

Webinar Transcript

Prevalence of Opioids and the Workforce to Provide Treatment in Rural and Urban Settings

Presented by John Gale, Jennifer Lenardson and Holly Andrilla on June 25th, 2015

{Moderator}

Welcome and thank you for standing by. At this time all participants are in a listen-only mode, during the questions and answer session please press Star (*) and 1 on your touchtone phone. Today's conference is being recorded, if you have any objections you may disconnect at this time. I am turning the meeting over to Ms. Shawnda Schroeder.

{Shawnda Schroeder, RHRC}

Thank you, good morning and good afternoon to all of you on the call today. Today the Rural Health Research Gateway will be hosting a webinar entitled "Prevalence of Opioids and the Workforce to Provide Treatment in Rural and Urban Settings." You are going to hear from Holly Andrilla from WWAMI and from John Gale & Jennifer Lenardson from the Maine Rural Health Research Center. Thank you again to all three of you for agreeing to share this presentation with us today.

I do want to note that following this presentation this webinar will be posted on the Rural Health Research Gateway website. This website is a site which provides free access to publications and projects that are funded through the Federal Office of Rural Health Policy. You can find Gateway at ruralhealthresearch.org and I have also included the link on your screen. You can also sign up to receive periodic updates from Gateway through our Gateway Alert; or you will receive email updates when there are new publications and policy briefs, including today's webinar.

We do have all lines muted; I will encourage you to use the question-and-answer chat box at the bottom of your screen to type in any questions you may have for our presenters. Also when asking a question today in the Q & A box, or when you ask questions on the line at the end of the call please begin by identifying which researcher your question for. And if there are any remaining questions in the Q & A box at the end of the hour today, I will send those out to our presenters and have their responses shared through the Gateway Alert along with an archived copy of the webinar.

Thank you again for joining us and now I want to introduce our presenters. Since joining the University of Southern Maine Rural Health Research Center, rural hospitals and delivery system issues have formed at the core of Mr. Gale's research. His work concentrates on the operations of rural delivery and safety net systems involving critical access and other rural hospitals; and includes studies on the role of hospitals in their communities. Also including their community needs assessment, engagement and benefit activities, performance improvement and population health initiative. His other research activities involve rural health clinics, primary care of behavioral health integration, behavioral health issues, use of health information and telehealth technology and program management in evaluation. He serves on the Board of Trustees for the

National Rural Health Association and the New England Rural Health Round Table. He is a senior fellow of the Health Research in Educational Trust of the American hospital Association and an adjunct faculty member of the Public Health program in the University of New England College of Graduate and Professional Studies.

Joining him today is Jennifer Lenardson, she is a research associate also at the Maine Rural Health Research Center. She specializes in substance abuse prevalence and treatment differences across rural and urban areas. In recent years she has used national data to examine rural and urban adolescent alcohol use, availability of detoxification services and the distribution of treatment facilities.

We also have joining us today is Holly Andrilla. She is a research scientist and biostatistician at the WWAMI Rural Health Research Center in Seattle where she has worked since 1993. She's an expert at managing large data sets, designing, performing and interpreting complex statistical analyses, and conducting survey research Ms. Andrilla has had a major analytical role in workforce studies of physicians, physician assistants, dentists, dental hygienists, registered nurses, advanced practice nurses and other groups. She worked close with the late Dr. Rosenblatt on the study covered in today's webinar on the geographic and the specialty distribution of the physicians trained to treat those with severe opioid use disorder.

John I now turn the presentation over to you

{John Gale, MS}

Thank you very much. Welcome everyone, good afternoon, or good morning depending on where you are in the country. I am going to set the stage for the presentation by my colleagues on the line today. I will talk to you a little bit about the real issues that we see with opiate and heroine abuse, it is a very complex problem. Before we go to much further, Holly will share the sentiments we have to acknowledge the support for our work on opiate use, and Holly's work and WWAMI's on buprenorphine physician services, they are an important source of funding for the work that we do.

The background material, it's no surprise, people have been hearing about opiates for while and many experts have declared opiate use as a national epidemic. We'll provide a little bit of background data; in 2013 Centers for Disease Control and Prevention, produced data and highlighted the complexity of overprescribing controlled medications. In 2013 there were 16,235 deaths from prescription opioids which was up 1% from 2012. In 2013 there were almost half as many heroine related deaths up 39% from 2012. In the National Survey of Drug Use and Health, provides data that shows over 2.1 million people in the US suffer from substance abuse disorders related to prescription opiate pain relievers. In 467,000 people over 4000 are addicted to heroin.

This is a complex problem, because there is a very direct relationship between the increasing nonmedical use of opioid analgesics and heroine in the United States. And when I say that, what I really mean is that they are fairly affective substances for one another.

So then if someone – and there are different pathways to the abuse of opioids, some start with prescription pain medication, because of chronic pain or injuries, they become dependent on

prescription painkillers and start moving into the area of abuse. If the prescription pain killers are not accessible, they will move to heroine and it will feed that. On the other hand there are others who start in the more illicit drug world use heroine will find it will become yet one other path for obtaining the drugs that they need to feed their habits, through misdirecting prescription drug use.

So what we are seeing is a very complex system. When we see changes in one, trends will push use to other side. If law enforcement is becoming particularly effective at stemming the flow of heroine, the use of nonprescription meds goes up. If we start making inroads in prescription medication, then we will see the other happening. The control and the price of heroine and the supply demand go up. Some years ago, and I think one of the things important to note is that heroine is cheap. It is ranged from five dollars a dose and with the current demand and some of the market economics, it is \$10-\$25 a dose. And the purity has improved substantially.

So our challenge is to confront opioid abuse, while preserving the medical role of prescription pain relievers. And that's just not easy, because a lot of primary care providers are getting very uncomfortable because there is a legitimate role for prescription pain relievers, but it is a fine balance. Many family physicians, primary care providers and practitioners are not necessarily trained in managing pain the way they need to, it makes them very uncomfortable. The number of prescriptions for opiates have increased substantially in recent years, part of that is marketing, part of that is the increase in demand. What you are looking at is the increase of 76 million prescriptions in 1991, to nearly 207 million in 2013. And the number of past year heroin users (people who have reported at some point in the past year they have used heroine) have increased between 2005 and 2012 from 380,000 to 670,000 people.

This is a slide I have pained from Nora Volko from the Narcotics Control and it gives you some of the links, between prescription medication and heroin use. So if you look at OxyContin for example which is the second line, we have heard about the challenges of OxyContin, over the years we've done a better job in educating providers and controlling prescriptions and limiting some of the misuse. But at the same time the changes in heroine, which is the bottom line, it has increased. You see there is a pretty direct relationship as we control for codeine, oxycodone and other opiates, and the demand for heroine goes up.

To show you the variability of opiate prescription patterns, this is a map that was produced by the Centers for Disease Control and Prevention in 2010. It comes from the mortality and morbidity weekly report, this shows the different prescription patterns and in some ways it reflects the rural nature of opiate use. You will see in Oregon and Washington, Nevada, Maine, the Carolina's, Oklahoma, my geography isn't that good so I'm not able to pick everything out, but this is where you see heavy utilization, and prescription patterns, that's a challenge. Our goal is to try to figure out how to moderate that, and to make sure there are standards for providers.

Finally I will conclude my last slide before turning it over to Jennifer. This is a long standing issue in rural communities. We have heard about this for years, in many ways when OxyContin first came out, the concern started to arise, it was very big in the Appalachia region in West Virginia, in many of these states it was called hillbilly heroin. They would buy it, and crush it

and use it in much of the same way. We have seen the use of heroine as a substitute for prescription painkillers. This was a case that happened in Maine by those in local seasonal and extraction industries (fishing, lumber, farming) without insurance would use heroine to control work related pain, because it was cheaper than buying prescription medication.

We are seeing major initiatives in states like Vermont and Ohio and others, not limited to those, have made real recognition of the problem. Partially by the fact heroine is cheap, accessible and stronger than it ever used to be. Also, in other rural areas, we find treatment resources and law enforcement resources are much more limited. At this point I will turn it over to Jennifer.

{Jennifer Lenardson, MHS}

Well I am going to present some findings from our study looking at opioid prevalence, and by opioids I am looking at heroine and nonmedical use of pain relievers. We are using data from the National Survey Drug Use and Health 2008-2013. We have approximately 56,000 respondents each year, so that gives us 340,000 respondents over the six-year period. The rural/urban variable that we are using is the traditional O&B metro/non-metro variable. So far we have done cross tabs on rural and urban use prevalence, age at first use, various sociodemographic characteristics, receipt of limited treatment options, source for pain relievers and negative behaviors, like driving under the influence of drugs.

What we found is that when we look whether it was “ever having used heroin or pain relievers non-medically,” or “past year use,” or “past month use,” we found that the rate of use was higher, statistically higher among urban residents. But you will notice that the magnitude of that difference is very small. And you will see on the left hand side of the screen that heroine use is a low prevalence activity where pain reliever use is quite high. 14% of the population over the age of 12 has used pain relievers non-medically.

Sociodemographic characteristics for persons who ever used heroine are very similar between the rural and the urban areas on most indicators with the exception of race, which we found that for rural people that have ever used heroine were more likely to be white, something we had expected. If you will look to the left in the bar chart, you will see that rural persons who have ever used heroine were more likely to have very low income compared to urban, and more likely to be uninsured. Looking just within rural areas, we found that persons who had ever used heroin were more likely to have certain characteristics than those who had never used heroine. They were more likely to be between the ages of 2- to 49, so were not very young and not over 50. They were more likely to be male, white, in poor health, less than a high school education, to be low income and uninsured.

Looking at persons who would ever use pain relievers, we found that rural persons who were more likely to demonstrate some socio-demographic vulnerabilities compared to urban, and you will see across the board that at the significance level, rural users of pain relievers were likely to be very young, under the age of 19, fair or poor health statuses, to have limited educational attainment, to have served in the military; they were more likely to be unemployed, to have low income and to be uninsured. Within rural areas only, those who had ever use pain relievers non-medically were different on certain characteristics than ones who have never used pain relievers.

Like heroine users they were more likely to be between the ages of 20 to 49, male, white, unmarried, to have no military background, limited educational attainment, low income, uninsured and somewhat surprising to me, they were more likely to be employed.

When we looked at access to treatment we found variation by the recency of that treatment and whether they lived in a rural or urban area. When you look at the left-hand bar chart, we found that among those who had ever used heroin, rural users were less likely to have received treatment for drugs or alcohol in the past year. But among those who have ever use pain relievers, rural users were more likely to have ever have received treatment for drugs or alcohol. And this variation relates to the timeframe, past year treatment versus having treatment, or perhaps it has to do with the multiple use of drugs or alcohol. Also these variables are not very specific to the drugs that we were interested in this particular study, you will note they were for drugs or alcohol use.

When we looked at sources for pain relievers, first we found that there were no differences by rural/urban residents. The numbers you are seeing here are for the total of the US population that had used pain relievers. Friends or relatives where the majority source, 70%; 21% had obtained pain relievers from one or more doctors. A small percentage had obtained them from a drug dealer, the Internet or some other source. Less than 1% had obtained it through a fake prescription or theft from a provider.

We found that negative behaviors are very high among persons who have ever used heroin or pain relievers non-medically, in the slide we combined heroin and pain relievers together to indicate opioid use and we did not find a rural/urban difference for driving under the influence. One third of all opioid users had driven under the influence of drugs in the past year. Looking at probation status in the past year, rural users were more likely to have been on probation in the past year, and there are a very large percentage of opioid users have ever been arrested for breaking the law; that has been statistically higher for rural residents. At this point I am going to turn it back over to John.

{John Gale}

Thank you Jennifer. I'm going to spend just a few minutes talking about the treatment resources that are available in rural communities, and then we will turn our slides back over to Holly. We did a little bit of work in looking at treatment resources; we use the 2015 SAMHSA Treatment Services Locator. It is a new data set for us; the problem being the traditional data sets Substance Abuse and Treatment Service file has been put on hold by SAMHSA. They had trouble with folks being identifying with the provider agency. This will give you a little bit of a look at the disparities of treatment resources.

We look specifically at opiate treatment programs. The treatment that we all hear so much about involves medication, and the use of methadone buprenorphine known as Suboxone and now Naltrexone to moderate the detox process for folks on opiates.

The reason why this is important is because these are one of the few drugs we have that ability to really intervene in that way. Methadone being the more common and older of the treatment

methodologies, but having some issues; methadone generally is highly addictive. It is an alternative to heroin, it is not quite as addictive, but it still has problems when being used for chronic pain. Typically a client from a methadone program is required to go on site every day to get their dose. They are rarely – they are discouraged the use of daily treatments because methadone has a street value. So we have heard many stories of rural residence having to drive two to four hours each way to obtain medication. They have to do this on a daily basis. Buprenorphine was the first, the more recent drug is Suboxone Buprenorphine and Holly will talk more about that but it basically has less of an opiate characteristic. It can be taken orally, and can be done by IV, and it is a use in some communities; it did not evolve as quickly as some had expected.

Now Naltrexone is another way to monitor and control the cravings for heroin at the neurotransmitter level. Now if you look at this, if you move from the urban to the small rural, and isolated rural, you see a pretty straight forward pattern; the concentration of these services are for detox, methadone maintenance, in the urban communities. The prevalence and availability drops in larger communities with some limited exceptions. Drops even more in smaller rural areas and isolated rural areas; the exception being the use of injectable vivitrol and buprenorphine. Now Naltrexone in isolated rural communities, just because they are a little more prevalent, doesn't mean they are more readily accessible because you are covering substantially larger geographic areas.

Then going into general treatment services, where we see the same patterns in patient care, is the most common and in some cases very noticeably so. This is the whole population, so we didn't bother doing significant testing because we have all inpatient treatment services. But when you look at the 9.9% of services in urban communities versus the 2.9% for isolated rural and the same is true. What this really tells us there is a substantial barrier so even though there may not be more heroin and opiate abuse in rural communities they will have farther to travel and fewer resources to access and that's the important piece.

The other piece I will make before I turn slides over to Holly is that we look at the prevalence rate between urban and rural areas, we are always looking for those differences, and sometimes we do not see them. But then you are looking at prevalence at a national level across all urban and all rural areas, where this becomes more of a challenge. This is where you go to a much smaller area, so county levels or communities. There you tend to see somewhat more patterns of use in differences. Unfortunately within the public use files of NSD UH, we were not able to get at that. There is a process to obtain more information but SAMHSA has just changed vendors and it has been put hold for a bit.

So when we think about this and as you think about opiate use in your states, I encourage you to really think about looking at the smaller areas and understanding the patterns of abuse that will vary from community to community. That being said I am done and I will go over my conclusions and turn the slides over. Overuse remains a treatment problem in rural areas. It varies from community to community, the fear of over prescribing and the impact on licensure is really creating challenges for primary care providers. We have heard from primary care folks

that tell us they are afraid to prescribe prescription meds, because they are afraid that patients are Dr. shopping.

The treatment services, in summary, are less available in rural communities, they may be less experience in recognizing and treating opiate abuse, and longer travel distances and longer delays are common for rural residents.

The complexity of the problem calls for a multi-sectoral approach; health care, law enforcements, schools, public health, prescription monitoring programs are all needed. And what we really need to look at for the future is how to service capacity, particularly for Buprenorphine and Methadone within rural communities to help through withdrawal. Manage access for the use of prescription meds and the use of heroin, which is an illicit drug, help providers manage pain in a way that doesn't further abuse and reduce unnecessary opiate prescriptions. Thank you.

{Holly Andrilla, MS}

Thank you John and Jennifer, my name is Holly Andrilla. I am a research scientist and biostatistician at the WWAMI Rural Health Research Center. I want to share the results of a recent research study looking at the geographic and specialty distribution of US physicians trained to treat opioid use disorder. I would like to start by acknowledging the other members of our study team who include Mary Catlin, Dr. Eric Larson the director of our center and of course the late Dr. Roger Rosenblatt. Dr. Rosenblatt was a family physician who was passionate about rural health and was passionate about treatment for opioid use disorder. I feel really privileged to have got to work with him on one of his final pieces of work. I want to thank the Federal Office of Rural Health for their funding and make note that the conclusions, opinions and results express here are those of the RHRC authors.

I think John and Jennifer set up a pretty good background for you regarding the epidemic of opioid related deaths. I will go through these slides a little quicker than I was planning. There is an epidemic of opioid related deaths across the United States. There are many factors that have contributed to that including excessive prescribing by physicians, misuse of prescription drugs, and as John pointed out, those two practices are related in an increase use of heroin. Five million Americans in 2013 had either abused or were dependent on opiates. The vast majorities were prescription pain relievers, but more than half a million people were estimated heroin users; with a large number of new users from the previous year. The death rate from prescription opioid overdose has more than quadrupled since 1999 and 2010. Opioid analgesics were involved in a much higher percentage of drug overdose related deaths than they were in 1999, with 60% in 2010 – that's twice as high. This slide is just the number of deaths from prescription opioid pain relievers, you can see that it has increased threefold between 2001 and 2013, I think the reader's digest message is: this is a huge problem.

Buprenorphine Naltrexone is an effective treatment opioid use disorder that can be provided in an office setting. US Congress passed the Drug Addiction Treatment Act to expand the options and one of the advantages for buprenorphine treatment for rural populations is that it does not require patients to travel long distances. And John alluded to that some of those distances can be 2 to 4 hours one way to get their treatment that some of the other traditional treatments do

require. Authorized under the Drug Addiction Treatment Act a physician can complete a training course and obtain a waiver to prescribe buprenorphine. In the first year after getting their waiver, they are allowed to treat up to 30 patients concurrently, after one year they can apply to have that limit increased to treat up to 100 patients at the same time.

The WWAMI Rural Health Research Center was interested in the workforce that could address this topic of opioid addiction and had some questions about the DEA workforce. Specifically we were interested what were the characteristics of physicians that obtained a waiver to prescribe buprenorphine and when I say the characteristics, what I'm talking about, not only their demographics but also their specialty that they practice. We were also interested in understanding where physicians with DEA waivers were located. And then wondering based on where they were located, were there certain segments of the population that lacked access to this buprenorphine as a treatment option because there was no provider there.

We used primarily three data sources in this research. We used the Drug Enforcement Administration Waived Physician List and this is a list that's updated quarterly. We happened to use the list from July 2012 and it includes information about the physician and includes address, name, and how many treatment slots as we refer to them, either 30- or 100 slots that they're able to treat. We used the AMA Masterfile also from 2012 and we used the US Department of Agriculture County Typology Data. And I will explain to you in just a minute how we used that data. So we linked the DEA and AMA data using the provider's DEA number. We did this for all the states except for Wisconsin. Wisconsin does not include the DEA number as part of their licensing records and so we did not have demographic information for the physicians in Wisconsin. We were able to locate them and find where they practiced but we do not know their age and gender or their specialty.

We use the physician's practice zip code to determine what county the physician's practice was located and then using the county level urban influence code, we assigned all counties and therefore for all physicians to one of four geographic categories. The categories were Metropolitan County and then the three different categories of non-metropolitan were broken into Adjacent-Metropolitan Counties, Micropolitan that were not adjacent to metropolitan and then Small/Remote Rural Counties. What we found is that significantly more men physicians than women had obtained a waiver to prescribe buprenorphine. Low percentages in both cases, 2.4% and 1.8% respectively. We found that younger physicians were less likely to have obtained a waiver. Physicians that are less than 35 years old represent 7.8% of the workforce, only 2.6% of Buprenorphine providers. Physicians that were over 35 had obtained a waiver at a rate of 2.3% and physicians that were age 55 to 64, was the group most likely. We had the highest percentage of waived physicians in that group; it was almost 3% of those physicians.

We were also interested in who were the physicians that were obtaining these waivers and what were their specialties. And if you would look at just in the left-hand column of this table, I'm going to focus on that first; you can see at the bottom of that where I highlighted 18,225 which was the number of waived physicians across the US in 2012. Of those 18,000, 41% were psychiatrists and it's interesting to know if you work at a rural health center that psychiatry is not a specialty that is prevalent in rural locations. Primary care providers made up of slightly more

than a third of all waived physicians with 22.3% of waived physicians being family physicians and 14.4% of waived physicians having the specialty in general/internal medicine. If you look over at the lower right hand side – I guess I can point – of this slide, you can see that I've highlighted the 2.2 and that's the percent of the entire US physician population that actually has a waiver; so only 2.2% of physicians have a waiver to treat opioid abuse disorder with buprenorphine. I also highlighted in the previous column the 3.6%. We were particularly interested in that number; 3.6% of family physicians have a waiver to prescribe buprenorphine and we were interested in that because for rural populations the vast majority of physician providers are family physicians.

We were interested in not only the specialty of the physicians, but where they were located, and this slide goes through that information. I'm going to start and just point out that at the top row, I don't know if you can see my pointer, shows the US population and you can see that 83.6% of the US population resides in the Metropolitan County and then the bottom row of this table shows the percent of the waived physicians that are in a Metropolitan County. So you can see that 90% of the physicians that have a waiver are also in those same metropolitan counties. As you move to the right, the county designation becomes more rural, so you can see in counties that are adjacent to the Metropolitan areas, about 11% of the US population resides there and only 6% of physicians with waivers are there and that continues. You can see in the small remote counties 2.4% of the US population is in small and remote rural counties but only 1.3% of waived providers.

The row I want to highlight is the one I've shown in red, we designated every County in the country as either a county with one or more physicians that had a waiver to prescribe Buprenorphine, or as a county that had no physician with a waiver to prescribe Buprenorphine. You can see more than a fourth of the counties of the Metropolitan counties in the US don't even have a single provider that could prescribe Buprenorphine (26.7%) and that seems really high to me. As you moved to the rural counties, you can see that number getting much larger. So in counties that are adjacent to metropolitan counties 60% of those counties do not have a provider that could prescribe Buprenorphine. When you get to the smallest counties, 82.5% of those counties lack even a single provider that could provide buprenorphine treatment and when you couple that with the travel distance you can see the impact that it has on the rural population. Overall, 53.4%, more than half of the counties in the US lack even a single provider that's waived to prescribe buprenorphine.

If you map these results, this is the map of the US at the county level. This is what you get. The dark gray counties are counties where there is at least one buprenorphine provider, and the white counties are the counties where there is not even one waived physician. You can see down the West Coast that there is good coverage or good potential coverage for buprenorphine providers. And you can see in the northeast, Maine down to Florida there's pretty good coverage, but you can see in the middle of the map, there is a large white stripe down the Midwest and in these areas there are large geographic areas where there are no Buprenorphine providers available. I think it would be kind of interesting to compare this map with the map that John and Jennifer showed of the prescribing patterns and see how the two are related.

So for summarizing what we found, majority of US counties have no physician with a waiver. If you just look at the counties that don't have a waiver you'll find that 82% of them are rural counties.

And even when you look at the ratio of waived physicians to population you'll find it is much lower in the most rural places. With those small and remote counties only having 3.1 waived physicians to 100,000 residents compared to 6.3 waived physicians per 100,000 in metropolitan counties; more than twice as much. 30 million people, almost 10% of the US population live in a place without a waived physician who can prescribe Buprenorphine and 2/3 of those people or about 20 million are rural residents. That might seem like the take-home message but actually it's not. Having a physician that is waived in your county does not mean Buprenorphine treatment is necessarily available. In Washington State there was a study of physicians that were trained in 2010-2011 and obtained a waiver to prescribe buprenorphine and only 28% of them reported ever prescribing Buprenorphine. So if that percentage or anything even remotely like it, were to hold [anything like it], the access to this problem would be much more worse than our data indicated, potentially.

Given that information, the WWAMI Rural Health Research Center will be attempting to answer the question: who treats opioid addiction in rural America? The questions we are specifically looking to answer are what proportion of the physicians that are in rural areas that have a DEA waiver are actually using it in their practices?

We're wondering how many patients with opioid use disorder do physicians treat and what kind of patients they're treating. We're wondering what if waived physicians only provide treatment to their own patients (patients in their own practice) or if they provide treatment for patients from the community at large and therefore acting as a resource for their community. We're also going to explore the reasons that physicians choose to include office-based treatment in their practice and look at the barriers and reasons physicians choose to not include this treatment in their practice.

I have provided a list of references that I used in this presentation, as well as my contact information. We did have a comprehensive list of the waived providers which included the number of treatment slots that each had and we have calculated specific information for states' and counties' ratios of providers to population which varies greatly across the US. So if somebody is interested in finding out information for their area, you could contact me and I would be happy to share that information with you. You can look for this work and other work from the WWAMI RHRC and all of the RHRCs' at the Rural Health Research Gateway. Thank you very much.

{Shawnda Schroeder}

Thank you Holly, Jennifer, and John for that presentation, and I do want to provide some time now for those who are on the call to ask questions about your research and what you've been finding, I will turn over to the moderator to open for questions.

{Moderator}

Thank you, if you'd like to ask a question please press Star (*) and 1 on your touchtone phone. You will be prompted to record your name, please be sure to unmute your phone and record your name. Again press Star (*) and 1 with any questions. One moment while we wait for the first one.

Again If you have any questions please press Star (*) and 1 and record your name. One moment we do have a question.

We do have a question from Joe Ibal.

{Joe Ibal}

Hi guys, can you hear me okay?

>> I can.

Ok great. Thank you very much for your presentation, I am a researcher up in Northern Ontario School up in Canada. We've got a really similar issue in that a lot of patients that require methadone or Symboxone are either located in real rural remote or even fly-in communities. And I was curious, if you've seen anything with different treatment modalities and if they're being up taken? A lot of the methadone maintenance and Buprenorphine maintenance that we have in Ontario is being provided via telemedicine or video conferencing. And I'm just curious if there's been much activity within the states with that approach? So the physician is located in one region or one place and the patient actually shows up at a clinic or location where the nurse can provide the observed dose of either methadone or buprenorphine. I am curious if that is going on and if you think there is any merit to that? And just another quick question, are the slides available? Or can we pick them up at the RHRC Research Gateway? Thanks.

{Holly Andrilla}

This is Holly, I don't know about the slide thing I think it will be on the gateway. I do want to tell you that in Washington we had a project that was called Project ROAM, which was Rural Opioid Addiction Management and it was a telehealth project that linked physicians in remote places or providers and sort of experts in Seattle where they could get kind of coaching on how to treat it. There are some write-ups on this project; Dr. Rosenblatt was very involved on that project. It is completed at this point in time.

{John Gale}

This is John Gale, I will be honest I have heard of fewer examples of telehealth use. Certainly, I think we have to explore all opportunities. One of the problems that we run into in opiate and methadone use anyway is the challenge of licensure and who have prescriptive privileges. One of the – part of me that's a bit of a sceptic on having worked in and managed substance and practices is that some of the ways the systems are set up and driven by regulatory issued licensures. Some of it is the way that things have been done, hopefully it is changing. And then some of it is quite honestly is how some of the clinics and providers are reimbursed. Typically there is a reluctance to send methadone patients alone home with medications because they do have street value and they do have very strict guidelines. There are state regulations that are in

place, there are HRSA substandards and Federal regulations. The short end of it is we tend to see the on-site programs more often than not. And I think if we were to look at telehealth there'll have to be some real discussions about driving and managing it and how they can be controlled. I'd actually love to hear what your project is doing at some point because that sounds really very interesting.

{Joe Ibal}

Yeah, we'd be happy to follow up after the call, maybe I'll send you an email follow up?

{John Gale}

That would be great thanks.

{Shawnda Schroeder}

Yes and on behalf of Gateway, I will also say this webinar along with the slides presented will be available on our website and also sent out through the alerts as soon as they are available.

{Moderator}

One moment we do have another question. Go ahead.

{On-call Speaker}

Thank you, if I understood correctly I think you said 28% of doctors who had waivers did not prescribe, is that because they do not have enough demand in their practice for it? Or are there time constraints that prevent them from taking that on?

{Jennifer Lenardson}

Well that is one of the questions we are following up on. There is a paper that Elisha Hutchenson at the UW (was the first author) she did an extensive interview of all providers that were waived to prescribe Buprenorphine and it goes into discussions of what the barriers were to prescribing but It was not because there was not a need, it was not the reason these physician cited.

{On-Call Speaker}

Okay, Thank you.

{Moderator}

Again, if you have any questions please press Star (*) and 1 and record your name. Again Star (*) and 1 with any questions. I am not showing any questions at this time.

{Shawnda Schroeder}

This is Shawnda Schroeder again and if there are no questions on the lin, I would like to read a couple of the questions in the question and answer box so those can be addressed. One of the questions related to insurance coverage – the question is are there any ideas on how well

buprenorphine is covered by health insurance and is it typically on the health insurance plan formulary?

{Holly Andrilla}

I do not want to speak to that because I'm not sure that I'm completely up to date on that, this is Holly. I don't know if you are up to date on that John?

{John Gale}

My past experience with our physician groups and it's certainly no current in terms with the world of reimbursement, but it would depend on the plan. The Medicaid we found in Maine was better. Often times frankly by the time someone seeking treatment for opiate abuse, they have been appearances their employment is frequently uninsured or under insured. Now the paraded legislation which has been passed, it is taken effect between physical health and substance/mental health conditions they may have been moderated but I suspect if they are providing coverage, it is certainly an option.

{Shawnda Schroeder}

Thank you we have one more typed question. Since many rural health clinics have run and managed by nurse practitioners [NP], very little MD involvement, is it possible for an NP to obtain a DEA waiver?

{Holly Andrilla}

I don't – it's my understanding at this point in time that's not the case but I don't know that for sure. Again that's a – I think as NP score of practice is increasing that may have changed since I have last investigated..

{John Gale}

I don't know if I've ever been asked that question, or looked at that issue, it would be worth looking at certainly with prescription patterns that are based on state licensure.

{Holly Andrilla}

Sure and there's obviously a wide range of scope of practice this -- laws for NP's in general.

{John Gale}

I don't know the accreditation process and the designation process.

{Shawnda Schroeder}

Are there any other questions on the line?

{Moderator}

Yes we did just have another one queue up. One moment. We have a question from Susan, go ahead.

{Susan}

Hi, thank you. Excellent information. Referring to a comment about – I forgot what slide it is I can't back up on it – higher arrests in rural settings, I am curious what the crimes are.

{Jennifer Lenardson}

This is Jennifer. We do not know what the arrests are for and all we know is on the data set and the question is “Were you ever arrested and booked for breaking the law?” We do not know even if it was related to use or not. So it's pretty unclear whether those two things are linked or not, we are not sure, but obviously these are folks that are using risky behaviors.

{Susan}

Thank you very much.

{Moderator}

No further questions holding.

{Shawnda Schroeder}

If there are no further questions, I do want to again thank all three of our presenters today, and to thank the Federal Office of Rural Health for funding, the Rural Health Research Gateway for allowing us to hold webinars and to house products of the research centers online free for access for those interested in the topic. With that said this webinar and along with the slides that were presented today will be sent out through our research alert system. If you do not already receive our research alerts, I do encourage you to sign up for our email listserve at ruralhealthresearch.org/alerts. You can see the link on your screen at this time. Those alerts are sent whenever there is a new product and policy brief completed by one of our seven rural health research centers. Otherwise, I thank you all for your time today, thank you again to the presenters and have an excellent afternoon.

{Moderator}

That concludes today's conference you may disconnect at this time. Thank you.

[Event Concluded]