Medical School Addiction Education 2014

AOAAM Addiction Medicine Education Program
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Disclosures

- None
Objectives

- To better understand substance use disorders resulting in both direct pathology and a negative impact on all other illnesses.
- Consider the importance of addiction medicine inclusion in the Osteopathic medical education curriculum can improve healthcare in general.
- To review a model of how this is currently being address through a collaboration of COPE and SAMHSA.
Professional Satisfaction Experienced When Caring for Substance-abusing Patients

Table 2. Professional Satisfaction of Primary Care Physicians Caring for Patients with Addictions and Other Diagnoses

<table>
<thead>
<tr>
<th>% Who Experience &quot;A Great Deal&quot; or a &quot;Moderate&quot; Amount of Satisfaction When Caring for Patients With...</th>
<th>Residents</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol problems*</td>
<td>32</td>
<td>49$</td>
</tr>
<tr>
<td>Drug problems</td>
<td>30</td>
<td>31†</td>
</tr>
<tr>
<td>Depression</td>
<td>43‡</td>
<td>69</td>
</tr>
<tr>
<td>Hypertension</td>
<td>79</td>
<td>76</td>
</tr>
</tbody>
</table>

Saitz, R et. al., Journal of General Internal Medicine 2005, 17 (5), 373-376
Integrated Care

- Equity Act (parity)
- Affordable Care Act, ACA
- Health Homes
- Health IT
- Chronic Care Model
Past Month Illicit Drug Use among Persons Aged 12 or Older: 2012

- Illicit Drugs: 23.9 million
- Marijuana: 18.9 million
- Psychotherapeutics: 6.8 million
- Cocaine: 1.6 million
- Hallucinogens: 1.1 million
- Inhalants: 0.5 million
- Heroin: 0.3 million
Past Month Nonmedical Use of Types of Psychotherapeutic Drugs among Persons Aged 12 or Older: 2002-2012
Past Month and Past Year Heroin Use among Persons Aged 12 or Older: 2002-2012

Numbers in Thousands

- **Past Month**
  - 2002: 166
  - 2003: 119
  - 2004: 166
  - 2005: 136
  - 2006: 161
  - 2007: 213
  - 2008: 193
  - 2009: 239
  - 2010: 281
  - 2011: 335

- **Past Year**
  - 2002: 404
  - 2003: 314
  - 2004: 398
  - 2005: 379
  - 2006: 560
  - 2007: 373
  - 2008: 455
  - 2009: 582
  - 2010: 621
  - 2011: 620
  - 2012: 669
Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2011-2012

**Source Where User Obtained**
- More than One Doctor (1.8%)
- One Doctor (19.7%)
- Other¹ (5.1%)
- Bought on Internet (0.2%)
- Drug Dealer/ Stranger (4.3%)
- Bought/Took from Friend/Relative (14.9%)

**Source Where Friend/Relative Obtained**
- One Doctor (82.2%)
- More than One Doctor (3.6%)
- Free from Friend/ Relative (5.4%)
- Bought/Took from Friend/Relative (5.4%)
- Other¹ (1.8%)
- Drug Dealer/ Stranger (1.4%)
- Bought on Internet (0.2%)
Current, Binge, and Heavy Alcohol Use among Persons Aged 12 or Older, by Age: 201
Past Month Tobacco Use among Persons Aged 12 or Older: 2002-2012

- Tobacco Products
- Cigarettes
- Cigars
- Smokeless Tobacco
- Pipe Tobacco

Percent Using in Past Month

- 2002: 30.4
- 2003: 29.8
- 2004: 29.2
- 2005: 29.4
- 2006: 29.6
- 2007: 28.7
- 2008: 28.4
- 2009: 27.7
- 2010: 27.5
- 2011: 26.5
- 2012: 26.7

Cigarettes:
- 2002: 26.0
- 2003: 25.4
- 2004: 24.9
- 2005: 24.9
- 2006: 25.0
- 2007: 24.3
- 2008: 24.0
- 2009: 23.3
- 2010: 23.0
- 2011: 22.1
- 2012: 22.1

Cigars:
- 2002: 5.4
- 2003: 5.4
- 2004: 5.7
- 2005: 5.6
- 2006: 5.6
- 2007: 5.4
- 2008: 5.3
- 2009: 5.3
- 2010: 5.2
- 2011: 5.0
- 2012: 5.2

Smokeless Tobacco:
- 2002: 0.8
- 2003: 0.7
- 2004: 0.8
- 2005: 0.9
- 2006: 0.9
- 2007: 0.8
- 2008: 0.8
- 2009: 0.8
- 2010: 0.8
- 2011: 0.8
- 2012: 1.0

Pipe Tobacco:
- 2002: 3.3
- 2003: 3.3
- 2004: 3.0
- 2005: 3.2
- 2006: 3.3
- 2007: 3.3
- 2008: 3.5
- 2009: 3.4
- 2010: 3.5
- 2011: 3.2
- 2012: 3.5
WHO Report on Substance Abuse and Health

- Teens who smoke:
  - three times more likely than nonsmokers to use alcohol,
  - eight times more likely to use marijuana,
  - 22 times more likely to use cocaine.
- Smoking is associated with a host of other risky behaviors, such as fighting and engaging in unprotected sex.
- Tobacco use continues to be the leading global cause of preventable death.
- Alcohol is the world’s third largest risk factor for disease burden; it is the leading risk factor in the Western Pacific and the Americas and the second largest in Europe.
Past Month Tobacco Use among Youths Aged 12 to 17: 2002-2012
First Specific Drug Associated with Initiation of Illicit Drug Use among Past Year Illicit Drug Initiates Aged 12 or Older: 2012

- Marijuana (65.6%)
- Pain Relievers (17.0%)
- Inhalants (6.3%)
- Tranquilizers (4.1%)
- Stimulants (3.6%)
- Hallucinogens (2.0%)
- Sedatives (1.3%)
- Cocaine (0.1%)
- Heroin (0.1%)

2.9 Million Initiates of Illicit Drugs
SUDs and Health Care

- Alcohol and drug addiction associated health care costs to American society $193 billion annually (ONDCP)
- This includes significant secondary health care costs:
  - lung disease, hepatitis, HIV/AIDS, cardiovascular disease, and cancer and mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia.
    - nine times greater risk of congestive heart failure.
    - 12 times greater risk of liver cirrhosis.
    - 12 times the risk of developing pneumonia.
- 20% of all PC visits are associated with SUD
- To often when persons with addictions have co-occurring physical illnesses, they don’t get it because it is not traditionally available in, or linked to, specialty substance abuse care.
Health Impact of Substance Abuse

- Substance abuse contributes to a number of negative health outcomes and public health problems, including:
  - Pregnancy complications
  - Teenage pregnancy
  - Sexually transmitted diseases (STDs)
  - Domestic violence
  - Child abuse
  - Motor vehicle Accidents
  - Homicide
  - Suicide
Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2012

- Did Not Feel They Needed Treatment: 94.6%
- Felt They Needed Treatment and Did Not Make an Effort: 3.7%
- Felt They Needed Treatment and Did Make an Effort: 1.7%

20.6 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use
Alcohol and Primary Care

- 94% of primary care physician failed to include substance abuse among the five diagnoses in patients with early symptoms of alcohol abuse.
- Negative beliefs about patients with substance use disorders can persist or are enhanced throughout medical school.

CASA, Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse. 2000


Eugene J. Barone, Annals of Behavioral Science and Medical Education 2011, Vol. 17, No. 1, 10-13
Integrated Care

- Integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care.
  - Improved clinical outcome and cost.
  - Back-and-forth referrals between behavioral health and primary care offices result in up to 80% of individuals not receiving care.

- Substance abuse disorders can also complicate the management of other chronic disorders.
  - Patients with HIV/AIDS who reported alcohol and drug use were more likely to be non-adherent to antiretroviral treatment.
  - Substance abuse disorders, depression, and medical comorbidities relate to poor adherence to medications to treatment
  - Many patients in specialty substance abuse settings do not have a primary care provider.
Medical Model

- Sick person seeking wellness
- SUDs as chronic diseases
  - Biological basis
  - Identifiable signs and symptoms
  - Predictable course and outcome
- Treatment improves outcomes
Prevention

- SBIRT
  - Screening
  - Brief Intervention
  - Referral to Treatment
Treatment is Effective

- SUDs common and easily identified
- Effective treatment exists
- Similar outcomes to other chronic diseases
- Transform hopelessness into optimism
Evaluation of A Hypothetical Treatment

HYPERTENSION

Symptom Severity

Pre - During - Post

Stage of Treatment

ADDICTION

Symptom Severity

Pre - Post

Just Like Hypertension, Addiction Is A Chronic Disease That Requires Continued Care—but the RESULTS are usually measured AFTER THE TREATMENT CONDITION HAS BEEN WITHDRAWN!

Source: McLellan, AT, Addiction 97, 249-252,
Medical School
Addiction Medicine Education
Addiction Medicine Education

- **Undergraduate Medical Education**: Overall, undergraduate medical education about SUDs is inadequate, inconsistently applied and generally not viewed as a high priority.

  Scott, Mental Health Services Research 2004; Mar;6(1):47-60

- National surveys of medical schools have found widespread failures to offer or require training about SUDs.

- Training that does occur rarely is integrated across the four years of undergraduate medical education, frequently omits training for tobacco intervention, and often fails to address cultural issues.

  Ferry, Journal of the American Medical Association 1999; Sep;282(9):825-829
Addiction Medicine Education

- Medical school curricula need to be examined in terms of the multiple stages traversed by a medical student on the way to acquiring the knowledge and skills needed for the good practice of medicine.
  - Traditionally, the basic sciences – where SUD education would begin – have been taught in the first two years.

- A variety of attempts have been made to establish a core curriculum for teaching about SUDs.
Coalition of Physician Educators in Substance Use Disorders - COPE

- Goal: To improve the education of all medical students about the nature of alcohol, tobacco and other drug use disorders –
  - Ranging from problematic or risky use to addiction
  - Establish that students are receiving appropriate training in the skills to: Prevent, Screen For, Diagnose, and Manage SUDs regardless of the location or specialty area the patient is seen.
COPE - Objectives

- Adequate Medical School Curriculum in Addiction Medicine is:
  - Optimal patient care
  - Appropriate Public Health Policy
  - Fiscally responsible care
COPE - Objectives

• Collaborating with Medical School in the development of core competencies.
  • What Attitude, Skills, and Knowledge of this area of patient care should be established by graduation.

• Recognition that “one size” does not fit all.

• Establish resources for reflecting the best current evidence.

• Attempts to complement other organizations (AOAAM, ASAM, AAAP, AMERSA) activities in part by informing students of the availability of addiction specialist for consultation and mentoring.
COPE – SAMHSA Regional Meetings

- SAMHSA Region collaborative meetings
  - 10 SAMHSA Regions
  - 30 Colleges of Osteopathic Medicine
  - 126 Allopathic Medical Schools
- Completed 3 regional meetings
  - Region 1 - New England (11 schools)
  - Region 5 - Great Lakes (30 schools)
  - Region 3 – Mid Atlantic (25 schools)
COPE Regional Meetings

- Participants from Osteopathic Schools
  - University of New England COM
  - Midwestern COM
  - University of Ohio COM
  - Michigan State COM
  - West Virginia COM
  - Philadelphia COM
Addiction Medicine Education

- Establish an identifiable faculty member as a leader or advocate for or director of services and education. Ideally operating from a Department of Addiction Medicine
  - Accountable for development, implementation, and maintenance of the didactic program
  - Establishment clerkships that integrate SUD knowledge into practice.

- Medical school should proactively sponsor a faculty development initiative and/or solicit the expertise from another institution.
Group 1: Creating a Faculty Resource Center

- Understand the resource needs of medical school faculty in multiple departments.
- Identify (through the curriculum survey and other means) resources that are likely to meet those needs.
- Devise a method for curating resources to assure their quality and appropriateness.
- Archive the resources in an online COPE Resource Center that is user-friendly and easy to update.
Group 1: Current initiatives

• Complete the organizational design of the Resource Center.
• Adopt a process for curating potential resources.
• Recruit volunteers to assist with collecting and curating materials.
Group 2: The Medical School Curriculum Survey - Objectives

- Identify resource needs of faculty in every department where teaching about SUDs and related disorders is relevant and appropriate.
- Identify teaching strategies and tools that faculty have developed and/or found useful.
- Make this information available to faculty at all medical schools.
Group 2: The Medical School Curriculum Survey - Rationale

- On a system-wide basis, we don’t know what’s being taught now, and in what departments and years.
- Without such knowledge, there is no way to target new resources appropriately and to match our efforts to faculty needs.
Group 2: The Medical School Curriculum Survey - Plan

- Devise a survey and pilot it in several regions.
- Solicit feedback from those who complete the survey as to ways to make it more meaningful and user-friendly.
- Revise the survey to reflect faculty input and experience gained.
- Take it to multiple departments in each school.
Group 2: The Medical School Curriculum Survey - Results

- 90% participation in regions 1, 3, 5
- Altogether, the survey contained 12 items (a 13th was added recently). The first 11 items ask whether specific subjects are part of the curriculum at the respondent’s medical school.
- Every item also contains open-ended questions asking when and how each subject is taught and what teaching resources the respondent endorses or is seeking.
Group 3: Defining Core Competencies - Objectives

- Develop a statement of core competencies for medical school graduates that can provide a framework for efforts to ensure that the undergraduate curriculum provides students with the knowledge and skills they need to address substance use disorders, regardless of their ultimate choice of specialty or practice setting.
- Promote adoption of these core competencies by U.S. medical schools.
Group 3: Defining Core Competencies - Rationale

- A statement of core competencies would clarify the information and skills needed by medical school graduates, thus bringing more coherence to the diverse approaches currently employed.
- A statement of core competencies would allow medical schools to develop their own curricula.
- Such a statement would help to focus other activities (grant funding, resource development, etc.) on the topics of highest priority for undergraduate medical education.
The existence of a statement of core competencies would put teaching about SUDs on par with other subjects addressed during the medical school years.

To the best of our knowledge, such a statement of core competencies for undergraduate medical education does not currently exist.

Current LCME standards call for 4 hours of training on SUDs, but do not specify the content of that training.
Group 3: Defining Core Competencies–Plan

- An early step will be to define the knowledge and skill sets that constitute the core competencies.
- To do so, Group 3 is collect and analyzing statements of core competency developed for other disciplines or levels of medical education (e.g., residents and practicing physicians).
Group 3: Defining Core Competencies – Plan (cont’)

Examples include:

• A report of the HRSA Physician Consortium (1991)
• A report of the Macy Conference on Medical Education (1994)
• The Project Mainstream reports (2002)
• An AMA policy statement on medical education (2007)
• An undergraduate medical education curriculum developed for the British Ministry of Health (2007)
• An undergraduate medical education curriculum developed for osteopathic medical schools in the U.S. (2010)
The core competencies identified by Group 3 and through outside field reviews will provide an organizational structure for the COPE Resource Center.
Group 3: Defining Core Competencies—Current Initiatives

• Group 3 will begin by analyzing the documents cited earlier and using them to compile a list of the knowledge areas and skill sets cited.

• While that work is under way, collection of additional statements of competency will continue.

• Use the data collected from the COPE Curriculum Surveys to identify areas of current strengths and weaknesses vis-à-vis the identified competencies.
Group 4: Medical Student Initiatives - Objectives

- Engage medical students in thinking about SUDs and related disorders as treatable medical conditions that are within their realm of interest and responsibility.
- Collect information about methods that have been used successfully to engage students.
- Stimulate and support programs that identify and intervene with medical students who exhibit risky behaviors or diagnosable SUDs.
- Build networks of interested medical students within each HHS Region.
Group 4: Medical Student Initiatives - Rationale

- One of the most frequently voiced explanations for lack of physician engagement in identifying and treating SUDs is that they “didn’t learn about it in medical school.”
- The ACA and other changes in the health care system will require a physician workforce that is better able to manage SUDs and related disorders in multiple specialty and practice settings.
- The best — in fact, the ONLY — time to reach all physicians-in-training with this information is during the medical school years.
Group 4: Medical Student Initiatives - Plan

As an initial project, Group 4 is collaborating with Group 2 to extend the reach of the Medical School Curriculum Survey.

- A student at Chicago College of Osteopathic Medicine has volunteered to administer the survey to faculty in as many departments of that school as possible.
- In addition, the student will assist the members of Groups 2 and 4 in creating a version of the survey instrument for medical students, and administering that survey to fellow students.
- Students who complete the survey will receive a Starbucks gift card as thanks for their time.
Group 4: Medical Student Initiatives - Plan

- The student will work under the direction of a faculty mentor.
- The student will be designated a "(SAMHSA)-COPE Research Scholar" in recognition of his contributions.
- If the pilot is judged to be successful, it will be replicated at schools in the three HHS Regions where COPE currently is active, with the help of other medical students and faculty mentors.
Group 4: Medical Student Initiatives - Initiatives

- Recruiting students and mentors at the various medical schools.

(A student already has volunteered for the pilot program and is ready to begin the survey process.)
Summary

- In the United States, A.T. Still predicted that the United States would have a major drug problem if physicians did not stop over-prescribing addictive drugs.
- “……… witnessed in the war and its aftermath, seeing so many men in so much pain and suffering addicted to morphine and/or alcohol, brought about a recognition that there must be a better way of treating the sick and dying. ”
- “and that alcohol abuse could lead to destructive ends.”

History of Craniosacral Therapy
Regina C. Green and Acorn Seminars, Inc.
Resources

- COPE – Coalition of Physician Educators in Substance Use Disorders - www.cope-assn.org/
- Prescriber Clinical Support System – Opiates
  - www.PCSSO.org
- Physician Clinical Support System – MAT
  - www.PCSSMAT.org