"Pathways of Collaboration and Communication: Breaking Down Silos in Addiction Medicine"

Podcast Episode 21: November 2025

Guest: Christine Fishman

Bevin: Hello, everybody, and welcome back to the latest episode of Changing Minds, where we look at behavior change in the clinical setting, particularly with frontline clinicians who are the movers and shakers that are taking care of patients day in and day out, and who need extra support. And that's where our field of public health detailing and academic detailing really come into play.

I am so delighted to have Christine Fishman of Metro Health in Ohio here with us today, and she's going to speak more to the beauty of academic detailing and the ways in which building a strong, supportive relationship with those frontline clinicians can really be so integral in leveraging the kind of change that makes patients healthier. So, Christine, how are you doing? And I know you go by Chris. So do you prefer Chris today?

Chris: Sure. Sounds good!

Bevin: So, Chris, how are you? What's going on? And talk to us a little bit about your role in Metro Health, what you like about it, and really what the essence of it is. You have described academic detailing as being able to have your finger on the pulse of what clinicians want and need and know. So, talk to us a little bit about you checking the pulse points on clinicians within Metro Health and how that's been for you.

Chris: Okay. Well, thank you so much for having me today. I am so excited to be here. So, I became a pharmacist in 1998, and then I practiced in the community for 11 or 12 years, and then I took time away to raise my kids. So, I went back and got my public health degree and started working at the Metro Health system as an academic detailer.

The position was created so that I could go out and talk to our physicians about prescribing and how to find alternatives, and what to do with legacy patients, all kinds of things like that. And what that did for me is it allowed me to listen to them and hear ***their*** pain points and just get to know them and understand.

I focused on primary care providers because I figured that was where the biggest impact was going to happen. You know, they see so many different types of patients, they treat so many different conditions. And a lot of them were left so many patients that were prescribed opioids in the past. So I learned, you know, that, you know, the hospital, for instance, had expectations that people had to check the prescription drug monitoring program.

But there was really no good way of doing that. It was integrated in our EHR, but it was not something that came automatic. And so physicians and APPs had to remember, "Oh, I need to check the prescription drug monitoring program." There was never a prompt. So, listening to that and hearing our physicians talk, one of the projects that we've been working on is trying to implement an OPA or, you know, a heart stop to try to remind them if they don't check the PDMP to go ahead and check. No harm, like no, nobody's getting into trouble.

And, you know, we're working through that. We also learned that they were struggling with control substance agreements. There were pieces of papers that they were filling out.

Well, we reached out to our EHR and they were able to create a way for our providers to access and read the agreement with the patient right then and there and get signatures. We had patients, we had physicians who had legacy patients they didn't know what to do with and learning that.

Bevin: And when you say "legacy patients", just in case somebody who's not from this field is tuning in…we're talking patients who were inherited by, you know, perhaps a new, a new provider maybe has an older patient who had seen a different provider who may have retired. Talk a little bit just about that for a second and what the complications there are.

Chris: Yeah. So I guess the focus of my work was on opioids and anything related to opioids. So when I'm talking about "legacy patients", they would be patients who may have been seen by a specialist and transferred to primary care. The primary care provider has been prescribing for them. And then, um, retired and now a new physician or a, you know, or provider has taken over and they're like, "Oh my gosh, I do not want this patient to be on these opioids for such a long time!"

Bevin: But they're used to it. They're used to it. They say, this is what Dr. So-and-so always gave me. Yeah. That's tricky. That's tricky.

Chris: And so, and you, and you cannot just abruptly discontinue because that is one of the reasons why we had such a terrible opioid crisis. And so what we're trying to do is help our providers find different ways of helping patients through the use of, you know, maybe a partial agonist buprenorphine, that is, has an indication for pain, but is much safer to use than a full agonist opioid. We have a pain pharmacist who works within our hospital system who can meet with patients and plant seeds and kind of understand where the patients are coming from and help address their pain and make recommendations to the provider.

So, it was a way for us to learn what the pain points were for our physicians, whether they're related to regulatory affairs or patient care to kind of form a group within our office that supports our providers. And that's what we work towards. And actually our office meets every week to discuss the issues that we find within the hospital system.

And a lot of it comes from academic detailing and my time with providers.

Bevin: That's amazing. That's amazing. What feel—when you meet with a provider, let's say it's a new provider you haven't met with before…what feels like the most important thing for you to establish right up front about who you are and why you're there?

Chris: I always try to tell them if you need anything at all, please reach out to me. If I don't have the answer for you, I know somebody who can find the answer.

Bevin: I love that. Yep. Yep. And that's a key component of being a detailer, right? It's not being the library of every resource in your brain at all times, it's being the connector. In what other ways do you feel like you're connecting people? You're connecting people to resources…what is sort of some of the, the essence of how you are connecting knowledge and relationships across Metro Health?

So one of the projects that we just started at Metro—actually about a year ago—is, one time I was detailing the trauma team at our hospital...we're a level one trauma center, which is awesome. And I was educating them on how to treat patients for pain while they're taking buprenorphine for opioid use disorder.

And all of a sudden the conversation switched to, “Well, we don't know what to do, and we don't feel comfortable doing this, and we don't feel comfortable prescribing in certain ways. We just don't know what to do with these patients.”

Bevin: So was it a stigma piece? Was it a fear factor?

Chris: They, first of all, it was, they weren't able to identify patients until the patients started going through withdrawal or were having problems. And then the other piece was, they didn't know what to do once the patients did go through any kind of withdrawal because some of the patients would walk out against medical advice…because when you're struggling and you're in pain, you need to do everything you can in order to, you know, get what you need. You want to make the pain of withdrawal subside in whatever way possible.

Those surgeons felt terrible because they really wanted to take good care of their patients. I mean, I could tell they were very passionate and very distraught about the idea that they could not provide these patients the help they needed.

And so what we did was we formed a group that has our pain pharmacist, our addiction medicine consult, pain specialists. We started working together and we figured out a way first to identify patients. We even involved our substance use navigators in this project, because they were the ones who identified patients within our system who had a substance use disorder. We worked together to create a method to identify patients for the trauma team and give the information to the trauma team.

Then, we worked with the addiction medicine consult service to create an order set that would allow them to prescribe or actually initiate the patient into treatment. And now when I go talk to the trauma team, they are much more relaxed, and they're actually excited about doing more stuff to improve the patient care.

So academic detailing is not always about—I mean, I'll be honest with you: it's not something that brings in money to a health system. And you know, that can be a little scary at times, but in other ways, it can really help create pathways of communication and collaboration between different groups in the system.

Bevin: I love that: “pathways of collaboration and communication.” That is what a detailer does, in essence, is create those pathways and think strategically about where those pathways are missing and where those pathways should be. And then the practical ways to kind of carve out those pathways.

What I would love to know too, is: what's on both ends of doing that work, in terms of your most challenging experiences or things that are hardest about it, and the things that are most rewarding?

Chris: You know what? I tend to look at the world through rosy colored glasses.

Bevin: We love that. We love that! So you're not going to, you're not going to tell us about the challenges.

Chris: The challenges would be to coordinate everything and to keep everything straight. That is not my forte. That's just how Chris Fishman was built. You know? I mean, if I could have like a little person with me that helps me organize everything, things would be great. So that's where I start…

Bevin: If our executive functioning were tighter than no issues! But tell us about the most rewarding pieces of this. Like you've been doing this for years now, so there must be components that just really keep you feeling connected to your work.

Chris: Well, the fact that we've seen some changes happen within our system—we now have ways to improve PDMP checks. We have a way to do controlled substance agreements so that our providers can use them as a tool to hold patients accountable. We have these projects trying to help patients who need alternatives to opioids or could use an alternative.

It's just opened up a lot of different collaborations, you know? I am not an expert in addiction medicine, but I know that our addiction medicine consult service, they were willing to help and create these order sets with us and work hand-in-hand with the trauma team and get input from everybody, so that we could improve the lives of our patients and their outcomes within our hospital system. It's just, it seems to work really well. You don't have to be—as the academic detailer—you don't have to be the expert, but you can be the person that breaks down the silos and be willing to collaborate.

Bevin: You know, I love that so much. You not only don't have to be the expert, you don't need to—it's not necessary. And I think a lot of people who come through our trainings at NaRCAD, they feel worried about imposter syndrome. They feel worried that maybe because they don't have clinical expertise or even some of the background that you have, Chris, in pharmacy, that they're not going to be able to make a difference.

As we're starting to wrap up this episode, I have a couple of questions for you.

The first one is: what would you say to those people out there who are really good communicators that do worry about that imposter syndrome, that do worry that they don't have, you know, 5, 6, 7 years of experience understanding, the brain chemistry of addiction and things like that? How would you encourage them to still pursue the field of academic detailing and make that palpable change that you're seeing at Metro Health?

Chris: I don't know if you remember this, but when I first started, I hadn't even trained yet. I reached out to NaRCAD and I said, "I'm starting an academic detailing program at my hospital, and I don't know what I'm doing! I'm not getting trained for three months, but I have to start right now!"

Bevin: I didn't remember that! I didn't remember that, but I'm glad you found us.

Chris: You guys were gracious enough to link me with a mentor who basically calmed me down and said, "You don't need to have all the training just yet. Just go in there, be honest with them. Don't pretend that you know everything, just be humble, listen to what they have to say, and then go back and think about it and see what you can do to help them."

Bevin: That's great. You don't have to be an expert. You just need to listen.

Chris: And then as you know, what the pain points or the gaps are, you can teach yourself about them. You can spend time learning more and doing more and trying to find ways to make things better for your providers. That's the essence, for me, of academic detailing.

I'm not just listening to you because it's my job. I'm listening to you because I care about the outcomes of your patients. I care about, you know, the public health aspect of academic detailing…it's what really fuels my fire, because we are making an impact on not on just one person, but a population, by talking to one person.

Bevin: I love that. That ripple effect is, is just so important. And I feel like you really captured that. Let's wrap up with just one more question. You brought back the memory of first starting this out and saying, "Hey, I don't know what I'm doing!" What would you, what would be the number one thing you would say to the version of Chris Fishman who was in that space? In addition to what you just shared—what would you offer as sort of the number one or two things to keep in mind as you are about to start this journey?

Because I think a lot of people listening may either be just about to start this journey or maybe thinking, "Hmm…what would it be like to be an educator that supports clinicians?" And, you know, "Do I have what it takes?" So, anything else you would offer for advice?

Chris: I would say, be kind to yourself and know that you're going to be okay. And that if you, if you have the right, "WHY" in your heart, you're going to succeed.

Bevin: "The right 'why'!" I love that. Yes. And I think it's really tricky for a lot of folks who don't work within a hospital system, like you do to see the impact of the work that they do.
So, I guess I do have one last question. One more, for those folks who don't have the benefit of seeing their impact more directly, you know, they don't see the changes, the systemic changes—maybe they're visiting clinics across a rural state. What would you, if you were in that situation, tell yourself in order to feel like, "Hey, I'm doing good work!"?

Chris: Well, I do experience some of that here too. And I have to remind myself that I'm not doing this work because I'm either paid to do it, or I'm doing this work because ultimately I'm hoping that there will some benefit will arrive from it. You don't do something with the expectation that you're going to get a reward. You do something because it's the right thing to do.

Bevin: Yes! Knowing that you're doing the right thing and knowing that you're doing it for a good reason and a good cause hopefully can help sustain—yeah! That substantive enough, right? Doing it because of your own moral compass and knowing that you are making clinicians lives that much easier, that much more robust in terms of having the best evidence-based information, having the best tools and resources, and that they will then, you know, be doing the work they need to do at just even such a higher caliber level. And letting them know that you're there for them and that you're there to help them do better.

Chris: You know, I mean, I wouldn't say "I'm here to help you do better" (*laughs*), but I'm here to help—

Bevin: Not actually use those words – no!

Chris: —I'm here to help support you in any way, you know, feel free to reach out to me at any time. I'm happy to provide you with whatever you need. I will be there for you to support you because I know that you're seeing, 40 patients a day or 30 patients a day, and you're overwhelmed. And if there's anything I can do to make your life just teensy bit easier, please, you can count on me. I'll be there for you.

Bevin: Yes. Love that. And that is really what it's all about. Honestly, you know, at the end of the day, whether you're providing somebody with evidence or a tool or just a moment to listen, the impact you can have, even in that short interaction, with a clinician is truly substantive.

Chris, thank you so much for spending time with us today. We're getting into the early winter. I know it's technically not winter yet, but we're getting into the, the doldrums and the, the, the

cold times and the uncertain times. And I think a lot of people listening to this will really feel elevated by what you've had to share. And if you have any more questions about academic detailing—maybe you're listening and feeling inspired—you can certainly go online to narcad.org, and you can peruse our Event Hubs and watch Christine and her colleagues speak about some of the work that's been done at Metro health through the substance use navigation program and Christine's academic detailing program. So, I will include those links in the description of this podcast, but for now, thank you, Chris. And we hope to talk to you again, further down the road and see how everything is going. Talk to you soon.

Chris: Thank you so much for having me. It's been an honor.