Stigma Kills: Addressing Opioid Use Disorder by Changing Culture

March 23, 2021 | 11AM-12PM
The IPRO QIN-QIO: Where We Are

The IPRO QIN-QIO Region

**IPRO:**
New York, New Jersey, and Ohio

**Healthcentric Advisors:**
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

**Qlarant:**
Maryland, Delaware, and the District of Columbia

Working to ensure high-quality, safe healthcare for 20% of the nation’s Medicare FFS beneficiaries
About This SWEEP

Addressing Health Disparities to Reduce Opioid Use Harm

• Identify, prioritize, monitor, and eliminate health disparities
• Improve patient and organizational health literacy
• Promote culturally & linguistically appropriate services
• Discuss perceptions of addiction, stigma, implicit bias
• Screen & address social determinants of health
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STIGMA KILLS
Addressing Opioid Use Disorder by Changing Culture

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DISCLOSURES

No commercial interests to disclose relating to the educational content of this webinar.

But, I’m from New Jersey and am very passionate about this content. I will try not to speak too quickly.
WHY AM I SPEAKING TODAY?

Our Journey: A Brief Story

OBJECTIVES:
- Define stigma and its different forms
- Describe the impact of stigma on care delivery
- Identify opportunities to offer hospital-based Opioid Use Disorder (OUD) treatment
WHY ISN’T HOSPITAL-BASED TREATMENT THE STANDARD OF CARE?

Education + Systems-Based Practice + Stigma* =
DEFINITION OF STIGMA

Originates from Greek “stizein”
A mark burned onto the skin of slaves to signify their low place in the social hierarchy in ancient times.¹

“An attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one.”²

“A social construct whereby a distinguished mark of social disgrace is attached to others in order to identify and to devalue them. Thus, stigma and the process of stigmatization consist of two fundamental elements: the recognition of the differentiating ‘mark’ and the subsequent devaluation of the person.”³

1. Link & Phelan, 2001
2. Goffman, 1963, p. 11
WHAT EXACTLY IS STIGMA?

Stereotype (Beliefs) → Prejudice (Feelings) → Discrimination (Marginalization)

Corrigan & Nieweglowski, 2018
Types of Stigma

- Social Stigma
- Structural Stigma
- Self stigma

Why even try?

- Awareness
- Agreement
- Application
- Harm

Corrigan & Rao, 2012; Akdağ et al., 2018; Can & Tannverdi, 2015
# STIGMA IS COMPLICATED

## Describing Stigma: What stigma looks and feels like
- Negative attitudes, judgements, and stereotypes
- Problematic labels and language use
- Negative client-provider interactions
- Shame and the internalization of addiction
- Punitive and exclusionary policies and practices

## Impacts of Stigma: How stigma gets in the way
- Affects how we conceptualize, frame, and prioritize the current crisis
- Leads to hiding and creates barriers to help seeking
- Contributes to ongoing system mistrust and avoidance of services, particularly among marginalized populations
- Results in poorer quality care and response

## Sources of Stigma: Tension points and contributing factors
- Punitive views about addiction, treatment, and recovery
- Illegality of illicit opioids and other drugs
- Viewing people with opioid use problems through a paradigm of worthiness and deservingness
- Trauma, compassion fatigue, and burnout

## Tackling Stigma: Promising approaches
- Education on addiction, treatment, and recovery
- Interventions focused on building client-provider trust
- Social contact as a key stigma reduction tool
- Training in trauma informed practice and care
- Inward-facing training to build resilience and mitigate burnout
- Address system gaps and barriers

MHC Canada, 2019
HOW DO PATIENTS REFER TO THEMSELVES?

• 250+ patients evaluated at a Massachusetts substance use clinic

Pivovarova & Stein, 2019; Ashford, Brown, & Curtis, 2019
HOW DOES STIGMA MANIFEST IN CLINICAL PRACTICE?

Health professionals have a negative attitude towards patients with SUDs.

Stigmatizing language in the medical record → Decreased treatment of pain

Medical student stigma → Resident stigma → Attending physician stigma

Goddu et al., 2018; Goddu, Anna et al., 2018; van Boekel et al., 2013
HOW DOES STIGMA MANIFEST IN CLINICAL PRACTICE?

• Discontinuation of life-saving treatment to receive liver transplant.
• Denial of valve repair surgery in endocarditis.
• Shame, prolonged hospitalization, and potential justice-system involvement for pregnant patients.

Wakeman et al., 2018; Aultman et al., 2018; Howard, 2015
HOW DOES STIGMA MANIFEST IN CLINICAL PRACTICE?

Substance use disorders are treated as a moral failing.

In reality:
- SUDs are driven by genetic and environmental factors
- Rates of recurrence very similar to other chronic diseases

NIDA, 2005
DEFINITION OF ADDICTION

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

-American Society of Addiction Medicine, 2019
HOW DOES THE GENERAL PUBLIC THINK ABOUT SUDs?

- SUDs are seen as being intimately linked to HIV, hep C, and DUI.
- In a survey of 1,000 adults, 75% felt patients with OUD were, themselves, to blame.

Nieweglowski et al., 2019; Kennedy-Hendricks et al., 2017; Furr-Holden et al., 2016
1970s “War on Drugs”

- Cocaine then, heroin now.
- Responsible for large disparities among individuals of racial minority groups.
- Today, White patients are 35 times more likely to receive treatment for OUD compared to Black patients.

Santoro & Santoro, 2018; Lagisetty et al., 2019
HOW DO HOSPITALS COME INTO PLAY?

Hospitals are **CRITICAL** access points.

and...

OUD screening, management, treatment, and harm reduction must be better addressed in hospitals.

(True of all SUDs.)

Furr-Holden et al., 2016
WHAT WE DO AT MOST HOSPITALS TODAY:

- “Treat” withdrawal
- No long term treatment plans

Chutuape, et al., 2001
PATIENTS HOSPITALIZED FOR OUD CONSEQUENCES

- Overdose/Poisonings
- Withdrawal
- Sexually transmitted infections
- Hepatitis C
- Endocarditis
- Epidural/spinal abscesses
- Cellulitis

Hospitalization is a reachable moment.

- 25-30% of patients leave AMA
- Inadequate treatment of withdrawal
- Fear of mistreatment
- Opioid cravings
- 12% of patients provided ONLY a follow-up appointment enter outpatient treatment
- 72% of patients started on buprenorphine enter outpatient treatment

Lianping Ti et al. (2015); Liebschutz et al. (2014)
Patients with SUDs are more likely to be readmitted within 30-days. Even when adjusted for: Age, Sex, Depression, Insurance, Housing, Charlson score. 1.7 times more likely to be readmitted.

Walley, 2012
Among patients with opioid use disorder taking buprenorphine at the time of hospital admission...

53% reduction

30-day hospital readmission

Moreno, Jessica L., PharmD; Wakeman, Sarah E., MD, et al. Predictors for 30-Day and 90-Day Hospital Readmission Among Patients With Opioid Use Disorder. J Addict Med. doi: 10.1097/ADM.0000000000000499
THE QUADRUPLE AIM
BACK TO OUR JOURNEY

Our problem: How can we treat hospitalized patients with opioid use disorder at our 200-bed academic hospital without a formal addiction medicine service?

Our solution: Empower existing teams
THE BUPRENORPHINE TEAM

An interprofessional and multidisciplinary group that works to:

Screen
- Residents
- Attendings
- Nurses
- Social Workers
- Service Lines

Initiate
- Clinical Assessment
- Pharmacist intervention
- Just-In-Time Training
- Chaplaincy

Link
- Refer to outpatient MOUD
- Bridge prescription provided
- Naloxone distribution
- Peer Recovery Support

Educate
- Institutional education to reduce stigma and promote MOUD

* Without the presence of addiction medicine consultation service but with planned obsolescence
WHAT WE LEARNED ABOUT OUD TREATMENT AND STIGMA

Our initial focus was on medication administration but we inadvertently reduced stigma by:

Education
Messaging
Facilitating conversation
Role-modeling

The Bottom Line:
We recognize our hospital as a critical access point. Addressing OUD is now our standard of care.
WHAT CAN YOU DO?

- Use person-first recovery-centered language
- Identify and eliminate structural barriers
- Sympathetic narratives → share patient stories
- Focus on solutions, not “problems”
USE APPROPRIATE LANGUAGE

Changing the Language of Addiction

Terms that stigmatize addiction can affect the perspective and behavior of patients, clients, scientists, and clinicians. Clinicians especially need to be aware of person-first language and avoid more stigmatizing terms.

Terms Not to Use
- addict, abuser, user, junkie, druggie
- alcoholic, drunk
- oxy-addict, meth-head
- ex-addict, former alcoholic
- clean/dirty (drug test)
- addictions, addictive disorders

Terms to Use
- person with a substance use disorder
- person with an alcohol use disorder
- person with an opioid use disorder
- person in recovery
- negative/positive result(s)
- addiction, substance use disorder
IDENTIFY STRUCTURAL BARRIERS

Policies or institutional actions that restrict the opportunities of targeted groups, whether intentional or not.

- Starting or continuing MOUD during hospitalization
- Formulary restrictions
- Care coordination
- Misunderstanding of regulatory environment (x-waiver)

Corrigan, 2004
SYMPATHETIC NARRATIVE AND PATIENT STORIES
CONTINUE LEARNING

Reducing Stigma Educational Tools (ReSET)

www.ResetStigma.org
CONTINUE LEARNING

www.Shatterproof.org
THANK YOU

Please reach out with questions and collaborations!

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We welcome your questions and comments in the Chat.
Eliminating Stigma Toolbox
What We Bring to the Room: Reflecting on the Impact of Bias in Care

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Tuesday, April 20, 2021
11:00 AM – 12:00 PM

REGISTER
Have a question? Contact us!

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