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Expanding Access To “Medication Assisted Treatment” for Opioid Use Disorders to Patients in the Hospital

Christopher Welsh M.D.
Associate Professor
Department of Psychiatry
University of Maryland School of Medicine
Contents

• Terms
• Epidemiology
• History of treatment of Opioid Use Disorder
• The Law & Opioids
• OUD in the Hospital
  – Psychiatric Inpatient - Consult Liaison
  – Emergency Department - Psychiatric ED
• Education on OUD
Confusing Terms

- Addiction
- Dependence/Dependency/Substance Dependence
- Use
- Misuse
- Abuse
- Risky/At-risk Use
- Problematic Use
- Non-medical Use
- Non-prescribed Use
- Illicit Use
- Illicit Use of a Licit Substance
- Healthy Experimentation
Other Terms

ADDICT
LOSER
JUNKIE
DRUGGIE
Dope Fiend
USER
SWAF
Alchie
shooter
DRUNK
Injector
WINO
Dirty
“Go ahead ... treat me like dirt.”
>74,000 total fatalities
Opioid Involvement in Cocaine Overdose

- Deaths Involving Cocaine
- Cocaine in Combination with Any Opioid
- Cocaine Only

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths Involving Cocaine in Combination with Non-Methadone Opioid Synthetics

Source: National Center for Health Statistics, CDC Wonder

2,282 total fatalities
NATIONAL RATE OF OPIOID-RELATED INPATIENT STAYS AND EMERGENCY DEPARTMENT VISITS, 2005-2014

64.1% cumulative increase
5.7% average annual growth rate

99.4% cumulative increase
8.0% average annual growth rate
RATE OF OPIOID-RELATED EMERGENCY DEPARTMENT VISITS BY STATE, 2014

- Massachusetts: 450.2
- Maryland: 393.7
- Rhode Island: 368.8
- District of Columbia: 352.2
- New York: 337.5
- West Virginia: 349.3
- Connecticut: 333.5
- Washington: 328.8
- Oregon: 312.2
- Illinois: 306.5
- Maine: 300.6
- Ohio: 292.9
- New Jersey: 288.7
- Pennsylvania: 285.1
- Kentucky: 280.4
- Missouri: 261.4
- Tennessee: 251.6
- Minnesota: 247.2
- Arizona: 247.0
- Florida: 254.9
- Michigan: 229.6
- North Carolina: 226.6
- New Mexico: 220.0
- Montana: 215.4
- Wisconsin: 213.6
- Utah: 212.8
- Vermont: 204.4
- Indiana: 203.3
- Tennessee: 196.5
- Minnesota: 186.1
- Hawaii: 174.1
- California: 168.3
- Colorado: 156.5
- Nevada: 141.5
- Virginia: 139.3
- North Dakota: 130.3
- South Dakota: 120.3
- Georgia: 119.5
- Kansas: 104.3
- Arkansas: 96.7
- South Dakota: 78.6
- Nebraska: 72.7
- Iowa: 45.1

RATE OF OPIOID-RELATED INPATIENT STAYS BY STATE, 2014

- Maryland: 483.8
- Massachusetts: 393.7
- District of Columbia: 368.8
- Rhode Island: 352.2
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- New Mexico: 220.0
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- Wisconsin: 213.6
- Utah: 212.8
- Vermont: 204.4
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- Iowa: 45.1
PEOPLE CAN CHANGE
PEOPLE CAN CHANGE
ADDICTION IS TREATABLE!!!
Maintenance Medications For OUD

• FDA Approved
  – Methadone (Methadose; Dolophine)
  – Buprenorphine (Suboxone; Suboxone Film; Subutex; Bunavail; Zubsolv; Sublocade)
  – Naltrexone (Trexan; Vivitrol)

• Experimental/Not Approved
  – Ibogaine
  – Heroin
  – Hydromorphone
“I received a note from her when she had used this. She was much encouraged and had ordered two pounds more... I saw her recently when she assured me that she had no desire for morphine.”

Dr. W.H. Bentley

_Detroit Therapeutic Gazette, 1880_ 

-about a woman for whom he prescribed one pound of cocaine for morphine addiction-
MORPHINE, OPIUM, COCAINE
AND ALL OTHER DRUG HABITS
PERMANENTLY CURED IN 10 TO 15 DAYS!
NO HYPODERMICS USED.

Our care antidotes and eliminates all Nervous Poisons from the system, revives and restores the dormant nerve cells, clears and strengthens the mind, and the broken-down and debilitated patient is reinvigorated and rebuilt into a strong and healthy being again.

We positively guarantee to cure any case of Morphine, Opium, Codine, Chloroform, Chloral, Cocaine, or other Drug habit, in from ten to fifteen days, without causing the patient the slightest sickness or pain. Patients need not pay one cent until satisfied in their own minds that they are cured.

LIQUOR HABIT-DRUNKENNESS-CURED IN ONE WEEK
NO HYPODERMICS USED.

We positively guarantee to cure the Liquor Habit, Drunkenness in one week, without the least sickness, confinement of any kind or effect. Our cure consists of a specific which is absolutely harmless, yet speedy and certain in its action, and it is the only cure known to modern science which permanently removes all need, craving or desire for whisky, beer, wine or other alcoholic stimulants. It makes them see all the advantages of the sober state and serves the patient in perfect health, physically and mentally. After a case has been effected the smell of liquor becomes extremely offensive and the taste sickening and disgusting.

Dr. F. H. Kuykendall, who was formerly on the staff of physicians of Dr. Leslie L. Kuykendall, and who has made a careful study of the methods for the Liquor Habit at the various leading sanatoriums of the country, writes as follows of the success of the Patient of the Magnetic Springs Sanatorium:

"The cure is a complete one, and the patient is permanently cured of his Laugher's Disease. I have had experience in treating many cases of this nature, and I can assure you that this is the most successful method I have ever tried. The patient was discharged from the hospital cured of his habit and has returned to his work with renewed energy."

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C. A. REED, M. D., Medical Director, Box 616, EUREKA SPRINGS, ARKANSAS.

Sanatorium for Convalescents, for Persons in Search of Rest, for Patients suffering from Nervous Weakness, Disturbances of the Digestive System, Inflammation of the Stomach and Bowels, Diabetic, Rheumatism, Infections, and all other diseases and ailments which are not cured by Habit, but which are not. The Magnetic Springs Sanatorium is equipped with every modern improvement and convenience. A competent staff of physicians is always in attendance under the direction of Dr. C. A. Reed, the medical director. Full information concerning the treatment, terms, etc., can be obtained by addressing:

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C. A. REED, M. D., Medical Director, Box 616, EUREKA SPRINGS, ARKANSAS.
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PROTARGOL

QUINALGEN

HEROIN
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LYCETOL
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FARBEFABRIKEN OF ELBERFELD CO.
40 STONE ST
NEW YORK.
Opioids and the Law

- Harrison Narcotics Act (1914)
- Narcotic Addict Treatment Act (1974)
- Comprehensive Addiction & Recovery Act (CARA) (2016)
The Harrison Narcotics Act (1914)
“The shallow pretense that drug addiction is “a disease” which the specialist must be allowed to “treat,” which pretended treatment consists of supplying victims with the drug has caused their physical and moral debauchery...”

American Medical Association
Report of the Committee on the Narcotic Drug Situation, 1920
A Medical Treatment for Diacetylmorphine (Heroin) Addiction

A Clinical Trial With Methadone Hydrochloride

Vincent P. Dole, MD, and Marie Nynanider, MD

A group of 22 patients, previously addicted to diacetylmorphine (heroin), have been stabilized with oral methadone hydrochloride. This medication appears to have two useful effects: (1) relief of narcotic hunger, and (2) induction of sufficient tolerance to block the euphoric effect of an average illegal dose of diacetylmorphine. With this medication, and a comprehensive program of rehabilitation, patients have shown marked improvement: they have returned to school, obtained jobs, and have become reconciled with their families. Medical and psychometric tests have disclosed no signs of toxicity, apart from constipation. This treatment requires careful medical supervision and many social services. In our opinion, both the medication and the supporting program are essential.

The question of “maintenance treatment” of addicts is one that is often argued but seldom clearly defined. If this procedure is conceived as no more than an unsupervised distribution of narcotic drugs to addicts for self-administration of doses and at times of their choosing, then few physicians could accept it as proper medical practice. An uncontrolled supply of drugs would trap confirmed addicts in a closed world of drug taking, and tend to spread addiction. This procedure certainly would not qualify as “maintenance” in a medical sense. Uncontrolled distribution is mentioned here only to reject it, and to emphasize the distinction between distribution and medical prescription. The question at issue in the present study was whether a narcotic medicine, prescribed by physicians as part of a treatment program, could help in the return of addict patients to normal society.

No definitive study of medical maintenance has yet been reported. The Council on Mental Health of the American Medical Association, after a thorough review of evidence available in 1957, concluded that “The advisability of establishing clinics or some equivalent system to dispense opiates to addicts cannot be settled on the basis of objective facts. Any position taken is necessarily based in part on opinion, and on this question opinions are divided.” With respect to previous trials of maintenance treatment, the Council found that “Assessment of the operations of the narcotic dispensaries between 1919 and 1923 is difficult because of the paucity of published material. Much of the small amount of data that is available is not sufficiently objective to be of great value in formulating any clear-cut opinion of the purpose of the clinics, the way in which they operated, or the results attained.” No new studies bearing on the question of maintenance treatment have appeared in the eight years since this report was published. Meanwhile, various medical and legal committees have called for additional research.

See also page 673.

The present study, conducted under the auspices of the departments of health and hospitals, New York City, has yielded encouraging results; patients who before treatment appeared hopelessly addicted are now engaged in useful occupations and are not using diacetylmorphine (heroin). As measured by social performance, these patients have ceased to be addicts. It must be emphasized that this paper is only a progress report, based on treatment of 22 patients for periods of 1 to 15 months. Such limited study obviously does not establish a new treatment for general application. The results, however, appear sufficiently promising to justify further trial of the procedure on a larger scale.

Procedure

The patients admitted to the program to date were men, aged 19 to 37, “mainline” diacetylmorphine users for several years with history of failures.
Comprehensive Drug Abuse Prevention and Control Act of 1970

- “Controlled Substances Act”
- Effectively replaced all previous laws dealing with “narcotic”/dangerous drugs
- Established a commission on marijuana and substance use disorders.
- Divided drugs into 5 “schedules”
Comprehensive Drug Abuse Prevention and Control Act of 1970

• Generally, there are 2 requirements that a practitioner must meet if they wish to “administer or dispense directly ... a narcotic drug listed in any schedule to a narcotic dependent person for the purpose of maintenance or detoxification treatment . . .”
  1. Practitioner must be separately registered with the DEA as a narcotic treatment program.
  2. Practitioner must be in compliance with DEA regulations, including those for treatment qualifications, security, records, and unsupervised use of the drugs
     – 2 exceptions
Relief of Acute Withdrawal Exception

- The “3-day rule” provides an exception to the CSA.
- Title 21 C.F.R. § 1306.07
- allows a physician to “administer (but not prescribe) narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. However, the prescriber may not administer more than one day’s medication at one time and such treatment may not last for more than 3 days; no renewals or extensions of that period are permitted.”

- Applies in out-patient and Emergency Department settings
Incidental Adjunct Exception

- The “adjunct rule” provides an exception to the CSA.
- Title 21 C.F.R. § 1306.07
- allows “a physician or authorized hospital staff to administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction, or to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible or none has been found after reasonable efforts.”
- Unclear if this applies in the Emergency Department setting
- Generally does not apply in sub-acute hospital setting
Narcotic Addict Treatment Act (1974)

• Primarily spells out requirements for methadone programs
• Added a provision for “Use of narcotic drugs in hospitals”:
  – “For hospitalized patients, the use of a narcotic drug for
    narcotic addict treatment may be administered or
    dispensed only for detoxification treatment....This does not
    preclude the maintenance treatment of a patient who is
    hospitalized for treatment of medical conditions other
    than addiction and who requires temporary maintenance
    treatment during critical period of his or her stay or whose
    enrollment in a program which has approval for
    maintenance treatment using narcotic drugs has been
    verified.”
Narcotic Addict Treatment Act (1974)

• Any hospital which already has received approval under this paragraph may serve as a temporary narcotic treatment program when an approved treatment program has been terminated and there is no other facility immediately available in the area to provide narcotic drug treatment for the patients.
Drug Abuse Treatment Act Of 2000

Section 3502 of The Children’s Health Act of 2000
Schedule III, IV, and V medications* (Buprenorphine) approved for detoxification and maintenance

Allows:

**physicians to prescribe** (in office-based setting) & **pharmacists to dispense** “narcotics”, specifically buprenorphine, to treat opioid addiction

*does not apply to methadone or other opioids that are Schedule II
Comprehensive Addiction & Recovery Act (CARA) 2016

Allows:

Nurse practitioners and physicians assistants to prescribe buprenorphine (requires extra training)

Allows certified addiction specialists to treat 275 patients at a time (with extra reporting requirements)
Full Agonist Activity Levels

Increasing full agonist dose produces increasing mu opioid receptor specific activity.

Full Agonist (e.g. heroin)

Mu Receptor Intrinsic Activity

%
Partial Agonist Activity Levels

- **Mu Receptor Intrinsic Activity**

  - Full Agonist (e.g. heroin)
  - Partial Agonist (e.g. buprenorphine)

  - Like full agonists, partial agonist drugs produce increasing mu opioid receptor specific activity at lower doses.

  - But due to its “ceiling” maximum opioid agonist effect is never achieved.

  - Drug Dose: no drug, low dose, high dose.
Opioid antagonists bind and occupy µ opioid receptors but result in no specific intrinsic activity regardless of dose.

Antagonist (e.g. naloxone)
Opioid Use Disorder Management Applied Across Different Hospital Settings
Med/Surg Hospitalization

- Identifying patients with opioid use disorder can be an initial barrier to care.
- Identifying withdrawal
  - Clinical Opioid Withdrawal Scale, the Subjective Opioid Withdrawal Scale and the Objective Opioid Withdrawal Scale.
- Choosing how to treat withdrawal should consider
  - The patient’s preference for MAT
  - Potential adverse effects (QTc prolongation; drug-drug interaction)
  - Availability for follow-up
- Initiation of opioid agonist therapy during an acute hospital admission reduces AMA discharges and increases chances of transition to long-term outpatient addiction treatment.
Buprenorphine Outpatient Outcomes Project: can Suboxone be a viable outpatient option for heroin addiction?

Charmani D. Sittambalam, MD,* Radhika Vij, MD, and Robert P. Ferguson, MD

Abstract

Background

Opioid dependence treatment traditionally involves methadone clinics, for which dispensing schedules can be cumbersome. Buprenorphine, a partial agonist of the mu receptor and antagonist of the kappa receptor, is a potential outpatient alternative to methadone. Funded by a grant from the State of Maryland's Community Health Resources Commission (CHRC), the Buprenorphine Outpatient Outcomes Project (BOOP) evaluates the outcome of Suboxone (buprenorphine/naloxone) treatment on abstinence from heroin use, rates of emergency room visits and hospitalizations, legal issues, and quality of life.

Methods

Active heroin users were recruited between June 2007 and June 2010 and induction therapy with Suboxone was instituted during hospitalization. Once discharged, patients were followed as outpatients for maintenance treatment and counseling. Data were collected from electronic medical records, Maryland state legal records, and SF-36® Health Surveys regarding several parameters and patients were categorized according to duration of treatment with Suboxone into one of three groups: <1 month, 1–3 months, and >3 months.

Results
Hospital Buprenorphine Induction

• 220 patients enrolled
• 38% remained in treatment for 1 month, 17% for > 3 months
• During the year following enrollment compared to the year prior to enrollment:
  • ED visits decreased by 23%
  • Hospitalizations decreased by 45%
Med/Surg Hospitalization

- Pain Management
- If the patient’s future plans include buprenorphine
  - Short acting opioids alone
  - Buprenorphine +/- short acting (given buprenorphine's high affinity it mostly blocks other opioids)
  - Split Buprenorphine to TID
- If patient’s future plans include methadone maintenance
  - Initiate methadone (or cont if already on) +/- additional short-acting opioids titrated to pain.
  - Split the patient’s daily methadone dose into TID
Buprenorphine & Pain

• In-patient
  – the CSA exception allows any opioid to be used.

• Out-patient
  – The formulations FDA approved for treatment of OUD can be used off label for the management of pain.
  – The formulations FDA approved for treatment of pain can not be used to treat OUD (per DATA 2000)
Vignette #1

• CJ is a 28yo female with a hx of opioid use d/o, and cocaine use d/o who presents to the ED with chest pain, fever and chills.
• She reports she “speedballs” around $100/day and has for past 4-5 years. In this time she has not had more than a day of abstinence and experiences significant withdrawal symptoms. She has never been on maintenance treatment. Her last use of heroin was minutes before coming to the hospital.
• She is found to have bacterial endocarditis and is being admitted to the hospital for 6 weeks of IV antibiotics. She will likely go to a sub-acute nursing facility (SNF)
SNFs

• AKA:
  – Sub-acute Nursing Facilities
  – Skilled Nursing Facilities
  – Long-term Care Facilities
  – Nursing homes
  – “rehab” (not the SUD treatment kind)

• SNFs traditionally do not fall under the “adjunct exception.”
  – Murky DEA status
Vignette #2

- 54 y.o. female
- Admitted to hospital for pneumonia
- No significant Medical Hx; denies other meds
- Reports being on methadone 40mg/day for past 3 years; receives 13 “take-homes”
- Clinic is called and confirms the dose & that patient received 13 “take-homes” 3 days prior
- Medical team starts patient on 40mg/day
- Following day, patient is sedated with slowed respirations & constricted pupils
Psychiatric Hospitalization

• Substance use disorders are DSM identified disorders, however, patients do not typically meet criteria for inpatient psychiatry units for SUD alone
  – Varies by state

• Many patients have co-morbid SUD with their other psychiatric illnesses
Vignette #3

• BT is a 57 yo CM with hx of MDD and OUD, admitted to psychiatry after a suicide attempt by overdose on heroin/fentanyl (patient had some hypoxic brain injury).

• Patient was treated with SSRIs and underwent ECT. He agreed to “MAT” and was started on Suboxone, titrated to 12mg daily.

• Aftercare placement was very difficult. After several weeks, he was accepted at a recovery house program but they did not accept patient’s on Suboxone. He underwent a Suboxone taper prior to discharge.
NALTREXONE
Vignette #4

• RM is a 50 y.o. male with hx of Schizophrenia admitted for worsening psychosis.
• Also with hx of heroin use disorder; on methadone 100mg daily
• His Quetiapine is increased over several days from 300mg to 600mg qhs
• Begins to experience lightheadedness, palpitations and has an episode of syncope
• QTc is found to be 610msec
Emergency Department

• **SBIRT alone is not generally effective** for drugs
  – need a treatment approach that utilizes early initiation of pharmacotherapy in combination with psychosocial approaches.

• **ED initiated buprenorphine treatment** can result in significantly decreased opioid use, increased engagement in outpatient substance abuse treatment, and decreased use of inpatient addiction services.

• Several “Models”
Yale ED-Initiated Bup Study

• 3 Groups
  – ED-initiated buprenorphine (BUP) w/ 3-day prescription and referral to primary care buprenorphine provider
  – Brief intervention (BI) and facilitated referral to drug treatment
  – Simple referral (REF) to drug treatment
• Engagement in treatment at 30 days
  – BUP Group  78%*
  – BI Group  45%
  – REF Group  37%
• Self-Reported Illicit Opioid Use (days per week)
  – BUP Group  5.4 to 0.9*
  – BI Group  5.6 to 2.4
  – REF Group  5.4 to 2.3
• Urine Toxicology Negative for Opioids at 30 days
  – BUP Group  58%
  – BI Group  43%
  – REF Group  54%

*statistically significant

D’Onofrio, et al. JAMA; 2015  313(16): 1636–
## ED-Initiated Buprenorphine
### Baltimore City (2/17-4/18)

<table>
<thead>
<tr>
<th>Buprenorphine Data Elements</th>
<th>Hospital 1</th>
<th>Hospital 2</th>
<th>Hospital 3</th>
<th>Hospital 4</th>
<th>Hospital 5</th>
<th>Hospital 6</th>
<th>Hospital 7</th>
<th>Total</th>
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<tbody>
<tr>
<td>Number of months using buprenorphine protocol</td>
<td>14</td>
<td>13</td>
<td>12</td>
<td>12</td>
<td>11</td>
<td>9</td>
<td>1</td>
<td></td>
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<tr>
<td>Number of candidates identified in ED</td>
<td>79</td>
<td>32</td>
<td>31</td>
<td>18</td>
<td>182</td>
<td>72</td>
<td>4</td>
<td>418</td>
</tr>
<tr>
<td>Number of patients receiving buprenorphine &amp; referred to treatment</td>
<td>17</td>
<td>18</td>
<td>16</td>
<td>16</td>
<td>160</td>
<td>53</td>
<td>2</td>
<td>282</td>
</tr>
<tr>
<td>Number of patients who entered outpatient treatment</td>
<td>9 (52.9%)</td>
<td>10 (55.6%)</td>
<td>10 (62.5%)</td>
<td>8 (505)</td>
<td>92 (57.5%)</td>
<td>46 (86.8%)</td>
<td>2 (100%)</td>
<td>177 (62.8%)</td>
</tr>
</tbody>
</table>
Expanding buprenorphine access is a key step in Baltimore's long struggle against addiction.

As the scourge of addiction continues to claim hundreds of lives in Baltimore City, health officials are racing to expand access to buprenorphine, a medication that blocks addicts' craving for heroin and other opioids. There's no silver bullet to solve the

---

**The New York Times**

This E.R. Treats Opioid Addiction on Demand. That's Very Rare.

---

**Mainebiz**

Mid Coast Hospital is first in Maine to prescribe Suboxone in ER

---

**Medical News**

MGH Becomes 1st Mass. ER To Offer Addiction Medication, Maps Seamless Path To Recovery

---

**Daily News**

Syracuse doctor puts ER on front line of opioid epidemic

---

**New York Times**

By James T. Mulder, jmulder@syracuse.com

SYRACUSE, N.Y. - Dr. Ross Sullivan used to tell heroin and painkiller overdose patients in Upstate University Hospital's emergency room to stop using drugs and go to local addiction treatment programs for help.
Hospital-based safe consumption site to open in Edmonton next week

Facility at Royal Alexandra designed to help inpatients who use drugs

CBC News · Posted: Mar 27, 2018 1:14 PM MT | Last Updated: March 27

A safe consumption site will open Monday for inpatients at Edmonton's Royal Alexandra Hospital. (Emilio Avalos/CBC)
Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder
Hospital Levels of Care

On April 30, Mayor Catherine E. Pugh and Health Commissioner Dr. Leana Wen joined the leadership of Baltimore City’s 11 acute-care hospitals to launch the Levels of Care for Baltimore City Hospitals Responding to the Opioid Epidemic. Now open for public comment.
Academic Medicine’s Response to THE OPIOID EPIDEMIC

Through their missions of education, research, and clinical care, medical schools and teaching hospitals are actively responding to this public health crisis and preparing the next generation of health care professionals to address the epidemic.

Integrating Content Throughout Medical Education

Each medical school tailors its curriculum within the framework required by the Liaison Committee on Medical Education (LCME), the accrediting body for medical education programs. This dynamic structure ensures consistent baseline standards among all medical schools, while allowing programs to adapt education to the individual needs of the communities and the populations the schools serve. Medical school faculty introduce substance abuse or pain management subjects in preclinical coursework, then reinforce content through multiple instructional methods as students advance through medical school. According to the LCME’s 2015–2016 Annual Medical School Questionnaire:

» 139 of 142 medical schools with students enrolled reported that content on “substance abuse” was included in a required course, with 140 teaching the content in pre-clerkship courses and 132 teaching it in one or more required clerkships
time for questions
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