A message from the California Society of Addiction Medicine (CSAM) to the Substance Abuse Coordination Committee (SACC):

Our Goal: We want California's programs to be run with best practices, as programs in other states are, and we believe that we have to work together to change the Uniform Standards to achieve that.

What are the Uniform Standards?

Uniform Standards are 16 requirements that the diversion program of any licensing Board *must* follow. They were put in place in 2009, then revised in 2011.

Having uniform standards that make each program follow the same principles would be a good idea because:

- It could give us confidence that all programs would be based on best practices
- All programs could be held similarly accountable for adherence to the same principles

However, in their current form, these Uniform Standards are:

- Outdated – they have not been kept current with accumulated experience, or with accepted best practices, or with drug testing methodology
- Difficult to implement because some are not practical (not possible in the face of real life conditions)
- Some are contradictory
- Some are confusing
- Punitive – not in line with what is known about achieving rehabilitation

They make people unwilling to enter the programs. We know that because the numbers of referrals and voluntary participation have both declined since the Uniform Standards were put in place and because of the word of mouth information that has spread among the participants over the years.

The programs cannot be protecting the public if those who should be in the program won't enter and instead **continue to practice until formal action can be taken to put them on probation.**

What changes are needed?

CSAM has submitted proposed specific changes, with exact language, to the SACC.

The proposed changes put into regulatory language how to implement a program based on best practices and documented experience.

Please refer to the attachment for the recommended revisions to Uniform Standard #4 (Drug Testing) and the principles on which the recommendations are based. We hope that the SACC will similarly take up the review of each of the 16 standards and update those that are outdated and a barrier to efforts to increase enrollment in diversion programs.

Examples:

- The 102 fixed tests per year, required by the current Uniform Standards, sidesteps a thoughtful, science-driven approach. If the number of screens is set in stone, it makes it impractical for newer testing methods – with more clinically meaningful results -- to be used. Newer testing is becoming more sensitive. It makes more sense to use multiple modalities. Again, if you have fixed screens the more sensitive and accurate methods will not be used.
- The Uniform Standards specify routinely testing a participant's urine. In anesthesia providers, the recommendation is to use hair fentanyl testing and even hair propofol occasionally. Hair testing can detect usage within a several month window. Fentanyl is difficult to detect in the urine. **This is ALL determined clinically and the Uniform Standards must be changed to require clinical determinations of drug testing frequency and type.**

Why It's Important

For licensing boards with Diversion Programs, enrollment has been **dropping steadily** since the Uniform Standards were adopted nearly a decade ago.

The drop-off in enrollment and the overall low numbers of participants in these programs is a serious threat to public safety that must be addressed by the SACC.

The Uniform Standards have not been reviewed or updated since 2011 and there is no formal requirement or process for regular review and updating. It took a piece of legislation to initiate this review (but it is only a partial review).

SB-796 (Hill), signed by the Governor on October 8, 2017, mandated the review of Uniform Standard #4, which pertains specifically to drug testing. The California Society of Addiction Medicine (CSAM) and California Public Protection and Physician Health, Inc. (CPPPH), chose to go a step further and reviewed all 16 Uniform Standards. It was the consensus within CSAM and other state medical organizations—including the California Psychiatric Association, the California Medical Association, and the California Hospital Association—that all the standards

were in similar need of revision. All of the Standards are essential to the appropriate design and effective operation of monitoring programs.

Solution

If we update Uniform Standards to bring them in line with best practices, we will have the benefits that standards can bring and the benefit of having programs that take full advantage of clinical decision-making and best practices. All the licensing Boards in DCA can successfully **increase the number of referrals and new participants,** and all healing arts licensees would be better served. And the programs can be a powerful tool for the Boards in their mission to protect the public.

Please refer to the attached recommendations for revisions to Uniform Standard #4 (Drug Testing) and to the principles on which the recommendations are based.

We hope that the SACC will similarly take up the review and updating of the remaining standards also clearly outdated and a barrier to efforts to increase enrollment in diversion programs.

6-11-2018

CSAM CALIFORNIA SOCIETY OF ADDICTION MEDICINE

Contents

California Society of Addiction Medicine
575 Market Street, Suite 2125, San Francisco, CA 94105
Phone: 415/764-4855 • Fax: 415/764-4915 • csam@csam-asam.org • www.csam-asam.org

CSAM Recommended Changes to Uniform Standard #4 -- required drug testing

#4 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomnicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

#4 Uniform Standard

The program shall require licensees to abstain from the use, consumption, ingestion, or administration of prohibited substances unless an exception is specified in the licensee's agreement with the program.

The program shall have a protocol governing all aspects of the testing required to determine compliance with the agreement between the licensee and the program.

The protocol shall include the testing frequency schedule, any exceptions thereto, the consequences to the licensee for non-compliance with his/her testing schedule as described in Uniform Standards 8, 9, and 10, and all other elements listed below.

The protocol shall describe the biological specimens to be tested and the testing methods to be used. Examples of current testing methods that may be utilized, but are not limited to any one include: urine drug testing (UDT), and biological matrices such as oral fluid (saliva), hair, nails, sweat and breath when those matrices match the intended assessment process.[1] The protocol shall describe how additions to the protocol will be made as additional methods become accepted.

The protocol shall include provisions that will apply if a licensee is being treated with prescribed medications for a medical condition. The protocol will cover both a time-limited course of treatment and an ongoing treatment regimen. The protocol will include the requirements that treatment be under the direction of a physician who meets the criteria and requirements of the program and has been accepted by the program as the licensee's treating physician. Both the licensee and the treating physician must agree to share information with the program and to communicate with the program's Medical Director or his/her designee.

---

[1] Appropriate Use of Drug Testing in Clinical Addiction Medicine, American Society of Addiction Medicine (2017)

When a licensee is receiving prescribed medications as part of treatment for a medical condition, the following elements shall be added to his/her agreement:

- drug tests shall include tests for the presence of the prescribed medication
- regular reports must be submitted to the program by the licensee's treating physician, documenting that the licensee is continuing in treatment and progressing toward treatment goals and that the licensee is in compliance with the prescribing physician's prescribed medication regimen

The protocol shall include a provision for periodic review and adjustment, if any, to the licensee's current situation.

The program's protocol shall be submitted to the Board for review and acceptance before the program accepts its first licensee, and again on a regular recurring schedule no less than once per year.

TESTING FREQUENCY SCHEDULE

The program may order a licensee to drug test at any time. Additionally, each licensee shall be tested RANDOMLY in accordance with the schedule defined by the program for the individual licensee. The testing schedule shall be determined by the Medical Director or his/her designee and shall be based on the licensee's particular history and diagnosis and on the monitoring technology or technologies to be used. Testing on a frequency appropriate for the licensee shall be in place for the duration of the time the licensee is in the program.

Nothing precludes the program from increasing the number of random tests for any reason. If the program determines that a licensee has failed to comply with the testing schedule, the program will put in place the consequences defined in both the program's protocol and the licensee's agreement.

EXCEPTIONS TO TESTING FREQUENCY SCHEDULE

The program's Medical Director or his/her designee shall take into consideration these elements when determining the testing schedule for a particular licensee:

I. PREVIOUS TESTING/SOBRIETY In cases where the program has evidence that a licensee has successfully completed or is currently participating in a treatment or monitoring program requiring random testing, the program may give consideration to that testing in altering the testing frequency schedule so that it is equivalent to what would be designed for this licensee.

In such a situation, the licensee must agree in writing to the exchange of all test results conducted by the treatment or monitoring program before this standard is applied. The test panel used by the treatment or monitoring program must be reasonably comparable to the test panel used by the program.

II. VIOLATION(S) OUTSIDE OF EMPLOYMENT The program's protocol may allow for a testing schedule appropriate for an individual whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor.

III. NOT EMPLOYED IN HEALTH CARE FIELD The program's protocol may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the licensee's board. Prior to returning to any health care employment, the licensee shall be subject to a drug testing schedule designed by the program sufficient to document abstinence for at least 60 days. At such time the person returns to employment (in a health care field), if the licensee has not previously met the requirement for documented abstinence for 60 days, the licensee shall be subject to completing a full year of the testing frequency schedule designed by the program.

IV. TOLLING The program's protocol shall provide for a licensee to continue in its testing program while residing outside of California if the program has approved such a change in the licensee's agreement and has modified the specifics of the testing program accordingly. If a licensee participates in a testing program that has been modified by the program to accommodate the licensee, all conditions and consequences shall apply and shall be enforced by the program.

A board may postpone all testing for any person whose probation or diversion is placed in a tolling status if the overall length of the probationary or diversion period is also tolled. A licensee shall notify the program upon the licensee's return to California and shall be subject to testing as provided in this standard. If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

V. SUBSTANCE USE DISORDER NOT DIAGNOSED In cases where no current substance use disorder diagnosis is made, the program shall require monitoring and toxicology screening on a schedule appropriate for the licensee.

OTHER DRUG STANDARDS

The program's drug testing protocol shall include the following requirements:

Drug testing may be required on any day, including weekends and holidays.

The scheduling of drug tests shall be done on a random basis, preferably by a computer program, so that a licensee can make no reasonable assumption of when he/she will be tested again. Boards should be prepared to report data to support back-to-back testing as well as numerous different intervals of testing.

Licensees shall be required to make daily contact to determine if drug testing is required.

Licensees shall be drug tested on the date of notification.

Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.

Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.

Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.

Collection of specimens shall follow the requirements of the program's protocol for observed collection. The protocol shall include steps to allow collection that meets the program's requirements if observed collection is not available.

Prior to vacation or absence, alternative drug testing location(s) must be approved by the program.

Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.

Laboratories shall be capable of reflex testing.[2]

The program's protocol shall specify "reflex tests" for its screening tests.

A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens.

The laboratory shall process results and provide legally defensible test results within seven (7) days of receipt of the specimen.

The program will be notified of any confirmed positive test result within one (1) business day and will be notified of negative test results within seven (7) business days.

[2] A reflex test is an additional laboratory test that is automatically obtained when the results of a screening test indicate the need for further study. The secondary tests are almost always an additional charge above the initial test.

PETITIONS FOR REINSTATEMENT

Nothing herein shall limit a board's authority to reduce or eliminate the standards specified herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code section 11522 or statutes applicable to the board that contains different provisions for reinstatement or reduction of penalty.

OUTCOMES AND AMENDMENTS

For purposes of measuring outcomes and effectiveness, each board shall collect and report historical and post implementation data as follows:

Historical Data - Two Years Prior to Implementation of Standard

Each board should collect the following historical data (as available) for a period of two years prior to implementation of this standard, for each person subject to testing for banned substances, who has 1) tested positive for a banned substance, 2) failed to appear or call in for testing on more than three occasions, 3) failed to pay testing costs, or 4) a person who has given a dilute or invalid specimen.

Post Implementation Data - Three Years

Each board should collect the following data annually, for a period of three years, for every probationer and diversion participant subject to testing for banned substances, following the implementation of this standard.

Data Collection

The data to be collected shall be reported to the Department of Consumer Affairs and the Legislature, upon request, and shall include, but may not be limited to:

Probationer/Diversion Participant Unique Identifier
License Type
Probation/Diversion Effective Date
General Range of Testing Frequency by/for Each Probationer/Diversion Participant
Dates Testing Requested
Dates Tested
Identify the Entity that Performed Each Test
Dates Tested Positive
Dates Contractor (if applicable) was informed of Positive Test
Dates Board was informed of Positive Test
Dates of Questionable Tests (e.g. dilute, high levels)
Date Contractor Notified Board of Questionable Test
Identify Substances Detected or Questionably Detected
Dates Failed to Appear
Dates Contractor Notified Board of Failed to Appear
Dates Failed to Call In for Testing
Dates Contractor Notified Board of Failed to Call In for Testing
Dates Failed to Pay for Testing
Date(s) Removed/Suspended from Practice (identify which)
Final Outcome and Effective Date (if applicable)

##

For your reference:

Uniform Standard #4 – Required Drug Testing -- as it stands now

#4 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomnicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

#4 Uniform Standard

The following standards shall govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance use:

TESTING FREQUENCY SCHEDULE

A board may order a licensee to drug test at any time. Additionally, each licensee shall be tested RANDOMLY in accordance with the schedule below:

> Level 1: Year 1 of Probation/Diversion: minimum range of number of random tests: 52-104 per year
>
> Level 2: Year 2 through up to 5 years of Probation/Diversion: minimum range of number of random tests: 36-104 per year

*The minimum range of 36-104 tests identified in level II, is for the second year of probation or diversion, and each year thereafter, up to five (5) years. Thereafter, administration of one (1) time per month if there have been no positive drug tests in the previous five (5) consecutive years of probation or diversion.

Nothing precludes a board from increasing the number of random tests for any reason. Any board who finds or has suspicion that a licensee has committed a violation of a board's testing program or who has committed a Major Violation, as identified in Uniform Standard 10, may reestablish the testing cycle by placing that licensee at the beginning of level I, in addition to any other disciplinary action that may be pursued.

EXCEPTIONS TO TESTING FREQUENCY SCHEDULE

I. PREVIOUS TESTING/SOBRIETY
In cases where a board has evidence that a licensee has participated in a treatment or monitoring program requiring random testing, prior to being subject to testing by the board, the board may give consideration to that testing in altering the testing frequency schedule so that it is equivalent to this standard.

II. VIOLATION(S) OUTSIDE OF EMPLOYMENT An individual whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass level I and participate in level II of the testing frequency schedule.

III. NOT EMPLOYED IN HEALTH CARE FIELD A board may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the licensee's board. Prior to returning to any health care employment, the licensee shall be subject to level I testing frequency for at least 60 days. At such time the person returns to employment (in a health care field), if the licensee has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

IV. TOLLING A board may postpone all testing for any person whose probation or diversion is placed in a tolling status if the overall length of the probationary or diversion period is also tolled. A licensee shall notify the board upon the licensee's return to California and shall be subject to testing as provided in this standard. If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

II. V. SUBSTANCE USE DISORDER NOT DIAGNOSED In cases where no current substance use disorder diagnosis is made, a lesser period of monitoring and toxicology

OTHER DRUG STANDARDS

Drug testing may be required on any day, including weekends and holidays.

The scheduling of drug tests shall be done on a random basis, preferably by a computer program, so that a licensee can make no reasonable assumption of when he/she will be tested again. Boards should be prepared to report data to support back-to-back testing as well as, numerous different intervals of testing.

Licensees shall be required to make daily contact to determine if drug testing is required.

Licensees shall be drug tested on the date of notification as directed by the board.

Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.

Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.

Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.

Collection of specimens shall be observed.

Prior to vacation or absence, alternative drug testing location(s) must be approved by the board.

Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.

A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven (7) days of receipt of the specimen. The appropriate board will be notified of non-negative test results within one (1) business day and will be notified of negative test results within seven (7) business days.

A board may use other testing methods in place of, or to supplement biological fluid testing, if the alternate testing method is appropriate.

PETITIONS FOR REINSTATEMENT

Nothing herein shall limit a board's authority to reduce or eliminate the standards specified herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code section 11522 or statutes applicable to the board that contains different provisions for reinstatement or reduction of penalty.

OUTCOMES AND AMENDMENTS

For purposes of measuring outcomes and effectiveness, each board shall collect and report historical and post implementation data as follows:

Historical Data - Two Years Prior to Implementation of Standard

Each board should collect the following historical data (as available), for a period of two years, prior to implementation of this standard, for each person subject to testing for banned substances, who has 1) tested positive for a banned substance, 2) failed to appear or call in, for testing on more than three occasions, 3) failed to pay testing costs, or 4) a person who has given a dilute or invalid specimen.

Post Implementation Data- Three Years

Each board should collect the following data annually, for a period of three years, for every probationer and diversion participant subject to testing for banned substances, following the implementation of this standard.

Data Collection

The data to be collected shall be reported to the Department of Consumer Affairs and the Legislature, upon request, and shall include, but may not be limited to:

Probationer/Diversion Participant Unique Identifier
License Type
Probation/Diversion Effective Date
General Range of Testing Frequency by/for Each Probationer/Diversion Participant
Dates Testing Requested
Dates Tested
Identify the Entity that Performed Each Test
Dates Tested Positive
Dates Contractor (if applicable) was informed of Positive Test
Dates Board was informed of Positive Test
Dates of Questionable Tests (e.g. dilute, high levels)
Date Contractor Notified Board of Questionable Test
Identify Substances Detected or Questionably Detected
Dates Failed to Appear
Date Contractor Notified Board of Failed to Appear
Dates Failed to Call In for Testing
Date Contractor Notified Board of Failed to Call In for Testing
Dates Failed to Pay for Testing
Date(s) Removed/Suspended from Practice (identify which)
Final Outcome and Effective Date (if applicable)

CSAM CALIFORNIA SOCIETY OF ADDICTION MEDICINE

From CSAM Task Force on Review of Uniform Standards April 2018

PRINCIPLES FOLLOWED IN CHOOSING THE RECOMMENDED WORDING FOR MODIFICATION OF UNIFORM STANDARDS THAT WILL GOVERN THE PROGRAMS FOR ALL LICENSING AGENCIES UNDER DEPARTMENT OF CONSUMER AFFAIRS – SUBSTANCE ABUSE COORDINATING COMMITTEE

1. The Board's responsibility to protect the public should be exercised in ways demonstrated to be effective.

2. The program should be able to be implemented in a realistic and practical manner; standards that are unreasonably difficult to meet should be modified.

3. The programs are not treatment programs; they are monitoring programs. Because the elements of a monitoring plan are considered part of after care (an extension of treatment) and are based on the treatment goals, and because implementing a monitoring program requires the understanding of treatment history and the application of clinical judgment, monitoring should be under the direction of a qualified clinician.

4. The responses required by the Uniform Standards to "major" and "minor" "offenses" should be based on the understanding of the progression of the stages of treatment and recovery for the diagnosis of substance use disorders of all types defined in DSM V. Each program's responses should be in line with the therapeutic responses described in commonly accepted guidelines.

5. The program should be under the direction of a Medical Director. Others in positions where judgment or interpretation is a factor (such as group facilitators and case managers) should be required to be licensed clinicians with clinical experience treating physicians as patients.

6. All clinical details should be deleted from regulation. All clinical information and all clinical determinations and decisions should be the responsibility of the program's Medical Director or his/her designee.

575 Market Street, Suite 2125, San Francisco, CA 94105
415/764-4855 • www.csam-asam.org • email: csam@csam-asam.org

7. The cost of an appropriate and effective program is too great to be borne solely by participants. The costs should be spread across all licenses in the state. The program should be supported primarily (not necessarily exclusively) by licensure fees from all licensees in the state.

8. Those who enter the program will have voluntarily relinquished their rights before their licensing agency in order to gain the benefits of participating in the program. Nonetheless, the program's governing regulations, policies and procedures should recognize and honor the individual's rights to the extent that is reasonably in line with the purpose of the program.

    a. Within appropriate limits, all participants have the right to privacy.

    b. Within appropriate limits, participants have the right to pursue their profession.

    c. Participants have the right to timely and appropriate treatment and monitoring methods that meet currently accepted standards and acknowledged best practices.

9. The program's governing regulations regarding reporting names of participants to the public should be different for "self-referrals" than they are for participants referred into the program by the licensing agency.

REFERENCES:

Federation of State Physician Health Programs (FSPHP) – Physician Health Program Guidelines (2005)

Federation of State Medical Boards (FSMB) - Policy on Physician Impairment (April 2011)

CSAM CALIFORNIA SOCIETY OF ADDICTION MEDICINE

CSAM Task Force for Addressing California's Uniform Standards

In December 2017, the California Society of Addiction Medicine assembled an expert panel to review and make recommendations on the Uniform Standards. The following experts participated in this task force:

Karen Miotto, MD, DFASAM, Director, UCLA Physician Wellness Program; Professor, Psychiatry and Biobehavioral Sciences; Chair of the CSAM Committee on Physician Well-Being *(Chair, Task Force)*
Gregory Abrams, Attorney in private practice representing physicians and medical staffs, Oakland
David Balfour, Attorney, Nossaman, LLP, San Diego
Richard Barton, Attorney, Procopio, San Diego
Christopher Bundy, MD, MPH, Medical Director, Washington Physicians Health Program
Kevin Cauley, CA Professional Licensing and Health Care Attorney; Attorney for Georgia PHP
Yvonne Choong, Vice President, Center for Health Policy, California Medical Association
Itai Danovitch, MD, Chair, Department of Psychiatry and Behavioral Neurosciences, Cedars-Sinai Medical Center, Los Angeles
Paul Earley, MD, DFASAM, President, Federation of State Physician Health Programs; President, American Society of Addiction Medicine (ASAM); Medical Director, Georgia PHP
Francine Farrell, MS, LMFT, CADC-II, President, Pacific Assistance Group North
Tina Felahi, Attorney, Procopio, San Diego
Denise Fuson, MD, Chair, Kaiser Permanente Physician Wellbeing Committee, and Chair of the Physician's Advisory Committee of ACCMA (Alameda Contra Costa Medical Association)
Matthew Goldenberg, DO, Founder, Professionals Health Solutions, Santa Monica
Christopher Hamilton, Ph.D., Monitoring Programs Director, Oregon Physician Health Program
Scott A. Humphreys, MD, Associate Medical Director, Colorado Physician Health Program
Gail Jara, Former Executive Director, California Public Protection and Physician Health (CPPPH)
Virginia Matthews, RN, BSN, Project Manager, Maximus
Marcia Nelson, MD, MMM, CPE, FAAFP, FACPE, Vice President, Medical Affairs at Enloe Medical Center, Chico
Kerry Parker, CAE, MPA, Executive Director, California Society of Addiction Medicine
David Perrott, MD, DDS, Senior Vice President & Chief Medical Officer, California Hospital Association
Gregory Skipper, MD, Medical Director of Professionals Treatment Program, Los Angeles; former Medical Director, Alabama PHP
Lee Thomas Snook, Jr., MD, FACP, DAMPM, FASAM, Board of Trustees, California Medical Association (CMA), and an officer on the Board of California Public Protection and Physician Health (CPPPH)
Tracy Zemansky, PhD, President, Pacific Assistance Group South

April 2018

575 Market Street, Suite 2125, San Francisco, CA 94105
415/764-4855 • www.csam-asam.org • email: csam@csam-asam.org