Addiction medicine

Background

Addiction medicine focuses on the prevention, evaluation, and treatment of substance-related disorders in patients of all ages. Addiction is a primary, chronic disease, which is characterized by impaired control over the use of a psychoactive substance. Like other chronic diseases, addiction can be progressive, relapsing, and fatal.

Common features of addiction are:
➤ Changes in mood and relief from negative emotions
➤ Preoccupation with substance use or ritualistic behavior
➤ Continued substance use and behavior despite adverse physical, psychological, and social consequences

Physicians who practice addiction medicine are called addictionists. They apply specialized knowledge about various treatment modalities, their indications and contraindications, and their expected benefits and costs to care for a wide variety of patients. These patients include those who inject, sniff, or smoke drugs, or abuse prescription medications. They also include people with medical problems secondary to drug use, cigarette smokers, adolescents who get into trouble because of drug use, healthcare professionals with drug and alcohol abuse issues, and family members of people who suffer from drug-related problems.

The following two organizations offer certification for addictionists:
➤ As of 2009, the American Board of Addiction Medicine (ABAM) offers a certificate in addiction medicine, which is available to all medical specialists who work in the addiction field.
➤ The American Osteopathic Association (AOA) grants a certificate of added qualifications (CAQ) in addiction medicine. Interested osteopathic specialty boards such as the American Osteopathic Board of Anesthesiology (AOBA), the American Osteopathic Board of Family Physicians (AOBFP), the American Osteopathic Board of Internal Medicine, and the American Osteopathic Board of Neurology and Psychiatry (AOBNP) conjointly developed the certificate examination. However, the AOBA and AOBFP no longer issue a CAQ in addiction medicine.

The American Board of Psychiatry and Neurology grants subspecialty certification in the related field of addiction psychiatry. The American Board of Medical Specialties (ABMS) recognizes this certification. For more information on this subspecialty, see Clinical Privilege White Paper, Addiction psychiatry—Practice area 426.
Involved specialties

Addictionists

Positions of specialty boards

**ABAM**

Applicants for addiction medicine certification by ABAM must meet the following minimum requirements:

- Hold a valid, unrestricted license to practice medicine in the United States, its territories, or Canada

- Graduation from a medical school in the United States or Canada approved by the Liaison Committee on Medical Education or the Committee of Accreditation of Canadian Medical Schools, or from a school of osteopathic medicine approved by the AOA

- Certification by a member board of the ABMS, or certification by the AOA, or successful completion of an accredited residency training program in any medical specialty

- Completion of practice or specialized training for addiction medicine, which may be fulfilled by:
  - A one-year full-time equivalent of activity in the field of addiction medicine, which is equal to at least 1,950 hours over the previous five years in teaching, research, administration, and clinical care or the prevention and treatment of substance use disorders in affected or at-risk individuals. At least 400 of these hours must have been spent in direct clinical care of patients. This practice experience in the field of addiction medicine must be in addition to, and not concurrent with, residency training in any other field.
  - A one-year ABAM Foundation–accredited addiction medicine residency training program

- Lifelong learning represented by 50 hours of addiction medicine educational course work

- Good standing in the medical community as evidenced by at least one letter of recommendation

**AOBNP**

The examination program for CAQ in addiction medicine through the AOBNP is designed to recognize excellence among those with advanced or concentrated training in addiction psychiatry. Applicants must meet the following minimum requirements:

- Hold primary certification awarded by the AOA in psychiatry or neurology.

- Hold a valid and unrestricted license to practice medicine in the state where practice is conducted.

- Be a current member in good standing of the AOA or the Canadian Osteopathic Association for at least two consecutive years prior to the date of the CAQ.
 Completion of one year of AOA training in addiction psychiatry evidenced by a copy of the addiction psychiatry certificate and letter of recommendation from the program director, or completion of at least four years of practice experience with at least 25% of the total practice devoted to addiction psychiatry or medicine with the documentation of at least 200 CME hours per the AOA Individual Activity Report within the four-year period and with at least 100 hours in addiction medicine.

The period of eligibility is six years from the date of completion of the AOA-approved addiction psychiatry program.

The application must contain substantiation of the diplomate’s satisfactory clinical competence in addiction psychiatry. This substantiation must be provided by the program director in the addiction psychiatry–approved training program or, if applying under the clinical practice pathway, verification of competence and good standing in the addiction psychiatry medical community from a minimum of two sources. Clinical practice pathway applicants must submit a letter of recommendation from the medical director or department chairperson and another from a physician practicing addiction psychiatry/medicine in the applicant’s community.

Positions of societies, academies, colleges, and associations

ASAM

The American Society of Addiction Medicine (ASAM) represents nearly 3,000 physicians working to improve the quality of addiction treatment, educate physicians and the public, support research, and promote the appropriate role of physicians in patient care as it relates to addiction medicine. The ASAM previously administered the exam for certification in addiction medicine before transferring the examination to ABAM.

In 1996, the ASAM established a fellowship program to highlight members of the ABAM who made significant contributions to the field of addiction medicine. To qualify, candidates must meet the following criteria:

➤ Be a member of ASAM for a minimum of five consecutive years
➤ Be certified by ASAM or ABAM
➤ Give significant service to ASAM in at least two of the following ways:
  − Served on the ASAM Board of Directors
  − Served as a chair or member of an ASAM committee, task force, or work group
  − Served as an ASAM delegate or alternate to the AMA
  − Served as an officer of a state society or chapter of ASAM
  − Served as a speaker, chair, or been involved in the planning of an ASAM conference
  − Published in an ASAM publication or served on an ASAM editorial board
  − Made significant contributions at the state or chapter level of ASAM or other state specialty medical society or organization
Make and continue to make significant contributions to at least three of the seven areas below:

- Participation in other medical and professional organizations such as the AMA, AOA, Advanced Studies in Medicine, American Psychiatric Association, RSA, etc., or state and local medical societies
- Participation in uncompensated activities of social significance, such as volunteer work at community health agencies, volunteer services on a board of directors for a healthcare agency, or volunteer work with schools, Planned Parenthood, Boy Scouts, etc.
- Political or legislative involvement, grassroots or other lobbying, holding elected or appointed public office, serving as a committee member in the political process to further the goals of addiction medicine or ASAM, and/or testifying before local, state, or federal legislative bodies to further the goals of addiction medicine or ASAM
- Clinical contributions such as developing a unique model for addiction treatment or advancing the knowledge base of addiction medicine
- Administrative appointments, for a minimum of three years, such as a position of authority within a hospital, hospital committee, or substance abuse treatment program; boards of substance abuse treatment programs; and federal or state departments of alcoholism and/or drug abuse
- Teaching contributions, for a minimum of five years, such as appointment to medical school faculty in substance abuse teaching, volunteer teaching of alcoholism and drug abuse information to patients in publicly funded treatment or education programs, or presentations of formal lectures in the substance abuse field to physicians and/or healthcare providers in the addiction field, on a consistent basis
- Published writings in peer-reviewed journals and/or books, or chapters of books, written for the education of professionals

Pay a $250 application fee, which must accompany the application.

ASAM also publishes *A Guideline for Credentialing and Privileging of Clinical Professionals for Care of Substance-Related Disorders: A Joint Statement of the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association* (2005). This document calls for the development of policies and procedures for credentialing and privileging specific to the area of addiction medicine, and presents a framework for privileging. The accompanying frameworks document, *General Overview of Clinical Privileges for Care of Substance-Related Disorders*, outlines the following breakdown of privileges with regard to addiction medicine:

- Privileges applicable to primary care physicians, nurse practitioners, physician assistants, general psychiatrists, mental health clinical nurse specialists, general psychologists, other mental health professionals, addictionists, and addiction specialists from nursing, psychology, social work, and professional counseling:
  - Prevention
  - Screening
Addiction medicine

Practice area 123

- Assessment/diagnosis of intoxication
- Brief intervention
- Referral

➤ Privileges applicable to primary care physicians, nurse practitioners, physician assistants, general psychiatrists, mental health clinical nurse specialists, addictionists, and addiction specialists from nursing:
  - Assessment/diagnosis of withdrawal
  - Management of mild to moderate withdrawal
  - Management of mild to moderate intoxication
  - Medication management of addiction

➤ Privileges applicable to general psychiatrists, addictionists, addiction specialists from nursing, psychology and professional counseling, primary care physicians, psychologists, mental health clinical nurse specialists, and other mental health professionals:
  - Assessment/diagnosis of addiction and substance-related disorders

➤ Privileges applicable to general psychiatrists, addictionists, selected primary care physicians, addiction specialists from nursing, psychology and professional counseling, plus psychologists, mental health clinical nurse specialists, and other mental health professionals:
  - Individual, group, and family addiction counseling

➤ Privileges applicable to primary care physicians, addictionists from primary care and other medical specialties, and selected addictionists whose primary specialty is in psychiatry:
  - Management of severe or complex intoxication
  - Management of severe or complex withdrawal

➤ Privileges applicable to primary care physicians and addictionists from primary care and other medical specialties:
  - Management of medical complications of addiction and other substance-related disorders

➤ Privileges applicable to general psychiatrists, addictionists whose primary specialty is in psychiatry, general psychologists, mental health clinical nurse specialists, and addiction specialists from psychology:
  - Management of psychiatric complications of addiction and other substance-related disorders

➤ Privileges applicable to addictionists, addiction specialists from nursing, psychology and professional counseling, general psychiatrists, psychologists, mental health clinical nurse specialists, and other mental health professionals:
  - Screening/referral for dual diagnosis (mental health disorder plus addictive disorder)

➤ Privileges applicable to addictionists whose primary specialty is in psychiatry, addiction specialists from psychology, selected general psychiatrists, selected general psychologists, and selected addictionists from primary care and other medical specialties:
  - Assessment/management of dual diagnosis (mental health disorder plus addictive disorder)
AOA

In its *Basic Standards for Fellowship Training in Addiction Medicine*, the AOA, in conjunction with the American College of Osteopathic Family Physicians, the American College of Osteopathic Internists, and the American College of Osteopathic Neurologists and Psychiatrists, sets forth standards designed to provide the osteopathic fellow with advanced and concentrated training in addiction medicine and to prepare the fellow for examination for certification in addiction medicine by the Addiction Medicine Conjoint CAQ Exam Committee.

The goal of addiction medicine fellowship training is to prepare fellows for competency in the following seven core areas:

➤ **Osteopathic philosophy and osteopathic manipulative medicine (OMM)**
  – The integration of osteopathic principles into the daily practice of addiction medicine
  – The application of OMM to addiction medicine patient management

➤ **Medical knowledge**
  – Maintain current knowledge of clinical medicine that reflects the majority of patient care issues that present to addiction medicine settings
  – Maintain current knowledge of behavioral medicine that reflects the majority of patient care issues that present to addiction medicine settings

➤ **Patient care**
  – Provide osteopathic addiction medicine patient care service in ambulatory, continuity, and inpatient sites
  – Accurately gather essential information from all sources including patients, caregivers, other professionals, electronic sources, and paper sources

➤ **Interpersonal and communication skills**
  – Develop doctor-patient relationships in all addiction medicine settings
  – Develop listening, written, oral, and electronic communication skills in professional interactions with patients, families, and other health professionals

➤ **Professionalism**
  – Demonstrate respect for patients and families and advocate for the primacy of patients’ welfare and autonomy
  – Adhere to ethical principles in the practice of addiction medicine
  – Demonstrate awareness and attention to issues of culture, religion, age, gender, sexual orientation, and mental and physical disabilities

➤ **Practice-based learning and improvement**
  – Apply the principles of evidence-based medicine to addiction medicine
  – Participate in practice-based objective performance improvement projects in addiction medicine settings

➤ **Systems-based practice**
  – Function within local and national healthcare delivery systems to provide high-quality addiction medicine services
  – Function within a team to provide care to addiction medicine populations
Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for addiction medicine. However, the CMS Conditions of Participation (CoP) define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical
privileges or membership should be continued, discontinued, revised, or otherwise changed.

**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for addiction medicine. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:

- The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
- Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
- Consistent application of criteria
- A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges request

A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested

Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism

A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)

A process to determine whether there is sufficient clinical performance information to make a decision related to privileges

A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws

Information regarding any changes to practitioners’ clinical privileges, updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the
ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for addiction medicine. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

DNV has no formal position concerning the delineation of privileges for addiction medicine. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted
to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

➤ The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements

➤ Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status

➤ Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding this practice area. The core privileges and accompanying procedures list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.
Minimum threshold criteria for requesting privileges in addiction medicine

Basic education: MD or DO
Minimal formal training: Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or AOA-accredited residency in any medical specialty.
AND/OR
Current certification or active participation in the examination process (with achievement of certification within \([n]\) years) leading to certification by the ABMS or the American Osteopathic Boards and successful completion of an accredited training program in addiction medicine, and one year’s full-time equivalent in the field of alcoholism or drug dependencies in addition to, and not concurrent with, residency training; and 50 hours Category I CME related to addiction in the past two years, or current certification by ABAM.

Required current experience: The successful applicant must demonstrate provision of care, treatment, or services, reflective of the scope of privileges requested, to at least 50 diagnostic or therapeutic addiction medicine cases in the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

References
If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Core privileges in addiction medicine
Core privileges in addiction medicine include the ability to admit, evaluate, consult, and provide care to patients of all ages with problems of addiction and substance-related disorders, including management of severe or complex intoxication, severe or complex withdrawal, medical complications of addiction and other substance-related disorders, social and psychological complications of addiction and other substance-related disorders, and integration of addiction medicine expertise with other healthcare providers. This includes performance history and physical exam. Practitioners may provide care to patients in the intensive care setting in conformance with unit policies. Practitioners may also assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

Reappointment
Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.
Addiction medicine

To be eligible to renew privileges in addiction medicine, candidates must have current demonstrated competence and an adequate volume of experience (100 diagnostic or therapeutic addiction medicine patients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, continuing education related to addiction medicine should be required.

For more information

**American Board of Addiction Medicine**
4601 North Park Avenue, Upper Arcade, Suite 101
Chevy Chase, MD 20815
Telephone: 301-656-3378
Fax: 301-656-3815
Website: [www.abam.net](http://www.abam.net)

**American Osteopathic Association**
142 East Ontario Street
Chicago, IL 60611
Telephone: 312-202-8000
Fax: 312-202-8200
Website: [www.osteopathic.org](http://www.osteopathic.org)

**Centers for Medicare & Medicaid Services**
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877-267-2323
Website: [www.cms.hhs.gov](http://www.cms.hhs.gov)

**DNV Healthcare, Inc.**
400 Techne Center Drive, Suite 350
Milford, OH 45150
Website: [www.dnvaccreditation.com](http://www.dnvaccreditation.com)

**Healthcare Facilities Accreditation Program**
142 E. Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: [www.hfap.org](http://www.hfap.org)
The information contained in this document is general. It has been designed and is intended for use by hospitals and their credentials committees in developing their own local approaches and policies for various credentialing issues. This information, including the materials, opinions, and draft criteria set forth herein, should not be adopted for use without careful consideration, discussion, additional research by physicians and counsel in local settings, and adaptation to local needs. The Credentialing Resource Center does not provide legal or clinical advice; for such advice, the counsel of competent individuals in these fields must be obtained.

Reproduction in any form outside the recipient’s institution is forbidden without prior written permission. Copyright © 2012 HCPro, Inc., Danvers, MA 01923.