Positions: 4

Program Director: Shannon C. Miller, MD, FASAM, FAPA
Veterans Affairs Medical Center
3200 Vine Street, B712
Cincinnati, OH 45220

Program email: christi.banks@va.gov
URL:  http://www.psychiatry.uc.edu/Education/fellowships/addiction/about.aspx

Program Description

The Center for Treatment, Research, and Education in Addictive Disorders (CeTREAD: Cincinnati VA and University of Cincinnati Department of Psychiatry and Behavioral Neuroscience) offers a 2-year ABAM Foundation-accredited Addiction Medicine Fellowship and a 1-year ACGME-accredited Addiction Psychiatry Fellowship.

Fellows train together in shared clinical and didactic experiences and are exposed to a rich assortment of clinical rotations in a nationally recognized VA Clinical Program of Excellence in Substance Use Disorders providing more than 10 addiction sub-specialty clinics/wards. Fellows also rotate in non-VA settings for rotations relating to maternal-fetal issues, adolescents, and women/family. Addiction-specific formal psychotherapy training is provided, with specific attention to Motivational Enhancement Therapy, Seeking Safety, CBT, etc. Integrated within one of the few national VA Tobacco Cessation Clinical Resource Centers, nicotine specialty training is superb. The fellowships share an extremely broad and robust learning library. Pharmacotherapy and psychotherapy research training is supported by several NIH-funded researchers including our NIDA Clinical Trials Node spanning 10 U.S. states, the largest in NIDA CTN. CeTREAD’s aggregate addiction-specific research grant funding totals over $60 million. Support includes the Center for Imaging Research featuring 4-Tesla MRI and the Center for Clinical and Translational Science and Training (supporting the educational/training needs of our clinical/translational research community) – one of few such centers in the country.

Faculty include ABAM-certified physicians and multidisciplinary addiction specialists. The Program Director also functions as co-editor for ASAM’s textbook (provided to the fellow) and journal. Multidisciplinary team-based clinical learning is interwoven with more than 80 addiction-specific didactics, addiction-specific Journal Club, Grand Rounds, live patient board-style examinations, a scholarly project, and 360-degree feedback sessions. Graduates are highly sought for clinical, administrative, and research roles. Moonlighting opportunities to enhance income abound. Graduate ABAM certification rates are very strong.
Geisinger Addiction Medicine Residency at Marworth

Sponsoring Institution: Geisinger Health System
Location: Waverly, PA
Length of Training: 1 Year
Total ABAM Foundation Approved Positions: 2

Program Director: David J. Withers, MD
Marworth Treatment Center
PO Box 36
Lily Lake Road
Waverly, PA 18471

Email: djwithers@geisinger.edu
URL: www.geisinger.edu/Fellowships/addiction

Program Description

The Geisinger Addiction Medicine Program at Marworth seeks to provide the physician with approaches to caring for the addicted individual. The residency is intended to provide broad training directed at the treatment of a wide variety of co-morbid medical and psychiatric conditions. The graduates of the Marworth Addiction Medicine Residency should be well prepared to pass the ABAM certification examination while having developed life-long learning skills.

The residency is comprised of experiences in the following settings: Marworth inpatient, Marworth outpatient, Geisinger Wyoming Valley Hospital Consultation Service, Miner’s Methadone Clinic, Geisinger Pain Clinic, and Clarks Summit State Psychiatric Hospital. The patient populations span all economic strata, many ethnic groups and age groups. In each of these venues, and with each population, the resident must learn to explore the specifics of scientifically based problem solving. The graduate needs to be able to incorporate new and developing strategies, both pharmacologic and psychological into her/his skill set and to adapt as the field expands.

The resident will pursue a variety of scholarly activities, including active participation in journal club, individual reading, conferences, didactic exercises and preparation of a poster or scientific paper.

The Addiction Medicine Residency at Marworth is designed to provide each graduate with a command of clinical skills and knowledge that will permit him/her to practice clinical addiction medicine in virtually any setting. Recent graduates have been recruited for positions in well known and respected facilities and health care systems, often as the new medical directors.
Loyola University Medical Center Addiction Medicine Fellowship

Sponsoring Institution: Loyola University Medical Center
Location: Hines, IL
Length of Training: 1 Year
Total ABAM Foundation Approved Positions: 1

Program Director: Christina Girgis, MD
Edward Hines Jr VA Hospital
5000 South Fifth Ave.
Hines, IL 60141

Email: christina.girgis@va.gov

Program Coordinator: Maralee Powderly
Email: mpowder@lumc.edu

URL: http://www.stritch.luc.edu/depts/psych/index.htm

Program Description

In 2011 Edward Hines Jr. VA Hospital and Loyola University Medical Center founded an exciting fellowship opportunity open to a PGY-IV psychiatry, internal medicine, or family medicine resident interested in advanced training and clinical experience in Addiction Medicine. We are accepting applications in September 2014 for a start date of July 1, 2015, with flexibility if needed. The fellowship provides the eligibility criteria to sit for the American Board of Addiction Medicine.

The fellow trains as part of a multi-disciplinary team with supervision of addiction psychiatrists, treating patients across all ages and genders with all types of addictions in inpatient and outpatient settings, including patients with complex co-morbid diagnoses. Fellows train in evidence-based medical management and psychotherapy. Clinical work is primarily at Hines VA with some time spent at Loyola University. Hines VA is a highly innovative and comprehensive hospital with inpatient and outpatient psychiatric services. The fellow participates in settings including Outpatient Addiction Treatment Program, Opiate Substitution Clinic, Substance Abuse Residential Rehabilitation Program, Inpatient Psychiatry, Consultation-Liaison Psychiatry Service, Pain Clinic, Primary Care Behavioral Health Clinic and scholarly/research collaborations.

The fellowship provides state-of-the-art training in treating patients with addiction, including detoxification, pharmacotherapy, abstinence and harm-reduction recovery models, motivational interviewing, 12-Step facilitation, consultation for medical and psychiatric hospital services, and psychosocial approaches to the treatment of patients with addiction and pain.

Qualified applicants must have completed three years of an ACGME-accredited residency program at the time of entry into the fellowship and be eligible for a permanent Illinois medical license.

Qualified applicants should send their curriculum vitae to christina.girgis@va.gov. Additional application requirements will include: Three letters of recommendation; Personal statement (500 words or less) detailing the development and current direction of your interest in Addiction Medicine; A recent photograph of yourself (2” x 3”); and a copy of current physician license.
Minnesota Addiction Medicine Residency Program: UM-HCMC-VA

Sponsoring Institution: University of Minnesota Medical School
Location: Minneapolis, MN
Length of Training: 2 Years
Total ABAM Foundation Approved Positions: 4

Program Director: Sheila M. Specker, MD
Department of Psychiatry
University of Minnesota
2450 Riverside Avenue
F282/2A West
Minneapolis, MN 55454

Email: speck001@umn.edu
URL: http://www.psychiatry.umn.edu/education/addictions/home.html

Program Description

The goal of this program is to provide comprehensive training in the assessment and clinical care of patients with addictive disorders and also to develop skills necessary to become a leader in the field. The focus of the program is on developing the knowledge and skills necessary to provide state-of-the-art care in private, public, or academic settings.

This is a unified program involving three institutions: the University of Minnesota (UM); the Hennepin County Medical Center (HCMC); and the VA Medical Center, Minneapolis (VA). Trainees will benefit from these institutions’ expertise and thus obtain extensive experience in dual disorders, pharmacotherapies, and medical subspecialties such as pain and GI. These institutions offer a broad range of patient demographics from adolescent to geriatric, varying complexities and substances of choice, and multiple levels of care from outpatient to medically managed inpatient. The University of Minnesota, as the host institution, has trained physicians for 30 years in addiction who have gone into all sectors of practice, including clinical (in both private and public sectors), academics and research. Many have assumed leadership positions. Graduates will be well equipped to become directors of addiction treatment programs.
Rushford Addiction Medicine Residency/Fellowship Program

Sponsoring Institution: Hartford Hospital
Location: Middletown, Connecticut
Length of Training: 1 Year
Total ABAM Foundation Approved Positions: 1

Program Director: Samuel Silverman, MD, F.A.PA.
Rushford Center
1250 Silver Street
Middletown, CT 06457

Email: s silverm@rushford.org

Associate Program Director: Vincent McClain MD.
Rushford Center
1250 Silver Street
Middletown, CT 06457

Email: vmcclain@rushford.org

Program Description

The Addiction Medicine residency/fellowship at Rushford Center offers a training opportunity in the evaluation and treatment of patients with substance abuse disorders, with or without co-occurring psychiatric disorders.

The core experience will take place within a comprehensive multi-site community-based system including a 16-bed acute detoxification unit, a 42-bed residential inpatient care unit, partial hospitalization programs, intensive outpatient programs, various adolescent and outpatient programs, and a 26-bed halfway house.

Other experiences will include management of acute intoxication and withdrawal syndromes, medically assisted treatment for opiate and alcohol use disorders, collaboration with various clinicians in team case conferences, and opportunity for elective specialty experiences. The qualified physician candidate will obtain an understanding and working knowledge of the nature of addiction and current psychopharmacological and psychosocial therapeutic modalities. Faculty include certified addiction physicians with an interest in education and advancing the role of the Addiction Medicine physician.

There will be opportunities for teaching other staff members in addition to Institute of Living/Hartford Hospital psychiatric residents, University of Connecticut third-year medical students, and physician assistants. An important goal of the residency/fellowship will be to prepare the candidate for independent practice and certification in Addiction Medicine through the American Board of Addiction Medicine (ABAM).
St. Joseph Mercy Hospital Ann Arbor Addiction Medicine Fellowship

Sponsoring Institution: St. Joseph Mercy Hospital Ann Arbor
Location: Ypsilanti, MI
Length of Training: 1 Year
Total ABAM Foundation-approved Positions: 1

Program Director: John A. Hopper, MD, FAAP, FACP, FASAM
5333 McAuley Dr.
Suite R3009
Ypsilanti, MI 48197

Email: hoppejoa@trinity-health.org

Program Description

Based in St. Joseph Mercy Hospital Ann Arbor, this program is designed to help fellows pursue individual paths toward active practice in addiction medicine. It emphasizes compassion, social justice and care for the underserved, as well as respect, excellence and the core competencies. The program’s 11 physician faculty represent diverse backgrounds, including Internal Medicine, Family Medicine, Psychiatry, Obstetrics-Gynecology, and Geriatric Psychiatry. Rotations include experience in intensive outpatient, residential detoxification, and community-based ambulatory settings, as well as an established Addiction Medicine consultation service and inpatient psychiatric consultation. Electives include a toxicology/research rotation in which the fellow can work with Emergency Medicine staff in a regional poison control center.
St. Paul’s Hospital Goldcorp Addiction Medicine Fellowship

Sponsoring Institution: St. Paul’s Hospital
Location: Vancouver, British Columbia, Canada
Length of Training: 1 Year
Total ABAM Foundation Approved Positions: 4

Program Director: Launette Rieb, MD, MSc
Department of Family and Community Medicine
St. Paul’s Hospital
1081 Burrard St.
Vancouver, B.C. V6Z 1Y6
Canada

Email: lrieb@addictionmedicinefellowship.org

Program Assistant: Ms. Carmen Rock
Email: crock@cfenet.ubc.ca
Phone: 604-682-2344 x 66373

URL: www.addictionmedicinefellowship.org

Program Description

The St. Paul’s Hospital Goldcorp Addiction Medicine Fellowship is a one-year multidisciplinary training program that promotes excellence in clinical skill development, scholarship, research and advocacy in the field of Addiction Medicine. This exciting new Clinical Fellowship is targeted for trainees from Psychiatry, Internal Medicine, and Family Medicine, though others may apply. The program objectives are to prepare Fellows to work clinically in the field of Addiction Medicine, to take leadership roles in an academic setting, and to pass the American Board of Addiction Medicine (ABAM) certification exam.

Within the fellowship there are nine rotation blocks that cover all of the ABAM core requirements for inpatient and outpatient detoxification, residential treatment, inpatient addiction consult service, community clinic-based opioid agonist treatment, and psychiatric assessment and stabilization. Some rotations of particular interest in our program include Youth Addictions and Mental Health, and Pain Management. In addition, there are two to three months of elective time available so the program can be tailored to meet individual needs. Academic half-days are supplemented by supported online training, conference attendance, experiential events, and monthly journal clubs.

Vancouver is a beautiful, vibrant multicultural city with an innovative range of public health and addiction treatment options that fellows have the opportunity to explore. St. Paul’s Hospital is Vancouver’s key inner city hospital and postgraduate training site affiliated with the University of British Columbia.
St. Vincent Charity Medical Center Addiction Medicine Fellowship

Sponsoring Institution: St. Vincent Charity Medical Center
Location: Cleveland, OH
Length of Training: 1-2 Years
Total ABAM Foundation-approved Positions: 2

Program Director: Christopher L. Adelman, MD
St. Vincent Charity Medical Center
Rosary Hall
2351 E. 22nd Street
Cleveland, OH  44115

Email: Chris.Adelman@stvincentcharity.com

Program Description

Based in St. Vincent Charity Medical Center, which is affiliated with Case Western Reserve University and Northeast Ohio Medical University, this program can train up to two fellows in a one-year curriculum with an optional second practicum year. The program director is certified in Emergency Medicine as well as Addiction Medicine, and has more than 20 years' experience in addiction training. The five other physician faculty represent Internal Medicine, Family Medicine, Addiction Psychiatry and Anesthesia. Fellows have access to resources through St. Vincent Charity’s long-time involvement in addiction and mental health care, and didactics are shared with the Addiction Psychiatry fellowship at Case Western. Rotations include experience with adolescent, geriatric and OB/GYN patients, as well as methadone and buprenorphine treatment. Fellows participate in clinical research.
Stanford Addiction Medicine Program

Sponsoring Institution: Stanford Hospital and Clinics
Location: Stanford, CA
Length of Training: 1 Year
Total ABAM Foundation-approved Positions: 2

Program Director: Anna Lembke, MD
Department of Psychiatry and Behavioral Sciences
Stanford University
401 Quarry Road
Stanford, CA 94305

Email: alembke@stanford.edu

URL: http://psychiatry.stanford.edu/education/Addiction/index.html

Program Description

The Stanford Addiction Medicine Program (SAMP) is a one-year, advanced fellowship opportunity in Addiction Medicine, open to physicians who have completed an ACGME-accredited residency in any clinical specialty. The SAMP provides state-of-the-art training in the treatment of patients with addiction, including detoxification, pharmacotherapy for addiction, abstinence-based recovery models, harm-reduction recovery models, motivational interviewing, 12-Step facilitation, consultation for medical and psychiatric hospital services, and psychosocial approaches to the treatment of patients with addiction and pain. The program is tailored to the individual background and interests of the applicant, and includes but is not limited to experiences in the following settings: Stanford Inpatient Psychiatry, Stanford Outpatient Dual Diagnosis/Addiction Clinic, Stanford Consult-Liaison Psychiatry, Stanford Pain Clinic, Stanford Family Medicine Clinic, Kaiser Santa Clara Chemical Dependency and Rehabilitation Program, Menlo Park and Palo Alto Veterans Administration Hospital Programs for Addiction, and scholarly/research collaborations. Our goal is to train physicians in all aspects of treating patients with substance use disorders, behavioral addictions, and co-occurring psychiatric and medical disorders. We also hope to promote future leaders in the field of Addiction Medicine.
Summa Addiction Medicine Fellowship

Sponsoring Institution: Summa Health System
Location: Akron, OH
Length of Training: 1 Year
Total ABAM Foundation Approved Positions: 2

Program Director: Nicole Labor, DO
444 North Main Street
Akron, OH 44310

Email: quiricoster@gmail.com

Program Description

The Summa Addiction Medicine Fellowship includes experiences in outpatient care of patients with coexistent psychiatric conditions and substance use, noncritical medical management of patients in a residential treatment facility, pain management, intensive outpatient care, and participation in a busy chemical dependency consultation service. The program is based in St. Thomas Hospital, which established the nation’s first alcoholism treatment ward, and the four other clinical training sites offer a diverse experience.

Fellows are given significant and increasing supervised responsibility in the detox rotation, where they see a wide variety of cases and work collaboratively with other physicians and nurses. In the residential treatment facility rotation, fellows participate in both individual and group treatments, and they employ a range of treatments including pharmacotherapy and cognitive behavioral techniques. Fellows care for a multiethnic patient population, from 18 to geriatric, and the rotation in a community-based opiate dependence clinic includes a number of pregnant women. The pain management rotation exposes fellows to all modalities and focuses on interventional techniques, and a second consultation rotation allows fellows to evaluate patients admitted to an inpatient psychiatric facility.

Interaction occurs frequently with family medicine residents, psychiatry residents and medical students, and fellows receive mentorship in teaching patients and other health professionals. Fellows also participate in a research project.
Swedish Addiction Medicine Fellowship

Sponsoring Institution: Swedish Medical Center
Location: Seattle, WA
Length of Training: 1 Year
Total ABAM Foundation Approved Positions: 1

Program Director: James Walsh, MD
5350 Tallman Avenue NW
Seattle, WA 98122

Email: jim.walsh@swedish.org

Program Description

Bringing together the many resources of Swedish and the Seattle community, the fellowship will offer family physicians comprehensive training in providing care to patients with substance dependence. Fellows will be primarily based in our Addiction Recovery Service, which offers both acute medical detoxification for a diverse group of patients, and long-term inpatient treatment for pregnant women. Opiate maintenance treatment, using methadone and buprenorphine as well as opiate antagonists, is taught in outpatient settings. Medication management approaches to the treatment of alcohol dependence are offered at our Addiction Medicine outpatient clinic. Training at the Swedish Pain Center will offer fellows expertise in the management of chronic pain patients and the interface of addiction and pain. Fellows will visit local recovery centers and learn about 12-step and other approaches to recovery.

Fellows will continue to develop their Family Medicine skills in a continuity clinic offered through the Swedish Family Medicine Residency Program at the Cherry Hill Campus. They will participate in the obstetric care of women with substance use.

The fellowship is offered by the Swedish Addiction Recovery Service and the Swedish Family Medicine Residency Program / Cherry Hill Campus in conjunction with the Evergreen Treatment Service’s methadone maintenance program.
University at Buffalo Addiction Medicine Fellowship

Sponsoring Institution: University at Buffalo School of Medicine
Location: Buffalo, NY
Length of Training: 1-2 Years
Total ABAM Foundation Approved Positions: 2

Program Director: Lorne Campbell, MD
Department of Family Medicine
University at Buffalo
77 Goodell Street, Suite 220
Buffalo, NY 14203

Email: lornecampbellSr@gmail.com
URL: http://wings.buffalo.edu/smbs/fam-med/AddMedFellow.html

Program Description

This 1-to-2 year program offers a variety of clinical, research and didactic experiences designed to prepare trainees for the broad range of Addiction Medicine practice.

There are 3 main content areas of the UB Addiction Medicine program: 1) Clinical Addiction Medicine skills; 2) Analytic and research skills, including epidemiology, public health, biostatistics, biomedical writing, and health care services disparities research; and 3) Academic career skills, including teaching, leadership and administration.

Clinical skills training is based at Erie County Medical Center. The program offers inpatient and outpatient experiences that include pharmacological management, detoxification, psychotherapeutic treatment, pain management, and consultation on a high-volume psychiatric emergency unit, among others.

The UB Primary Care Research Institute is the main setting for public health and research methodology training as well as overall academic skills development. The central focus is related to health disparities in urban, disadvantaged and minority populations.
University of Colorado Addiction Medicine Fellowship

Sponsoring Institution: University of Colorado School of Medicine
Location: Aurora, CO
Length of Training: 1 Year
Total ABAM Foundation Approved Positions: 1

Program Director: Patricia A. Pade, MD
1693 N. Quentin St.
Aurora, CO  80045

Coordinator: Tara Wood
Email:  Tara.Wood@ucdenver.edu

URL:
http://www.ucdenver.edu/academics/colleges/medicalschool/departments/familymed/education/fellowship/AddictionMedicineFellowship/Pages/default.aspx

Program Description

The University of Colorado Addiction Medicine Fellowship is a one-year multidisciplinary program providing training in the treatment of patients with substance use disorders. The Addiction Medicine fellow will acquire knowledge of prevention, evaluation and treatment modalities addressing substance abuse and addiction in a variety of settings including ambulatory care, acute care, pain management, primary care, psychiatric and residential treatment sites. Core clinical experiences will occur at the University of Colorado Hospital’s Center for Dependency, Addiction and Rehabilitation (CeDAR) treatment facility, Denver Health Medical Center, University of Colorado Hospital Addiction Medicine Consult-Liaison Service, Addiction Research and Treatment Services (ARTS) and the A.F. Williams Family Medicine Clinic at Stapleton offering exposure to a markedly diverse patient population with respect to socioeconomics, ethnicity and age.

The mission of the program, based in Family Medicine, derives from the acknowledgement that increasing portions of current and future substance use disorder treatment will be integrated into primary care settings, with fellowship-trained addiction medicine specialists having a crucial impact not only in direct patient care, but also in the training and education of primary care providers in addiction treatment.

The objectives of the program include training the Fellow to practice Addiction Medicine independently with life-long learning skills, and preparing the Fellow to certify through the American Board of Addiction Medicine and ultimately assume a leadership role in the Addiction Medicine field.

In addition to the clinical rotations, the Fellow will participate in a variety of scholarly activities, including journal club, didactic exercises held jointly with University of Colorado’s established Addiction Psychiatry Fellowship, and engage in a performance improvement project, ongoing faculty research or original research with mentoring faculty.
University of Florida Addiction Medicine Program

Sponsoring Institution: University of Florida College of Medicine
Location: Gainesville, FL
Length of Training: 1-2 Years
Total ABAM Foundation Approved Positions: 6

Program Director: Scott A. Teitelbaum, MD, FAAP, FASAM
Department of Psychiatry
University of Florida College of Medicine
Springhill Professional Center
FRC
3850 NW 83rd St., Ste. 201
Gainesville, FL  32606

Email:  teitesa@ufl.edu
Program email: FRC@psychiatry.ufl.edu

URL:  http://psychiatry.ufl.edu/education/residency-and-training/fellowship-training/addiction-medicine/index.shtml

Program Description

The University of Florida (UF) Addiction Medicine Program offers a well-rounded training environment, diverse in both didactics and clinical experience. It is designed to prepare physicians for the independent practice of Addiction Medicine and to expose them to the wide range of career opportunities available in academics, research, clinical practice and the various Addiction Medicine subspecialties.

The Florida Recovery Center (FRC), a leading institution in the field, is the training site. Residents will rotate on the UF Addiction Medicine inpatient unit, making clinical rounds with the attending physician and actively participating in a variety of group therapy sessions. Patients admitted on this unit include those under professional evaluation/stabilization and evaluation of those suspected of having substance use disorders as well as those with comorbid / co-occurring disorders. The patient population consists of adults, the majority aged 21-50. The program specializes in treatment of healthcare professionals, so a sizable percentage of patients are licensed physicians, nurses, etc. In addition to substance dependence, approximately 50% of patients also have significant comorbid psychiatric conditions, most commonly mood disorders, anxiety disorders and chronic pain conditions.

In addition to the inpatient unit, residents will make clinical rounds and participate in a variety of group therapy sessions at the Florida Recovery Center Partial Hospitalization Program. Residents are assigned specific patents, but at the discretion of the attending physician(s), they may take a broader role in the treatment administration process.

Residents may also participate in clinical care at the Intensive Outpatient Program and the Child and Adolescent Addiction / Psychiatric Consultation service. Residents will also attend weekly didactic sessions.
University of Kentucky Addiction Medicine Fellowship Program

Sponsoring Institution: University of Kentucky College of Medicine  
Location: Lexington, KY  
Length of Training: 1 Year  
Total ABAM Foundation Approved Positions: 1  

Program Director: Lon Hays, MD, MBA  
   University of Kentucky, Dept. of Psychiatry  
   245 Fountain Court  
   Lexington, KY 40509  

Email: lrhays@uky.edu  
URL:  http://psychiatry.med.uky.edu/

Program Description

The Addiction Medicine Fellowship at the University of Kentucky builds on a long history of addiction research and treatment in Lexington, KY. Fellows take part in a year of training with exposure to multiple disciplines including Psychiatry, Internal Medicine, Emergency Medicine, Obstetrics, and Adolescent Medicine. They are exposed to inpatient programs, partial hospitalization program, and an intensive outpatient program at Ridge Behavioral Health, a private psychiatric facility with a longstanding relationship with the University of Kentucky Department of Psychiatry. Inpatient experiences with an addiction consult-liaison service and psychiatric consult service and treatment of opioid-addicted pregnant women take place at the University of Kentucky Chandler Medical Center and University of Kentucky Good Samaritan Hospital; a dual diagnosis program takes place at Eastern State Hospital. Outpatient rotations include the University of Kentucky’s Internal Medicine GI clinic (including Hepatology and Transplant), Adolescent Medicine clinic, Methadone Maintenance and a longitudinal clinical experience through the University of Kentucky Outpatient Psychiatry clinic including Suboxone treatment and adolescent addiction treatment.  

A clinical research opportunity is available through the University of Kentucky Center on Drug and Alcohol Research (CDAR), which includes R01-funded projects and mentoring from nationally/internationally known researchers. Didactic experience is part of some clinical rotations and is also supplemented and administered by the program director and Addiction Medicine faculty.  

The overall educational goal of the Addiction Medicine Fellowship is to produce a physician who has good understanding of the biopsychosocial framework for individuals with addiction, as well as for the individual with substance-related health conditions. The training that the Addiction Medicine Fellow receives from inpatient and outpatient settings includes screening, prevention, medical evaluation, treatment modalities and intervention. There is significant focus on the addicted individual with medical and psychiatric comorbidities, and there is exposure to individuals from the very young to the very old, including special populations (e.g., pregnant women and those in need of liver transplantation). The Addiction Medicine Fellow will complete the program with the knowledge that addiction medicine is a key component in overall health care and will have the ability to collaborate and coordinate addiction care in any treatment setting.
University of Maryland- Sheppard Pratt Training Program

Sponsoring Institution: University of Maryland Medical System  
Location: Baltimore, MD  
Length of Training: 1 Year  
Total ABAM Foundation Approved Positions: 2

Program Director: Devang H. Gandhi, MBBS, MD, FASAM  
University of Maryland School of Medicine  
110 S. Paca St.  
4N148  
Baltimore, MD  21201

Email: dgandhi@psych.umaryland.edu  
URL:  http://www.umm.edu/psychiatry/index.htm

Program Description

The University of Maryland-Sheppard Pratt Addiction Medicine Training Program is a one-year program with a strong clinical orientation. Led by dedicated core faculty certified in Addiction Medicine and/or Addiction Psychiatry, the program offers a comprehensive range of training experiences in addiction treatment based at the University of Maryland Medical Center, Baltimore VA Medical Center, and several affiliated community-based programs.

Major rotations include ambulatory detoxification, intensive outpatient treatment, addiction in special populations (pregnant and post-partum women, adolescents, older adults), substance abuse consultation-liaison, outpatient addiction and dual-diagnosis treatment, residential treatment, medication assisted treatments (methadone, buprenorphine, alcohol pharmacotherapies), pain and addiction, etc. Elective experiences may also be arranged in areas of special interest.

There is an active academic program and access to an excellent health sciences library. There is close interaction with UM- Sheppard Pratt Addiction Psychiatry residents, and opportunity to work with Psychiatry residents and/or medical students on some rotations. Residents are expected to submit an academic project as a requirement for graduation.

The program has a strong track record of training residents in Addiction Psychiatry since the 1980s, and the Addiction Psychiatry program was among the first in the nation to be accredited by the ACGME. It has also trained several Addiction Medicine fellows prior to recent accreditation by The American Board of Addiction Medicine Foundation. The major strength of the program is the comprehensive clinical training within an academic environment.
University of Oklahoma Addiction Medicine Fellowship

Sponsoring Institution: University of Oklahoma School of Community Medicine, at Tulsa  
Location: Tulsa, OK  
Length of Training: 1 Year  
Total ABAM Foundation Approved Positions: 1  

Program Director: William H. Yarborough, MD  
University of Oklahoma College of Medicine  
4502 East 41st Street  
Tulsa, OK  74135  

Email: william-yarborough@ouhsc.edu

Program Description

The University of Oklahoma School of Community Medicine, at Tulsa, Addiction Medicine, is a program, centered around two sites. The primary clinical sites are the OU Physicians, Schusterman Center Clinic, on the campus of OU-Tulsa, and 12&12 Alcohol & Drug Treatment Center in Tulsa. 12&12 is a 200-bed comprehensive addiction treatment center that offers a full continuum of treatments for addictions. Detoxification, both inpatient and ambulatory, outpatient treatment, residential treatment, co-occurring disorder treatment, sober living, and halfway treatments are all housed on the same campus. Ambulatory Addiction Medicine experience is a major part of the program, where experience in evaluations and medical treatments for addiction are attained, at the OU-Tulsa site. Experience in an Opiate Treatment Program is also available. The Fellowship is centered in the Department of Medicine, but has faculty from Psychiatry and Palliative Care (pain management).

The focus of the program is training in clinical addiction medicine, with emphasis on detoxification, the physician’s role in treatment, addiction related medical issues, medical pain management, and medical therapies for addiction. Experiences around hospital consultation services for these roles are also available. The Fellow will also gain experience in administrative skills in the addiction treatment area, and have opportunities for developing leadership skills.

The Fellow will regularly interact with 4th year medical students, Internal Medicine residents and Psychiatry residents, and will be expected to supervise and teach these learners principles of clinical Addiction Medicine. Clinical research is available, and strongly encouraged.
University of Wisconsin Addiction Medicine Fellowship

Sponsoring Institution: University of Wisconsin School of Medicine and Public Health
Location: Madison, WI
Length of Training: 1-2 Years
Total ABAM Foundation Approved Positions: 4

Program Director: Randall T. Brown, MD, PhD
   UWHC Center for Addictive Disorders
   University of Wisconsin School of Medicine and Public Health
   1100 Delaplaine Ct.
   Madison, WI  53715

Email: Randy.Brown@FAMMED.WISC.EDU

URL:  http://www.fammed.wisc.edu/fellowships/addiction-med

Program Description

The University of Wisconsin Addiction Medicine Fellowship, in collaboration with the William S. Middleton Veterans Hospital, provides clinical experience and instruction in the management of substance use disorders. Trainees will gain expertise in: management of acute withdrawal syndromes; medication-assisted treatment of substance use disorders (including naltrexone, acamprosate, and disulfiram for alcohol dependence, buprenorphine and methadone for opioid dependence, injectable naltrexone for opioid dependence and for alcohol dependence); medical management of substance use disorders and their complications; chronic pain and addiction; and relapse prevention.

Clinical experiences include: continuity practice at the Middleton VA's Primary Care/Alcohol Disorders Clinic; rotations at the multi-disciplinary VA Addictive Disorders Treatment Program; hospital consultation on patients in acute withdrawal at the University of Wisconsin Hospital; outpatient addiction consultation clinic one half-day per week at Access/Wingra Community Health Center (a Federally Qualified Health Center); rotations at the NewStart Addiction Consult Service at Meriter Hospital; rotations at the Herrington Recovery Center residential treatment facility; and rotations at Madison Health Services Methadone Treatment Facility.

Fellows will be supervised by a variety of nationally and internationally recognized faculty with certification and expertise in Addiction Medicine, Addiction Psychiatry, Family Medicine, Substance Abuse Counseling, Social Work, Pain Management, and Medication-Assisted Treatment.
Yale University Addiction Medicine Fellowship

Sponsoring Institution: Yale-New Haven Hospital  
Location: New Haven, CT  
Length of Training: 2 years  
Total ABAM Foundation approved positions: 4

Program Director: Jeanette M. Tetrault, MD, FACP  
Assistant Professor of Medicine  
Yale University School of Medicine  
367 Cedar Street, 4th Floor  
New Haven CT, 06512

Email: jeanette.tetrault@yale.edu

Program Description

The newly developed two-year Addiction Medicine Fellowship Program at Yale University School of Medicine offers robust clinical and research training in Addiction Medicine. This novel program builds on Yale’s preeminence in the fields of medical education and substance abuse, and international reputation for expanding addiction treatment into general medical settings (e.g., primary care, emergency department). Working in close collaboration with our well-established Addiction Psychiatry training program, fellows, all of whom will have completed residency training, will 1) have the opportunity to rotate at several Yale-affiliated training sites as well as a number of community addiction treatment facilities; 2) take part in a robust Addiction Medicine didactic curriculum focusing on the biopsychosocial treatment of patients with addiction; and 3) have exposure to faculty from both the School of Medicine and the School of Public Health who are internationally recognized for epidemiologic and clinical trial research focusing on substance use and related medical (e.g., HIV, Hepatitis C) and psychiatric co-morbidities.

First-year fellows will obtain clinical training in Addiction Medicine through a variety of inpatient and outpatient training experiences. Training sites include Yale-New Haven Hospital and its affiliated outpatient clinics; the West Haven Veterans Affairs Medical Center; the APT Foundation, which is a multi-specialty addiction treatment facility; and the South Central Rehabilitation Center for inpatient detoxification. Additionally, fellows will have the unique opportunity to gain added training in the complex relationship between addiction and chronic pain. Opportunities to engage in clinical research or medical education projects will begin in the first year.

The second year of the program will consist of a year-long practicum. The practicum component will consist of a Research Track or an Education Track, designed to train addiction physicians for careers as clinician-investigators and clinician-educators, respectively. Both tracks share a common curriculum with a research component and a non-research component. The practicum will be tailored to the individual interest of the fellow and mentorship opportunities will be established.
APPENDIX XII
KEY REFERENCES IN ADDICTION MEDICINE

Key Texts

Ries, Richard; Fiellin, David; Miller, Shannon and Saitz, Richard
Wolters Kluwer, 2014

*The ASAM Essentials of Addiction Medicine*
Herron, Abigail and Brennan, Timothy
Lippincott Williams & Wilkins, 2015

*Neurobiology of Addiction*
Koob, George F. and Le Moal, Michel
Elsevier, 2005

*The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*
Mee Lee, David, Editor
American Society of Addiction Medicine, 2014

Key Reports

*Addiction Medicine: Closing the Gap between Science and Practice*
The National Center of Addiction and Substance Abuse at Columbia University, 2012

Key Journals (U.S. only)

*Addiction Science & Clinical Practice*
BioMed Central

*Addictive Disorders and Their Treatment*
Wolters Kluwer

*Alcoholism Treatment Quarterly*
Taylor & Francis

*Alcohol Research and Health*
National Institute on Alcohol Abuse and Alcoholism

*Alcoholism: Clinical and Experimental Research*
John Wiley & Sons, Inc.

*American Journal of Drug and Alcohol Abuse*
Informa Healthcare
Contemporary Drug Problems
SAGE Publications

Drug and Alcohol Dependence
Elsevier

International Journal of Drug Testing
Elsevier

Journal of Addiction Medicine
Lippincott Williams & Wilkins

Journal of Addictive Diseases
Taylor & Francis

Journal of Child and Adolescent Substance Abuse
Taylor & Francis

Journal of Drug and Alcohol Research
Ashdin Publishing

Journal of Psychoactive Drugs
Routledge

Journal of Studies on Alcohol and Drugs
Rutgers Center of Alcohol Studies

Journal of Substance Abuse Treatment
Elsevier

Journal of Teaching in the Addictions
Elsevier

Substance Abuse Treatment, Prevention, and Policy
BioMed Central
APPENDIX XIII
ADDICTION DEFINED

Short Definition of Addiction

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Long Definition of Addiction

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Addiction affects neurotransmission and interactions within reward structures of the brain, including the nucleus accumbens, anterior cingulate cortex, basal forebrain and amygdala, such that motivational hierarchies are altered and addictive behaviors, which may or may not include alcohol and other drug use, supplant healthy, self-care related behaviors. Addiction also affects neurotransmission and interactions between cortical and hippocampal circuits and brain reward structures, such that the memory of previous exposures to rewards (such as food, sex, alcohol and other drugs) leads to a biological and behavioral response to external cues, in turn triggering craving and/or engagement in addictive behaviors.

The neurobiology of addiction encompasses more than the neurochemistry of reward. The frontal cortex of the brain and underlying white matter connections between the frontal cortex and circuits of reward, motivation and memory are fundamental in the manifestations of altered impulse control, altered judgment, and the dysfunctional pursuit of rewards (which is often experienced by the affected person as a desire to “be normal”) seen in addiction--despite cumulative adverse consequences experienced from engagement in substance use and other addictive behaviors. The frontal lobes are important in inhibiting impulsivity and in assisting individuals to appropriately delay gratification. When persons with addiction manifest problems in deferring gratification, there is a neurological locus of these problems in the frontal cortex. Frontal lobe morphology, connectivity and functioning are still in the process of maturation during adolescence and young adulthood, and early exposure to substance use is another significant factor in the development of addiction. Many neuroscientists believe that developmental morphology is the basis that makes early-life exposure to substances such an important factor.

Genetic factors account for about half of the likelihood that an individual will develop addiction. Environmental factors interact with the person’s biology and affect the extent to which genetic factors exert their influence. Resiliencies the individual acquires (through parenting or later life experiences) can affect the extent to which genetic predispositions lead to the behavioral and other
manifestations of addiction. Culture also plays a role in how addiction becomes actualized in persons with biological vulnerabilities to the development of addiction.

**Other factors** that can contribute to the appearance of addiction, leading to its characteristic biopsychosocio-spiritual manifestations, include:

a. The presence of an underlying biological deficit in the function of reward circuits, such that drugs and behaviors that enhance reward function are preferred and sought as reinforcers;
b. The repeated engagement in drug use or other addictive behaviors, causing neuroadaptation in motivational circuitry leading to impaired control over further drug use or engagement in addictive behaviors;
c. Cognitive and affective distortions, which impair perceptions and compromise the ability to deal with feelings, resulting in significant self-deception;
d. Disruption of healthy social supports and problems in interpersonal relationships that impact the development or impact of resiliencies;
e. Exposure to trauma or stressors that overwhelm an individual’s coping abilities;
f. Distortion in meaning, purpose and values that guide attitudes, thinking and behavior;
g. Distortions in a person’s connection with self, with others and with the transcendent (referred to as God by many, the Higher Power by 12-steps groups, or higher consciousness by others); and
h. The presence of co-occurring psychiatric disorders in persons who engage in substance use or other addictive behaviors.

**Addiction** is characterized by:

a. **Inability to consistently Abstain**;

b. **Impairment in Behavioral control**;

c. **Craving**; or increased “hunger” for drugs or rewarding experiences;

d. **Diminished recognition of significant problems** with one’s behaviors and interpersonal relationships; and

e. **A dysfunctional Emotional response**.

The **power of external cues** to trigger craving and drug use, as well as to increase the frequency of engagement in other potentially addictive behaviors, is also a characteristic of addiction, with the hippocampus being important in memory of previous euphoric or dysphoric experiences, and with the amygdala being important in having motivation concentrate on selecting behaviors associated with these past experiences.

Although some believe that the difference between those who have addiction, and those who do not, is the quantity or frequency of alcohol/drug use, engagement in addictive behaviors (such as
gambling or spending)\(^3\), or exposure to other external rewards (such as food or sex), a characteristic aspect of addiction is the \textit{qualitative way} in which the individual responds to such exposures, stressors and environmental cues. A particularly pathological aspect of \textit{the way} that persons with addiction pursue substance use or external rewards is that preoccupation with, obsession with and/or pursuit of rewards (e.g., alcohol and other drug use) persist despite the accumulation of adverse consequences. These manifestations can occur compulsively or impulsively, as a reflection of impaired control.

**Persistent risk and/or recurrence of relapse**, after periods of abstinence, is another fundamental feature of addiction. This can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits.\(^4\)

**In addiction there is a significant impairment in executive functioning**, which manifests in problems with perception, learning, impulse control, compulsivity, and judgment. People with addiction often demonstrate a lower readiness to change their dysfunctional behaviors despite mounting concerns expressed by significant others in their lives; and display an apparent lack of appreciation of the magnitude of cumulative problems and complications. The still developing frontal lobes of adolescents may both compound these deficits in executive functioning and predispose youngsters to engage in “high risk” behaviors, including engaging in alcohol or other drug use. The profound drive or craving to use substances or engage in apparently rewarding behaviors, which is seen in many patients with addiction, underscores the compulsive or avolitional aspect of this disease. This is the connection with “powerlessness” over addiction and “unmanageability” of life, as is described in Step 1 of 12 Steps programs.

**Addiction is more than a behavioral disorder**. Features of addiction include aspects of a person’s behaviors, cognitions, emotions, and interactions with others, including a person’s ability to relate to members of his or her family, to members of his/her community, to his/her own psychological state, and to things that transcend his/her daily experience.

**Behavioral manifestations and complications** of addiction, primarily due to impaired control, can include:

- Excessive use and/or engagement in addictive behaviors, at higher frequencies and/or quantities than the person intended, often associated with a persistent desire for and unsuccessful attempts at behavioral control;

- Excessive time lost in substance use or recovering from the effects of substance use and/or engagement in addictive behaviors, with significant adverse impact on social and occupational functioning (e.g. the development of interpersonal relationship problems or the neglect of responsibilities at home, school or work);

- Continued use and/or engagement in addictive behaviors, despite the presence of persistent or recurrent physical or psychological problems which may have been caused or exacerbated by substance use and/or related addictive behaviors;

- A narrowing of the behavioral repertoire focusing on rewards that are part of addiction; and
e. An apparent lack of ability and/or readiness to take consistent, ameliorative action despite recognition of problems.

**Cognitive changes** in addiction can include:

a. Preoccupation with substance use;

b. Altered evaluations of the relative benefits and detriments associated with drugs or rewarding behaviors; and

c. The inaccurate belief that problems experienced in one’s life are attributable to other causes rather than being a predictable consequence of addiction.

**Emotional changes** in addiction can include:

a. Increased anxiety, dysphoria and emotional pain;

b. Increased sensitivity to stressors associated with the recruitment of brain stress systems, so that “things seem more stressful” as a result; and

c. Difficulty in identifying feelings, distinguishing between feelings and the bodily sensations of emotional arousal, and describing feelings to other people (sometimes referred to as alexithymia).

The emotional aspects of addiction are quite complex. Some persons use alcohol or other drugs or pathologically pursue other rewards because they are seeking “positive reinforcement” or the creation of a positive emotional state (“euphoria”). Others pursue substance use or other rewards because they have experienced relief from negative emotional states (“dysphoria”), which constitutes “negative reinforcement.” Beyond the initial experiences of reward and relief, there is a **dysfunctional emotional state** present in most cases of addiction that is associated with the persistence of engagement with addictive behaviors. The state of addiction is not the same as the state of intoxication. When anyone experiences mild intoxication through the use of alcohol or other drugs, or when one engages non-pathologically in potentially addictive behaviors such as gambling or eating, one may experience a “high,” felt as a “positive” emotional state associated with increased dopamine and opioid peptide activity in reward circuits. After such an experience, there is a neurochemical rebound, in which the reward function does not simply revert to baseline, but often drops below the original levels. This is usually not consciously perceptible by the individual and is not necessarily associated with functional impairments.

Over time, repeated experiences with substance use or addictive behaviors are not associated with ever increasing reward circuit activity and are not as subjectively rewarding. Once a person experiences withdrawal from drug use or comparable behaviors, there is an anxious, agitated, dysphoric and labile emotional experience, related to suboptimal reward and the recruitment of brain and hormonal stress systems, which is associated with withdrawal from virtually all pharmacological classes of addictive drugs. While tolerance develops to the “high,” tolerance does not develop to the emotional “low” associated with the cycle of intoxication and withdrawal. Thus, in addiction, persons repeatedly attempt to create a “high”--but what they mostly experience is a deeper and deeper “low.” While anyone may “want” to get “high,” those with addiction feel a
“need” to use the addictive substance or engage in the addictive behavior in order to try to resolve their dysphoric emotional state or their physiological symptoms of withdrawal. Persons with addiction compulsively use even though it may not make them feel good, in some cases long after the pursuit of “rewards” is not actually pleasurable. Although people from any culture may choose to “get high” from one or another activity, it is important to appreciate that addiction is not solely a function of choice. Simply put, addiction is not a desired condition.

Periods of relapse, which may interrupt spans of remission, are a common feature of addiction, as it is a chronic disease. It is also important to recognize that return to drug use or pathological pursuit of rewards is not inevitable.

Clinical interventions can be quite effective in altering the course of addiction. Close monitoring of the behaviors of the individual and contingency management, sometimes including behavioral consequences for relapse behaviors, can contribute to positive clinical outcomes. Engagement in health promotion activities which promote personal responsibility and accountability, connection with others, and personal growth also contribute to recovery. It is important to recognize that addiction can cause disability or premature death, especially when left untreated or treated inadequately.

The qualitative ways in which the brain and behavior respond to drug exposure and engagement in addictive behaviors are different at later stages of addiction than in earlier stages, indicating progression, which may not be overtly apparent. As is the case with other chronic diseases, the condition must be monitored and managed over time to:

a. Decrease the frequency and intensity of relapses;

b. Sustain periods of remission; and

c. Optimize the person’s level of functioning during periods of remission.

In some cases of addiction, medication management can improve treatment outcomes. In most cases of addiction, the integration of psychosocial rehabilitation and ongoing care with evidence-based pharmacological therapy provides the best results. Chronic disease management is important for minimization of episodes of relapse and their impact. Treatment of addiction saves lives.†

Addiction professionals and persons in recovery know the hope that is found in recovery. Recovery is available even to persons who may not at first be able to perceive this hope, especially when the focus is on linking the health consequences to the disease of addiction. As in other health conditions, self-management, with mutual support, is very important in recovery from addiction. Peer support such as that found in various “self-help” activities is beneficial in optimizing health status and functional outcomes in recovery. ‡

Recovery from addiction is best achieved through a combination of self-management, mutual support, and professional care provided by trained and certified professionals.

† See ASAM Public Policy Statement on Treatment for Alcohol and Other Drug Addiction, Adopted: May 1, 1980, Revised: January 1, 2010

Explanatory footnotes:

1. The neurobiology of reward has been well understood for decades, whereas the neurobiology of addiction is still being explored. Most clinicians have learned of reward pathways including projections from the ventral tegmental area (VTA) of the brain, through the median forebrain bundle (MFB), and terminating in the nucleus accumbens (Nuc Acc), in which dopamine neurons are prominent. Current neuroscience recognizes that the neurocircuitry of reward also involves a rich bi-directional circuitry connecting the nucleus accumbens and the basal forebrain. It is the reward circuitry where reward is registered, and where the most fundamental rewards such as food, hydration, sex, and nurturing exert a strong and life-sustaining influence. Alcohol, nicotine, other drugs and pathological gambling behaviors exert their initial effects by acting on the same reward circuitry that appears in the brain to make food and sex, for example, profoundly reinforcing. Other effects, such as intoxication and emotional euphoria from rewards, derive from activation of the reward circuitry. While intoxication and withdrawal are well understood through the study of reward circuitry, understanding of addiction requires understanding of a broader network of neural connections involving forebrain as well as midbrain structures. Selection of certain rewards, preoccupation with certain rewards, response to triggers to pursue certain rewards, and motivational drives to use alcohol and other drugs and/or pathologically seek other rewards, involve multiple brain regions outside of reward neurocircuitry itself.

2. These five features are not intended to be used as “diagnostic criteria” for determining if addiction is present or not. Although these characteristic features are widely present in most cases of addiction, regardless of the pharmacology of the substance use seen in addiction or the reward that is pathologically pursued, each feature may not be equally prominent in every case. The diagnosis of addiction requires a comprehensive biological, psychological, social and spiritual assessment by a trained and certified professional.

3. In this document, the term “addictive behaviors” refers to behaviors that are commonly rewarding and are a feature in many cases of addiction. Exposure to these behaviors, just as occurs with exposure to rewarding drugs, is facilitative of the addiction process rather than causative of addiction. The state of brain anatomy and physiology is the underlying variable that is more directly causative of addiction. Thus, in this document, the term “addictive behaviors” does not refer to dysfunctional or socially disapproved behaviors, which can appear in many cases of addiction. Behaviors, such as dishonesty, violation of one’s values or the values of others, criminal acts etc., can be a component of addiction; these are best viewed as complications that result from, rather than contribute to, addiction.

4. The anatomy (the brain circuitry involved) and the physiology (the neuro-transmitters involved) in these three modes of relapse (drug- or reward-triggered relapse vs. cue-triggered relapse vs. stress-triggered relapse) have been delineated through neuroscience research.
Relapse triggered by exposure to addictive/rewarding drugs, including alcohol, involves the nucleus accumbens and the VTA-MFB-Nuc Acc neural axis (the brain’s mesolimbic dopaminergic “incentive salience circuitry”--see footnote 2 above). Reward-triggered relapse also is mediated by glutamatergic circuits projecting to the nucleus accumbens from the frontal cortex.

Relapse triggered by exposure to conditioned cues from the environment involves glutamate circuits, originating in the frontal cortex, insula, hippocampus and amygdala, and projecting to mesolimbic incentive salience circuitry.

Relapse triggered by exposure to stressful experiences involves brain stress circuits beyond the hypothalamic-pituitary-adrenal axis that is well known as the core of the endocrine stress system. There are two of these relapse-triggering brain stress circuits – one originates in noradrenergic nucleus A2 in the lateral tegmental area of the brain stem and projects to the hypothalamus, nucleus accumbens, frontal cortex, and bed nucleus of the stria terminalis, and uses norepinephrine as its neurotransmitter; the other originates in the central nucleus of the amygdala, projects to the bed nucleus of the stria terminalis and uses corticotrophin-releasing factor (CRF) as its neurotransmitter.

5. Pathologically pursuing reward (mentioned in the Short Version of this definition) thus has multiple components. It is not necessarily the amount of exposure to the reward (e.g., the dosage of a drug) or the frequency or duration of the exposure that is pathological. In addiction, pursuit of rewards persists, despite life problems that accumulate due to addictive behaviors, even when engagement in the behaviors ceases to be pleasurable. Similarly, in earlier stages of addiction, or even before the outward manifestations of addiction have become apparent, substance use or engagement in addictive behaviors can be an attempt to pursue relief from dysphoria; while in later stages of the disease, engagement in addictive behaviors can persist even though the behavior no longer provides relief.