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CHIME PODCAST
SCRIPT (Discussion Outline)

JANET:

Welcome to our podcast, **Addressing Stigma in the Treatment of Opioid and Substance Use Disorder** with Dr. Sarah Porter. This podcast is one in a series organized through CHIME's Opioid Task Force and Action Center. CHIME, which stands for the College of Healthcare Information Management Executives, is a professional organization for chief information officers and other senior healthcare IT leaders.

The CHIME Opioid Task Force (OTF) was launched in early 2018 with a simple mission: to turn the tide on the opioid epidemic using the knowledge and expertise of the nation's healthcare IT leaders. The CHIME Opioid Action Center is an online source that provides a wealth of informational resources.

My name is Janet Desroche. I am an Associate Vice President at MEDITECH and have the privilege of being a member of the CHIME opioid task force. I am pleased and honored to be joined by Dr. Sarah Porter today for a discussion concerning the stigma associated with opioid and substance use disorder, how stigma can create barriers to effective treatment and recovery, and Dr. Porter's insights on how we can improve. We'll also be exploring how the EHR, technology and data can be a catalyst for positive change.

According to recent provisional data from the CDC, more than 83,000 drug overdose deaths occurred in the United States in the 12 months ending in June 2020, the highest number of overdose deaths ever recorded in a 12-month period, and an increase of over 21% compared to the previous year.[1]

Furthermore, in a paper published this past November by the National Academy of Medicine titled "Combatting the Stigma of Addiction - The need for a Comprehensive Health System Approach"[2], the authors point out that not only is the the opioid epidemic raging within the

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[1] https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[2] https://nam.edu/combatting-the-stigma-of-addiction-the-need-for-a-comprehensive-health-system-approach/

COVID-19 pandemic, with more than 40 states reporting increases in opioid-related overdoses and deaths but certain marginalized populations are being disproportionately affected. Stigma is a major factor and barrier. Stigma is a pervasive force alienating those who experience addiction from medical care and recovery support. Pre-COVID-19, only 10 percent of those with SUDs received treatment, contributing to the 70,000 annual deaths from drug overdose, of which more than two-thirds are opioid-related. The pandemic has exacerbated the weaknesses of an already fragile system—a system rife with both individual and structural stigma against patients and medications for treatment—that many individuals with opioid use disorder (OUD) found difficult to enter and navigate. The need to address stigma has never been more pressing.

Dr. Sarah Porter, our guest today, is a physician leader from Southern Ohio Medical Center in Portsmouth, Ohio - the focal point of Sam Quinones book Dreamland (A True Tale of America's Epidemic) which chronicles the opioid crisis and its real impact on people, families and communities. She has been the Senior Medical Director of Family Practice with SOMC since 2015, where she supports 16 locations of primary care. Dr. Porter is a member of SOMC's Physician Informatics Committee and believes strongly in clinical standardization across the organization. She has also been a part of numerous quality improvement initiatives. Dr. Porter is the mother of five children which is amazing particularly when you hear her story and the connection to the opioid crisis.

Dr. Porter - why is this topic of the opioid epidemic and specifically the issue of stigma so important to you? How does it relate to where you work and live?

DR. PORTER:

You mentioned Dreamland. The **Dreamland** in the title of Sam Quinones book was the name of a company built swimming pool in Portsmouth, Ohio, a typical company town in the industrial heartland of America. We're in Portsmouth and Portsmouth is a main character in the book, and we are seen as the epicenter of the opioid epidemic due to a lot of different reasons. This is not just SOMC's journey but a personal journey as well. I'm going to preface that because you are going to hear a lot about my failures.

In looking at data back from 2012, you could see that we were in a hot spot in terms of # of opioid prescriptions per person - the area where Ohio, Kentucky and West Virginia come together. How did that happen?

In 1996, when oxycontin was first introduced, it was aggressively marketed to the Appalachian region because there are a lot of laborers, a lot of miners, a lot of injuries, and it was seen as something that would not be addictive, which we clearly know is not true now. Also, the first pill

mill was in South Shore, Kentucky, which is directly across the river from Portsmouth, Ohio.

And then in 2002, pain became the fifth vital sign by the joint commission. We all began to focus on treating pain, and treating pain with pills. And then of course, the increased availability of heroin from Mexico, which targeted rural America and suburbia. This is all kind of a culmination and the truth is if you haven't read Dreamland, that is a concise overview of the book.

So because of the increased prescriptions, we also ended up with a significant number of overdoses.

Kentucky, West Virginia and Ohio, they rank up there in the top, even in 2019, we were still in a significant problem area. I can't express how rural we really are, except to know that the community that I serve, the county that I practice in has about 16,000 people. This is what's happening and it's devastating our communities.

The national overdose deaths continue to climb. We had been climbing and then in 2018, there was a little bit of a dip but in 2019 and definitely in 2020, those numbers are going up even more. And so, when looking at opioids, you have to really understand where we're at to know where we're going. So in 2010, everything was going along, not too bad then heroin use picked up. Darvocet was taken off the market in 2010, was that part of the problem? Hydrocodone was changed to a Schedule 2 drug, less physicians were then writing it, they were pulling back. So more of those patients who were started on prescription drugs then turned to other sources, and heroin was that source. And then we ended up with fentanyl increasing. The United States has the highest drug death rate in the world; 1 in 10 Americans ages 12 and older are addicted or will be addicted. A pretty staggering statistic. Again, it doesn't matter how old you are, it doesn't matter what ethnicity you are, it is a problem throughout.

JANET:

That's a strong connection. This is about your community. How did the mission of addressing the opioid crisis and specifically the systemic problem of stigma become a passion and personal for you?

DR. PORTER:

So in 2015, I took over as the Senior Medical Director of Primary Care for SOMC. I heard rumors there was a physician that was overprescribing. I kind of got my feet under me and addressed that. But then I was like wait a minute here, maybe I need to take a look at what's going on with my prescribing. So again, I'm telling you this as this is much a story of my journey and my failures, so don't judge me too harshly, okay?

First thing I did was look at my own practice (in 2017)

- I do a trial of other medications, I do the incense, I do physical therapy, I do exercises, I do all these different things for pain, of course with the exception of cancer and palliative diagnosis.

And when writing narcotics, I gave that patient a narcotic contract, which was pretty punitive in

hindsight.
When the CDC guidelines came out, I really worked hard on weaning my patients from opioids that were being treated for chronic musculoskeletal pain.

I did regular PDMP inquiries every 3 months as dictated by law and I performed urine drug screens at least yearly, unless of course I suspected they were abusing or diverting their pills.

So with great hubris, I terminated patients regularly by letter for failed urine drug screens, one single data point in their care.

I did not have difficult conversations about addiction or diversion for fear.

To give you a bit more perspective, I did not change my last name when I got married because during residency, I actually had a couple of death threats all based on patients wanting opioids. And I didn't want my husband or my family, my children to have the same last name. That's totally not a normal thought, but that's exactly what I was thinking when I did that. So I didn't want to have those tough conversations for fear. I did not have difficult conversations about addiction or diversion, and I rarely diagnosed substance use disorder, and I did not document addiction behaviors. When I read through this list, I realized, I'm not doing a good job. Maybe I am contributing to this opioid epidemic.

So, I looked at my group and sent out a survey monkey. I wanted to see what others thought. In 2017, it was a smaller group of 25. Now, we're closer to 40.

And so I asked them if they had any problems with diagnosing substance abuse disorder. Low and behold, it was really telling.

- (nurse practitioners and physicians) stated they didn't even know the criteria.
- Many said that they don't screen for substance abuse disorder. I thought, that's a social history, why aren't we doing that?
- I am uncomfortable labeling the patient. 40% of the clinicians were uncomfortable with that, and
- I do not have patients with substance abuse disorder in my practice (1 in 5 of my clinicians thought they didn't have a single patient who was an addict in their practice.

I thought, wow, we have some real issues. The perception is not accurate at all, especially not in a place where we're considered the epicenter of the problem.

All of that being known, 90% of them were writing for an opioid. So again, thinking through this, it didn't make sense.

Do you diagnose substance abuse disorder? And again 70% said no

I asked, what are your barriers? And again it's just shocking. And I think the majority of us30% of my providers probably have all gone through that if we've been practicing any amount of time.

And then I ask, have you written narcan/naloxone in the last month? 90% said no. Again, in a community that's ravaged by opioids, we're not giving prescriptions that could be life saving.

So why? Why weren't you writing narcan? What I heard is - I don't have any substance use disorder patients in my practice.

33% of my clinicians felt that way.

40% were not aware of the recommendations for prescribing.

This was two years ago, and I hope after the education I have given them they would not respond this way, but again, it was really telling and very troubling in our area.

So I had to really face this head on and recognize the bias. Substance abuse disorder affects 20.8 million people in the United States, the same number of people who have type 2 diabetes. Well, that's my bread and butter in primary care. If I see 10 patients a day, which is probably a low number for diabetes, am I really not seeing anybody with an addiction problem?

Then to really cap it off, 80% of opioid addicts begin their addiction from a prescription of opioids given for pain. Well, 90% of my clinicians were prescribing opioids yet there was a real discrepancy here.

The faces of substance abuse disorder really got personal in 2017. I usually show a picture when I tell this story. The picture is of Anthony, Matthew and Neveah. The picture was taken about nine hours after I received a call from DCBS to come and get them and bring them home with me. Their parents had been arrested for domestic violence and under the influence. Matthew and Naveya are twins, they were 3 at the time, Anthony was 5. I've now had them in my home for almost four years and they are just like my children. However, this helped me to understand what we're dealing with here. This is more than just something that is somebody else's problem. This brought the problem home to me.

A generation of kids are being born exposed in-utero to opioids and other substances. In fact, in our organization, 12% of births have in-utero exposure. A staggering number. Neonatal Abstinance Syndrome and it's lasting effects is a real problem. These kids need access to services for most of their young lives.

I've had the 3 siblings for three years now, and there is a noticeable improvement in their demeanor. They're happy but they still have concerns and issues. Anthony had a lot of exposure in-utero. I have the medical records to prove it. We have impulse control problems. We have serious anger issues. We question if there is some autism, and we struggle to get help for him because he's in the system and we're just his guardians. And because of his trauma, so many people don't want to label him anything else. So this is a real story and a real problem, and something I really had to challenge myself on. So we must challenge our biases completely.

JANET:

Dr. Porter - I commend you for the personal sacrifice and the love. I'm sure that it is difficult and also brings joy and inspiration on so many levels.

We know that stigma and bias is a difficult challenge to address. Studies show that only about one in 12 people with substance use disorder get treatment and that stigma is a key barrier for many people who don't seek treatment. Studies also show that even health care professionals and the treatment decisions they make are influenced by how we talk about addiction. Using the right language has a real and direct impact on lessening stigma and on whether people with

substance use disorder get the treatment they need. Understanding this, organizations including the American Society of Addiction Medicine have mounted efforts to promote the use of non-stigmatizing language.[3]

Dr. Porter - you introduced me to a new term and concept “Cognitive Behavorial Leadership Model”. And, in fact if our listeners do a search on the term (Cognitive Behavorial Leadership Model), they will find a paper written by Dr. Stewart, SOMC’s CMO.[4]

Tell us more about the program and how you use the process and techniques to change attitudes and behaviors related to opioid and substance use disorder, shifting from bias to respect and empathy.

DR PORTER:

At SOMC we like to focus on our failures to see what we can do differently? Let us learn through our failure of addressing substance abuse disorder, how can we improve on our approach to treat patients.

Our Cognitive Behavorial Leadership Model (or CBL) includes POLOs or **Problem oriented leadership learning opportunities.**

Our CMO and medical staff leadership meet two Fridays each month during which we present one or two POLOs.

In my old feelings, I was annoyed when I saw dug seekers. I think we all, if we’ve been in medicine a couple of years, have had an annoyance with a patient who is seeking drugs. I was frustrated that patients were wasting my time just for their fix, and I felt giddy when I caught them in their lies so I could terminate them from the practice. It almost became a “gotcha”

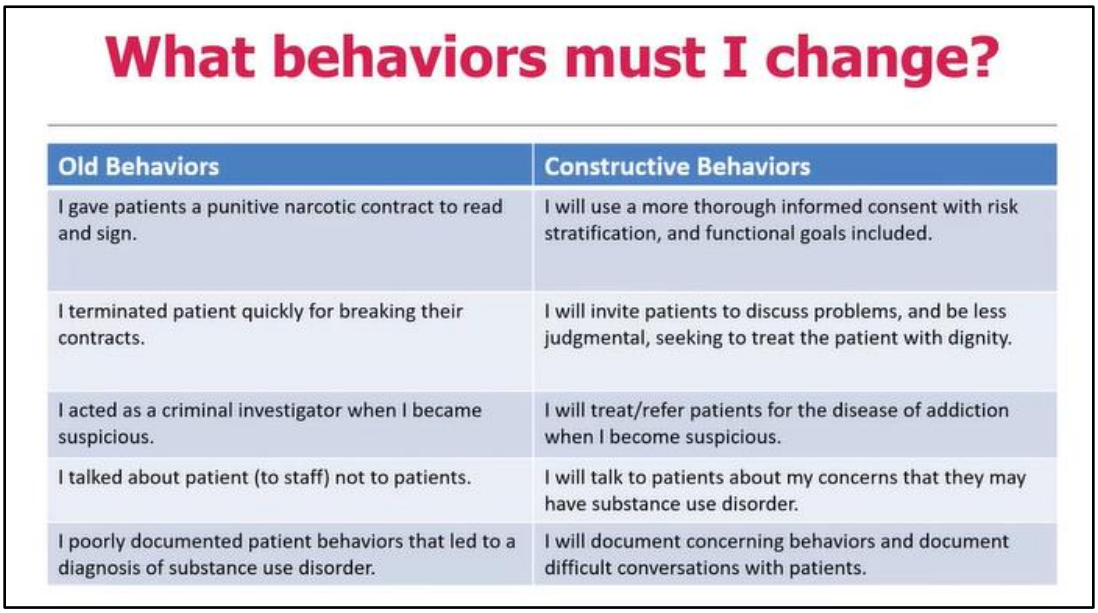
[3] https://www.bmc.org/sites/default/files/Patient_Care/Specialty_Care/Addiction-Medicine/LANDING/files/Words-Matter-Pledge.pdf
[4] https://www.somc.org/content/uploads/2018/03/The-Cognitive-Behavioral-Leadership-Model.pdf

moment.

My new feeling, which sometimes I have to really think about is that I will be grateful at the chance of treating a patient with dignity for a disease that I acknowledge. I didn't acknowledge that disease process in the past so I had to really focus there. I will feel proud that I can treat patients with dignity with a disease that is taboo and often misunderstood. In the great scheme of things, what I realized was there are lots of addictions out there. I struggle with the Mountain Dew and Snickers bar, but that's not so taboo.

People are not offended when I'm drinking my Mountain Dew and eating my Snickers bar. However, if I found a patient in my office shooting up with heroin, I think we would have a big problem. So it's very taboo. I will be very empathetic to patients who are non-compliant, reminding myself that many patients display noncompliance, not just addicts.

So what beliefs did I have to change?



Destructive vs constructive beliefs

- Addiction is a choice.

This one was a tough one. It was ingrained and no matter where you stand on this, the science is clear, it definitely is a disease process. The first drink/drug use experience may be a choice but addiction is a disease process involving our dopamine pathway and pleasure sensors. I have to remind a lot of my clinicians about that when they are getting frustrated with patients who have addiction.

- I can discern a drug addict from the rest of the population.

I think we all believe we can, but the truth of the matter is, I'm able to see the long term physical effects of long term drug use but many people are functioning addicts and go to work every day and do normal things, and are indiscernible from the rest of the population. Those are the patients that I'm going to really need to be aware of. The ones that are showing physical effects,

well just like dialysis and diabetes patients, it's the end stage.

- I can't do anything to help the opioid problem.

I just told you I'm a rural doc in the middle of Kentucky and Southern Ohio Medical Center is considered the opioid epicenter, but what can we do in this big problem? Well, I had to really take that monkey, take it on my back because I can use evidenced based medicine to treat patients but I can also hold ambulatory primary care providers to the same standard and I can present to other healthcare workers, just like I'm doing today, to challenge their bias. So today that's really what I'm here for is to help you to challenge yourself and to be able to see some tools to help with that.

- It is my job to be the keeper of the narcotics using my investigating skills when needed.

I can remember actually gel tracker on multiple occasions. Has that person been in jail for this? Have they been trafficking? Well, I'm not going to write that. Well that's not really my job. My job is to be a physician. Take an appropriate history, communicate with my patient and understand that 100% is unlikely in all disease cases, not just the addict.
So, what did I do? What behaviors did I change?

- The punitive narcotic contract, I had to really rethink that. And maybe that's something you are doing now. I actually use now an informed consent, and the first two pages (and yes, it's a 3 page consent) are me describing what the opioid is, what the addiction risk is. Going through that opioid risk tool with them, then talking through what their functional goals are, and then when we should consider weaning down. The last page is theirs, of things I expect them to do. Keeping it in a safe, locked box. Getting rid of it if they don't need it. All of those things that were typically in the punitive contract before.
- I terminated patients quickly for breaking their contracts in the past. Well, I will invite patients to discuss the problem, be less judgemental, seeking to treat the patient with dignity.
- I acted as a criminal investigator. Nope not going to do that anymore. I'm going to treat/refer patients for the disease when I become suspicious.
- I talked about patients not to patients. I think we do that in a lot of places in our lives, we talk about things instead of to people. I will talk to patients about my concerns even when I'm uncomfortable about my concerns, I'm going to force myself to do that
- I poorly documented patient behavior that led to a diagnosis of substance abuse disorder. I will document concerning behaviors, and I will document those conversations with patients.

And that all led to 2017, SOMC developing what we called a "Pain and Opioid Use Toolkit". It went right along with exactly what MEDITECH provided to us as part of our implementation of Expanse. It included the opioid risk tool, it included the informed consent, and it included algorithms of how to wean down when you have an abnormal drug screen. Lots of different information that gave people lots of ability to read and know exactly what to do and what each state authority (Kentucky, Ohio, West Virginia) around us required, which is a moving target.

The other big thing that we did was we challenged the status quo and we took this all the way up to our Ethics committee and developed a physician's statement because I told on myself. I said I am not doing well with these patients, I am not treating them well. And I think that the majority of my group are not doing that, and if we're not others aren't.

There is one part that I definitely want to read to you, "We accept that our patients have the right to seek or refuse treatment for their substance use disorders, and the right to decide what

treatment to pursue, and that we are obligated to accept their decisions even when we believe their informed decisions are not in their best interest." This was based quite a bit on the VA work.

We know if these patients do not seek help that they could easily end up in the ER or a call to the coroner for an overdose, but all we can do is give them the tools.

JANET:

I applaud your courage and compassion. Yours is a human journey and you inspire us. Given that many of our listeners are healthcare professionals who are involved in using technology and informatics to support positive change and improved outcomes, I would like to talk a bit about the role of the EHR and technology in providing data and tools that support the caregivers, the patients and that can drive improvement.

We know that in March of 2016, the CDC posted their evidence based guidelines for prescribing opioids. You referenced the guidelines earlier. That set of guidelines is the foundation of what we at MEDITECH (and EHR healthcare technology vendors) have used to operationalize clinical decision support tools, care guidelines and analytics.

Can you speak to how you have used the EHR and technology to provide tools and data that drive improved and equitable care?

DR. PORTER:

I'm going to speak to our experience based on what was made available to us as a result of our recent implementation of MEDITECH which provides integrated tools across all settings of care and data analytics provide key insights.

When we went shopping around for EHRs and we recognized the opioid toolkit was in MEDITECH, we were excited. I was excited, maybe I was more excited than anybody, because we would be able to have the analytics to hold our providers accountable.

So some of our goals:

- Improve our PDMP use to 100%.

We really had no way to measure that unless clinicians gave us their data, which nobody was really inclined to do. And we want to be able to apply that to our Individual Provider Dashboards.

- Improve our naloxone prescribing for identified patients.

We only had 20 prescriptions out of 43,000 patients. Deplorable data. Where we live, we know more naloxone needs to be written so that is something we definitely want to utilize.

- Identify high addiction risk patients and flag chart.

We also, moving forward using the opioid risk tool, or the opioid toolkit from MEDITECH, now identify high addiction risk patients and we can place a special indicator. This indicator has to be added or removed by the provider. This high risk for substance misuse is not just the patient already diagnosed for substance use disorder, it is the person who scores high on the opioid risk tool. They may just have a family history and be at high risk, so it really changes the

dynamics of what we've been thinking.

- Decrease opioid prescribing for high risk patients.

We want to be able to identify opioid use disorder earlier in the disease process, utilizing multiple data points, including urine drug screens, pill counts and PDMP.

- Utilization of registries.

We also have the registries now with the opioids to track and manage patients who are taking opioids, who are prescribed opioids, and begin to really look through these patients, should we try to wean down and look at it more of a population health instead of just episodic care.

This is all based on the CDC guidelines which have also evolved since 2016. For example, they have additionally provided guidelines and protocols for safely discontinuing and tapering opioids.

In a recent article in the Journal of General Internal Medicine, Medicare beneficiaries (our older folks) were increasingly likely to have long-term opioid therapy stopped in recent years and medication changes were often abrupt, not tapered. The proportion of abrupt opioid discontinuations increased over time, from 70.1% in 2012 to 81.2% in 2017.[5] This can have devastating effects. We need to track and incorporate guidance for weaning patients from opioids.

JANET:

What progress have you made and what's next?

DR. PORTER:

- We have completed provider education on the EHR toolkit and clinical decision support tools
- As I mentioned, we want to continue to leverage the registry tools
- We are also reviewing, validating and refining the analytics
- We want to track and improve utilization of the PDMP data and documentation.I have 3 practices in Kentucky and the rest in Ohio. Ohio we have figured it out pretty good. Kentucky, we still have a little bit of work, and that's just in the way we set things up. So, we still have some processes we are working on.
- We also have added widgets, the opioid widget onto our front page. I have found that very useful. This is all driven from reason for visit. Pain management or any kind of pain, triggers this toolkit.

JANET:

For patients who are identified with OUD or SUD, what barriers still exist? I was reading an article published this month in JAMA on the continued increases in overdose deaths related to synthetic opioids points out that treatment with FDA approved medications such as methadone, buprenorphine, and extended-release naltrexone remain standard care, but gaps persist, with

[5] https://www.medpagetoday.com/neurology/opioids/91060

only an estimated 20% of persons receiving medications for opioid use disorder (MOUD).[6]

DR. PORTER:
Yes, there are still barriers. First, as I have discussed, we need to identify the people who have OUD/SUD and need help. Then we need to ensure that we have X Waiver approval. We also need support for referrals. Prescribing providers have to work through SAMHSA for an X waiver. In addition to prescribing the medications to a patient, they need to provide a referral for follow up counselling and case-management services.[7] We don't have anyone to refer to in our area. Telehealth may open options in this area as long as that the policies and payment structures support that.

We are not at the end of this tunnel. Kentucky, West Virginia and Ohio all report at least a 50% increase in ED visits due to opioid overdose between April and May of last year. All because of the lockdowns and what I read in multiple articles was these were deaths by despair. COVID has taken its toll on the healthcare system and contributed to the death and the opioid use disorder. I'm hopeful that utilizing the registries of both patients on meds and with opioid use disorder diagnosis we can effectively address and improve these rates. At least, I'm certainly optimistic.

[6] https://jamanetwork.com/journals/jama/fullarticle/2776544?guestAccessKey=6fe4ff05-913f-4d43-af58-d501fe136529&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=021121
[7] https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner