

# *Strategies to Combat Opioid Use in Rural Communities*

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## Topics to Be Covered

- Key take away messages
- Opioid use across rural settings
- What is different about rural areas?
- Drivers of rural opioid use
- Burden of opioid use in rural communities
- Evidence-based prevention, treatment, and recovery strategies to address rural opioid use

## Key Take Away Messages

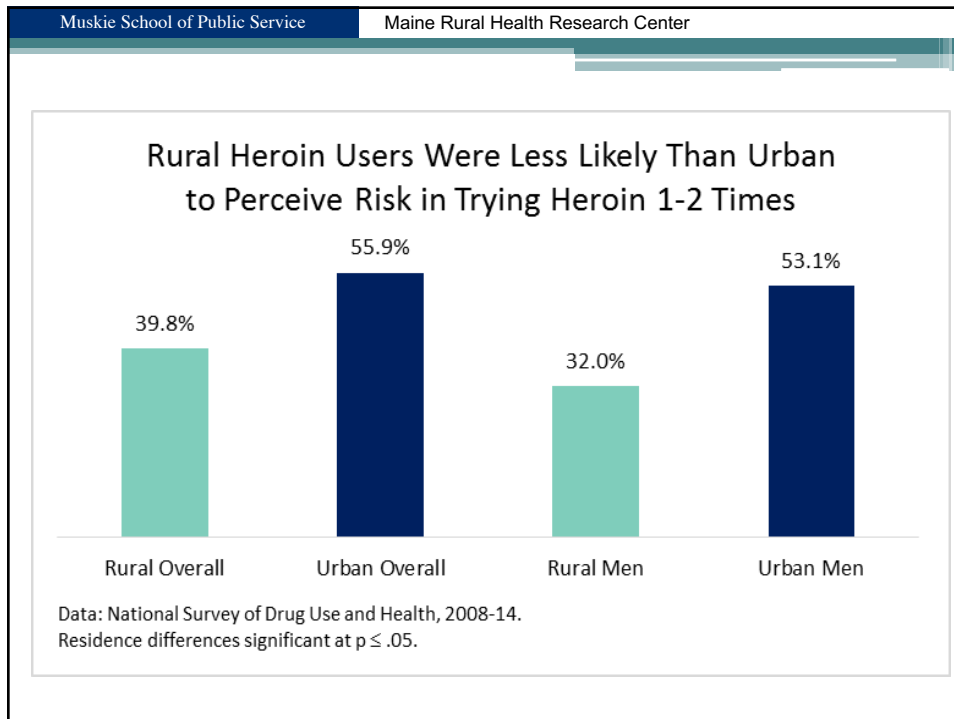
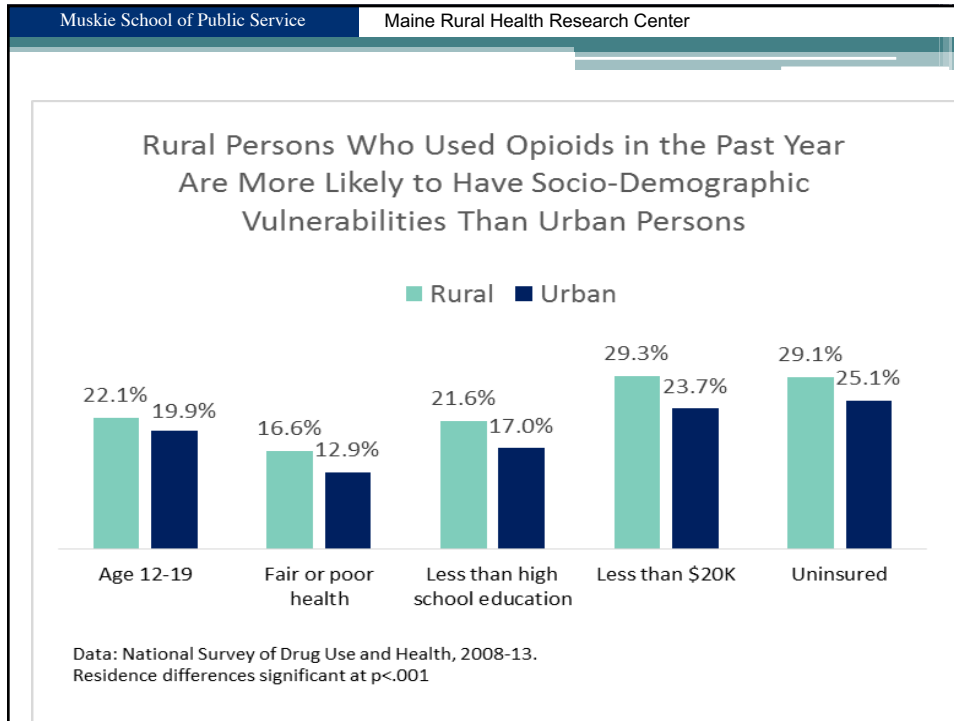
- It takes a village - Community engagement and involvement are central to addressing opioid use
- Opioid use is common in rural areas and driven by a complex mix of socioeconomic issues
- Rural areas suffer disproportionately from these issues
- Travel barriers and isolation exacerbate these problems
- Significant gaps exist in substance use prevention, treatment, and recovery in rural communities
- Models must be adapted to the geographic, resource, and cultural realities of rural areas

## Opioid Use – A Complex Problem

- The good:
  - A class of prescription medications providing significant benefits to patients with acute severe pain
- The bad:
  - Undue influence of pharmaceutical companies
  - Early failure to acknowledge the risks of prescription opioids
  - Slow adoption of evidence-based prescribing guidelines
  - Growing patient demand for opioids
- Complications:
  - Direct linkage between prescription opioid and heroin use
  - Multiple, interrelated pathways to opioid addiction

## Rural Opioid Issues

- Opioid use is the primary cause of unintentional drug overdose deaths
- Several rural states are experiencing the highest rates of overdose deaths - WV, NM, NH, and KY
- Misuse of pain relievers is higher among rural youth, women who are pregnant or experiencing partner violence, persons with co-occurring disorders, and felony probationers
- Heroin use has begun to migrate away from urban communities and now more typically occurs in small urban or non-urban areas
- Prescription opioid and heroin use are strongly linked



## Factors Associated with Rural Opioid Use

- Controlling for: residence, age, sex, race/ethnicity, health, education, marital status, employment, health insurance & income, rural persons:
  - Were 20% less likely to have past year opioid use than urban
  - Ages 12-19 were 70% more likely to use opioids than 30-49
  - Under 30 had higher odds of opioid use than 30 and over
  - Who were married had 40% reduced odds of use compared to rural persons who were not married
  - Males were 30% more likely than females to use opioids
  - In poor health, with limited education, and no health insurance had higher odds of opioid use
  - Who were uninsured had 58% higher odds of opioid use compared to those with private coverage.

## Socioeconomic Drivers of Rural Opioid Use



## Role of Rural Place as a Driver of Opioid Use

- Rural places suffer from a variety of health and socio-economic disparities
  - Greater sense of stigma
  - Higher sense of isolation and hopelessness
  - Lower education rates
  - Higher rates of poverty
  - Fewer opportunities for employment
  - Higher rates of chronic illnesses
- Influence of cultural, ethnic, religious differences

## Risk Factors for OU

- Family history of substance abuse
- Personal history of substance abuse
- Young age
- History of criminal activity and/or legal problems
- Regular contact with high-risk people or environments
- Mental disorders
- Risk taking or thrill seeking behavior.
- Heavy tobacco use.
- History of severe depression or anxiety.
- Psychosocial stressors.
- Prior drug and/or alcohol rehabilitation

## Interaction between Opioid Use and Risk Factors

- Opioid use is driven by socioeconomic factors
- It also contributes to a self-perpetuating cycle that is difficult to break
- Individuals with opioid use disorders have lower levels of academic achievement, arrest records, greater rates of poverty, etc.
- Intergenerational substance use
- Intergenerational trauma
- Stigma plays a crucial role

## Other Rural Issues

- Long standing issue in rural communities
- Non-medical use of prescription opiates in rural areas
- Heroin as a substitute for prescription opioids by those without health insurance – Maine
- Major initiatives– Vermont, Ohio, other rural states
- Heroin is cheap, accessible, and stronger
- Limited treatment & law enforcement resources
- Substantial variations in opioid prescribing rates

## Policy Implications

- Despite social vulnerabilities, rural opioid users have slightly lower prevalence rates than urban opioid users
  - Social ties, support, and other buffers may protect rural residents from even higher prevalence rates
- Prevention efforts have not effectively reached rural residents – especially young people and men – who do not perceive risks from heroin use
- Harm reduction and syringe exchange programs are also important, though far less common, in rural areas
- Significant efforts to manage opioid prescribing rates are needed

## A Public Health Model for OU

- Systematic data collection on scope, characteristics, and consequences of substance misuse
- Identify risk and protective factors for OU and factors that could be modified through interventions
- Collaborative efforts to address social, environmental, or economic drivers of OU
- Effective prevention and treatment interventions and recovery supports in a wide range of settings
- Monitor the impact of interventions on OU, related problems, and risk and protective factors
- Community leadership that mobilizes community organizations and resources to address OU



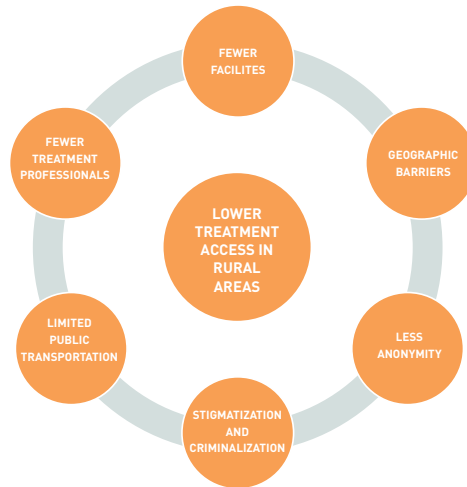
## Community Strategies

- Key to addressing the problem at the local level
- Important components
  - Broad-based support and engagement
  - Stigma reduction
  - Prevention
  - Harm reduction – naloxone and needle exchanges
  - Engaged law enforcement that avoids criminalizing users
  - Engaged providers using evidence-based prescribing guidelines and offering medication assisted therapy
  - Access to evidence-based treatment services, integrated with mainstream health care
  - Peer support and recovery services

## Engaging Hospitals and Primary Care Providers

- Problems are not limited to opioid use only, but include many other health and safety problems
- Hospitals, emergency departments, and primary care contribute to the opioid problem through prescribing practices
- Tax-exempt and publicly owned hospitals have an obligation to address unmet community needs
- Rural hospitals and primary care providers can play an effective role in addressing opioid use by filling gaps in specialty care system
- It provides an opportunity for collaborative action by hospitals, medical, and community stakeholders

## Barriers to Treatment Access in Rural Areas



## Barriers to OU Treatment

- Poor coverage for MAT services – OTPs are cash only services in some states
- Services are often clustered around urban centers – requiring long travel distances for rural residents
- Many buprenorphine providers operate below capacity
- MAT services are not enough – substance use, mental health, care coordination are needed
- Greater attention is needed on what happens after treatment – peer support and recovery services are needed to reduce likelihood of relapse

## Prevention Strategies

### Important Strategy Area # 1 - Prevention

- Opioid harms not restricted solely to those using heroin or misusing prescription medications
- Discourage/delay onset of OU
- Minimize related high risk behaviors
- Focus on children, adolescents, and young adults
- Community focused strategies
  - Community organizing and education
- Provider focused strategies
  - Reducing supply of opioids prescribed
  - Use of prescription drug monitoring programs
  - Offer alternative pain-management strategies
  - Provide opportunities to dispose of unneeded medications

## Prevention

- A primary component of a health-centered system to address OU use
- Evidence-based (EB) prevention programs effectively prevent initiation, harmful use, and related problems
- Prevention is cost-effective at different stages of life
- Must be adapted to the unique context of each community with fidelity to the intervention on which the evidence is based
- Communities are an organizing force to bring effective prevention programs to scale
- Key: Cross sector community coalitions to assess local risk and protective factors, OU problems, and implement interventions to match local priorities

## Activities to Engage Communities

- Community Organization and Engagement
- Prescriber education and behavior
- Supply reduction and diversion control
- Pain patient services and drug safety
- Drug treatment and demand reduction
- Harm reduction
- Community-based prevention education

## Key elements of effective community coalitions

- Understanding the community's needs and resources
- Widely shared and comprehensive vision
- Clear and focused strategic plan
- Diverse membership: key community leaders, local government officials, and volunteers
- Strong leadership and committed partners
- Diversified funding
- Well-managed structure: organized administration, effective communication among participants, and a comprehensive evaluation plan

## Evidence-based community organizing models

- Project Lazarus -
  - In all North Carolina Counties
  - In rural communities across the country - Project Bald Eagle, Williamsport, PA. Winnebago County Heroin Task Force in Wisconsin, Clark County Collaborative in Ohio, and Washtenaw Health Initiative Opioid Project in Michigan
- Project Vision, Rutland, VT
  - Uses a Drug Market Intervention model and community collaboration/engagement to reduce the supply of opioids
- SAMHSA'S Recovery Oriented Systems of Care
- Communities That Care

## Project Lazarus – Hub Activities

- Hub activities are central components supporting all other activities and reflect a community-based, bottom-up public health approach
  - Build public awareness of substance use through broad-based educational efforts and the use of local data to drive awareness
  - Coalition building and action to engage a broad range of community providers, agencies, and organizations
  - Identify data needs for planning and evaluation to build awareness, tailor programs to local needs, track progress, and sustain support and funding

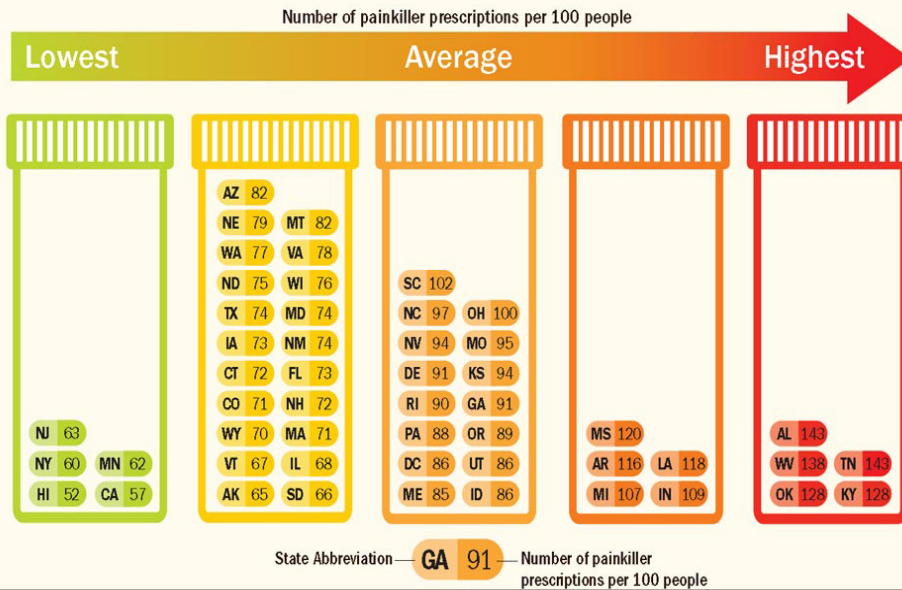
## Project Lazarus – Spoke Activities

- Spoke activities are optional areas of evidence-based prevention initiatives that communities can select and reflect a medical and law enforcement-based, top-down public health approach
  - Community education
  - Provider education
  - Hospital emergency department policies
  - Diversion control
  - Pain patient support
  - Addressing the consequences of use
  - Addiction treatment

## Project Vision – Addressing Supply Issues

- Project Vision, Rutland, VT
  - Goals: empower communities, strengthen neighborhoods, help people, change the future
  - Committees: Crime/Safety, Substance Abuse, Community/Neighborhoods/Housing
  - Use a Drug Market Intervention model and community collaboration/engagement to reduce the supply of opioids (heroin and illicitly distributed prescription opioids) in rural Rutland VT

### Health care providers in different states prescribe at different levels.



## Prescriber Education and Behaviour

- One-on-one prescriber education on pain management
- Continuing medical education on pain management
- Licensing actions against criminal prescribing
- Implement and monitor evidence-based prescribing guidelines among all providers
  - CDC guidelines, state programs such as Washington state
- **Strongly** encourage use of prescription drug monitoring programs
- Think about an “oxy free” emergency department
- Harm Reduction - Naloxone and Opioid user education on overdose prevention and response

## Hospital Prevention Strategies

- Participate in community-based prevention programs as part of hospital’s community benefit and/or community/population health initiatives
- Quality improvement: Focus on supply reduction
  - Prescribing guidelines
  - Encourage greater use of prescription drug monitoring programs
  - Use Project ECHO to support prescribing and pain management capacity of local providers
  - Implement an “oxy-free” emergency department
  - Engage in harm reduction strategies



## Midcoast Maine Prescription Opioid Reduction Program

- Implemented opioid prescribing guidelines for dental pain in two rural EDs in Maine
- Driven by ED chairman with input from physician group
- ED patients who request refills of controlled prescriptions, have multiple controlled substance prescriptions, or have multiple previous ED visits for painful conditions
- Guidelines recommend the use of analgesic alternatives such as nerve blocks and immobilization
- Results after 12 months - reductions in rates of opioid prescriptions and visits for dental pain

## Oxy-Free Emergency Departments (EDs)

- EDs are a significant source of opioid prescriptions and a frequent target for those seeking opioids
- ED prescribing developed by the Washington State Department of Health, the WA College of Emergency Physicians and the WA Hospital Association
- Included limitations on the prescription of opioids in EDs and the concept of an “oxy-free zone”
- Lower rates of ED visits by “frequent users” with low acuity diagnoses seeking opioids
- WA Medicaid estimated \$33.6 million in ED savings
- Hospitals are pleased with the strategy but some experienced early reductions in patient satisfaction scores related to pain management

## “Oxy-Free” EDs –McKenzie Health System

- In February 2013, McKenzie Health System's ED discontinued dispensing narcotic and sedative medications for complaints of chronic pain
- Results – 60% reduction in opioid prescription abuse within a 12 month period and reduced utilization of unnecessary and costly diagnostic work-ups
- Staff met with community mental health officials, county health officials, local primary care providers, law enforcement, pharmacies to explain the initiative
- Engaged in patient education

## “Oxy-Free” EDs –McKenzie Health System (con't)

- Process:
  - Thorough medical exam to rule out medical emergencies
  - Review of patient's complete file, including internal health records, outside health records, drug screening tests
  - If patient presents with a chronic pain condition or suspected narcotics abuses, physician will inform patient of the dangers of narcotic drug abuse and may not prescribe a narcotic pain medication
  - May receive a non-narcotic pain medication and information about O/SU programs and /or pain management specialists
  - If a narcotic pain medication is prescribed after careful review by the physician, it is only for a very limited amount of pills, until the patient can be seen by his or her physician

## Reducing Opioid Prescribing by Providing Pain Management Services

- Due to the limited availability of pain management services in rural communities, many providers rely on prescription opioids as a primary treatment modality
- Rural primary care providers often have limited experience with the management of chronic pain
- Strategies
  - Expand access to pain management services through contracts and/or telehealth
  - Improve the capacity of local providers to manage pain through use of program such as Project ECHO

## Expanding Local Pain Management Services: Salem Township Hospital

- Salem Township recruited a pain specialist to travel an hour from Marion, Ill., twice a month to treat patients.
  - Considering expansion to three to four times a month.
- Patients are seen in one hour increments
- Provides trigger-point injections for long-term pain and promotes physical therapy and alternative treatments
- Patients continuing with opioids must agree to regular drug tests and not ask for early refills
- Over 3 to 4 months, only 3 out of 56 patients have chosen to stick with opioids
- Minimal investment - \$25,000 for capital equipment

## Telehealth-Based Pain Management Program: Martha's Vineyard Hospital (MVH)

- Due to its island location off Cape Cod, MVH worked with Massachusetts General Hospital's Center for Pain Management to offer a pain service via telehealth
- MGH providers see patients in a telepain clinic 3 days per month and conduct on-site visits twice per month
- Services include initial consults and follow-up visits
- Vital signs/patients notes are recorded in a shared EHR
- An RN, trained in physical examination of pain and medical management, performs patient exams under direct physician supervision via live videoconference and also verbally announced all findings

## Telehealth-Based Pain Management Program: Martha's Vineyard Hospital (con't)

- Physical examinations are repeated by the physician during on-site visits prior to patient intervention
- Laboratory data and imaging studies are reviewed in the shared HER
- Over 13 months, 49 patients participated in 238 telepain video clinics and 121 on-site interventions
- Patients report reduced travel costs, improved access to care, and general satisfaction with the service
- Patients rated their satisfaction with care received by telepain lower than in-person visits and thought it harder to develop a relationship with the doctor
- This highlights the challenge of building a patient-physician relationship remotely

## Treatment Strategies

### Important Strategy Area # 2 - Treatment

- Implement consistent OU screening for all patients
- Develop referral relationships with SU/MH providers
- Explore local treatment opportunities
  - Medication assisted treatment – buprenorphine
  - Integrated behavioral health/SU/primary care services
  - Specialty substance use services
- Collaborative treatment programs – hub and spoke
- Explore use of technology to expand access to care
- Overdose reversal programs
- Alternative pain management programs
- Work with law enforcement to provide a treatment alternative to incarceration

## Provider Strategies and Treatment Services

- Rural residents deserve the same level of access to the full range of substance use treatment services as urban residents
- Substance use is a chronic, relapsing disease
  - Requires ongoing level of services
  - Reflects a primary care-based system of care framework
  - Conserves resources by matching services to patient needs using a level of care criteria
  - Professionally-directed, post-discharge care can enhance recovery, but relatively few receive such care
  - Distance to services is correlated with treatment completion (longer travel distances are associated with lower rates of completion)

## Definition of a System of Care

- An integrated spectrum of effective, community-based services and supports for rural people and their families at risk for or struggling with OU challenges
  - Organized into a coordinated network
  - Builds meaningful partnerships with individuals and their families
  - Addresses their cultural and linguistic needs, to help them function better at home, in school, in the community, and throughout life.

## Structure of Treatment Services

- Use of a regional orientation/model
- Reflects the realities of rural resource limitations
  - Uses technology (e.g., telehealth, mobile phones, etc.) to address distance barriers and maldistribution of resources across urban and rural areas
- Integration across services systems:
  - Substance use,
  - Mental health, and
  - Primary care

## Principals for Treatment

- Treatment must be available, accessible, attractive, and appropriate for needs
- Ethical standards must be observed
- Requires effective coordination between the criminal justice system and health and social services
- OUDs should be viewed as a health problem rather than criminal behavior: users should be treated in the health care rather than the criminal justice system when possible

### Principals for Treatment (cont'd)

- Based on scientific evidence and respond to specific needs of individuals with ouds
- Should respond to the needs of special subgroups and conditions
- Should ensure good clinical governance of treatment services and programs for OUDs
- Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated

### Opioid Screening Tools

- Can be used across different health care settings
  - Screener and Opioid Assessment for Patients in Pain Revised (SOAPP-R)
  - Current Opioid Misuse Measure (COMM)
  - Opioid Risk Tool (ORT)
  - Diagnosis, Intractability, Risk, and Efficacy (DIRE)
  - Screening Instrument for Substance Abuse Potential (SISAP)
  - (vi) The Pain Assessment and Documentation Tool (PADT)



## Bridgton Hospital Buprenorphine Clinic

- Coordinated efforts between Bridgton Hospital, North Bridgton Family Practice, Crooked River Counseling
  - Program has enrolled 200 patients in a rural Maine community
  - Started in 2009
  - Four physicians and two nurse practitioners prescribe buprenorphine in their primary care practice (North Bridgton)
  - Crooked River Counseling provides intensive outpatient counseling and group therapy for the patients
  - Bridgton Hospital provides comprehensive maternity care to women with OUD during their pregnancy
  - Services are interconnected and coordinated across providers
  - Key is the collaborative approach and communication

## Bridgton Hospital Buprenorphine Clinic

- Benefits
  - Lower regulatory/licensure barriers than methadone programs
  - SAMHSA prescribing waiver is comparatively easy to obtain
  - Can be integrated into primary care system
  - Gold standard of treatment for opioids
- Challenges
  - Buprenorphine alone is not sufficient to meet all patient needs
  - Can be difficult to incorporate into a busy practice without additional support
  - Linkages with bigger systems of care are needed

## Supporting MAT and OUD Services - Vermont

- Vermont's Hub and Spoke model supports the use of buprenorphine by primary care and community providers
  - Comprehensive care management
  - Care coordination and referral to local resources
  - Care transitions
  - Individual and family supports
  - Health promotion
  - Expands use of buprenorphine in primary care
  - Recognizes importance of mental health and traditional substance use services in treating opioid problems
  - Efficient use of scarce resources
  - Provides care in less stigmatizing settings

## Vermont Hub and Spoke (cont'd)

- Regional specialty treatment centers serve as the hubs
  - Coordinate care of individuals with complex OUDs and co-occurring SU and MH disorders
  - Provide full range of OUD care and support community providers by providing consultative support to primary care and other providers prescribing buprenorphine
- Physicians prescribing buprenorphine and collaborating health and addictions professionals serve as the spokes
  - Dispense buprenorphine, monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency mgt, and case mgt services
- Funded through Medicaid waiver

## Recovery Strategies

### Important Strategy Area # 3 - Recovery

- The third and often overlooked strategy to address OU disorders
- Provide support through programs or a structured milieu to support sobriety and substance free living
- Ideally, recovery begins before treatment
- Addresses social, rehabilitation, and vocational issues
- Provides a community to reinforce sobriety

## Recovery

- “Recovery is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.” SAMHSA
- Four dimensions that define a healthy life in recovery:
  - Health - Managing one’s disease(s) or symptoms; making informed choices that support physical/emotional wellbeing
  - Home – Having a safe and stable place to live
  - Purpose – Participating in meaningful daily activities and having the independence, income ,resources to participate in society
  - Community – Engaging in relationships and social networks that provide support, friendship, love, and hope
- Hospitals can coordinate with local recovery programs

## Recovery – Community Programs

- Does community create a supportive environment for recovery?
  - Stigma reduction – opportunities for a new start
  - Employment opportunities
  - Educational opportunities
  - Social, recreational outlets
  - Connection to cultural heritage
  - Twelve step programs
  - Peer support

## Evidence-Based Recovery Programs

- Department of Veteran's Affairs – Peer Recovery
  - Recruit veterans in recovery to support those going through the process
- Australian mental health peer support
  - Goal – avoidance of unnecessary hospitalizations
- Turning Point Center, Rutland, VT
  - Part of the Vermont Recovery Network
- Supporting Peer Recovery: The RECOVER Project, Franklin County, MA
- Project Angels, Gloucester, MA
  - Provides treatment as an alternative to incarceration

## Challenges to Developing Rural Programs

- Programs “imported” from outside the local area are often viewed with suspicion
- Community-based programs are important to create locally developed, culturally appropriate interventions
  - Must be sensitive to local cultural, religions, and ethnic issues (cultural humility) and engage local leaders
  - Limited opportunities after treatment, stigma, restricted social supports frequently leads to relapse – must support sober living
- Continuum of prevention, treatment, and recovery services must be developed simultaneously to address the needs of rural residents “where they are”

## Recommendations

- The Community is key!!
- Support the development and implementation of community coalitions - Project Lazarus or Project Vision
- Engage providers, businesses, schools, residents, law enforcement
- Conduct broad-based education on the dangers of opioids
- Build a local system of care that integrates prevention, treatment, and recovery and engages mental health , and substance use providers



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