



Stigma in Healthcare

Thursday, April 14, 2022

1:00 p.m. to 2:30 p.m.

WELCOME.

We're glad
you are here.



- All participants are in listen-only mode
- We encourage frequent use of the chat box to participate and ask questions
- Say hello now using the chat box to tell us your **name and organization**
- Please complete the three question survey towards the end of the webinar. We value your feedback!



**INTERACT FOR HEALTH PROMOTES
HEALTH EQUITY TO IMPROVE THE
HEALTH OF ALL PEOPLE IN OUR REGION.**

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REDUCING TOBACCO USE



HEALTHY LUNGS AT PLAY!



THIS IS A
SMOKE & VAPE
FREE PARK



WE APPRECIATE YOUR COOPERATION



Miami Township



KLEEM INC

SCHOOL-BASED HEALTH CENTERS

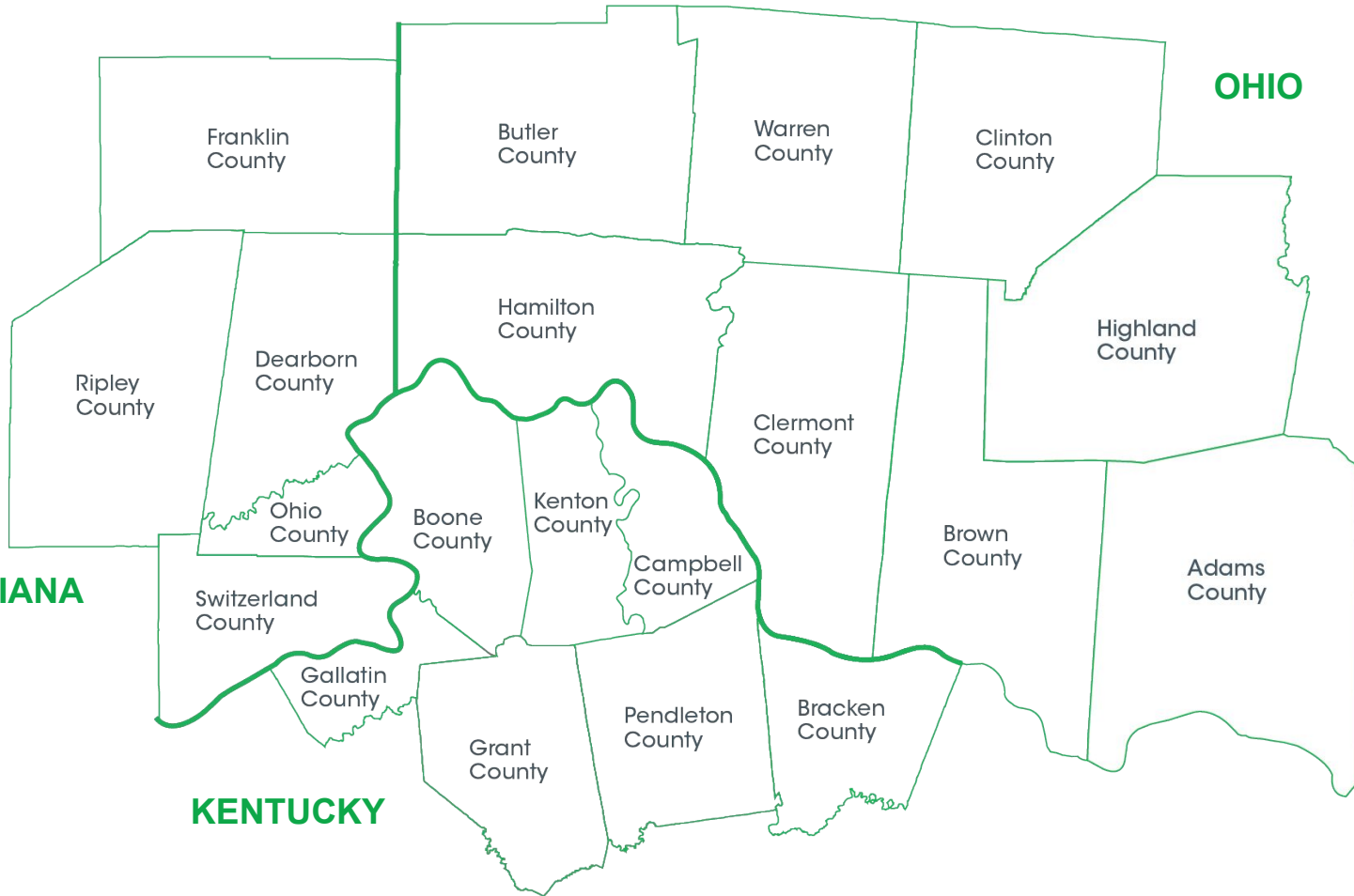


A close-up photograph showing a woman with blonde hair and glasses placing her hand on the shoulder of a man in a blue shirt. The man is seen from the back/side, and the woman is in profile, looking towards him. In the background, another woman is blurred. A large green diagonal shape is overlaid on the left side of the image.

**ADDRESSING
THE OPIOID
EPIDEMIC**



INDIANA



KENTUCKY

OHIO



Sonya Carrico
Senior Program Officer



Lisa Myers Program
Officer



Michelle Lydenberg
Evaluation Officer



Sachi Bhati
Intern

www.interactforhealth.org/addressing-the-opioid-epidemic



Goal: Reverse the trend of overdoses and deaths from opioids



Addressing SUD stigma in Health Care

Sachi Bhati
Interact for Health



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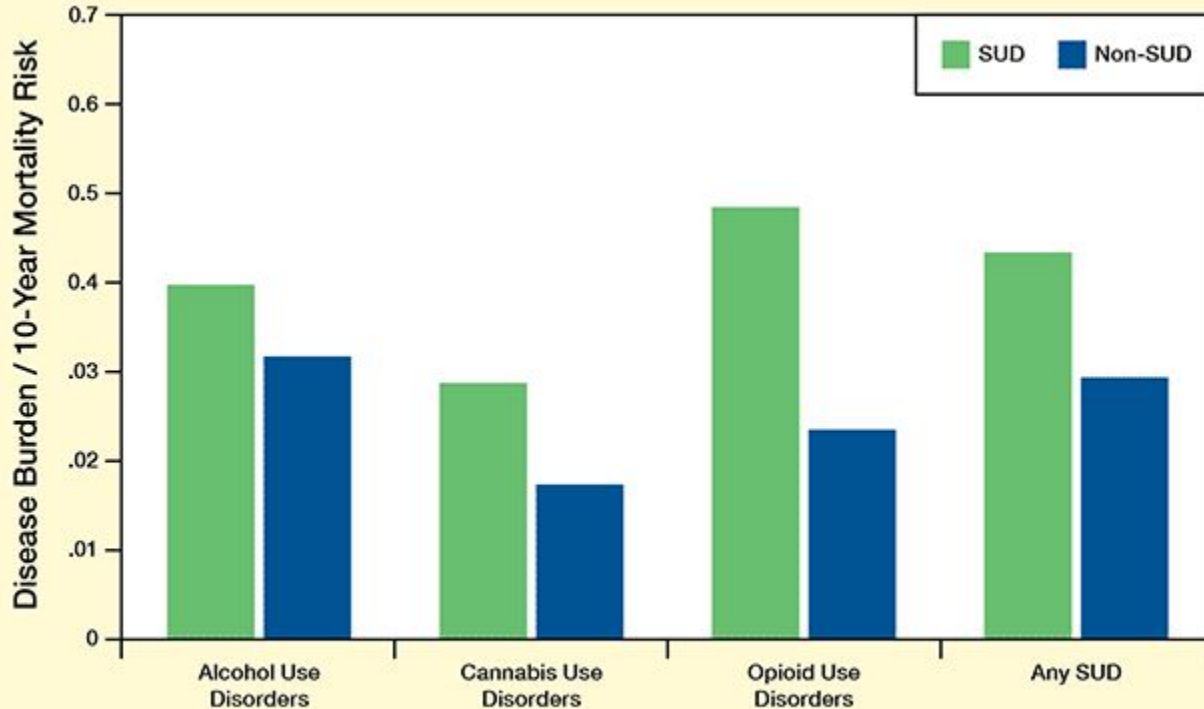
03

CA Bridge

04

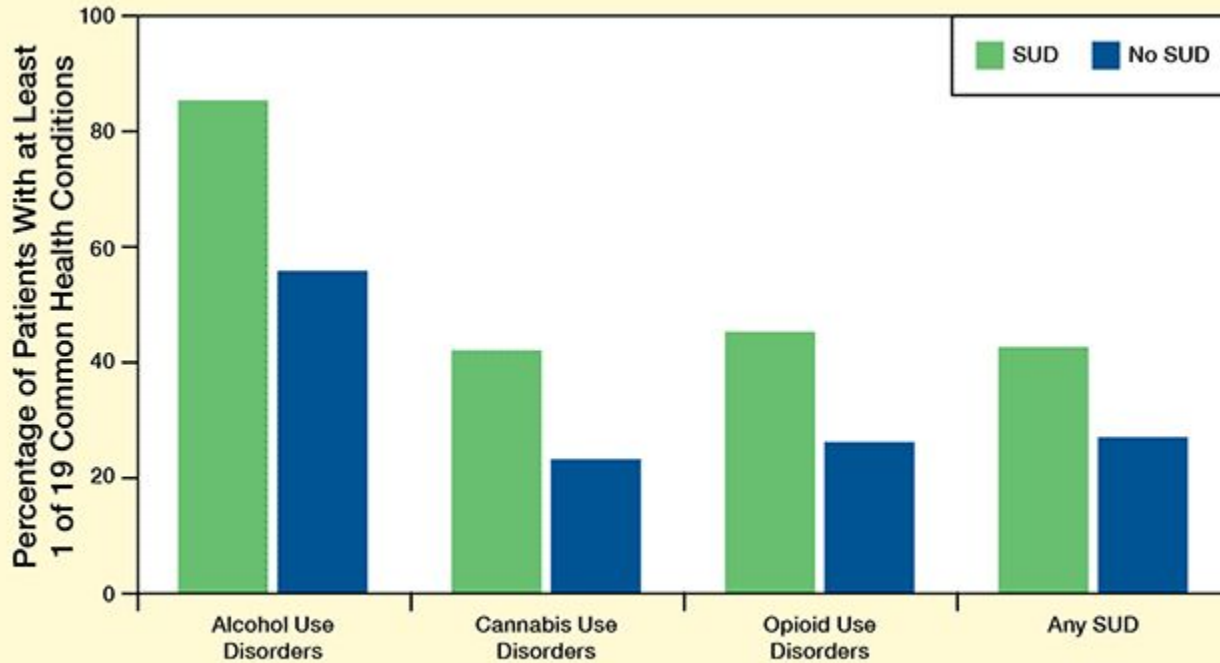
Q&A

Disease Burden



Adapted from Bahorik et al. 2017; permission for use of data provided by Dr. A. Bahorik.

Coexistence of additional health conditions



Permission for use of data provided by Dr. A. Bahorik.



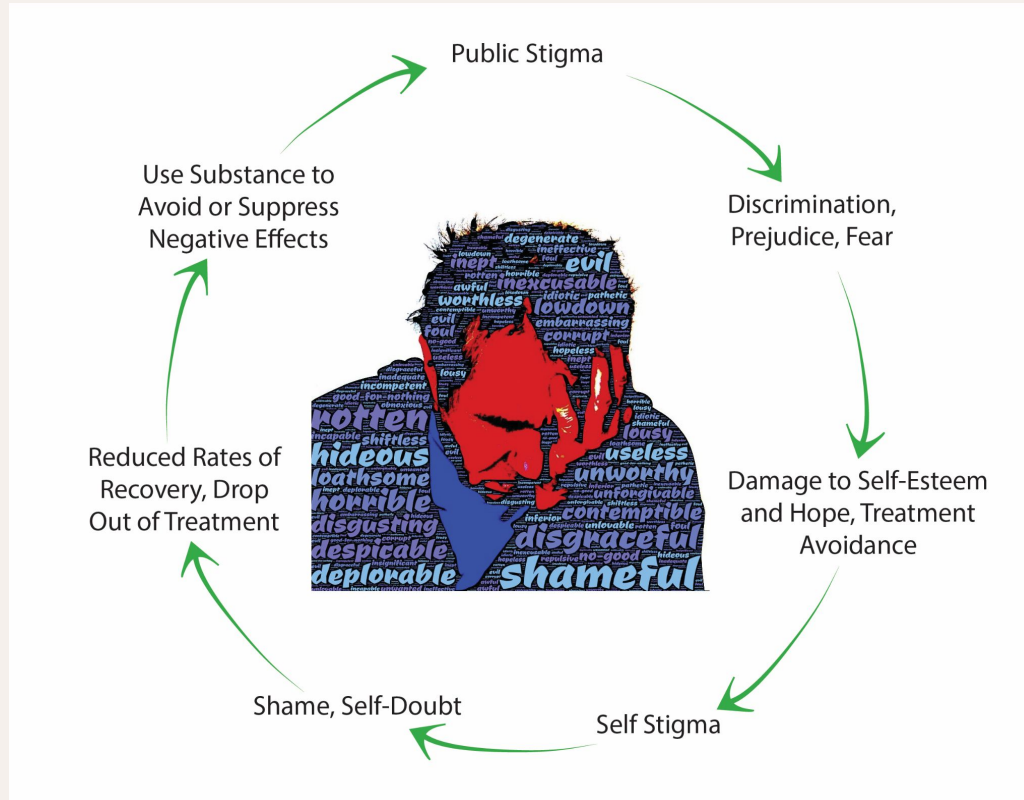
01

What is Stigma?

Stigma /'stigmə/

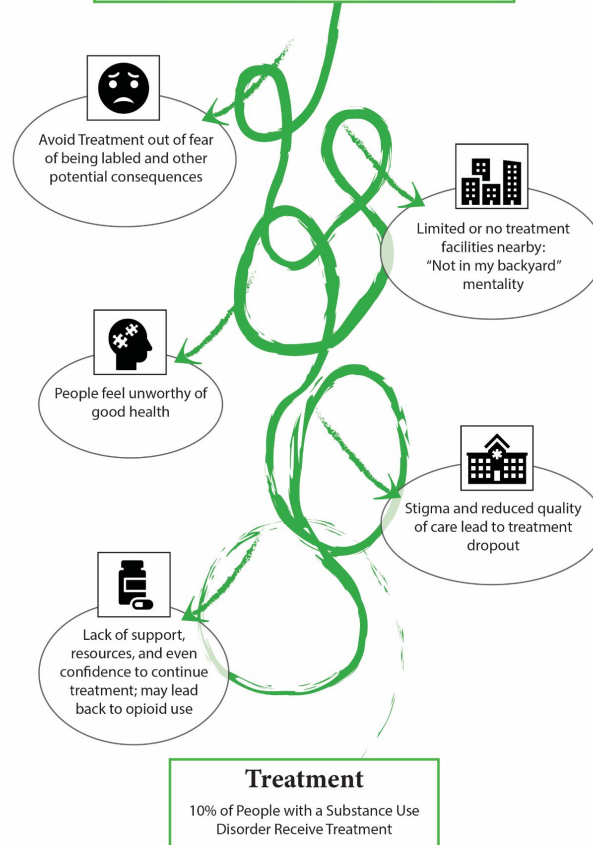
A set of negative and often unfair beliefs that a society or group of people have about something

Cycle of Stigma



The Pathway to Treatment

People with Opioid Use Disorder





02

Focus Group

Focus Group Questions



Where do you receive your healthcare – ED, Urgent Care, PCP, health departments, etc.?



Do you think they [providers] have this perception that you don't have to use illicit drugs?



Have you felt that other health-related issues have become minimized once a healthcare provider finds out you use drugs?



Is there a certain phrase or word that you wish healthcare providers would not use?

Participants



15 participants at Caracole's weekly SSP



12/15 developed OUD after receiving an opiate for an injury



All have been to an ED in Hamilton County as recent as 2 weeks prior to the FG



14/15 participants have experienced stigma in healthcare



15/15 participants could not remember the last time they got high



Stigma can lead to adverse health outcomes

“...and that can be really dangerous and I knew that and I still chose to just deal with it on my own rather than get treated that way that I get treated”



—SSP Participant

“...that’s not the reason why I’m coming, [chasing pain meds], I could get something stronger on the street. I’m here for a different reason...”

—SSP Participant



The Individual > SUD



“...you can handle the pain”



—SSP Participant

“...we are all human being at the end of the day, we should all be treated the same”

—SSP Participant



Constantly wanting to feel normal



“I actually wake up every morning and have to stick myself with a needle just to feel normal...I hate that”

—**SSP Participant**





Let's talk about it

“...It would be awesome if they
addressed the addiction”



—**SSP Participant**



Themes



**Desire for
Normalcy**



**Dismissal of
health and
wellness**

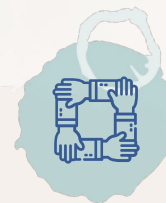
How can you reduce stigma



**Treat them like a
person not an
addiction**



**Have whole
health
conversations**



**Call out
stigma when
you see it**

Thank You!

INTERACT
FOR HEALTH



CA
BRIDGE

Doing Less Harm: Treating Opioid Use Disorder As A Brain Disease

Rais Vohra, MD

Jennifer Zhan, MD

Tommie Trevino, Substance Use Navigator



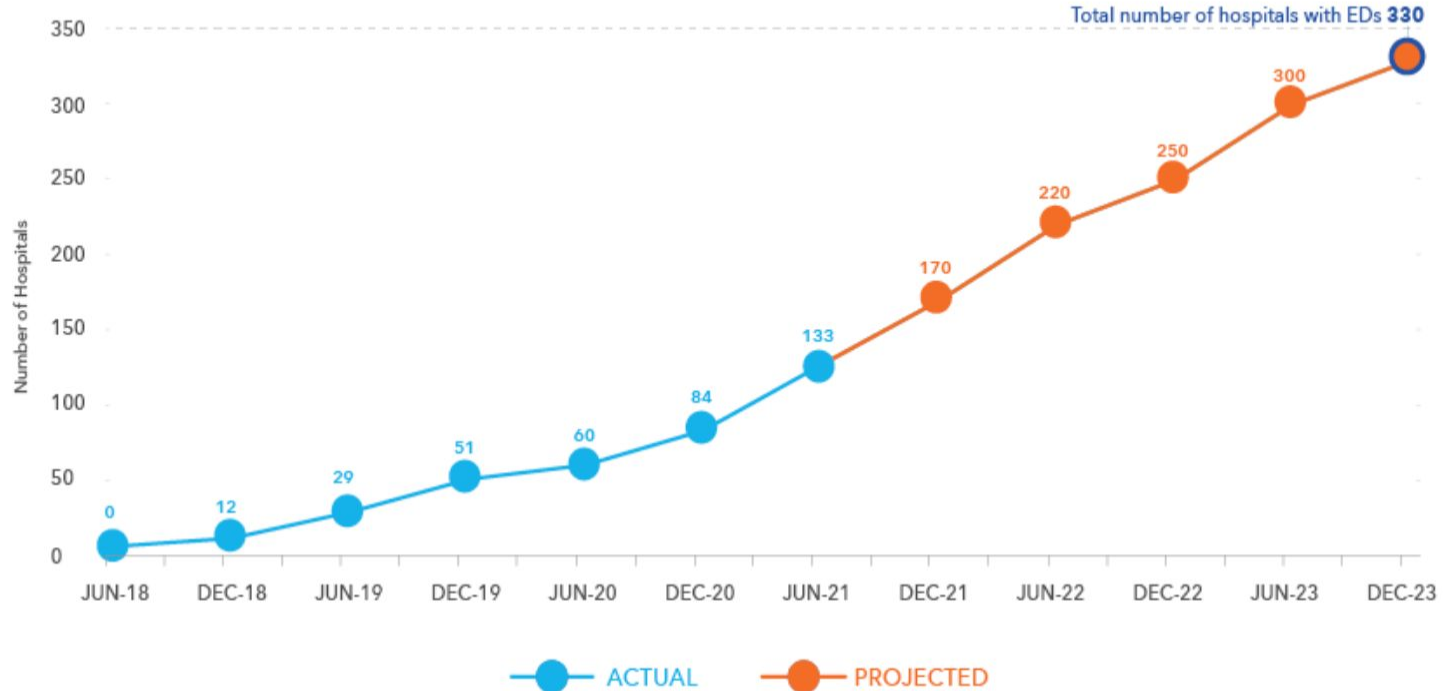


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<https://creativecommons.org/licenses/by-nc-nd/4.0/legalcode>.

Our goal is universal access to addiction treatment in all hospital emergency departments.



In 2018, the CA Bridge program began with just eight hospitals and today has expanded to 133. By the end of 2023, we aim to see all hospital emergency departments treating opioid use disorder.

The Opioid Epidemic



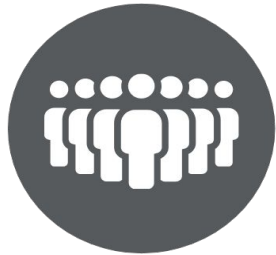
70,630

people died from drug overdose in 2019 (1)



10.1 million

People misused prescription opioids in the past year



1.6 million

People had an opioid use disorder in the past year (2)



745,000

People used heroin in the past year

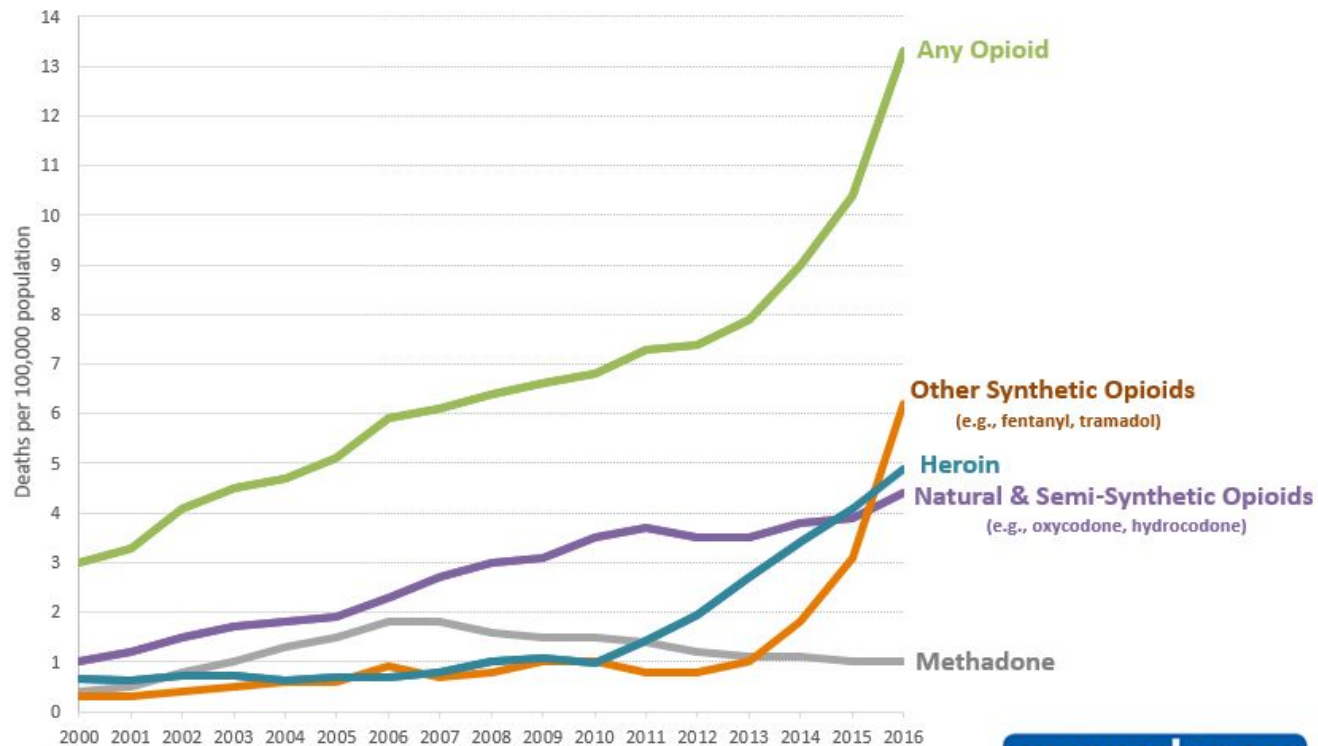
Sources

(1) NCHS Data Brief No. 394, December 2020.

(2) 2019 National Survey on Drug Use and Health, 2020 <https://www.hhs.gov/opioids/about-the-epidemic/index.html>

Opioid Crisis

Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2017. <https://wonder.cdc.gov/>.

CA Bridge Model

Revolutionizing The System Of Care



Low-Barrier Treatment



Connection to Care
and Community



Culture
of Harm Reduction

CA Bridge Impact: To-Date

Cumulative totals across all reporting CA Bridge sites (n = 190), April 2019-Sept 2021



77,930

SUN encounters



52,719

patients identified with
OUD



23,848

encounters where MAT was
prescribed or administered

SUN: Substance Use Navigator

OUD: Opioid Use Disorder

MAT: Medication for Addiction Treatment

CA Bridge Model: Connection

- Link patients to ongoing care through active support and follow up.
- Reach out to community organizations and people who use drugs to increase access to care.



CA Bridge helps hospitals implement the standard of care needed to support patients with substance use disorders. Together, a clinical champion and a substance use navigator bridge gaps in traditional treatment, linking patients to ongoing care.

**The CA
Bridge
Model in
Action**



**The clinical
champion**

provides assistance
to staff so they can
support the patient
with medication



**The substance use
navigator**

offers the patient
guidance and linkage
to ongoing treatment



The patient

gets evidence-based
care with better
outcomes, and lower
readmissions



CA Bridge Model: Culture

- Create a welcoming culture in the hospital that does not stigmatize substance use and does recognize racial disparities in access to care.
- Promote harm reduction and trauma-informed practices.
- Build trust through human interactions and lead with respect.



Working Smarter, Not Harder: The Story of Tony and Tony

Meet Tony P

Tony P is a 36 year old man. He checks in to the ED to seek help with a seizure disorder. He had a full-on, tonic-clonic seizure while at home, and because he didn't have time to take proper precautions before it came on, he developed a laceration to the left side of his scalp. He is evaluated by the triage nurse and triage MD and told to wait. Meanwhile he feels like his brain is on fire.

In the lobby, he has a partial seizure while waiting to be seen. Just before he has it, he yells for help and then collapses on the ground. He is helped to back to the chair and a bandage is applied to his bleeding scalp, but he continues to demonstrate seizure activity all the while.

He tries to ask for help with his seizure several times to lobby staff, but he is asked to wait for a long time. No one seems to understand why he would come in with both a scalp laceration and also an active seizure. No one seems to grasp that these two conditions might be related.

Eventually, he receives a series of responses to his request, but they are somewhat puzzling to him.

First, he is told that he needs to stay calm and follow up at a neurology clinic, where they will be able to evaluate his seizure disorder fully, and then prescribe him some medications to make his seizure stop.

The doctor treating him, who appears kind and youthful, smiles compassionately as he hurriedly jots down a phone number and an address, passing the slip into Tony's trembling hand as he stands up to go. "These folks will take really good care of you, just walk in. I really hope you get better, man. Good luck to you." Tony shakes his head, mumbles something while choking back tears, and walks back out of the ED lobby.

Now Meet Tony T

Tony T is a 36 year old man. He checks in to the ED to seek help with a ~~seizure disorder~~ **opioid use disorder**. He had full-on, ~~tonic-clonic seizure~~ **severe opioid withdrawal** while at home, and because he didn't have time to take proper precautions before it came on, he developed a ~~laceration~~ **an abscess** to the left side of his ~~scalp~~ **forearm**. He is evaluated by the triage nurse and triage MD and told to wait. Meanwhile, he feels like his brain is on fire.

In the lobby, he has a ~~partial seizure~~ **moderate withdrawal** while waiting to be seen. Just before he has it, he yells for help and then collapses on the ground. He is helped to back to the chair and a bandage is applied to his ~~bleeding scalp~~ **oozing forearm**, but he continues to demonstrate ~~seizure activity~~ **withdrawal** all the while.

He tries to ask for help with his ~~seizure~~ **withdrawal** several times to lobby staff, but he is asked to wait for a long time. No one seems to understand why he would come in with both a ~~scalp laceration~~ **forearm abscess** and ~~active seizure~~ **opioid withdrawal**. No one seems to grasp that these two conditions might be related.

Eventually, he receives a series of responses to his request, but they are somewhat puzzling to him.

First, he is told that he needs to stay calm and follow up at an ~~neurology~~ **addiction clinic**, where they will be able to evaluate his ~~seizure~~ **opioid use disorder** fully, and then prescribe him some medications to make his ~~seizure~~ **withdrawal** stop.

The doctor treating him, who appears kind and youthful, smiles compassionately as he hurriedly jots down a phone number and an address, passing the slip into Tony's trembling hand as he stands up to go. "These folks will take really good care of you, just walk in. I really hope you get better, man. Good luck to you." Tony shakes his head, mumbles something while choking back tears, and walks back out of the ED lobby.

(How) Is OUD actually a Seizure Disorder?

- A. The patient experience
- B. Historical considerations
- C. EEG studies
- D. How/why is this useful info?

DILEMMA:

Health care treats some brain illnesses well (epilepsy, MS, etc)

...But the system fails patients with the chronic brain illness of opioid addiction...

due to cultural, logistical, structural and pharmacological barriers to effective care

Historical Comparisons to Seizures

Bringing epilepsy out of the shadows

BMJ 1997 ; 315 doi: <https://doi.org/10.1136/bmj.315.7099.2> (Published 05 July 1997)

Cite this as: *BMJ* 1997;315:2

Article

Related content

Metrics

Responses

Wide treatment gap needs to be reduced

Rajendra Kale, Neurologista

Author affiliations 

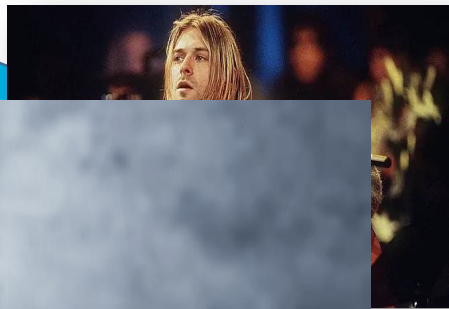
The history of epilepsy can be summarised as 4000 years of ignorance, superstition, and stigma followed by 100 years of knowledge, superstition, and stigma. Knowing that seizures result from sudden, excessive, abnormal electrical discharges of a set of neurones in the brain has done little to dispel misunderstanding about epilepsy in most of the world. More than three quarters of sufferers remain untreated despite the availability in phenobarbitone of a cheap antiepileptic drug. Epilepsy remains a hidden disease associated with discrimination in the work place, school, and home.



The
SPIRIT CATCHES YOU
AND YOU FALL DOWN
*A Hmong Child, Her American Doctors,
and the Collision of Two Cultures*
ANNE FADIMAN



Cultural Re...
Affected person...
as outcasts. ce



SEI



The Lost Prince - Prince
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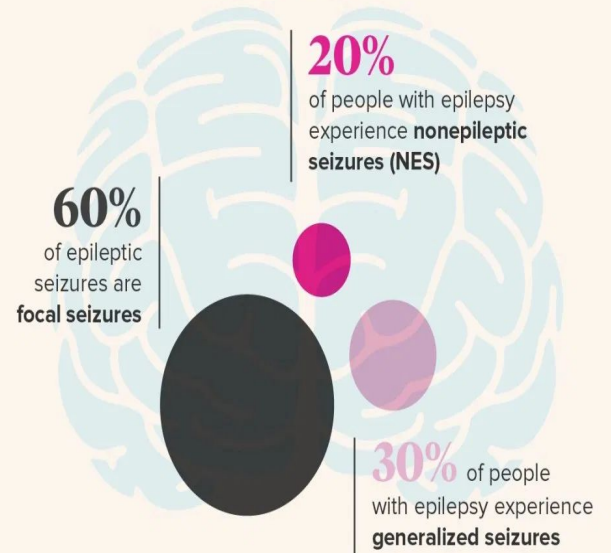


Should withdrawal be seen as a type of non-convulsive seizure?

MAYBE! Studies using EEG/EP suggest that:

- Opioid withdrawal induces characteristic EEG changes
- Withdrawal responds to methadone/opioids on EEG
- Craving has an EEG footprint in even “stable” patients
- Almost all studies are confounded by comorbid illnesses, co-intoxicants, var. methods and treatments
- Very few studies done in the ED MAT era with bup

SEIZURE TYPES and recurrence



Sources: National Institute of Neurological Disorders and Strokes
Epilepsy Foundation

healthline

Neuroelectro-physiological approaches in heroin addiction research: A review of literatures

Extensive review of the literature on electrophysiology studies in heroin addiction/OD

The results show decrements in attentional processing and dysfunctions in brain response inhibition as well as brain activity abnormalities induced by chronic heroin abuse. Findings confirm that electroencephalography (EEG) band power and coherence are associated with craving indices and heroin abuse history.

First symptoms of withdrawal can be seen in high-frequency EEG bands, and the severity of these symptoms is associated with brain functional connectivity.

EEG spectral changes and event-related potential (ERP) properties have been shown to be associated with abstinence length and tend to normalize within 3-6 months of abstinence.

From the conflicting criteria and confounding effects in neuro electrophysiological studies, the authors suggest a comprehensive longitudinal study with a multimethod approach for monitoring EEG and ERP attributes of heroin addicts from early stages of withdrawal until long-term abstinence to control the confounding effects, such as nicotine abuse and other comorbid and premorbid conditions.

Opioid withdrawal results in an increased local and remote functional connectivity at EEG alpha and beta frequency bands

Abstract

Withdrawal may be a natural model to study craving and compulsive drug seeking, since craving can be viewed as a conditioned dysphoric state.

It has been suggested that functional connectivity between brain areas may be of major value in explaining excessive craving and compulsive drug seeking by providing the essential link between psychological and biological processes.

We applied the novel operational architectonics approach that enables us to estimate both local and remote functional cortical connectivity by means of EEG structural synchrony measure.

In 13 withdrawal opioid-dependent patients, we found the evidence that local and remote cortical functional connectivity was indeed significantly enhanced (for both alpha and beta frequency oscillations).

Additionally, a statistical relationship between functional connectivity and the severity of opioid withdrawal has been found.

Quantitative EEG and Low-Resolution Electromagnetic Tomography (LORETA) imaging of patients undergoing methadone treatment for opiate addiction

Our study investigated differences in resting gamma power (37-41 Hz) between patients undergoing MMT for opiate dependence, illicit opiate users, and healthy controls subjects.

Electroencephalographic data were recorded from 26 sites according to the international 10-20 system. Compared with the healthy controls subjects, people either undergoing MMT or currently using illicit opiates exhibited significant increased gamma power. The sLORETA (standardized low-resolution electromagnetic tomography) between-group comparison revealed dysfunctional neuronal activity in the occipital, parietal, and frontal lobes in the patients undergoing MMT.

A more severe profile of dysfunction was observed in those using illicit opiates. **Our findings suggest that long-term exposure to opioids is associated with disrupted resting state network, which may be reduced after MMT.**

Acute effects of methadone on EEG power spectrum and event-related potentials among heroin dependents

This study aims to investigate the acute and short-term effects of methadone administration on the brain's electrophysiological properties before and after daily methadone intake over 10 weeks of treatment among heroin addicts.

EEG spectral analysis and single-trial event-related potential (ERP) measurements were used to investigate possible alterations in the brain's electrical activities, as well as the cognitive attributes associated with MMN and P3.

The results confirmed abnormal brain activities predominantly in the beta band and diminished information processing ability including lower amplitude and prolonged latency of cognitive responses among heroin addicts compared to healthy controls.

In addition, the alteration of EEG activities in the frontal and central regions was found to be associated with the withdrawal symptoms of drug users.

Certain brain regions were found to be influenced significantly by methadone intake; acute effects of methadone induction appeared to be associative to its dosage.

The findings suggest that methadone administration affects cognitive performance and activates the cortical neuronal networks, resulting in cognitive responses enhancement which may be influential in reorganizing cognitive dysfunctions among heroin addicts. This study also supports the notion that the brain's oscillation powers and ERPs can be utilized as neurophysiological indices for assessing the addiction treatment traits.

Why is Change Needed?

The current system frequently (spectacularly) fails patients with opioid addiction

- Denial, denial, denial!
- Getting opioids is easy, getting help for OUD is hard
- X-waiver requirement to prescribe MAT medications
- Referrals/appointment labyrinth
- Insurance authorizations, treatment contracts
- Stigma/social factors keep patients from access to help
- Abstinence-based treatment approaches are cruel/doomed
- What if we considered substance addiction as a brain disease instead of a moral failure?



Current Situation

Many barriers in "the system" keep patients from recovery!



Medical overprescribing of opioids and/or Street supply of opioids/ illicit drugs

Early use/mild OUD

- Daily dose may be low withdrawal is mild
- no recovery offered = missed opportunity

Severe OUD/IVDU

- Risky Behavior
- Severe Withdrawals
- Intervention appears futile = missed opportunity

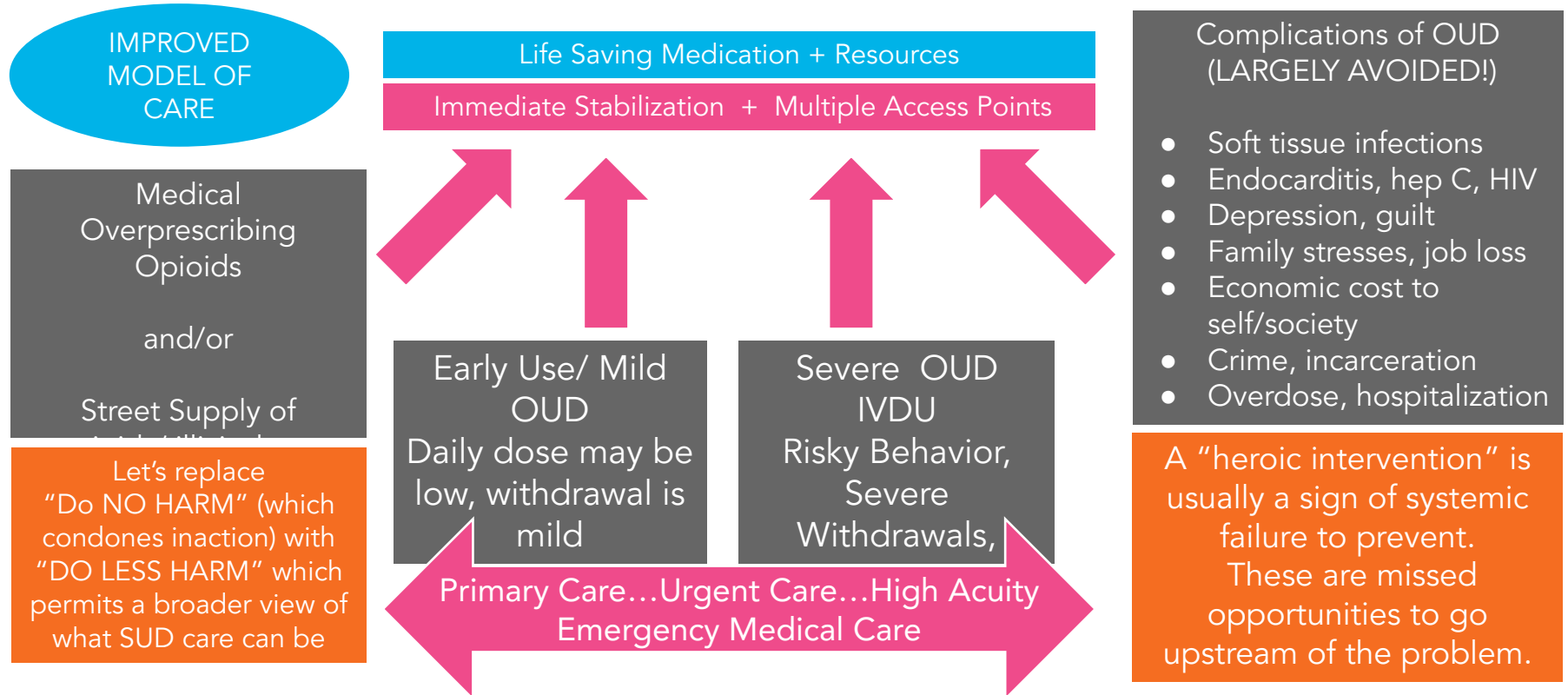
Complications of OUD

- Soft tissue Infections
- Endocarditis
- Hep C & HIV
- Depression, guilt, family stress
- Job loss
- Economic cost to self/society
- Crime & incarceration
- Overdose & hospitalization
- Death

Primary Care...Urgent Care...High Acuity ED Care

Goal: The Health System Can Identify, Treat And Refer At-risk OUD PATIENTS At Any Stage

...precisely the same thing that we have come to expect with EPILEPSY



RECAP: Working Smarter, Not Harder

- Health care treats some brain illnesses well (ex: epilepsy, MS, etc)...
- But it fails patients with the chronic brain illness of opioid addiction
- MANY logistical, structural, and cultural barriers to effective care

- When we treat opioid use disorder as a seizure disorder, it helps the ED team readily care for these patients within a familiar framework
- We don't have to "adopt" a new set of concepts (from addiction medicine), we could just expand what we already know/do in EM

THE BIG IDEA:

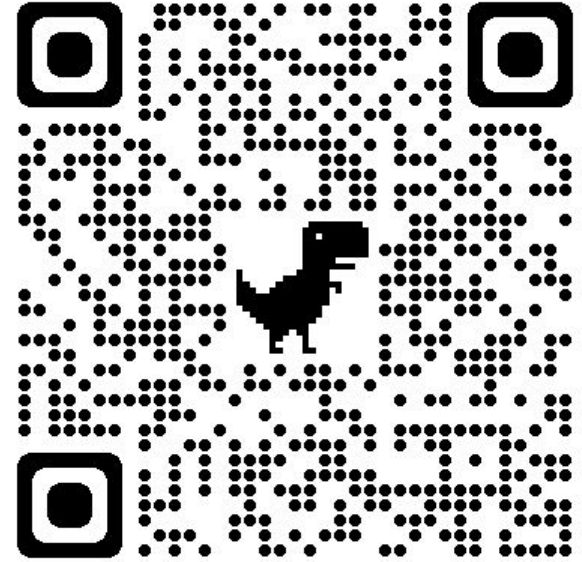
opioid withdrawal = active seizure = emergency!!

Stories from the frontline

A Patient-Centered,
Rapid Access
Approach to
Substance Use
Disorder



Harm Reduction Strategies for the Hospital Setting



Trauma-Informed Care



APRIL 2021

Trauma-Informed Care for Opioid Use Disorder

*Improving the Success of Medication for Opioid Use
Disorder by Integrating Trauma-Informed Approaches*



Culture of Care



NURSING RESOURCE

Culture of Care

Considering the **culture of healthcare** and framing **how we think about people who use drugs** is one of the most critical and challenging aspects of this work. Many healthcare providers have sustained moral injuries and developed discriminatory thoughts or behaviors related to substance use disorder (SUD).

“Moral injury describes the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control.”¹

If people have felt bias or stigma in the past, they may leave AMA² or even avoid seeking life-saving healthcare solely based on prior negative experiences or perceived discrimination. It is vital to be aware of our own perceptions and biases in order to **intentionally reduce stigma** and prioritize excellent patient care.

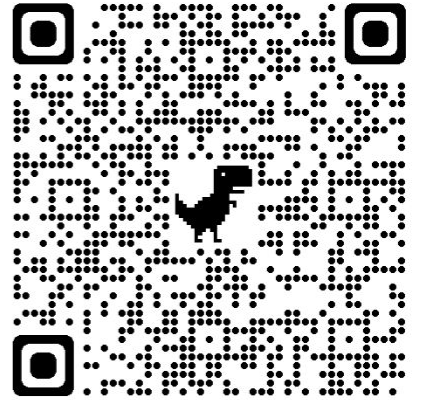


Advancing Equity and Reducing Harm to Communities of Color from Drug Use



Request Technical Assistance

CA Bridge provides technical assistance to any hospital or health system seeking support to educate clinicians and health systems on medication for addiction treatment (MAT). Submit a formal request here.



Join us.

cabridge.org

Visit our website for tools and resources

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[@BridgeToTx](https://twitter.com/BridgeToTx)



SUN
UC DAVIS
MEDICAL
CENTER



Substance Use
Navigator

Bridge Program

Overdose Prevention

SUN TEAM

Sandy Overby	SUN
Jovon Beck	SUN
Jolie Reyes	SUN
Kyle C	SUN
Tommie Trevino	SUN



Tommie

Jovon Sandy So





How our work saves lives

Problem

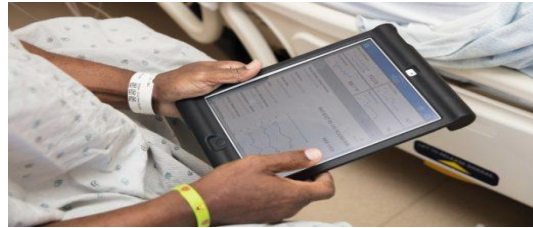
- Patients that struggle with Substance Abuse / Mental Health
- Insurances

Solution

- Meet Patients where there at Harm Reduction / Principles Relapse Strategies
- Clinics



Adapt to Pandemic





Learning to Adapt to Change Partnering with In House Units New Clinic

Success Story

Mr. Trevino, my name is MM. The caring staff, at UC DAVIS, which includes you, and Sandy saved my life. I am a true success story. If anyone has doubts...I can tell them that with a little patience, and the support from YOU AND SANDY, they can be on the road to great recovery. I am on suboxone. It saved my life. I am back at work; my husband and I we bought our first home. Even with the PANDEMIC, everything worked out great, because of your caring help and support .



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