Change the Things We Can:
Establishing Core Competencies in Addiction Medicine

2015 Joint AACOM & AODME Annual Conference

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Session Objectives

- Explain why it is important **all physicians**, especially those in primary care, **demonstrate competency** in knowledge, skills and attitudes regarding **the biomedical and behavioral constructs of addiction**.

- Describe a **set of competencies in addiction medicine** under construction that may **guide development of curriculum, instruction and assessment**.

- Construct **sample Core Entrustable Professional Activities for Entering Residency** in addiction medicine that could serve as an addendum to CEPAER.
Rationale for Addressing Substance Use Disorders
How important is this to my primary care practice?

- 20% of patients meet criteria for an SUD or are risk drinkers (Robbins NL, Arch. Gen Psych, 1984, 41:949-958, Manwell et al. 1998)

- 40% of all trauma is associated with alcohol (Rehm J, Lancet 2009, Vol.373)

- 6% of pregnant women have a substance use problem.

- 6% of 12th graders smoke marijuana daily, 20% have binged drank in the past 2 weeks. (Monitoring the Future, Univ. of Michigan, 2014)

- Less than 20% of PC physicians described themselves as very prepared to identify alcoholism or illegal drug use. CASA, Columbia University, 2012
Selected Clinical Disorders with Higher Prevalence in SUD Patients


*P<0.05, Year before index visit

Substance abusing patients = 747
Matched controls = 3,690
Selected Clinical Disorders with Higher Prevalence in SUD Patients

Percent

- Injuries / Overdose
- Depression
- Anxiety

Substance abusing patients = 747
Matched controls = 3,690

Distribution of Selected Opioids to US Pharmacies

Figure 1
Deaths per 100,000 related to unintentional overdose and annual sales of prescription opioids by year, 1990 - 2006

Source: Paulozzi, CDC, Congressional testimony, 2007
# Costs of the Disease

<table>
<thead>
<tr>
<th></th>
<th>Health Care</th>
<th>Total Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>$96 Billion</td>
<td>$193 Billion</td>
</tr>
<tr>
<td>Alcohol</td>
<td>$30 Billion</td>
<td>$235 Billion</td>
</tr>
<tr>
<td>Illicit Drugs</td>
<td>$11 Billion</td>
<td>$193 Billion</td>
</tr>
</tbody>
</table>
Monitoring The Future Study

Long Term Annual Trends in Prevalence

Perceived Risk of Marijuana Smoked Occasionally
Monitoring the Future Study

[Graph showing trends for Marijuana and Cigarettes from 1976 to 2014.]
Addiction as a Chronic Disease

- Patients present with the problem
- SUDs as chronic diseases
  - Biological basis
  - Identifiable signs and symptoms
  - Predictable course and outcome
- Treatment improves outcomes
Effects of High-Risk Drinking

- Numb, tingling toes.
- Painful nerves.
- Impaired sensation leading to falls.
- Inflammation of the pancreas.
- Vitamin deficiency.
- Bleeding.
- Severe inflammation of the stomach.
- Malnutrition.
- Cancer of throat and mouth
- Premature aging.
- Drinker's nose.
- Frequent colds.
- Weakness of heart muscle.
- Heart failure.
- Anemia.
- Impaired blood clotting.
- Breast cancer.
- Impaired sexual performance.
- Fetal alcohol syndrome.
- Aggressive, irrational behavior.
- Arguments.
- Violence.
- Nervousness.
- Alcohol dependence.
- Memory loss
- Ulcer.
- Vomiting.
- Diarrhea.
- Liver damage.
- Trembling hands.
- Tingling fingers.
- Numbness.
- Painful nerves.
- Trauma
- Reduced resistance to infection.
- Depression.
Top Drivers World Wide Morbidity and Mortality

WHO

1. Tobacco
2. Diet and Exercise
3. Alcohol
It works—EVEN WHEN the results are measured ‘one year post treatment’:

- 67% reduction in weekly cocaine use
- 65% reduction in weekly heroin use
- 52% reduction in heavy alcohol use
- 61% reduction in illegal activity
- 46% reduction in suicidal ideation

(Hubbard RL, 1997 DATOS data)
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!

Current Treatment Model

- Often managed in separate specialty areas with poor collaboration and/or communication.
  - addiction care
  - general medical care
  - psychiatric care

- This is a result of:
  - Professional training
  - Philosophical

- Results in:
  - Fragmented and episodic care
  - Parallel/redundant/inefficient

- Sub-optimal clinical outcomes

Samet, Friedmann and Saitz, Archives of Internal Medicine, 161:85-91, 2001
Chronic Care Model of Disease

- CDM care is associated with higher odds of:
  - addiction pharmacotherapy
  - mutual help group attendance
  - self-management plan
  - specialty addiction treatment utilization
Addiction as a Chronic Disease

The National Institutes of Health and the Institute of Medicine

- Encouraging organized medicine to make addiction a high priority.
- Like other chronic diseases, there is a role for both primary care physicians and referral to specialists when their expertise is needed to establish treatment initiatives and maintain ongoing care.
Coalition on Physician Education in Substance Use Disorders (COPE)


COPE's Goal:
- To improve the education of all medical students about the nature of alcohol and other drug use disorders (AOD).
- To help medical school faculty access the resources they need to provide their students with appropriate training in how to prevent, screen for, diagnose and manage AOD.
- To help the students recognize they will improve the health of their patients through improved education in addiction medicine regardless of the location or specialty in which they ultimately practice.
Coalition on Physician Education in Substance Use Disorders (COPE)

Benefits:
- Patients who are at risk for or experiencing problems with AOD benefit from early identification and intervention
- Good public policy; Economic and Societal
- Health Care Value, reducing overall health care costs while improving outcomes.

COPE supports and complements the work of organizations whose goal is to prepare the next generation of addiction specialists by ensuring that all medical students understand how to seek consultation from, or refer patients to, addiction specialists whenever appropriate.
COPE and SAMHSA have co-sponsored Medical Education Summits to bring together faculty from medical schools in HHS Regions I (New England), III (Mid-Atlantic States) and V (Great Lakes States). COPE has taken the lead in planning each of these Summits.

Region IV (Southeast) scheduled for May, 2015

Four work groups:
- Creating a Faculty Resource Center
- Medical School Curriculum Survey
- Defining Core Competencies
- Medical School Initiatives
The Coalition on Physician Education in Substance Use Disorders, LLC (COPE) is a voluntary organization devoted to improving patient care and the public health by assuring that all physicians are trained to prevent, identify, and provide specialty-appropriate interventions for patients who use tobacco or illicit drugs, or who engage in unhealthy use of alcohol or non-medical use of prescription medications.

http://www.cope-assn.org/
Think- Pair- Share

How are substance use disorders addressed in the educational program at your medical school?
Curriculum Survey
Project Rationale

- On a system-wide basis, there is no central source of information as to what is 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.
Curriculum Survey
Project 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.
Progress to Date

- The survey has been administered at medical schools in HHS Regions I (New England), III (Mid-Atlantic) and V (Great Lakes states).
- Excellent response rate – approaching 80% of medical schools.
- The survey instrument has been tweaked to reflect feedback from users.
## Survey Results to Date

<table>
<thead>
<tr>
<th>Topic</th>
<th>Percent of schools that include in curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic science/ pharmacology</td>
<td>98</td>
</tr>
<tr>
<td>Screening/brief intervention</td>
<td>91</td>
</tr>
<tr>
<td>Psychiatric disorders related to SUD</td>
<td>80</td>
</tr>
<tr>
<td>Medical disorders related to SUD</td>
<td>78</td>
</tr>
<tr>
<td>Referral to specialized treatment</td>
<td>78</td>
</tr>
<tr>
<td>Safe Prescribing</td>
<td>61</td>
</tr>
<tr>
<td>Adolescent/young adult and SUD</td>
<td>57</td>
</tr>
</tbody>
</table>
Survey Results to Date (cont’d.)

- Identify **core competencies**
- Develop **model curricula**
- **Compile and vet teaching materials** in a user-friendly Resource Center
Work Group on Core Competencies

**Attitude**
- Empathy
- Respect
- Receptive

**Skill/Behavior**
- Brief intervention/Motivational Interviewing
- Screening Tools
- Treatment Planning (Keep it on the problem list!)
  - Literature Available
  - Medication delivery protocols

**Knowledge**
- Origins of SUDs
- Prevalence
- Medical and Mental Health Indicators.
- Treatment options
TARGET OUTCOMES – KNOWLEDGE ➔ Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences relative to substance use and abuse, and the disease of addiction and how to apply them to basic patient care

• Summarize the basic neuroscience of addiction
• Explain the disease model of addiction, including basic underlying causes such as genetic factors and environmental influences
• Relate the natural history of addiction as a chronic disease
• Describe the risk factors for SUDs and addiction
• Know the effects of drugs of abuse
• Generate possible differential diagnoses
• Describe the steps in managing addiction as a chronic disease
• Identify sources for appropriate guidelines for patient care
• Know the basic pharmacotherapy for the treatment of addiction and SUDs, specifically in alcoholism and opioid dependence and addiction
• Recognize the proper prescribing of drugs in the treatment of addiction and SUDs
• Identify resources in the community to support patient care
• Summarize the epidemiology of SUDs in the general population
• Exhibit prescribing practices that result in the health and safety of the patient, society, and the physician, including prescription drug abuse and the role of physicians in reducing prescription diversion.
TARGET OUTCOMES – SKILLS ➔ provide patient care that is compassionate, appropriate, and effective for the treatment of addiction and SUDs and the promotion of health

- Screen for SUDs; Brief Intervention
- Recognize indications of possible diagnosis
- Conduct basic patient interview
- Perform appropriate physical exam
- Interpret basic lab findings
- Refer to appropriate providers and/or resources
- Assess potential role of SUDs in other illnesses
- Conduct motivational interview
- Present a clear explanation to the patient of why the patient presents with illness of addiction
- Present a clear explanation to the patient of how SUD contributes to other disease
- Give clear and compassionate advice to patient
- Prescribe appropriate medications
- Collect information from other providers
- Identify, critique and use resources that support quality patient care
- Identify own areas of weakness, research them and present them
TARGET OUTCOMES – ATTITUDES

Demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals, and demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

• Optimism that addiction can be managed like any chronic disease
• Empathy
• Non-judgmental stance
• Non-paternalistic/ maternalistic
• Respect for patient as partner in patient care
• Recognize own biases/ prejudices and work to transcend them
• Demonstrate professional responsibility for self, others, profession and community
<table>
<thead>
<tr>
<th><strong>OSTEOPATHIC PRINCIPLES &amp; PRACTICE</strong></th>
<th><strong>MEDICAL KNOWLEDGE</strong></th>
<th><strong>PATIENT CARE</strong></th>
<th><strong>INTERPERSONAL &amp; COMMUNICATION SKILLS</strong></th>
<th><strong>PROFESSIONALISM</strong></th>
<th><strong>PRACTICE-BASED LEARNING &amp; IMPROVEMENT</strong></th>
<th><strong>SYSTEMS-BASED PRACTICE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Summarize the basic neuroscience of addiction</td>
<td>Explain the effects of drugs of abuse</td>
<td>Conduct basic patient interview</td>
<td>Display optimism that addiction can be managed like any chronic disease</td>
<td>Exhibit prescribing practices that result in the health and safety of the patient, society, and the physician, including prescription drug abuse and the role of physicians in reducing prescription diversion</td>
<td>Identify resources in the community to support patient care</td>
<td></td>
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<tr>
<td>Explain the disease model of addiction, including basic underlying causes such as genetic factors and environmental influences</td>
<td>Generate possible differential diagnoses</td>
<td>Integrate basic screening for SUDs</td>
<td>Demonstrate a non-judgmental stance</td>
<td>Assess potential role of SUDs in other illnesses</td>
<td>Summarize the epidemiology of SUDs in the general population</td>
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<td>Relate the natural history of addiction as a chronic disease</td>
<td>Describe the steps in managing addiction as a chronic disease</td>
<td>Give clear and compassionate advice to patient</td>
<td>Show respect for patient as partner in patient care</td>
<td>Recognize own biases/prejudices and work to transcend them</td>
<td>Refer to appropriate providers and/or resources</td>
<td></td>
</tr>
<tr>
<td>Describe the risk factors for SUDs and addiction</td>
<td>Identify sources for appropriate guidelines for patient care</td>
<td>Express empathy</td>
<td>Demonstrate professional responsibility for self, others, profession and community</td>
<td>Identify, critique and use resources that support quality patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Know the basic pharmacotherapy for the treatment of addiction and SUDs, specifically in alcoholism and opioid dependence and addiction</td>
<td>Recognize indications of possible diagnosis</td>
<td>Perform appropriate physical exam</td>
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<td>Recognize the proper prescribing of drugs in the treatment of addiction and SUDs</td>
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<td>Interpret basic lab findings</td>
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Potential Assessments

- Multiple Choice Exams
- Reflective Essays
- OSCE/ Simulated Patients
- Core Entrustable Professional Activity? A la AAMC*
# Core Entrustable Professional Activities for Entering Residency

<table>
<thead>
<tr>
<th>EPAs</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td>• Well-known as the basis for assessment in GME</td>
</tr>
<tr>
<td>• Meaningful to faculty, learners &amp; the public</td>
<td>• Holistically define “what a good doctor should know &amp; be able to do”</td>
</tr>
<tr>
<td>• Grounded in the actual work professionals do</td>
<td>• Extensive literature base in Medical Knowledge &amp; Patient Care</td>
</tr>
<tr>
<td>• Translate competencies into the clinical setting</td>
<td>• Milestones developed or in progress for GME</td>
</tr>
<tr>
<td>• Make assessment practical</td>
<td></td>
</tr>
<tr>
<td>• Trust/supervision specified</td>
<td></td>
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</tbody>
</table>

| **Drawbacks**                                   | • Abstract                                                                   |
| • Recent introduction in literature             | • Don’t reflect how clinicians think about learners                         |
| • Few examples of implementation                |                                                                              |
| • Originally conceptualized as bases for transitioning to practice |                                                                              |

Adapted from AAMC November 2014
Core Entrustable Professional Activities for Entering Residency*

- **EPA 1**: Gather a history and perform a physical examination
- **EPA 2**: Prioritize a differential diagnosis following a clinical encounter
- **EPA 3**: Recommend and interpret common diagnostic and screening tests
- **EPA 4**: Enter and discuss orders and prescriptions
- **EPA 5**: Document a clinical encounter in the patient
- **EPA 6**: Provide an oral presentation of a clinical encounter
- **EPA 7**: Form clinical questions and retrieve evidence to advance patient care
- **EPA 8**: Give or receive a patient handover to transition care responsibility
- **EPA 9**: Collaborate as a member of an interprofessional team
- **EPA 10**: Recognize a patient requiring urgent or emergent care and initiate evaluation and management.
- **EPA 11**: Obtain informed consent for tests and/or procedures
- **EPA 12**: Perform general procedures of a physician
- **EPA 13**: Identify system failures and contribute to a culture of safety and improvement

Retrieved from AAMC November 2014
Core Entrustable Professional Activities for Entering Residency*

**EPA 1: Gather a history and perform a physical exam**

- In small groups, choosing *two or three items from the COPE competency list*, create:
  - Additional expected observable behaviors for the Entrustable learner
  - Additional expected observable behaviors for the Pre Entrustable learner
  - If there’s time, design a vignette that illustrates what an Entrustable learner might look like in a clinical setting

<table>
<thead>
<tr>
<th>Competency</th>
<th>PreEntrustable</th>
<th>Entrustable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems-Based Practice:</td>
<td>Knows little or nothing about resources in the community to which the patient can be referred</td>
<td>Shares knowledge of community support groups (AA, NA) and/ or learning activities (local library, etc.) and gives patient pamphlets and other materials to facilitate access</td>
</tr>
</tbody>
</table>
Review Session Objectives:
Did this session enable you to:

☐ Explain why it is important all physicians, especially those in primary care, demonstrate competency in knowledge, skills and attitudes regarding the biomedical and behavioral constructs of addiction.

☐ Describe a set of competencies in addiction medicine under construction that may guide development of curriculum, instruction and assessment.

☐ Construct sample Core Entrustable Professional Activities for Entering Residency in addiction medicine that could serve as an addendum to CEPAER.
Resources

• American Osteopathic Academy of Addiction Medicine
  www.aoaam.org

• American Society Of Addiction Medicine
  www.asam.org

• NIDA
  www.drugabuse.gov/

• NIAAA
  www.NIAAA.nih.gov/

• 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 – Buprenorphine
  www.PCSSMAT.org
References