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Breaking a cycle of stigma: An interprofessional team approach to building trust for hospitalized patients with substance use disorder

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INTRODUCTION

The stigma that people with substance use disorders (SUD) face from health care professionals leads to mistrustful relationships. Approximately 12% of all hospitalizations are related to SUD,[1] and in parts of the country more than 1 in 20 hospitalizations are directly related to opioid use disorder (OUD).[2] Despite hospitalists' frequent provision of care for people with SUD, outdated attitudes and practices persist that drive poor outcomes. For example, one-third of internists view SUD as being different from other chronic medical conditions and 10% believe people with SUD should be punished.[3] Most patients with OUD are not offered evidence-based treatment during acute hospitalization, even though treatment initiation during hospitalization reduces mortality and increases postdischarge treatment retention.[4]

If patients cannot trust that they will receive effective therapies from empathetic health professionals, they are unlikely to seek and engage in care for their SUD or for other acute medical needs. The current approach to improving health and care for people with addiction is failing, in part because of eroded trust between care providers and patients with SUD. In this perspective, we describe our experience and reflections on how hospital care teams can combine effective treatment options with compassionate, person-first interactions to generate patient trust, positive healthcare outcomes, and clinician fulfillment.

ADDRESSING MUTUAL MISTRUST

Frequently, "mutual mistrust" exists between care providers and hospitalized patients with SUD.[5] Prescribers may fear being deceived and express concern about the absence of a consistent approach for in-hospital SUD care. These factors often lead hospitalized patients with SUD to perceive that they are intentionally receiving apathetic, low quality, and inconsistent care. Patients who have previous negative experiences during hospitalization are likely to be increasingly cautious and skeptical of their care teams during subsequent hospitalizations, which in turn reinforces prescriber perceptions of deception. This cyclical relationship creates a self-fulfilling landslide of trust erosion. However, using hospitalization as a reachable moment to directly address SUD can build trust through humanizing care, demonstrating addiction expertise, reliability, and promoting patient autonomy.[6]

Our experience over the past 4 years creating a hospitalist-led program to increase access to addiction care for people with OUD, the "B-Team" (buprenorphine team),[7] reinforced the importance of focusing on trusting relationships. The origins of our work were rooted in

readmission prevention, but after providing care for the first patients it became clear that breaking the cycle of mistrust by changing institutional culture around SUD was both necessary and invigorating for the team's success. Building and maintaining trusting relationships with patients emerged as the raison d'etre for the team and informed our approach. Key components for reestablishing trust with patients that developed from our experience include (1) building, training, and empowering an interprofessional team that addresses psycho-spiritual-social interventions to provide whole-person care and strengthen the care team-patient relationship and (2) designing and implementing an evidence-based approach for care teams to treat patients with OUD. These elements address both sides of the mutual mistrust paradigm through allowing patients to experience compassionate, whole-person care and reducing provider discomfort and angst over working with patients with OUD.

A TEAM-BASED MODEL FOR PROVIDING TRUSTWORTHY CARE

Trust is built primarily on positive and secure relationships. It is possible to establish trustful relationships between patients and teams of health care professionals when those teams provide a cohesive approach that focuses on patient-centered goals.[8] Each member of the B-Team works closely together and provides different skillsets. The team includes physicians, nurses, social workers, pharmacists, chaplains, peer recovery support specialists, and a physician assistant, from multiple disciplines including hospital medicine, psychiatry, and palliative care. When a patient with OUD is admitted to the hospital, a cascade of care is initiated that includes screening, initiating of evidence-based treatment with buprenorphine or access to harm reduction resources, and robust care coordination with nonaffiliated outpatient addiction care clinics.[7]

The interprofessional aspect of our team's work is critical for instilling trust. Consistent patient-centered and holistic messaging from different members of the care team reinforces a sense of support and safety for patients.[6] While the clinicians' primary task is to guide and prescribe buprenorphine initiation, our B-Team chaplain and our peer recovery coach meet with the patient with the sole objective of providing support and a listening ear. Peer recovery coaches connect patients with people in the local community with lived experience and serve as "culture brokers"[9,10] while promoting ongoing recovery and care coordination. They extend the care the clinical team can deliver and provide a vehicle for the transference of trust between the patient and the clinical team. Patients have expressed astonishment that they were seen as a person in need of help rather than being seen "only as their addiction."

BUILDING TRUST PRAGMATICALLY

Our team is empowered to preserve patient autonomy and to advocate for the best interests of the patient. For example, one of our patients self-reported that they had used an illicit substance during hospitalization. Prior to the change in culture facilitated by the B-Team, this disclosure may have necessitated a harsh institutional response and potentially an administrative discharge. Instead, the patient was provided with empathy, support, and counseling. Together we developed a plan for trusting each other. They allowed us to safely dispose of remaining substances and placed their trust in our team to appropriately manage their transition onto buprenorphine. We committed to close monitoring of their withdrawal experience in order to administer buprenorphine as soon as possible and to being there, clinically and emotionally, when they needed us. The clinical team's effort and commitment led to the patient being more invested in their care and broke the expected cycle of punitive responses to behaviors driven by unaddressed SUD. This relatively small act toward building a trusting relationship may have done more to improve their outcome than any other medical intervention we provided. Our model has resulted in coordinated addiction care during hospitalization and relatively high outpatient follow-up addiction care.[11]

EQUIPPING CARE TEAMS WITH TOOLS AND TECHNIQUES TO TRANSFORM CARE AND BUILD TRUST

One of the sources of tension for health care providers when caring for patients with SUD is a sense of hopelessness driven by misunderstandings about the availability and efficacy of treatment options, and a lack of confidence in their ability to implement these treatments. However, demonstrating addiction expertise and establishing reliability are important qualities for creating trust with patients with SUD.[6] As the primary providers for hospitalized patients, hospitalists are critical to establishing that reliability and setting the tone for in-hospital interactions with patients.[12] To develop knowledge and competence across care teams, the B-Team provided comprehensive training on effective tools and techniques to deliver high-quality care for this patient population. The B-team partnered with pharmacy and nursing departments to develop consistent clinical protocols in accordance with institutional policy and based on the available formulary, which encourages primary inpatient teams to initiate OUD treatment as part of routine care delivered by hospitalists. We have seen many clinicians' attitudes shift as they witness positive responses to appropriate OUD treatment. Transition from the hospital to the outpatient setting at time of discharge is a make-or-break moment for individuals with OUD, thus the B-Team committed considerable effort to partnering with outpatient treatment providers and recovery-centered organizations. Our peer-recovery coach bridges this gap with patients.

The B-Team also provides institutional education about the importance of hospital addiction care and proactively addressing stigma. We have curated presentations and discussions with hospital executives, attending physicians and residents, and department leaders and managers including nursing, pharmacy, and social work. As part of a campaign to shift culture, we distributed flyers describing the program and its importance for patients throughout the hospital. We provide just-in-time training to care team members about clinical protocols and approaches to care coordination. These efforts equip care team members with the skills and knowledge needed to deliver high quality, empathetic care that engenders trust in their patients.

This hospitalist-led effort is a targeted intervention for a specific diagnosis, OUD. It is not a wraparound addiction medicine service. Specific facilitators and barriers of this approach are discussed elsewhere,[7] however it is our belief that trust built around OUD has direct transference to additional SUD diagnoses. This trust empowers our hospital to continue its journey to improve addiction care across the spectrum. For example, the work of the B-Team has informed recent local efforts to similarly address alcohol use disorder during hospitalization.

CONCLUSIONS

There have been calls for hospitalists to actively engage in addressing SUD during hospitalization.[12] While the clinical medicine and pharmacotherapy aspects of addressing addiction by hospitalists are important and timely, the ability to foster trust with this patient population is fundamental. Trust is an asset that contributes to patients continuing to seek care, adhering to treatments, and achieving positive health outcomes. Our experience is that hospitalists and hospitalist-led interventions for addiction care lay the foundation of a strong and trusting relationship between hospitalized patients and their care teams.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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