



# Using Patient Voice to Personalize the Opioid Epidemic: An Evaluation of 2 Educational Interventions

Jeffrey Schlaudecker, MA, MEd<sup>1,2</sup>, Olivia Zamudio<sup>1</sup> ,  
Keesha Goodnow, BAE<sup>1</sup> , Harini Pallerla, MS<sup>1</sup>,  
and Sandra Regan, PhD<sup>1</sup>

## Abstract

Despite rising opioid fatalities, attitudes remain indifferent toward those with opioid use disorder (OUD). Utilizing patient voice may be one way to move providers to action. We included persons with OUD in 2 educational sessions as an important tool of attitude change. Post-session surveys demonstrate increased compassion, deeper understanding of challenges, and positive change in attitude. Inclusion of patient voice was identified as the most useful feature of both educational sessions. Four themes emerged: value of patient voice; change in attitude; barriers to change; and enhanced provider role. Future educational sessions should include the voice of persons living with OUD.

## Keywords

continuing education, patient voice, patient-centered care, opioid education, narrative medicine, opioid use disorder

## Introduction

Despite the magnitude of rising opioid misuse and fatalities, the attitudes of many primary care providers remain indifferent or stigmatizing toward those with a substance use disorder (1). Although opioids are commonly prescribed by primary care providers to alleviate conditions in patients that experience acute and chronic pain, the dangers of misusing these prescriptions have shown an upward trend in the United States since the 1990s. Recent data shows the overall number of opioids in morphine milligram equivalents prescribed remains approximately 3 times higher than in 1999 (2). Multiple factors contribute to low utilization of various treatments, such as medication assisted treatment (MAT), including provider skepticism, biased attitudes toward addiction, and general misunderstandings about addiction treatment medications (3). Dismissive attitudes of providers act as a significant barrier to effective treatment (4).

In recent years, the United States has seen a large spike in opioid misuse, and in October of 2017, the government declared it a public health emergency (5). Rising use has been seen with both illicit and prescribed opioids (6). The rate of opioid overdoses steadily increased, and by 2010, heroin surpassed prescription opioids in overdose deaths.

In 2019, it is estimated that 130 people die every day from opioid overdoses in the United States (7).

While reports of national statistics can feel distant, the narrative of a patient with lived experience may effectively change provider perceptions and move them toward action and empathy. The National Academy of Science (2016) published a consensus document reviewing extensive literature of stigma and stigma change related to mental and substance use disorders (8). Their findings suggest combining contact-based interventions with educational interventions is most effective in attitude change. Exposing providers to patients who have experienced struggle and recovery with opioid use has been associated with altered

<sup>1</sup> Department of Family and Community Medicine Research Division, University of Cincinnati, Cincinnati, OH, USA

<sup>2</sup> The Christ Hospital/University of Cincinnati Family Medicine Residency, Cincinnati, OH, USA

## Corresponding Author:

Jeffrey Schlaudecker, Department of Family and Community Medicine Research Division, University of Cincinnati, Cincinnati OH 45221, USA; The Christ Hospital/University of Cincinnati Family Medicine Residency, 231 Albert Sabin Way, MSB 4010, Cincinnati OH 45221, USA.  
Email: jeffrey.schlaudecker@uc.edu



provider perspectives on using MAT, improvements in clinical practice, and ultimately alleviating the stigma, barriers, and bias that affected patients face (9). Decreasing stigma and improving attitudes of health care providers may foster and maintain a strong patient-provider relationship, ultimately aiding in recovery.

We included those living in active recovery as key presenters in 2 educational sessions as a means of grounding cognitive material presented with emotive patient stories. We hypothesized that hearing directly from patients in recovery would positively impact attitudes and beliefs of primary care providers. We evaluated self-reported compassion, understanding of challenges, and attitude following educational interventions through post-session surveys.

## Methods

The University of Cincinnati Department of Family and Community Medicine (UC DFCM) organized 2 professional development sessions presented in 2019, as part of a descriptive research study. These sessions targeted diverse audiences.

For session one, the UC DFCM in collaboration with The Christ Hospital Opioid Task Force held a Community Opioid Summit (COS). The half-day summit welcomed 154 attendees including physicians, nurses, pharmacists, social workers, students, and community members. Continuing Medical Education for physicians and social workers was offered. Presentations included naloxone training/distribution; therapeutic communication to decrease stigma; inpatient management of acute opioid withdrawal; medication assisted treatment of opioid use disorder (OUD); and a provider panel of 3 addiction treatment facilities. In addition, one session showcased patient voice through a semi-structured interview, detailing lived experience of prescription drug abuse, heroin use, homelessness, active recovery, and current employment in community outreach with more than 2 years of sobriety.

For session 2, 18 primary care providers of the UC DFCM voluntarily gathered for a 2-hour dinner-discussion (DD) event. Continuing Medical Education was not offered for session 2. Attendees of sessions did not overlap. Content included a presentation from a faculty member on opioid epidemic advocacy opportunities; discussion of an article recounting a primary care doctor's regret following a patient's death to overdose (10); and 2 discussions featuring persons living in active recovery from OUD, including an in-depth interview discussing the role primary care providers played in their personal journey from addiction to recovery.

Immediately following both sessions, anonymous surveys were completed. Multiple versions were iteratively reviewed and edited by 3 UC DFCM evaluators for content validity. The COS survey included 15 questions, focusing on learning objectives and attendee attitude change. The DD concluded with a similar 16 question survey. A 4-point Likert scale was used to assess each question. For quantitative analysis, responses were

dichotomized into strongly agree/agree and disagree/strongly disagree. A 7-question, online, follow-up survey was sent to attendees 2 months after the COS. Survey responses were analyzed in SPSS 25 using descriptive statistics.

Open ended survey data were analyzed using Thematic Analysis (11). An inductive approach was used to generate initial codes and develop a code book. Four authors reviewed responses, coded data, and identified emergent themes. Discrepancies in coding were reconciled by discussion among team members. The authors identified representative quotes for each subtheme. This study was approved by the institutional review of board of University of Cincinnati.

## Results

### Quantitative Results

Session evaluation was completed by 123 (79.9% response rate) of 154 COS attendees and 17 (94.4%) of 18 DD participants. Results demonstrated near unanimous agreement that contact-based interventions including persons with lived experience sharing their stories was an effective part of both educational sessions (98.3% COS, 100% DD). The inclusion of patient voice was identified as the most useful feature for both educational sessions (Figure 1).

Surveys also reported increased compassion for patients and families impacted by OUD (98.4% COS, 100% DD), deeper understanding of challenges faced by persons living with OUD (99.2% COS, 100% DD), and positive change in attitude toward persons living with OUD (96.7% COS, 100% DD).

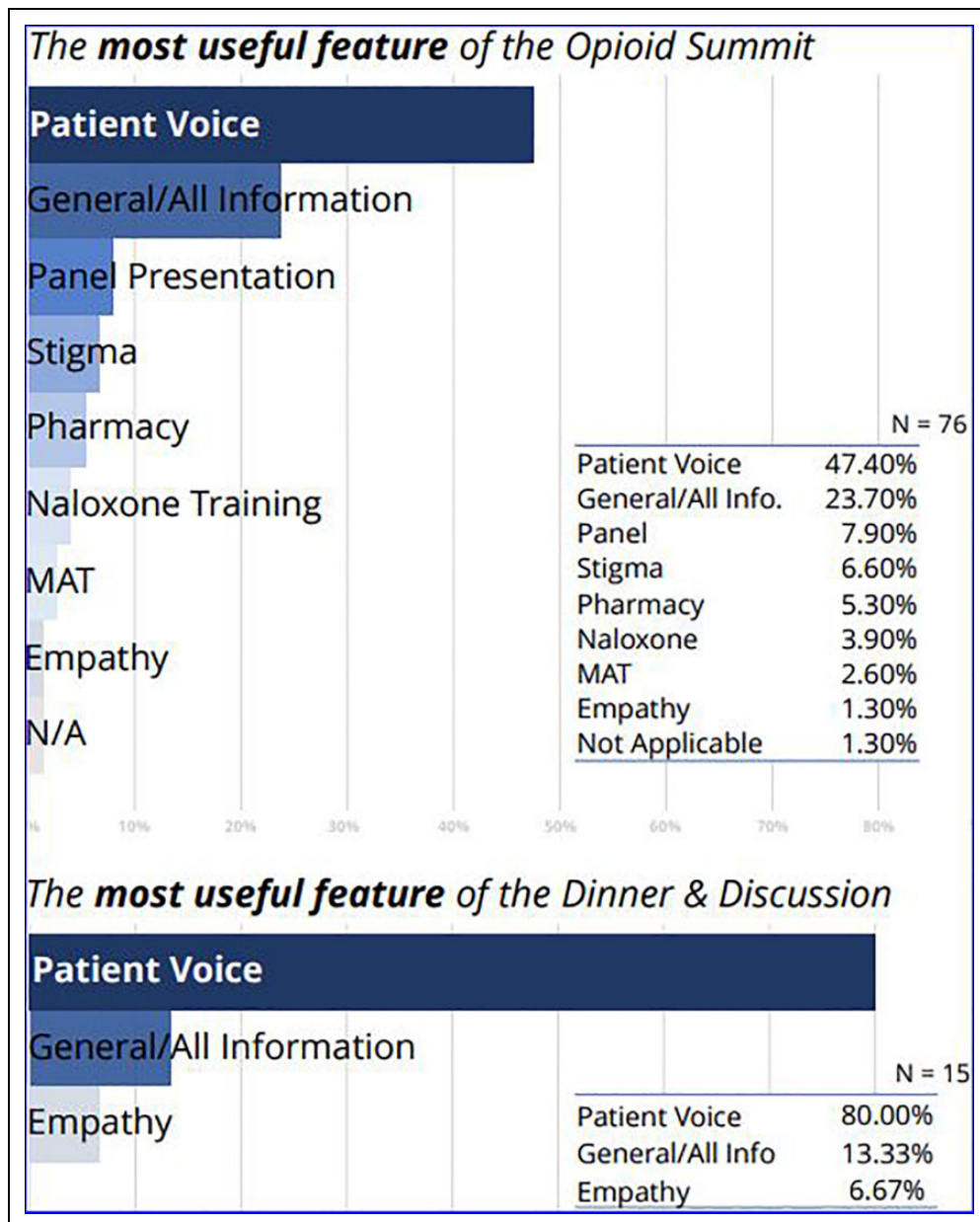
A 2-month follow-up online survey was completed by 62 (46.3%) of 134 respondents. In this survey, eligible prescribers were asked if they had started or completed their training toward getting their MAT waiver since the summit. Twenty-three eligible providers responded with 11 (48%) affirming commencing or completing the training for the MAT waiver.

### Qualitative Results

Four overarching themes emerged: value of patient voice, change in attitude, barriers to change, and enhanced provider role. Supplementary exemplar quotations are shown in Table 1.

**Value of patient voice.** "Thank you for your first-hand experience. We need to personalize the opioid problem. It's about humans who are suffering from a disease. So brave and THE most important voice at this conference," COS attendee. Respondents emphasized the value of hearing real stories about addiction from real people. In addition, both groups identified peers as an important resource for those struggling with addiction.

**Change in attitude.** "The most important message was changing our mindset of the addicted population," COS attendee. Subthemes of attitude change encompassed humanizing the patient, increasing empathy, decreasing stigma, acknowledging addiction as a disease, and remaining hopeful in the face of this epidemic. Attendees emphasized hearing from a person



**Figure 1.** Overview of most useful feature of educational interventions.

with lived experience challenged their preconceptions and assumptions.

**Barriers to change.** “Administrative gridlock keeps patients from getting what they need.” COS attendee. Many participants noted a frustration with system limitations including time, staffing, and resources. Some responses revealed limited educational opportunities as an obstacle to overcome.

**Enhanced provider role.** “Talking with patients, meeting them where they are, and giving the patient better care in relation to addiction is my goal!”—COS attendee. Participants universally acknowledged that providers have an important role

in promoting dialogue, providing resources, and supporting enhanced services for patients with OUD.

### Limitations

There are several important limitations of our study. While the COS was large-scale and interprofessional, the DD consisted of 18 providers from one small and singular teaching practice. Post-session surveys were used to accumulate all data, eliminating comparison data to determine attribution and magnitude of outcomes. While attendees were all present voluntarily, self-reported data were difficult to independently verify. Self-reported positive change could have been short-lived and/or biased by social desirability. In addition,

**Table 1.** Qualitative Themes and Exemplar Quotes From Open-Ended Survey Data.

Subtheme:	Definition:	Representative quotes:
<b>THEME 1: Value of patient voice</b>		
Patient experiences	The value of hearing real stories about addiction from real people	Thank you for your first-hand experience. We need to humanize/ personalize the opioid problem. It's about humans who are having a disease. So brave and the most important voice at this conference; having a person in recovery speak was powerful. We are on the outside. If we have never hit a baseball, how can we teach someone? Nothing parallels to hearing the patient first hand.
Connections	The value of peers as support/ resource for those struggling with addiction	Learning about the connection that mentors can provide with the community was extremely helpful; this patient story shows the benefits for peer advocates as well as importance of developing a system of supports/resources.
<b>THEME 2: Change in attitude</b>		
Humanizing	Recognition that people who struggle with addiction are no different from other people	As a grandfather of 8 (oldest is 11) I've urged my children to begin the conversation now, regarding the insidious threat of substance use disorder. I've emphasized that no one is immune; listening to someone affected, recovering from and living with addiction, was invaluable. This brought it to a basic human level.
Increased empathy	Feeling compassion for patients who have addiction	I feel this will help me to "up my empathy" for those with opioid addiction; we need to have much more compassion for those with the disorder.
Decreased stigma	Improve negative reputation of individuals who have addiction	The most important message was changing our mindset of the addicted population; altering the negative image of the addict; the information was relevant and presented with compassion and professionalism. I now view the substance abuse individual in a new light.
Addiction is a disease	Addiction is a chronic disease requiring management and treatment	The reminder that this is a disease was needed; I am leaving with an awareness that addiction is a disease not a choice! Spread the word more, it's a disease.
Hope	Grounds for feeling hopeful about the future	A great reminder that we do have power in this epidemic; they offered us hope!
<b>THEME 3: Barriers to change</b>		
Limited educational opportunities of individuals with OUD	Absence of training opportunities for treatment	I'm desperate for learning opportunities. Our organization as a whole is sorely lacking in expertise and I plan on doing my part to rectify this; we need better awareness of resources and more training on navigating this delicate topic.
Organizational support	System limitations: time, staffing, resources	Practicing medicine and assisting our patients in healing takes time and it can't always be about throughput and needing a bed. If we can't spend time with patients we can't truly assist them fully! Time! Time! Time! Schedule controlled by corporate factors reduces available patient slots.
<b>THEME 4: Enhance provider role</b>		
Communication with patients	Ask questions and promote dialogue with patients regarding addiction and treatment	Real conversations with patients is part of how I aspire to frame my practice as a primary care doctor; I want to begin a dialogue, hopefully patients will feel safe enough to confide in me; Talking with patients, meeting them where they are and giving the patient better care in relation to addiction!
Utilization of resources	provide resources for treatment and increase referrals to programs	I will try to refer patients sooner to treatment centers; I will refer more patients with SUD for multimodal therapy that includes MAT.
Medication Assisted professionals to willingness of health care Treatment as treatment provide/consider MAT for option their patients		This summit increased my consideration for MAT; Starting MAT is a next step for me; I will refer more patients with SUD for multimodal therapy that includes MAT.

Abbreviations: MAT, medication assisted treatment; OUD, opioid use disorder; SUD, substance use disorder.

no validated surveys for measurement of attitude specifically related to OUD exist.

## Discussion

The health care community in the United States has an important role to play in combatting the current epidemic

of opioid use and overdose deaths. Studies have been conducted that utilize patient voice to address harsh stigmas and how they may cloud the judgement of health care providers, ultimately influencing the care that the patient receives. Researchers found that gaining insight from the personal experience of a person living with HIV/AIDS and interacting with them directly decreased HIV-related prejudice. These

findings support multiple other studies suggesting interaction with patients in educational settings can reduce stigmas associated with certain health conditions (12). Our finding that using patient voice and stories of recovery to positively impact perspectives is consistent with the literature.

Another important finding of our study was that nearly half of eligible providers at 2 months had begun MAT waiver training. The power to move providers to concrete action is a critically important step to combat the opioid epidemic.

This study outlines 2 viable educational interventions that were well received by attendees and resulted in self-reported improved attitude toward patients with OUD. The long-term effects of these interventions are unknown; however, the inclusion of patient voice may contribute to a positive culture change. In the future, educational sessions on the opioid epidemic should consider including the voice of persons living with OUD as a critical component of attitude formation and change.

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### ORCID iDs

Olivia Zamudio  <https://orcid.org/0000-0002-6234-7478>

Keesha Goodnow  <https://orcid.org/0000-0002-8696-8105>

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### Author Biographies

**Jeffrey Schlaudecker**, MD, Med, is an associate professor of Family & Community Medicine at the University of Cincinnati, where he serves as the Kautz Family Foundation Endowed Chair of Geriatric Medical Education.

**Olivia Zamudio** is a fourth year undergraduate student of medical sciences at the University of Cincinnati, College of Medicine and a certificate in Minority Health from the College of Arts and Sciences.

**Keesha Goodnow**, BAE, is a research assistant at the University of Cincinnati, College of Medicine Department of Family and Community Medicine. She is the program coordinator for the department's Primary Care Training and Enhancement grant. She has been critical in the development, launch, and sustainability of multiple Patient and Family Advisory Councils and is a recognized voice on the importance of involving patients and families in healthcare.

**Harini Pallerla**, MS, is a principal research assistant at the University of Cincinnati, College of Medicine Department of Family and Community Medicine. She had Master's degree in Health Administration & Planning from the University of Cincinnati with a primary focus on Health Services Research.

**Sandra Regan**, PhD, is the director for the College of Medicine Department of Family and Community Medicine Research Division and is an adjunct assistant professor of Family Medicine at the University of Cincinnati.