Foundation *for* Opioid Response Efforts

Program Advisory Meeting Summary

MEDICAL EDUCATION AND TRAINING

June 26, 2019

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Program Advisory Meeting: Medical Education and Training

Note: This summary is not intended to be a consensus document, but instead represents the breadth of discussion and guidance provided to FORE during the meeting. The use of the term "participants" does not imply majority agreement.

Executive Summary

On June 26, 2019, the Foundation for Opioid Response Efforts (FORE) convened a program advisory meeting at their offices in New York, NY, to explore opportunities in medical education and training related to preventing, screening, and treating opioid use disorder (OUD).

Advisory participants were asked to enhance FORE's understanding of this issue by identifying what is currently being done, where the greatest needs are, what the current challenges are to address those needs, and how FORE can make the greatest impact. The challenges identified were:

- medical school funding and time constraints;
- stigma;
- lack of educational experiences that offer patient interactions and skills building; and
- requirements limiting the ability to prescribe buprenorphine.

Participants were asked for recommendations and guidance on the role that FORE could play in supporting work to advance this area through grantmaking, convening, partnerships, and information dissemination. Participants' recommendations included:

- advancing educational and training models that help reduce stigma and bias toward patients with addiction, including through community-based training; and
- funding opioid addiction "term chairs" at medical schools to provide protected time for highly qualified individuals at the junior faculty level.
- supporting interdisciplinary training;
- funding a certificate program in pain management and addiction;

Participants stressed the importance of increasing opportunities for medical students and residents to have practical training with patients so they can see firsthand the impacts of OUD and results of treatment. This exposure may encourage them to consider addiction medicine in their future practice.

Additionally, participants were asked to provide guidance on areas of work or topics that FORE should avoid because they may not provide added value or impact. Many participants cautioned FORE against duplicating efforts already underway, having too narrow a focus, or focusing too much on technology as a solution.

Introduction

FORE leaders began the Advisory Meeting with a brief presentation on the foundation's origins, vision, and mission, as well as its primary focus areas, which include provider education. FORE leaders said they will contribute to ending the opioid epidemic through grant support that will broaden and amplify current successful and promising activities, be centered around patient needs related to the full spectrum of OUD and explore new solutions.

I. MEDICAL EDUCATION AND TRAINING

A. Addiction Medicine Training

The discussion began with the observation that—while there are educational and training activities on OUD treatment occurring around the country—there is still significant opportunity to expand such training, as well as training in addiction medicine more broadly, in medical schools and residency programs. Multiple participants recommended that medical schools provide, as part of their curriculum, education on the waiver requirements under the Drug Addiction Treatment Act of 2000 (DATA 2000) so that new physicians will enter their residencies with a common, core knowledge on medication-based treatment (MBT)[1] and will be positioned to apply for a waiver to prescribe buprenorphine for OUD.

Preferred models of education would include course work, small group and active learning modules, clinical experiences treating OUD, an objective structured clinical examination (OSCE), and opportunities to practice within interdisciplinary teams. For example, the program at the University of North Carolina (UNC) includes DATA 2000 waiver training and MBT clinical experience as a core part of undergraduate medical curriculum. A full curriculum on addiction medicine is also incorporated into the first two years of medical school, as eight separate learning modules. Participants also noted that proper prescribing of opioids is part of a mandatory third-year clerkship program at Rowan University School of Osteopathic Medicine.

Additional examples of ways in which addiction medicine is included as part of residency training include:

- George Washington University (GWU) requires all residents to be trained in administering buprenorphine, and
- University of Washington offers to all residents, but does not mandate, training in administering buprenorphine.

Participants identified several considerations in implementing training in medical schools and residency programs. First, participants questioned whether such training should be given all at once or integrated into the curriculum throughout the full course of study or training program.

[1] *While the term medication-assisted treatment (MAT) is widely used to describe the combination of FDA-approved medication and behavioral health supports, for the purposes of this document and discussion, we will use the term medication-based treatment (MBT) to reflect the significance of medication in a patient's treatment plan.*

Also, while schools and residency programs may incorporate MBT training into their curriculum, participants were concerned that some do not provide clinical experiences that would allow students and residents to practice this skillset and build confidence in using it.

Furthermore, there is no standardized curriculum across all U.S. medical schools; even if addiction content were incorporated into one curriculum, there would still be many others without it. Participants discussed whether a requirement from the Liaison Committee on Medical Education (LCME) or the Accreditation Council for Graduate Medical Education (ACGME) would lead to more standardized training in addiction medicine across schools. Some participants pointed out that LCME and ACGME cannot tell medical schools how and what to teach, but they can develop standards and expectations. It was noted that deans do respond to requirements from these organizations. For example, ACGME developed common program requirements on pain and addiction last year (effective July 2019) and is now looking at gaps in training and potential resources to fill them. It plans to have recommendations and make resources available to program directors to set expectations. ACGME, however, will still need help from specialty organizations to align institutions and develop an action plan for successful implementation.

Critically, trained and expert faculty are needed. Participants expressed concern that many faculty members currently lack the required expertise. Many are not trained to treat individuals with OUD and do not possess a DATA 2000 waiver. Faculty members are also under pressure to engage in clinical care and research and may not have time to take on additional training and responsibilities. Moreover, training can be a years-long, expensive process—making many medical schools and hospitals loath to take on the costs without a clear revenue source from such an investment. Therefore, faculty training often requires outside funding.

Participants also said that having to obtain separate training (i.e., through the buprenorphine waiver process) to treat individuals with OUD perpetuates the stigma against patients. Participants recommended that medical students and residents be trained to treat individuals with buprenorphine just as they are trained to treat individuals with any other medication, such as insulin or anti-hypertensives. Additionally, they questioned whether the training should go beyond OUD and address all addictions. While we are in the midst of an opioid epidemic, the next epidemic could involve substances such as amphetamines or benzodiazepines, and individuals will need to be trained on how to identify and treat those SUDs as well.

Key Stakeholders in Medical Education and Training

Participants noted the following organizations are important stakeholders and potential partners:

- **ACGME** accredits sponsoring institutions and fellowship and residency programs, offers recognition for identified elements of these graduate medical programs, and provides resources to initiatives impacting graduate medical education.
- **American Board of Medical Specialties (ABMS)** works with 24 specialty member boards to maintain the certification standards for physicians.

- **Association of American Medical Colleges (AAMC)** focuses on transforming health care in four primary mission areas: medical education; patient care; medical research; and diversity, inclusion, and equity in health care. AAMC also develops the Medical College Admissions Test (MCAT) and sets the accreditation standards for medical schools.
- **The Federation of State Medical Boards (FSMB)** supports U.S. state medical boards in licensing and verifying credentials of physicians, as well as disciplining and regulating medical professionals.
- **Liaison Committee on Medical Education (LCME)** is the accrediting body for Doctor of Medicine (M.D. granting) programs in the U.S. and Canada.
- **The National Academy of Medicine (NAM)** is a private, nonprofit institution that works outside of the government to provide objective advice on matters of health. NAM has partnered with over 100 organizations to create the *Action Collaborative on Countering the U.S. Opioid Epidemic*, a unique public–private system of sharing knowledge and aligning initiatives related to complex solutions to the opioid crisis.

B. Pain Management Training

In addition to addiction medicine training, participants highlighted the need for pain management training for medical students, residents, and faculty. Currently, medical schools vastly differ in the scope of training for pain management, but there was agreement that attention to pain management has generally been insufficient. There is a need for robust training on the treatment of pain that incorporates how to use the full spectrum of treatments that are alternatives to opioids as well as how to use opioids appropriately. Training is also needed on how to overcome the stigma related to individuals who need treatment with opioids; how to speak with patients about pain, including non-pharmacologic pain management; and how to help patients who may need pain management but also have an OUD or misuse opioids. Participants acknowledged that such training and curricular changes are costly, and schools and hospitals currently do not have financial incentives to fund them. A subsequent Program Advisory Meeting organized by FORE focused specifically on the clinical practice of pain management.

C. Interdisciplinary Training

Participants repeatedly stressed the importance of interdisciplinary training for the treatment of OUD and pain. As is the case with treatment, training on pain management and OUD is fragmented. Physician education and training are typically separate from training for nurses, social workers, behavioral health specialists, pharmacists, and other prescribers such as nurse practitioners (NPs), physician assistants (PAs), and dentists. Yet effective management of addiction requires a team approach. Future training, therefore, should allow clinicians and other health care professionals to gain experience in team-based models of care.

Interdisciplinary training is often difficult to implement for multiple reasons. Medical, dental, nursing, and other schools may be proprietary about their own training, and clinicians who provide MBT may not be faculty at these schools.

To overcome these obstacles, participants suggested:

- Incorporating Project ECHO (Extension for Community Healthcare Outcomes) into schools and residencies. Project ECHO has networks led by a team of interdisciplinary experts (the "hub") who use videoconferencing to conduct virtual clinics with community providers (the "spokes"). In this way, primary care providers, nurses, and other clinicians learn how to provide specialty care in their communities. Community providers also contribute to the learning community by sharing best practices.[2] The model can bring together students, residents, fellows, and faculty to participate as part of the "hub" or "spokes." Some schools, including UNC, have already incorporated Project ECHO into their curriculum.

- Such training could combine in-person and online training. The University of Washington, for example, provides online training and mentoring on integrative mental health care to fully licensed psychiatric physicians, NPs, and PAs through a year-long online and in-person program. The participants can then immediately apply the skills they obtained in their clinical settings.

D. Humanism and Experiential Training

Participants expressed concern that—even if addiction medicine training is incorporated into medical schools or residency programs—it may be years before medical students and residents use these skills in clinical practice. Having personal interactions with patients coping with addiction, and learning their personal and medical history, can destigmatize OUD. Therefore, participants stressed that it is important to ensure that medical students and residents gain hands-on experience with patients with OUD early in their education and training.

E. Stigma and Bias Training

Throughout the meeting, participants expressed concerns that the stigma of OUD may be perpetuated among patients, clinicians, and the public. For example, clinicians may think OUD patients will be difficult, time-consuming, unlikely to follow through on a treatment plan, and/or unlikely to get better. Not addressing stigma as part of training misses the opportunity to promote patient-centered care and may discourage students and physicians from pursuing training in addiction medicine or taking care of these patients in their specialty of choice.

Participants highlighted the need for efforts to reduce stigma across the continuum of education, training and practice, among undergraduate medical students, residents, and clinical faculty, and across all disciplines including primary care providers, pediatricians, psychiatrists, and other specialist physicians. They stated that while the DATA 2000 law, which separates buprenorphine prescribing from other treatment by requiring waivers, may perpetuate stigma, the training itself can be an opportunity to reduce biases and stigma. Offering DATA 2000 trainings to medical students along with an OSCE may help to reduce stigma. Such a course could include a simulation of how to treat a patient with OUD in a holistic, patient centered manner.

[2] https://echo.unm.edu/; https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/project-echo.html

Participants noted that such trainings should focus on how to use compassionate, non-stigmatizing words. They also stated that the patients' voices and lived experiences should be included in such trainings to humanize the disease, and that stigma must be discussed in relation to racism and other types of bias. One person suggested OUD training could be accompanied by training on cultural competencies and the social determinants of health. While participants acknowledged that such trainings require funding, they also noted that schools are actively seeking ways to train students on humanism. This topic could be presented as such.

Participants also identified a deficiency in faculty understanding of OUD as a contributor to biases and stigma and a barrier to implementing effective courses in medical schools. As such, faculty must receive appropriate training as well.

Participants also suggested giving residents opportunities to learn how to treat OUD patients effectively over a significant time period; this could improve residents' understanding of the disease progression and impact of treatment. Residents may miss seeing patients improve if they rotate frequently between clinical settings. It may be helpful to extend the length of rotations involving addiction treatment to allow residents to witness what successful treatment looks like. For example, UNC has a six-month clinic. Participants said that a 12-month clinic would provide even greater opportunity for residents to see the outcomes of treatment.

Another strong option would be to provide opportunities to treat patients with OUD within a trainee's continuity clinic, which would give trainees ownership of patients' care and let them see their progression over the course of years. At the University of Washington, as well as other residencies, concerted efforts are being made to provide those opportunities within internal medicine, family medicine, and psychiatric residency continuity clinics. This would also normalize OUD treatment as part of residents' scope of practice and regular care. This normalization may not happen if residents are exposed to OUD treatment only within a special rotation.

Participants also expressed interest in reducing the stigma regarding OUD among patients, their families, and the public at large. They noted that while there are many informational materials available on nicotine treatment, there are few educational materials on OUD treatment. It is important to teach members of the public that OUD is a chronic brain disease and that patients do not have to address it on their own. In particular, participants noted the importance of destigmatizing relapse among both providers and patients. Participants advocated for an awareness campaign similar to "Act Up," which helped reduce the stigma of the AIDS epidemic in the 1980s. They also suggested that a shift was needed among groups such as Narcotics Anonymous and Alcoholics Anonymous so that their leaders teach participants that they have a disease rather than a moral failing.

Other suggestions to reduce stigma included conducting research and collecting data to understand implicit bias. Respondents questioned whether SUD was a topic in the implicit association test (IAT) and were interested in creating a module on SUDs and mental health if one does not exist. Such training could be incorporated into OSCE. They also suggested launching a social media campaign around the broader issues of stigma, fostering regional collaboration, sharing resources among institutions, and developing simulation resources.

One participant mentioned that trauma plays a major part in OUD, especially among women. Tools need to be further developed to assess and address OUD and underlying trauma, and clinician education and training need to incorporate this content.

In summary, an ideal education and training approach to address stigma related to OUD would include the following:

- ability to see behavior modeled at the "bedside";
- increased experience in outpatient settings;
- ability to see patients get better;
- a safe learning environment;
- faculty trained to teach appropriately; and
- a SUD module as part of implicit bias training.

F. Expanding Education and Training Capacity

1. Certificate Programs

Participants also discussed the benefits of creating standardized content related to OUD for a continuing medical education specialty certificate. Such certification programs could be offered to clinicians in different disciplines, through a school, academic medical center, or independent organization. The programs could span one to two years and combine online and in-person training. The certification could incorporate interdisciplinary training. An online program could make the program accessible to people in rural areas. While the certification program would not be accredited, it could be implemented more quickly and cheaply than a standardized curriculum in every medical school and hospital.

Additionally, such certification could have multiple benefits for practitioners and patients. Participants said such a certification would provide practitioners with an attractive credential for prospective employers. Patients could also feel confident that their practitioner has appropriate training to treat their disease. A certification program could also result in champions that could eventually develop an OUD curriculum in their medical schools and hospitals. Participants suggested that ongoing support for certification might be funded by the Centers for Medicare and Medicaid Services, insurers, or states.

An example of such an approach is the Education in Palliative and End-of-Life Care (EPEC) Program, based at Northwestern School of Medicine. The program, initiated in 1997, educates health professionals in the "essential clinical competencies of palliative and end-of-life care" as a way of integrating palliative care medicine into broader clinical practice. It is designed as case-based training; rather than making participants into specialists, it aims to help them understand palliative care principles and resources.

2. Junior Faculty Development – Addiction Medicine Chairs

Participants discussed the need to develop faculty early in their careers to become leaders in this field by teaching and mentoring them in treatment of OUD. Yet, they acknowledged that current medical school and hospital financial models often do not provide appropriate support for junior faculty members to teach or mentor students and residents in treatment of OUD. Given this challenge, participants discussed developing and funding a cohort of addiction medicine chairs for a term of up to five years. The funding could be tied to innovation in curriculum, clinical services, outcomes, and expectations. Funding a cohort of chairs would increase collaboration across schools and encourage sharing of best practices. Participants also suggested that schools and hospitals may be interested in using the outcomes of this program as part of promotion criteria.

Additionally, some participants stated that making the chair a prestigious position would entice more faculty to apply for it. Others cautioned against excluding lesser-known schools, where the need for capacity building may be even greater.

3. Creating or Expanding Addiction Medicine Fellowships

FORE asked participants about the need to create or expand addiction medicine fellowships across the country. It was noted that some medical centers lack such fellowships, and others may only offer them to a limited number of people and for a limited amount of time. Participants identified cost and revenues as the main barriers to creating these fellowship programs. Hospitals, not medical schools, receive funding for fellowships; therefore, hospitals determine which fellowships they will implement and fund. Hospitals receive revenue generated from the clinical care provided by fellows. Therefore, hospitals are incentivized to fund fellowships for programs such as surgery that will likely generate significant revenue, but not for programs such as primary care or addiction medicine that are less likely to do so. Additionally, fellowships are expensive to operate, with costs ranging from $165,000 to $195,000 a year per fellow. Given these barriers and funding constraints, many participants said that often the only way to create or expand an addiction medicine fellowship would be through outside funding specifically dedicated to it. While these programs cannot be funded by FORE in perpetuity, there is value in getting such a program started so that it can generate revenue, which could help sustain the program for years to come.

4. Include Nurse Practitioners and Physician Assistants

Participants noted that many fellowship and training programs are designed only for physicians and cannot be accessed by NPs and PAs. Yet, NPs and PAs can now treat individuals with OUD with buprenorphine and are a growing source of treatment in rural areas, where addiction specialists may not be available. There is interest in creating addiction medicine fellowships for these providers; funding programs to train more NPs and PAs may expand addiction treatment capacity fairly quickly.

5. Exams, Licensing, and Related Regulatory Approaches

Participants discussed ideas to address the current gaps in OUD training in standardized or regulatory approaches. Some participants suggested adding questions about identifying and treating pain and OUD to board certifications and licensing exams, noting that this strategy helped promote training in palliative care. Others acknowledged that often students memorize information for such exams and fail to implement new skills into their practice. Therefore, exam questions themselves may not translate into practitioners treating individuals with OUD.

Participants also suggested the development of registries for practitioners to assess their treatment practices. For example, a registry could compile dates of treatment, the type of treatment provided, whether the patient has insurance, urine drug screening results, and whether such results were reviewed properly. Such registries could also be used by practitioners to evaluate their own practice in caring for individuals across the spectrum of pain and addiction and prompt them to make changes to improve, including by seeking appropriate training. Such registries are used to improve clinical practice for other chronic diseases. Some participants pointed out that there are privacy concerns with registries, so they must be considered or developed carefully. Others also pointed out that improvements in technology do not necessarily lead to more effective care.

One participant suggested that FORE conduct a systematic literature review of the 30 to 40 studies that address current gaps in medical education, suggest best practices, and use the results as a basis to develop recommendations and build partnerships.

II. POTENTIAL OPPORTUNITIES AND ACTIONS FOR FORE TO CONSIDER

FORE asked each attendee to identify projects that FORE could consider supporting or undertaking to address the issues discussed at this meeting. Their suggestions included the following:

Communication / Information Sharing

- Identify exemplars of community-based learning and disseminate findings across schools and programs, which could reduce the stigma of OUD and promote interdisciplinary learning;
- Incorporate addiction medicine into current interdisciplinary models (e.g., collaborative care; chronic disease management; patient-centered medical homes; and health homes);
- Communicate the concept that treatment works;
- Develop a social media campaign to educate people on appropriate pain and addiction terminology, which could help reduce stigma and encourage treatment;
- Support literature review of current gaps in medical education and training;
- Conduct a study of the funding constraints associated with incorporating interdisciplinary, multispecialty training into medical schools and hospitals and provide policy recommendations to help overcome them; and

- Conduct a study of the return on investment for providing OUD treatment and broadly disseminate the results.

Medical School and Residency Curriculum

- Programs that incorporate medical students and residents into Project ECHO programs for real-world clinical training;
- An interdisciplinary training on the DATA 2000 waiver process for medical schools and support for schools that offer such a training as part of their core curriculum; and
- A longitudinal addiction treatment clinic for residents to gain experience and see the results of treatment. This could be incorporated into residents' continuity clinics.

Expanding Educational and Training Capacity

- Develop a standard, one- to two-year continuing medical education certification program that could be offered across disciplines and specialties for the treatment of OUD;
- Establish a prize to recognize, reward, and bolster those who have already done exemplary work and serve as a beacon for others;
- Fund term chairs at medical schools for up to five years, with funding tied to innovation in curriculum, clinical service, and evaluating outcomes; and
- Award long-term grants to support organizations that offer pain and addiction training for students, residents, fellows, and faculty but currently have limited funding.

Addressing Stigma and Bias

- A training on OUD for first responders and emergency department practitioners to reduce stigma and provide basic intervention or care navigation skills;
- An IAT for SUDs that would analyze and address bias, and an OSCE as a hands-on, real-world approach to test clinical performance and competence;
- Awareness campaign to educate students, residents, and faculty on nomenclature and compassionate, non-stigmatizing words;
- A social media campaign addressing stigma around addiction;
- Informational materials that explain that OUD is a chronic, relapsing brain disease; and
- Programs that offer practical, patient-centered training to reduce biases and stigma related to OUD.

III. ACTIONS FOR FORE TO AVOID

FORE leaders asked attendees for suggestions on what they should not do. Attendees advised against the following:

- Duplicating efforts. Instead, the organization should partner with existing organizations engaged in high-quality work or focus on projects that are not already being done;
- Having too narrow of a focus. Participants urged FORE to go beyond OUD and address broader treatment of all SUDs. Additionally, incentives should also address the broader pain continuum, and any effort must be across disciplines and specialties;
- Focusing too much on technology. Participants argued that improving technology does not necessarily translate into more practitioners who are willing and able to treat SUDs; and
- Focusing on incorporating test questions into the board and licensing exams. Instead, participants recommended focusing on increasing practical training with real patients so practitioners can see firsthand results.

IV. ATTENDEES

The following individuals attended the program advisory meeting. FORE is grateful for their time and contributions. Their participation in the meeting does not constitute their endorsement of this document.

Attendees:

- Chair: Risa Lavizzo-Mourey, M.D., M.B.A., Professor of Medicine at the University of Pennsylvania; Former CEO of the Robert Wood Johnson Foundation
- Hoover Adger, M.D., Professor of Pediatrics, Addiction Specialist at Johns Hopkins;
- Helen Burstin, M.D., M.P.H., Executive Vice President and CEO for the Council of Medical Specialty Societies; Associate Clinical Professor of Medicine, George Washington University
- John Combes, M.D., Senior Vice President for Policy, Accreditation Council for Graduate Medical Education
- Mark Duncan, M.D., Co-Medical Director, Psychiatry and Addiction Case Conference and Assistant Professor of Psychiatry and Behavioral Sciences, University of Washington
- John Franklin, M.D., Associate Dean, Northwestern Medical School
- Richard Jermyn, D.O., F.A.A.P.R.M., Professor and Chair, Department of Rehabilitation Medicine, Rowan University
- Robyn Jordan, M.D., Ph.D., Medical Director of Project ECHO; Clinical Assistant Professor at University of North Carolina

FORE Staff and Consultant:

- Karen A. Scott, M.D., M.P.H., President, FORE;
- Shibani Gambhir, M.P.A., Chief Operating Officer, FORE;
- Ken Shatzkes, Ph.D., Senior Program Officer, FORE;
- Lydia Tschoe, M.H.A., Program Assistant, FORE; and
- Shruti Kulkarni, Esq., Senior Associate, DCBA Law & Policy.