STFM 2010 Spring Conference **Lecture-Discussion:** 30 minutes lecture, 15 minutes discussion

Presenters: Ken Saffier, MD, Natasha Pinto, MD, MS

2010 Theme: "LEAD the Way: Leadership, Education, and Advocacy Development to Create a Patient-centered Medical Home".

**Title:** From Homeless to having a Medical Home: Buprenorphine treatment and resident education about opioid addiction

**Abstract**

Often literally homeless, opioid addicted patients frequently want to stop their drug use, but recurrent withdrawal, lack of treatment resources and access often prevent recovery from addiction. With the introduction of buprenorphine, often described as a “miracle drug” by many patients, treatment has become accessible and another opportunity for residents and staff to learn about addiction as a chronic disease. Buprenorphine group visits have become the foundation of a new patient-centered medical home, building stable relationships between these patients and family medicine residents and practitioners. We describe how patients’ first hand experiences with addiction and recovery motivates new patients to enter buprenorphine treatment. We also demonstrate a powerful learning tool using patients to educate a new generation of physicians to be competent and empathic.

**Behavioral objectives**

By the end of this presentation, participants will be able to:

1. Explain how buprenorphine, a partial opioid agonist, works as a treatment for opioid addiction.
2. Witness and understand how recovering patients’ in-person or video accounts can be formative educational experiences for both patients and family medicine residents.
3. Explain how buprenorphine group visits help create a patient-centered medical home for opioid addicted patients.
4. Demonstrate a positive attitude toward patients with addictive disease and its treatment.

**Background and knowledge gap**

This presentation will be attractive to family medicine educators because it combines innovative teaching techniques using video and live patient experiences to teach residents. It also describes treatment for a population of patients who are often under-diagnosed and often inadequately treated. With increases in opioid pain medication abuse, often inadvertently promoted by well-meaning physicians, this presentation describes how to teach residents about a useful therapy for these often challenging patients. Although buprenorphine is becoming recognized as a valuable tool to treat opioid addiction, there are few examples in the literature and in practice that describe its use and how it can be taught. The need is certainly there and family practitioners can definitely help meet this need.

Approximately 3 million people in the United States are harmfully dependent on opioid medications from medical or illicit sources. The majority do not receive therapy even though there are effective treatments for opioid addiction.

Since the passage of the Drug Abuse Treatment Act of 2000, a new medication, buprenorphine, became available in 2003 for the treatment of heroin and other opioid addictions. It can be used in an office based setting by physicians who attend an approved training course. Unfortunately, despite the overwhelming evidence that buprenorphine can be an effective treatment for the disease of opioid dependence, many patients who would benefit from this therapy do not have access to it, despite the approximately 10,000 physicians qualified to prescribe buprenorphine as of 2006 (Fiellin, 2007).

Effective means to motivate and assist physicians to prescribe buprenorphine are needed to promote this therapy to appropriate patients with opioid use disorders. An extremely powerful means to teach residents is to use live, first person accounts of recovering patients. In a seminar, video clips of a patient’s experiences as part of PowerPoint presentations in combination with a live patient have been consistently well received by residents and medical staff. Examining the effectiveness of this technique is the subject of a research project that will end September, 2009, one year after such a seminar. This study will measure resident attitudes and treatment referrals and the results will be available by the Spring STFM conference.

Group visits with buprenorphine patients have been employed over the past 2 years in our county-funded health system. As with teaching residents, personal patient accounts are extremely powerful and effective in engaging new and returning patients. These group visits have effectively become their patient-centered medical home. Patients have a regular, familiar therapeutic milieu where they can consistently receive support, education, brief counseling and their medication. Patients new to this treatment can be expertly oriented and introduced to this therapy by others who previously experienced the uniformly uncomfortable induction process that requires them to be in moderate to severe opioid withdrawal before taking their first dose. The timely encouragement and knowledge offered is invaluable for patients as well as residents who are learning about this treatment and the disease of addiction. During these facilitated group visits, there is a wealth of learning for all participants. Patients enthusiastically teach other patients as well as the physician and resident who lead the group.

Due to its popularity with patients and our limited resources, we are expanding this venue for several reasons. Although more patients (6-8) can be seen in an hour-long group visit than individually (4-5), the compelling advantage of group visits is their power and effectiveness. With this positive learning experience, residents are encouraged to take the on-line or formal CME course in buprenorphine to become “qualified” by the DEA to prescribe this drug during and then after their residency. More importantly, they will experience how addiction is a treatable chronic disease in which they can play an integral part to help their patients and families.

Reference:

Fiellin, D.A., The first three years of buprenorphine in the United States: Experience to date and future directions, J Addict Med. 2007;1:62-67.

**Substance of presentation**

After brief introductions and overview of this presentation, there will be two parts. The first will consist of PowerPoint excerpts from a resident seminar that will be presented and discussed. Embedded in the excerpts to be presented are three 1 – 2 minute video clips of a patient’s experience being addicted to OxyContin® that describe key points of the patient’s experience and reinforce how buprenorphine works. Importantly, this patient’s history describes how people who are addicted, think and behave in the throes of their addictive disease so we can better understand and be empathic as they struggle with their illness. The content of the video clips reinforce the basic science and psychopharmacology which will be briefly summarized for those unfamiliar with this medication. An interactive dialogue will be encouraged as occurs in the resident seminar with participants reflecting on this patient’s (and their other patients’) experiences and which can address their questions. Although the patient will not be present, one presenter (KS) will role play the patient and provide answers to participants’ questions about the patient’s experience. Involving other participants’ experiences and thoughts will enrich the formal content. Participants will also learn from this discussion the nature of the chronic illness that is characterized by addiction. The results of our soon to be completed educational study about this seminar will be briefly summarized.

The second section of this presentation will be a brief summary of how our group visits function to educate new patients as well as residents, one of whom will be present to share her experiences. The structure and content of the group visits will be described. We will share the challenges and joys of seeing patients (usually) improve in the context of these group visits. Data of how the groups have grown and what kinds of patients are referred and how they enter treatment will be summarized.

For the remainder of this presentation, we hope to hear others’ experiences with this treatment modality and training residents in its use as well as their reactions to the teaching modalities described. If not already a part of other programs’ curricula, we would like to encourage residency programs to make this a required part of training. We agree with the recommendation to have at least one faculty “champion” in addiction medicine which will help promote residents becoming “qualified” prescribers.

**Teaching methods employed**

For the first part, we will use a case-based presentation, consisting of examples of “mini”-lectures using PowerPoint, with integrated video clips to encourage reflection, discussion and to illustrate basic addiction and treatment issues. Questions about the case will be offered at strategic points in the presentation to stimulate reflection and discussion. A brief role-play will be used to simulate a live patient’s participation.

A resident who has taken the qualifying course and has participated in the buprenorphine groups will describe and discuss her experiences in learning about buprenorphine treatment from patients in this group setting. She will also identify what is needed by residents and physicians, in general, to consider prescribing buprenorphine in an office-based setting.

For the final 10 minutes we will ask for others’ experiences and questions to explore these educational and content issues further.

**Format justification**

The key teaching points and the demonstration of the educational process can be adequately achieved in 30 minutes. The additional time will be spent encouraging discussion and answering questions.

**Timeline**

Introductions and background of audience 3 minutes

Overview and review of learning objectives 5 minutes

Case presentation with PowerPoint and

 video clips 15 minutes

Buprenorphine group therapy 10 minutes

Questions/answers/discussion 10 minutes

Summary and additional resources 2 minutes

**Ken Saffier**, **MD**, is a family physician with Contra Costa Regional Medical Center’s FMR and specializes in addiction medicine and chronic pain management.  He graduated from SUNY at Stony Brook School of Medicine and completed his residency at Chicago’s Cook County Hospital.  In 2008, he completed a faculty development fellowship at USC’s Division of Medical Education. He is Clinical Professor, Department of Family and Community Medicine, University of California, San Francisco. He is interested in promoting faculty and curriculum development in addiction medicine and is active in the California Society of Addiction Medicine. He is certified by the American Society of Addiction Medicine.

**Natasha Pinto, MD, MS**

I am a California board-certified family medicine physician working at Richmond Health Center as part of the Contra Costa County system. I did my residency at the Contra Costa Family Medicine program based in Martinez and graduated in June 2010. I received my MD and MS from the UC Berkeley-UC San Francisco Joint Medical Program.