Shine a Light on Stigma Podcast

Transcript - Episode 3: Stigma and Addiction: A Pharmacist Perspective, with Denton Chancey, PharmD

Note: The Shine a Light on Stigma Podcast is produced for the ear and designed to be heard. This transcript is intended to augment the recording.

This podcast is part of a series that explores ways to eliminate stigma and help people with substance use disorders access the medical care they need. Produced by Superior Health Quality Alliance and Telligen, Quality Innovation Network-Quality Improvement Organizations under contract with the Centers for Medicare and Medicaid Services, an agency of the U.S. Department of Health and Human Services.

Mia Croyle: Hello, and welcome to the stigma podcast. In this podcast. We're talking about the ways that stigma impacts people living with substance use disorder, and we aim to inspire and empower our listeners to shift away from the culture of stigma towards one that promotes healing and recovery in a supportive and respectful way. I'm Mia and I'm here again with my co-host Brittany. Hi Brittany!

Brittany Rodriguez: Hey, guys, I'm excited to be back.

Mia: Before we jump into our content for today, I just want to invite any of you that are tuning in for the first time to take a moment either before or after you. Listen to this one and go back and listen to our first two podcasts, the first podcast, Brittany and I talked about our sort of our Why, what draws us to this work, and in the second podcast we reviewed some of the resources that our respective organizations have developed for tools to shift this culture of stigma.
So those are there, and you can find our podcast at your favorite podcast streaming service, and feel free to subscribe, because then you won't miss any of our future episodes moving forward from here. So this is episode number three, and we have a guest. This is our first episode with a guest joining Brittany and I, so, Brittany, do you want to introduce our first ever guest?

Brittany: Welcome. I feel like I should give a like come on down. The price is right! Today. I'm really excited to introduce you to my partner here at Telligen. His name is Dr. Denton Chancey, and he is a pharmacist joining us with a very vast background that really lends to benefit us here, especially on this conversation. So, he has a history. Well, let me back up. He actually attended Oklahoma University College of Pharmacy, and from there he went on to do multiple different things, serving in multiple areas of focus from pediatric inpatient to rural Oklahoma local pharmacy all the way into quality improvement and focusing in on opioid use disorder. So we are lucky to have him here and excited to really hear about what you have to say today.

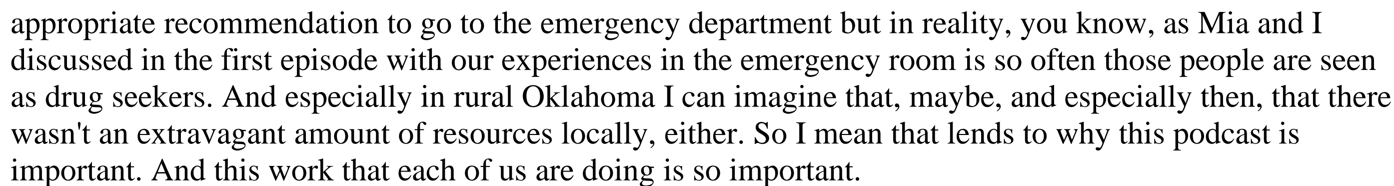
Denton Chancey: Thanks for the kind words, Brittany, and it's an honor to be here. I'm just excited to have this conversation.

Brittany: Yeah, we feel it's important, so we're excited, too. But as our first guest we wanted to start a tradition here on this shiny announcement, podcast, and that is to ask all of our guests their Why. You

know, why is this work important to you? And you know, how did you get here, really? And what's impacted you?

Denton: Yeah, that's a great question. I think you'll probably have a lot of really interesting answers come out that as you as you go through with the series. For me, you know, I remember being about three months out of pharmacy school, and so I'm a really young guy, and obviously a very new healthcare professional, and I am working in a rural town in Oklahoma, and I'm managing this pharmacy. And when I'd gotten there I had inherited a man and a woman they were, I'm guessing, probably around 60 or so. Very sweet, very kind people when they would come in, and I'd see them. But you know one thing that alarmed me was that they had I think they had about four different prescriptions, a couple of different opioids and a benzodiazepine and a muscle relaxer. And the doses of all these drugs were at the very tippy top level of acceptable. and probably pushing the envelope into unacceptably high doses of these of these drugs. And I'm new. I don't exactly know what to do with this. Unfortunately, the person who was my boss at this pharmacy his theory was: Well, this is great, you know. We could just make a lot of money off of these people, and maybe they'll tell their friends, so that wasn't really helpful. Yeah, not at all. It was fortunate, the situation sort of resolved itself, and that's the story I'd really like to tell. So, the gentleman called me one day, and he says our doctor has been arrested. Side story there is that eight of this physician's patients actually overdosed in like a four, six-week period for all the medications. Right? Horrible. This one of those stories that you hear about news. So he'd been arrested and taken into custody.
But it left these folks, these patients of mine, without their access to these medications. and even then, in that moment, so, being very, very green, I could tell that he was, you know, in the middle of withdrawals, which is very painful. It can be dangerous, you know. But what was interesting is he So he calls and he tells me this, and he's like I need help. What should I do? And I'm like Well, you know really what I would say is, and this is kind of a naive recommendation in hindsight, but you know I'm like, if you feel like your health is an imminent danger, you should go to the emergency department. And he says, you know I need. I need some of our pills. He's like. Can you help me with that. Can you give me these pills? And I'm like? Look, you know, there's really no way that I can do that. There's no legal mechanism for me to do that. I would be, you know. I just can't. It doesn't work like that. Controlled substances. No way. You know what I mean. That's a big no-no.
But the point of the story really comes next in that, you know, he begins to supplicate me in a way that I can only describe as begging. I mean, he was begging me for these medications, and we use that word a lot, right, you know. Oh, my kid was begging me for a popsicle or whatever. But I don't think most of us. I know it's probably the only time in my life I would say someone was actually begging me to do something for them. And that moment I think I see as a as a seed for all of the work that I've done in opioids, you know. Since then, just the change in my process, because I was a new pharmacist. I was a product of rural Oklahoma so definitely, not the most maybe enlightened, and some of my attitudes towards this stuff. In that moment I realized this is not some moral failing, that this guy and his wife have fallen into. This is a sickness. This is a disease they have that he's literally…God knows what symptoms he's having right now from not having these medications, and he's just begging me to make this go away for him. You know what I mean. He's not some sinister guy that like, you know, whatever the trope is that wasn't it. He was begging me to help him. And that moment stuck with me.

Brittany: I can imagine. I mean, that's a moving moment when you have someone you know almost at your mercy like they're asking for your help, and that. And I think you know you mentioned that maybe that was a naive recommendation, and I would disagree, I think, in the best case scenario world that would be an

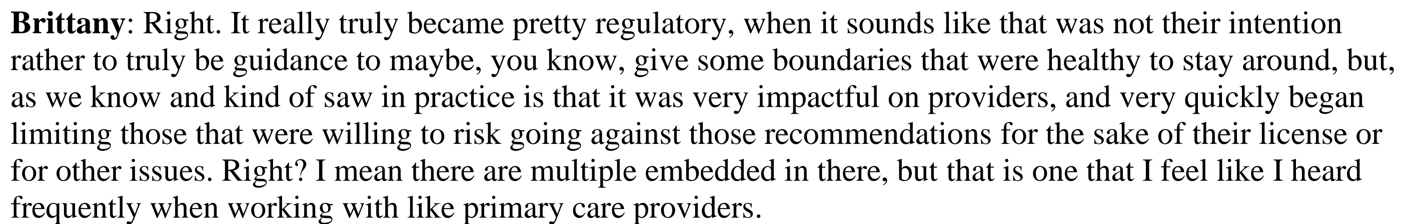


appropriate recommendation to go to the emergency department but in reality, you know, as Mia and I discussed in the first episode with our experiences in the emergency room is so often those people are seen as drug seekers. And especially in rural Oklahoma I can imagine that, maybe, and especially then, that there wasn't an extravagant amount of resources locally, either. So I mean that lends to why this podcast is important. And this work that each of us are doing is so important.

Denton: Yeah.

Mia: Yeah, and sort of fast forward to 2016, when we have the guidelines from the CDC. And then fast forward to today. And I think that's what you were wanting to talk with us a little bit about is, you know, just the idea that we have been making progress on the policy front, so can you share a little bit about what some of the new developments have been, and sort of situate those in their context for us a little bit, Denton?

Denton: It depends on how you approach it. Right? Because I've heard talks on this on these types of subjects that just make you want to like, you know, doze off. What I like to think about is the way that these things impact actual human lives and actual health outcomes and not the regulations and the policies in and of themselves are not that interesting to me. But I do find them interesting when they start to have or have the potential to have an impact on people. So, you know, looking at the 2016 guidelines from the CDC. That you mentioned, the opioid prescribing guidelines, was the that was a watershed moment. Those were necessary to, you know, they don't seem like it now, but in a lot of ways they were kind of a wakeup call of people being like you know, we shouldn't be prescribing more than this many days' worth of opioids we shouldn't be prescribing over these doses, because the benefit's not there to the patient, while the health, while the risk of these other poor outcomes is there. So don't do this. That was great, you know. We saw decreases in high-risk prescribing practices and by high risk I mean either a really high dose of opioids or co-prescribing opioids and benzodiazepines, which has been shown to increase the risk of overdose by a factor of 10. So, we saw reductions in those things which that's great, that's a good thing.
Unfortunately, also, coming out of that there was some inappropriate and some misapplications of the guidelines, and I really think more than anything that's what the CDC was trying to get at with this new revision last year, and I don't know why I say, I think that: they more or less state it in the guidelines. That's really in the introduction. That's really what they're trying to do is to walk back some of those inappropriate applications. So you had things like you know, it clearly states in the original 2016 addition, that these guidelines are not meant for patients that have cancer or patients who are receiving palliative care. But there's been several documented instances of that occurring, and those patients being caught up in the guidelines.
To quote the CDC directly, you know one of the central tenants of their guidelines, was supposed to be that it that the recommendations were voluntary and intended to be flexible to support and not supplant individualized patient-centered care. Well, coming out of the publication of those guidelines in 2016, we had insurers using those decisions, or those recommendations in their decisions, whether to cover certain things, how many days to cover, you know, and then also laws that were passed to kind of codify these recommendations into law. This does happen in different disease states. You'll see insurers, especially using guidelines to help make their formulary decisions, but I think the extent to which it limited the ability to individualize care was really at the heart of the CDC's concern.



Brittany: Right. It really truly became pretty regulatory, when it sounds like that was not their intention rather to truly be guidance to maybe, you know, give some boundaries that were healthy to stay around, but, as we know and kind of saw in practice is that it was very impactful on providers, and very quickly began limiting those that were willing to risk going against those recommendations for the sake of their license or for other issues. Right? I mean there are multiple embedded in there, but that is one that I feel like I heard frequently when working with like primary care providers.

Denton: One hundred percent. I can't help, but just real quickly put in a plug against the kind of legalized medical system that we all have to operate in. It's not helpful. If you read patient safety literature, the threat of legal action in relation to medical practice, is not helpful for patient safety. But I digress a little bit. Forgive me you all. But to get to get back to more specifically talking about opioids, yes, there were a lot of actions taken by individual providers, and these have been documented, and this is part of what led to the 2022 revision. But the question is, is, was this in reaction to either real or perceived threat to their license due to the original CDC guidelines? Or was this cover to kind of act upon some, some stigma, maybe, that they have about patients with opioid use disorder, and we'll never know.
But you know, some of these things look like rapid opioid tapers, like inappropriately rapid, abrupt discontinuation of opioid or benzodiazepine, therapy which is never appropriate and can be dangerous. Rigid application of dosage guidelines. And then, you know, even a patient dismissal and abandonment, due to you know, maybe someone had a positive urine drug screen, and

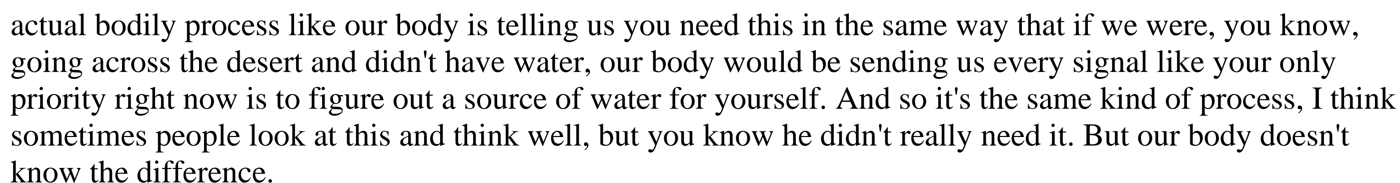
Brittany: Right, and even that piece is really interesting and impactful. Like that one patient abandonment, line, because of the strict nature of and the legal aspects involved with it; the second, that you have a positive drug screen, or anything that is seen in a negative light from a prescribers point of view you're fired, and good luck finding another provider, because they will call, and at that point it's essentially a death sentence. And those patients go from seeking medical help to going into withdrawal, and no longer being able to receive that medical help, but rather having to seek it out in other ways, which complicates this world even more.

Denton: It’s not a coincidence that as we begin to see a taper of prescription opioids going out back in kind of the early to mid-teens, we see an increase in elicit, opioid, overdose deaths originally heroin, now, fentanyl, and its analogs because the thing is is, if you take someone off of opioids abruptly, they're withdrawing, they're still a dependent upon those opioids. They still are going to suffer from the withdrawal symptoms, and for a lot of people that's going to lead them to using illicit opioids, which is not a moral failing. Once again, they are trying to treat their disease state when others, when the healthcare system won't, treat it.

Brittany: They are seeking a need that feels very real to them.

Denton: Well, it's like, going back to the gentleman on the phone with me as a as a brand new pharmacist, you know he, if you could hear it in his voice. He needed opioids the way that I need air, or I need water. And he was doing what he felt like he needed making that phone call to me to see if maybe I was a way that he get what he needed, he was gonna do it.

Mia: And when we say need, it's not just like I think sometimes that can be like a cognitive exercise, you know, like I’m thinking, oh, I need this, but you know I think it's important to always situate this that it's an



actual bodily process like our body is telling us you need this in the same way that if we were, you know, going across the desert and didn't have water, our body would be sending us every signal like your only priority right now is to figure out a source of water for yourself. And so it's the same kind of process, I think sometimes people look at this and think well, but you know he didn't really need it. But our body doesn't know the difference.

Denton: And one thing that I think a lot of times folks don't understand about dependence and withdrawal is we're not talking about seeking a euphoric experience at this point. Folks who have opioid use disorder generally are not experiencing an opioid euphoria, or you know, high is the colloquial term. What they're trying to do at that point is they – the long-term use of opioids has been shown to modify the way that the brain and the nervous system react – and taking opioids, actually just getting them back to baseline levels of neurotransmitters that those of us who don't have opioid use disorder we just have when we wake up in the morning.
And so you know, when you, when I think that's one thing people think. Oh, well, they're just trying to, you know there's chasing a high or whatever. That's not the case. They're trying to feel like normal people, you know that's the word that you hear a lot of times. They describe it themselves. They just want to feel normal.

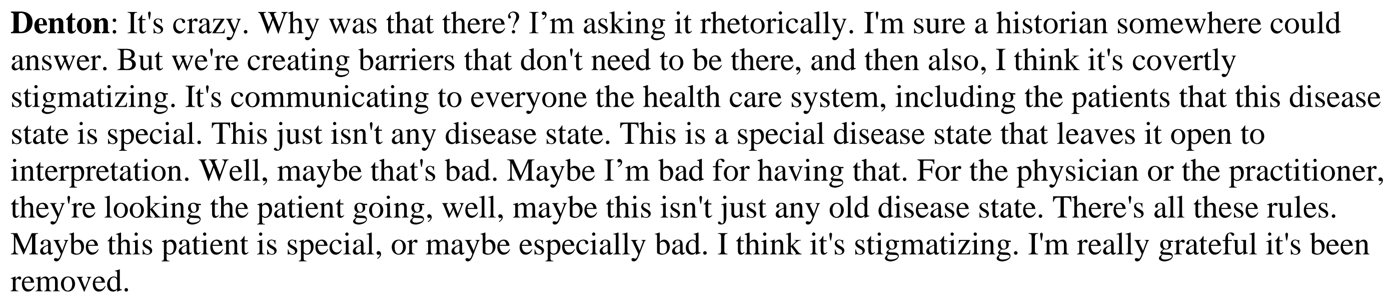
Brittany: Yeah, that is pretty impactful, because it does point to the fact of you know, back to the stigma that we've discussed so frequently here about it being a moral failing, or it being a choice, or you know they need their consequences. That tough love, when we really get down to the science of it, right, it doesn't quite bear that out. That's not really what it looks like.

Denton: One hundred percent.

Mia: And so Denton, if you, we mentioned that there's, you know, been this update about six months ago. What are the like top three things contained in that update, or what are the biggest changes from your point of view.

Denton: You know, I would almost just point to one, Mia. And really I would sum it up because the recommendations, the actual, like nuts and bolts of the recommendations really haven't shifted or changed in major groundbreaking ways. What I will say, though, is the tone. It is the emphasis on individualized care for patients. It is the emphasis on not codifying these things into law. And I think that in and of itself is anti-stigma because we don't spend the energy, you know codifying other types of health care guidelines. But for some reason with opioids, the need was felt there, and I'm not saying it's all bad. I'm not trying to throw the baby out with the bath water here, but I think that it's the tone is the shift in tone, I would say, and also one thing I don't think we've really delved into yet is the almost concurrent revocation of all the guidelines around MOUD medication for opioid use disorder, the fact that you know we don't have to have a special DEA license any more to prescribe suboxone. We don't have to have a data waiver. We don't have to have the training that went along with that. There's no caps on patient counts. No one is going to walk into a general practitioner's office and say, oh, you're treating! You can't treat more than you know 200 hypertension patients simultaneously.

Mia: Yeah.



Denton: It's crazy. Why was that there? I'm asking it rhetorically. I'm sure a historian somewhere could answer. But we're creating barriers that don't need to be there, and then also, I think it's covertly stigmatizing. It's communicating to everyone the health care system, including the patients that this disease state is special. This just isn't any disease state. This is a special disease state that leaves it open to interpretation. Well, maybe that's bad. Maybe I'm bad for having that. For the physician or the practitioner, they're looking the patient going, well, maybe this isn't just any old disease state. There's all these rules. Maybe this patient is special, or maybe especially bad. I think it's stigmatizing. I'm really grateful it's been removed.

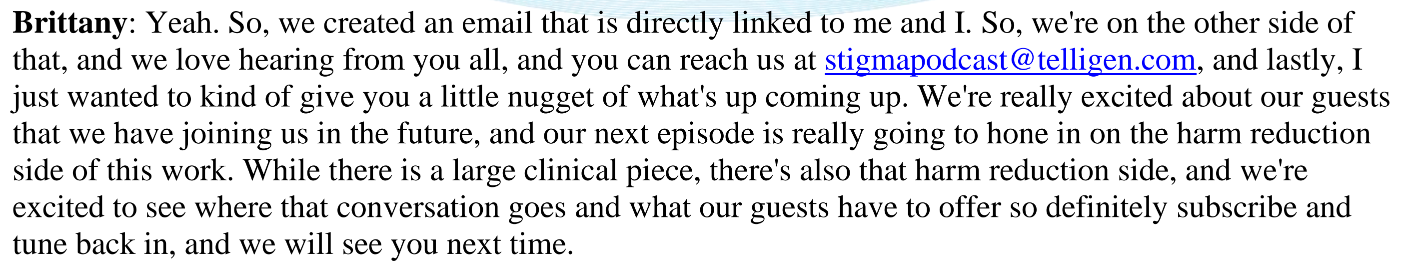
Mia: Yeah. And can you along those lines, you know one of the tools we've talked about in previous episodes to help us shift that stigma is language, and so you use the term MOUD or medication for opioid use disorder. Can you just talk really briefly about that contrasted with the I think the previous term that was in fashion was MAT or medication assisted treatment?

Denton: Yeah. The current science has shown that medication for opioid use disorder. So we're talking about, you know, buprenorphine with naloxone, buprenorphine by itself, methadone, those things, have been shown to improve survival for opioid use disorder patients with or without behavioral therapy. Now I love behavioral therapy. I think it's important. My spouse is a therapist, so I'm not anti-therapy at all. It's just in this particular disease state the science has shown out that the medication is kind of the main event, and the adjunct should be the therapy, not the other way around. But when you look at the term medication assisted treatment, it implies that medication is the sidekick in this particular treatment, and so that terminology medication for opioid use disorder is an attempt to rectify that, and I recommend it as the term it's what we use in all of our official communication at Telligen, and it's catching on slowly, I think. But I think it's a really important shift. Another great example of the change that we're seeing around this disease state.

Mia: Yeah. Yeah, I love it because it brings it more in line with the way we talk about other things in health care. We don't talk about insulin as medication assisted treatment. It's the medication, and there's certainly our behavioral changes that we work with our patients to make that are important, but they they're not the main, the main shebang, I guess.

Denton: Right. We want to give folks time to, you know, work through whatever their struggles are, and that time is bought so to speak, through the use of medication for opioid use disorder. And the science is really marked too. I will say I don't have time to go into all that right now, but I would encourage folks to reach out or look into it themselves. It's very marked.

Mia: Yeah, Great. Well, thank you so much, Denton. We are pleased to have had you as our very first guest. and I think we could keep talking, probably for hours, but in the interest of wrapping it up to a manageable podcast episode length, where I think we're gonna send our listeners out to digest all the wisdom you've just dropped on us, and we would love to hear from you listeners what stood out to you? What questions do you still have? Do you want us to have Denton back again for another conversation? Is there somebody else that you know that you think we should be talking to? So, we are open to any and all of that feedback. And really that feedback is going to be what helps us stay relevant and interesting. So please don't hesitate. And at that Brittany is gonna let you know how you can send us that feedback.



Brittany: Yeah. So, we created an email that is directly linked to me and I. So, we're on the other side of that, and we love hearing from you all, and you can reach us at stigmapodcast@telligen.com, and lastly, I just wanted to kind of give you a little nugget of what's up coming up. We're really excited about our guests that we have joining us in the future, and our next episode is really going to hone in on the harm reduction side of this work. While there is a large clinical piece, there's also that harm reduction side, and we're excited to see where that conversation goes and what our guests have to offer so definitely subscribe and tune back in, and we will see you next time.

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