Season 3 Episode 5
The Breadth of Addiction Medicine
Transcript

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Learning objectives:

1. Define the terms dependence, substance use disorder, and addiction.
2. Summarize 3 practice settings where addiction treatment occurs.
3. List 4 of the key components of the American Society of Addiction Medicine's multidimensional patient assessment for developing an addiction treatment plan.
4. Review some of the challenges with addiction in the setting of the COVID-19 pandemic.

[0:00-2:46] Introduction
Marianne: Welcome to the DEI Shift, a podcast focusing on shifting the way we think and talk about diversity, equity and inclusion in healthcare. My name is Marianne Parshley. I am a general internist practicing primary care medicine with a geriatric focus in Portland, Oregon. I serve as a Regent of the American College of Physicians and I'm an immediate past governor of the Oregon chapter of ACP. And I'm a healthcare advocacy enthusiast. I also love commuting by bike and getting out into the mountains to think.

Brittäne: And my name is Brittäne Parker. I am an internist and academic hospitalist with a strong focus on medical education. I've taught medical residents since my chief residency year and enjoy promoting wellness as well as modeling it myself. So in my spare time, you'll find me on the softball field or trail running in the Sonoran Desert.

Brittäne: As your co-hosts today, we're delighted to talk about the breadth of addiction medicine. We will first define some terms for our audience, and then we will introduce our guest. The first term that we would like to define is "*physical dependence*", which is a dependence on a substance, which does not necessarily indicate any disorder or addiction, and may simply reflect a pharmacological effect.

So some characteristics of this is tolerance, using larger amounts of substances to obtain the same effect. And then there is the word "*substance abuse*", which really has been changed to "*substance use disorder*", indicating unhealthy use, including hazardous or at-risk use of any substance, such as, but not limited to, alcohol and opiates.

These terms have been changed in recent medical literature to give a more medically defined term, and in order to use person first language, which decreases stigmatization. For instance, instead of stating that someone is an alcoholic or alcohol abuser, we would state that the patient has an alcohol use disorder.

Also, we avoid using other words in relation to substance use disorders, such as "*misuse*", as it seems to have an implied value judgment, or the term "*problem*" as this can be seen as a pejorative term. We will try to keep this in mind as we move forward in our discussions. And then we come to the word "*addiction*".

The American Society of Addiction Medicine defines addiction as a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. Some people with addiction use substances or engage in behaviors that become compulsive and can often continue despite harmful consequences.

[2:47-4:07] Introducing Dr. Chwen-Yuen Angie Chen
Marianne: Now that we've defined some of the terms we'll be using, let's introduce our guest: Dr. Chwen-Yuen Angie Chen. Dr. Chen graduated from the University of California, Davis School of Medicine and went on to complete a year of psychiatry internship at the California Pacific Medical Center in San Francisco before finishing her internal medicine training at Santa Clara Valley Medical Center in San Jose.

She is board certified in internal medicine and addiction medicine, clinical associate professor at Stanford University School of Medicine in the division of primary care and population health, and the governor of the Northern California chapter of ACP. She has worked in primary care and hospital settings, including a methadone clinic, and is currently the medical director of the primary care chemical dependency clinics within the Stanford healthcare system.

She is also a champion advocate. Governor Newsom just signed a bill Dr. Chen was instrumental in introducing and pushing through, which requires all substance use disorder programs in California to assess patients for tobacco use and offer treatment options. Dr. Chen,

welcome to the DEI Shift podcast. We often use first names on the DEI Shift. Is it okay if we call you by your first name?

Angie: Absolutely, that first part of it is a mouth full.

Marianne: Great.

[4:08-5:53] "A Step in Your Shoes" Segment
Marianne: Let's transition to our next segment, "A Step in Your Shoes".
Angie, in this segment, we ask our guests to share an element of their background or culture that has been important in their life. This could be anything from a type of food or drink, a song, poem, or a life experience. The goal is not only to get to know our guests on the show, but also to build cultural competency and humility. With that said, what would you like to share with us today?

Angie: Thanks for that question. I think I'll share an important part of my background that informs my relationship with patients. I left high school early and earned my equivalency diploma and then spent many years exploring, shall we say. I went on to study film at NYU. I later became a Tibetan Buddhist nun and all in all, probably had 31 different types of jobs, ice cream flavors in many sectors from waiting tables to teaching, to making floral arrangements and working at NASA.

I've been on public health, waiting months to get an infected tooth pulled and getting my care in emergency rooms. So my life has been filled with unexpected turns. Always strive to be true to myself and to answer to an internal compass of authenticity. And I was told many times you won't get into med school, so don't even bother.

So all of that has helped me relate to patients from all walks of life. And if there is anything, I know it's how to deliver the message of hope.

Marianne: Wonderful. Thank you, Angie.

Brittäne: Yeah, that is fantastic, thank you for sharing.

[5:54-9:49] The Continuum of Care in Addiction Medicine
Brittäne: So Angie, we're so glad to speak with you today on this topic of addiction medicine, and as a framework for our audience, I'm going to briefly outline the topics we plan to discuss during this episode.

We will be talking about the continuum of care in addiction medicine, an important topic for clinical practice and training education, as well as the destigmatization of addiction and the medical model of treatment of addiction, and the importance of screening, as well as some unique challenges during the COVID-19 pandemic.

So I think first, maybe we'll start off on a definition of addiction medicine, where it takes place, and the longitudinal nature of the care that's needed.

Angie: Sure. I want to add to that definition of addiction that was described before and mention that it is also described as a chronically relapsing and remitting disorder that's characterized by reward seeking, so the binge intoxication component. And then it develops into the compulsion to use, so craving, anticipation, and then there is the dysphoria component, so that's withdrawal, and there is an aspect of addiction that we don't often see in other disease processes, although we call it the disease model, and that is that loss of control, which is why the behavioral component is an important one that needs a different set of tools to address. It requires motivating to change, and that's perhaps the most challenging part of treating addiction.

Addiction medicine practice settings, you asked, range from the medical withdrawal management phase, otherwise known as detox, and that can be in the emergency room, the ICU or medical ward, to a residential facility that has full-time nursing staff. And then there are the outpatient settings such as partial hospitalizations or intensive outpatient treatment programs, IOP as they're known, to the ambulatory medical settings, such as the primary care office or an opioid treatment facilities, such as a methadone clinic. Withdrawal management and 28 day stints in a residential facility are, but the tip of the treatment process.

I often tell people developing an addiction doesn't happen overnight. It is often compounded by psychiatric illness, trauma, adverse childhood experiences… Therefore recovery from substance use disorder doesn't happen in 28 days. And I think the expectation that it can, perhaps, during let's say one rehab stint is what is a setup for disappointment and frustration.

Diabetes is a similar chronic process that can be well-controlled or can not be well-controlled and we are expected to follow it throughout a patient's life.

Brittäne: Yeah, thank you, Angie. You've brought up so many good points, and one thing that I definitely have learned in conversations with you before this conversation is the American Society of Addiction Medicine criteria, which is one of the widely used and comprehensive set of guidelines for the appropriate placement of patients in the outpatient or inpatient setting as you were discussing. But also they talk about adolescent and adult treatment plans, which are developed through a multidimensional patient assessment, looking at withdrawal potential, comorbidities, emotional and behavioral issues, as you discussed, as well as the readiness to change, relapse, and recovery.

And we definitely will add a link to these criteria and that website in our show notes for our listeners. So I'd like to also highlight the importance of destigmatization and addiction, and the fact that while a medical model of addiction exists, as a medical community, we could be doing a better job of implementing that. And I would really like for you to talk about some of your work as a champion advocate.

[09:50-12:40] Advocacy work in Addiction Medicine

Angie: Sure, thank you for asking. That started years ago, because I noticed that a lot of my patients would enter treatment, perhaps having tried to quit and successfully quit or have been naive to smoking tobacco, and then they would come back from rehab, smoking a pack a day, for instance. And this just frustrated me to no end. And it was just this personal peeve of mine that they go in with a whole host of issues and they work on them and then they come out with an extra one. It's the party favor, when you come back out!

But it just bothered me. So I started writing resolutions and trying to push it through, and it didn't have much success until I was introduced to my—I'm a constituent for my local legislator—and then I was introduced to him and then showed up to a coffee meeting at the local library and said, “Hey, I'd like to work on this topic. Do you have any interest?” And fortunately the timing was right and they did pick it up and then the work began and then to write it and to get all the stakeholders involved, such as the Consortium of Treatment Centers, getting society medicine, like California Society of Addiction Medicine, ACP signed on as well. And then, then COVID hit. And so testimonials stopped and then things were put on pause and there were greater fish to fry such as the pandemic.

And so finally it went through and so I'm really proud of it. And I want to put a shout out to my co-author Kathy McNaught-Donald who also found this to be really an annoying clinical issue. And if there's anything I can say about making legislation happen, it's a long process. And patience, and I've learned a lot about being patient and getting stakeholders involved. And you may shoot for something greater, such as wanting all tobacco use banned, but sometimes you fall short, but it's a first step.

And so taking that first step and being willing to negotiate and compromise is so important. And that's what I've learned in this process.

Marianne: That’s great, and those are lessons that I think all physicians need to learn. The ACP chapter in Oregon helped co-sponsor the measure that decriminalizes the possession of small amounts of illegal substances, and also is trying to get the use of the marijuana tax to fund free evidence-based culturally appropriate addiction treatment. And it wouldn't have happened without all of those things you mentioned.

[12:41-15:23]-Cultural competency and Destigmatization

Brittäne: Yeah, and I really hope that this is an encouragement to anyone who is listening, who is trying to work on different issues for their patients, and sees what they want to do or what they want to see change. And it takes time and effort and collaboration. So I think that your story highlights that, Angie.

Angie: Thank you. There's this subject of structural competency versus cultural competency that is being taught, and this is a higher order level of looking at barriers to treatment.

And the definition of structural competency is that trained ability to discern what you see clinically as being the result of upstream decisions that are more systemic. And there's some literature on this by Metsul and Hansen, and they talk about cultural sensitivity doesn't necessarily reduce stigma in practice.

So knowing someone's culture doesn't necessarily reduce the stigma or improve clinical outcomes. So cultural competency is often framed as ethnic identity and those types of things, and yet they don't solve the barriers to treatment necessarily. So there are these ethical, political, governmental bureaucracies that are involved and unspoken between us and the patient, way before the patient enters the room.

And part of the five core structural competencies includes talking about that language of structure, framing, a stigma as like structural violence and like tuberculosis and HIV, there was a lot of, I would say, structural violence against those people there.

Basically, what is that withholding? You're a system that withholds resources to a certain subgroup. The war on drugs is a violent war on black and brown people, for instance. And we talk about now, there is all this imperative to include DEI in all research and all CME's, and we talk about race, but we don't talk about what racism really is.

We talk about race affecting genetics and outcomes and all this stuff, but we don't talk about really how it makes people feel and what it is and how it's set up. And so then I think about addictions and the structural violence against those who suffer from use disorders and how resources are limited for so many people.

[15:24-20:48] The Screening Process

Marianne: So obviously in order to treat substance use disorder and addiction, we have to figure out who has it and who is at risk for it, which means that we need to be aggressive in screening for substance use disorder, both in primary care settings and in inpatient settings where patients are at increased risk for withdrawal.

ACP had a health and public policy paper on effective prevention and treatment of substance use disorders. And they had a quote in there, that in 2000, the National Center of Addiction and Substance Abuse published a study showing that 17% of primary care physicians felt very prepared to identify illegal drug use and 30% could identify drug misuse.

So ACP recommended education for physicians be rigorously elevated to ensure effectiveness and continued access to care and be designed also to prevent onerous burdens on patients and physicians. There are barriers to screening, which I'm sure you're aware of from your primary care background, and they include time and discomfort and lack of knowledge, but there's also a worry about impact on the patients just asking the questions.

So how do we, as physicians, talk about addiction without feeling like we're cramping our patient's lifestyle, and are there culturally appropriate screening tools that we should be using for risky drug and alcohol abuse?

Angie: So according to the statistics, it's 83% are uncomfortable. I think that's, perhaps phrasing it that way, just it highlights what the issue is that 83% are uncomfortable doing this. I get this question a lot from the trainees that they are uncomfortable asking, they're concerned about cramping someone's style or making a judgment and I think that contributes partially to the stigma of it. And there are a lot of components and a lot of structural forces behind that. You can't talk about why we don't screen and how should we screen, without talking about the stigma of substance use. And you can't do that without talking about the lack of education and why.

But to speak about screening in particular, I often say, can we provide nonjudgmental universal screening by just asking: how much do you use normally? So for instance, for alcohol, which is ubiquitous, alcohol use, how much alcohol do you normally use? Do you use weekly or daily? It's like a litmus test and you just ask rather than say, do you use alcohol. Someone could just. No. For instance, I went to my own annual visit and the medical assistant just looked at me and flat out said, “No alcohol.” And then she typed in, “No alcohol.” She didn't ask me. I know. Why would she assume that I don't drink? Because I'm an Asian woman who looks relatively healthy? So she just brushed over it.

I once met an 88-year-old Japanese woman who answered my screening question, as I just said, “How much alcohol do you normally use weekly or daily?” And she said she drank beer daily since she was five. I think simply asking in that way is helpful. And I think asking about cannabinoids and vaping will also be important.

But just asking as, as you assume that someone might use and that you just, you ask. Right. And making the specialty of addiction medicine known. I know that the real estate in the curriculum, real estate is limited. And, and so everyone's vying for a part of the teaching curriculum. And I say, so then make it a part of each discipline rather than a separate curriculum. If there isn't time to incorporate it into orthopedics, for instance, because you'll see plenty of substance use consulting in the ER, when you're consulting in the ED on a trauma service. You'll see it as a part of an oncological discussion of smoking and lung cancer, for instance, alcohol and breast cancer. Fold it into palliative care, certainly opioid use disorder falls there. And we see plenty of substance use in GI service, fold it in there. Certainly we can address it in internal, family medicine and psychiatry, as you mentioned.

I once saw a patient who was never asked about her alcohol use with B12 deficiency, macrocytosis, and persistent falls, over and over, each admission. And I think it's just, you don't know what you don't know. And so if it isn't mentioned, you, you just need a mention, right? So you're on GI service and you're like, alcohol is a huge thing so is injection drug use. And then the next instructor says the same thing. Oh and by the way, alcohol is a big thing, so it was injection drug use. You hear it enough times and then, like you go into trauma service and it's oh, alcohol is a big thing. It contributes to accidents. Oh, so does you know cannabis and alcohol together, oh. Eventually through repetition, I think we'll get the message. The thing is, it's not even part of the differential, sometimes.

Brittäne: Angie, you are right. There are so many places where we can incorporate screening into our practice.

[20:49-25:08] The New Challenges Arising from the COVID-19 Pandemic

Brittäne: And, since the COVID-19 pandemic we know that substance use has been on the rise. Especially with more of the population working from home.

There are a few statistics that I'd like to share with our listeners. So, a Nielson consumer study reported a 54% increase in national sales of alcohol for the week of March 21, 2020 compared with 1 year before; and online sales increased 262% from 2019 to 2020.

In August 2020, The *Morbidity and Mortality Weekly report which is prepared by the CDC stated* that 13.3% of nearly 5,500 surveyed U.S. adults reported that they had started or increased substance use in the last 30 days to cope with pandemic-related stress or emotions.

SImilarly, the American Psychological Association conducted a survey of US adults in late February 2021 by The Harris Poll which showed that nearly 1 in 4 adults (23%) reported drinking more alcohol to cope with their stress during the coronavirus pandemic. And this was really amplified among parents, essential workers and people of color. That March APA report warned that this is "likely to lead to significant, long term individual and societal consequences, including chronic illness and additional strain on the nation's health care system."

We can already see the downstream effects at New York City's Mount Sinai Hospital where interhospital patient transfers for alcohol associated liver diseases increased between the pre-pandemic period to the summer of 2020 by 62%. Their findings confirmed predictions of rising alcohol use disorder and liver disease as a consequence of the pandemic but also, they highlighted another contributing factor to the racial and ethnic disparities in COVID-19 morbidity and mortality. Dr. Gene Im, a hepatologist at the Recanati/Miller Transplantation Institute and Mount Sinai, along with his co-authors, noted that "the aftershock particularly affected ethnically diverse patients with alcohol-associated liver disease with high inpatient mortality, reflecting the disproportionate impact of COVID-19 on underserved and minority populations."

So we definitely have a problem on our hands. Angie, have you seen similar issues in your practice?

Angie: Oh, so many things to say about this, where to begin. Definitely the referrals I've received for alcohol liver disease have skyrocketed. And for the longest time we spoke about the opioid epidemic pre COVID and certainly that has been tragic.

But all along though, alcohol use disorders has, has had such a higher mortality, 14 million, as opposed to opioid use disorder with 2 million. Reflecting on this. It's partially not a surprise because pre pandemic there, there was already the messaging that wasn't done. And so this hearkens back to education where our perception of alcohol use was more perhaps, um, a benign one, we didn't screen universally and we didn't message the risks of use. Alcohol use disorder has hit every socioeconomic, ethnic category that you can think of.

Marianne: I'm going to add geriatrics to that. So it's every socioeconomic and age group. We assume people with early dementia don't drink.

And we assume people who are women at home don't drink, but I've seen this tremendous rise and just started thinking about it when I began to see older female patients, in particular, landing in the ER, with falls, and, to my surprise. An astute ER doc last summer, 2020 did an alcohol level on a patient when it was sky high and never been, ever been drinking before the pandemic, but somebody brought her a beer and then one thing led to another. Yeah, it's been a huge problem.

[25:09-29:57] Overdose Prevention Education

Marianne: Besides prevention, besides recognition and treatment, we can do something to prevent the overdoses, even though there are fewer people with substance use disorder and there's far more people who are using alcohol that way. There has been a rise according to the CDC of overdose deaths, by at least 18.2% in the months between May 2019 and May 2020, most of which happened between March, 2020 and May, 2020 and it's continued.

So the CDC published a health advisory, an emergency health advisory, in December, 2020, making some recommendations based on that and the first one was the provision and use of Naloxone and overdose prevention education.

Unfortunately, we aren't equipped well for that. There was a study in 2020 in the Journal of Addiction Medicine by Dr. Linda Wang and colleagues looking at IM residents' feelings of responsibility, confidence, clinical practice in opioid overdose prevention and Naloxone prescribing. A majority of the residents felt confident assessing the risk for opioid overdose, but only 45% of them felt confident in providing overdose prevention, education, and prescribing Naloxone.

And speaking from experience, primary care physicians really feel reluctant to do this often, or they forget about it, or they don't think about it or they get the drug management agreement in place and they do the urine drug screens, but they don't do the Naloxone prescriptions when the MED goes over 50. I guess I'm wondering how you would suggest that we go about spreading the word about that.

Angie: Various systems have made pop-up screens where you can't prescribe an opioid without Naloxone being prescribed. I think this is tremendously helpful from a systems point of view, but let's say you don't have that. I'm assuming that's what you're asking.

Marianne: Oh, we do have that, but it's not, it's not mandatory in our state, it's just, here's the notification that maybe this patient needs Naloxone. I think it's, I think it's a couple of things. I think, first of all, I think times, and yes, I've got to do six more clicks to get the Naloxone in. I also think it's lack of recognition so sometimes people can fly under the radar screen and still need it and when they're getting covered by a bunch of different people and different people in a practice or a team, or are okaying refills on medications, it's easy for it to rise. We've got the PDMP so we can see that, but many people don't check it.

Angie: This is where legislation helps. I think some sticks, unfortunately, or dangle some carrots, I don't know, try to incentivize it.

And so there's no wrong door. If anybody who remembers, seasoned opioid prescribers, you can add a Naloxone prescription to that. That reminds me also, these overdoses are often comorbid with other substances, especially alcohol and benzodiazepines. And I think since 2015, when at the height of all the discussion around the opioid overdose epidemic, I would often say, but then there's the benzodiazepine, the hidden epidemic that in conjunction with the opioids is where you have the highest risk for overdose.

And along with, let's say, alcohol is where you get the respiratory depression and then, the overdose. The PDMP can also see other controlled substances, especially benzodiazepines. And I think it's that co-prescribing, that is, that is so lethal.

And we also have to be mindful of that, it is overwhelming. Just speaking about it to you right now, I go, oh my God, you know this, and then COVID and this, and what are we asking of our physicians? What are we asking of our healthcare system? I, I get it.

Brittäne: Well, thank you so much for this discussion. We have talked about so much, including different terms like dependence, substance use disorder, and addiction, the continuum of care in addiction medicine, education for trainees and physicians, as well as screening for substance use disorder, harm reduction, overdose prevention, and the unique challenges that we faced during the COVID-19 pandemic, as well as the importance of de-stigmatizing addiction.

[29:57-31:39] Closing

Brittäne: So we would like our listeners to continue this discussion online. We'd like to hear your stories related to this topic, your questions, and any specific barriers or challenges you have faced yourself. We will have many resources, including some of the studies that we have outlined and some links to advocacy and working with state medical boards to change regulations.

It was great having you on today, Dr. Angie Chen and everyone, please tune in for future episodes.

Season 3 of The DEI Shift podcast is proudly sponsored by the American College of Physicians Southern California Region III Chapter.

The DEI Shift theme music is by Chris Dingman. Learn more at www.chrisdingman.com.

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