The Role of Rural Hospitals in Addressing Opioid and Other Substance Use Problems

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Learning Objectives

- Brief introduction to rural opioid and other substance use (O/SU) issues
- Socioeconomic drivers of rural O/SU
- Why should rural hospitals engage in O/SU initiatives?
- Component parts of an effective O/SU system of care
  - Prevention, Treatment, Recovery
- Importance of community engagement
- Hospital strategies and evidence-based strategies

Key Take Away Messages

- If you have seen one rural community……
- It takes a village - Community engagement and involvement are central to addressing O/SU
- Hospitals can play a central role addressing O/SU
  - Community benefit/CHNA obligations
  - Leadership role in the community
  - An important population health issue
- Models must be adapted to the geographic, resource, and cultural realities of rural areas

Important Strategy Area # 1 - Prevention

- Opioid harms extend to all users not just those using heroin or misusing prescription medications
- Discourage/delay onset of O/SU
- Focus on children, adolescents, and young adults
- Minimize related high risk behaviors
- Strategies can be external and community focused
  - Community organizing and education
- Internal, quality oriented activities
  - Reducing supply of opioids prescribed
  - Use of prescription drug monitoring programs
  - Offer alternative pain-management strategies
  - Provide opportunities to dispose of unneeded medications

Important Strategy Area # 2 - Treatment

- Implement consistent O/SU screening for all patients
  - Screening, brief intervention, and referral to treatment
- 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
- Overdose reversal programs
- Develop alternative pain management programs
- Work with law enforcement to provide a treatment alternative to incarceration

Important Strategy Area # 3 - Recovery

- The third and often overlooked strategy to address O/SU 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

Rural O/SU in the United States

- Overall rates of rural and urban O/SU are comparable
- At the sub-population level, variations emerge
- Past year alcohol, OxyContin, and meth use is higher among rural youth
- Rural 8th graders are more likely to use amphetamines, crack cocaine, cocaine, marijuana, and alcohol
- Rural youth first try alcohol at a younger age and have higher rates of driving under the influence
- Opioid use is higher among rural youth, young adults, women experiencing domestic violence, and in states with large rural populations
- Opioid overdose deaths are growing faster in rural counties

Socioeconomic Drivers of Rural O/SU

Barriers to Treatment in Rural Communities

Categories of Misused Substances

Categories	Examples
Alcohol	• Beer, wine, malt liquor, distilled spirits
Illicit drugs	• Cocaine, including crack • Heroin • Hallucinogens • Methamphetamines, including crystal meth • Marijuana, including hashish • Synthetic drugs, including K2, Spice, and "bath salts" • Prescription medications used for nonmedical purposes ○ Pain Relievers - synthetic, semi-synthetic, and non-synthetic opioid medications ○ Tranquilizers and muscle relaxants ○ Stimulants and methamphetamine ○ Sedatives and any barbiturates
Over the counter drugs and other substances	• Cough and cold medicines • Inhalants, including amyl nitrite, cleaning fluids, gasoline and lighter gases, anesthetics, solvents, spray paint, nitrous oxide

Rural Place as a Driver of SUDs

- 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

Why Should Hospitals Engage in O/SU initiatives?

- Problems are not limited to O/SUDs, but include many other health and safety problems
- Many patients treated for medical issues also have O/SUDs that complicate their treatment
- O/SU has serious economic consequences
- Tax-exempt and publicly owned hospitals have an obligation to address unmet community needs
- Rural hospitals can play an effective role in addressing O/SU
- It provides an opportunity for collaborative action by hospitals and community stakeholders
- It is the right thing to do!

A Public Health Model for O/SU

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

A Comprehensive Approach Is Needed

- Enhanced O/SU public education and demand for more effective policies and practices to address them
- Implementation of evidence-based prevention policies and programs to prevent O/SU and related harms
- Access to evidence-based treatment services, integrated with mainstream health care
- Recovery support services to assist individuals in maintaining remission and preventing relapse
- Research-informed public policies and financing strategies to ensure that O/SU services are accessible, compassionate, efficient, and sustainable

Prevention Strategies

Prevention

- Well supported scientific evidence for robust risk and prevention factors that predict O/SU use
- Evidence-based (EB) prevention programs effectively prevent initiation, harmful use, and related problems
- Prevention is cost-effective at different stages of the lifespan from infancy to adulthood
- Communities and populations have different levels of risk, protection, and O/SU
- Communities are an important organizing force for bring effective EB prevention programs to scale
- Key: Cross sector community coalitions to assess local risk and protective factors, O/SU problems, and implement EB interventions to match local priorities

Prevention

- Prevention is about the healthy and safe development of children and youth to realize their talents and become contributing members of their community and society
- Primary objective - Help people avoid or delay initiation into the use of drugs or to avoid developing disorders if they have already started
- Contributes to the positive engagement of children, young people and adults with their families, schools, workplace and community

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

Evidence-based community organizing models

- Project Lazarus -
  - In all North Carolina Counties
  - In rural communities across the country - Project Bald Eagle, Williamsport, PA
- 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

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

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

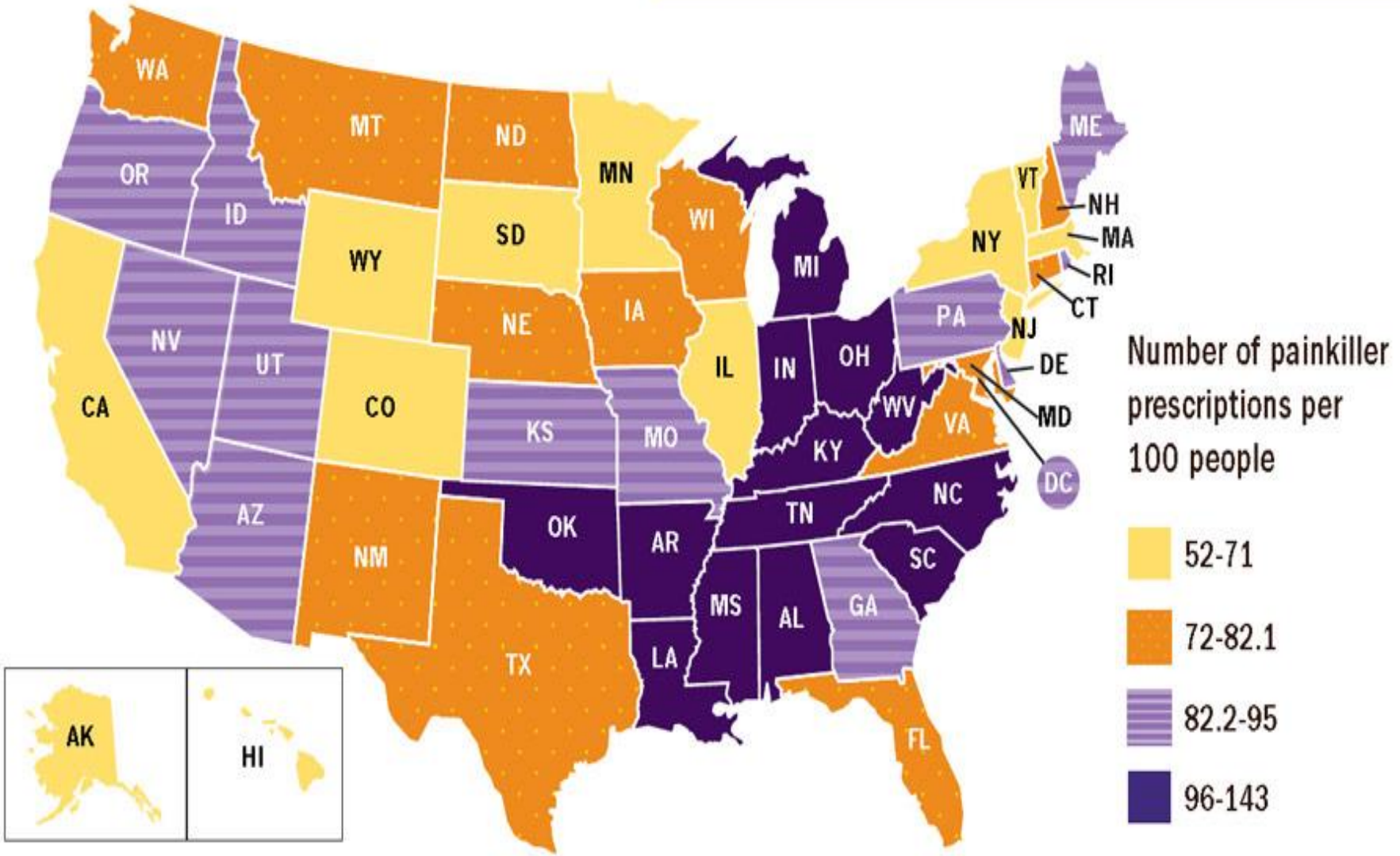
Community Based Prevention Education

- School-based education, including pledge cards
- Red Ribbon campaign - warnings not to share attached to dispensed prescription packages
- Billboard containing message against sharing medications
- Presentations at colleges, community forums, civic organizations, churches, etc.
- Radio and newspaper spots

Evidence-Based Prevention Models

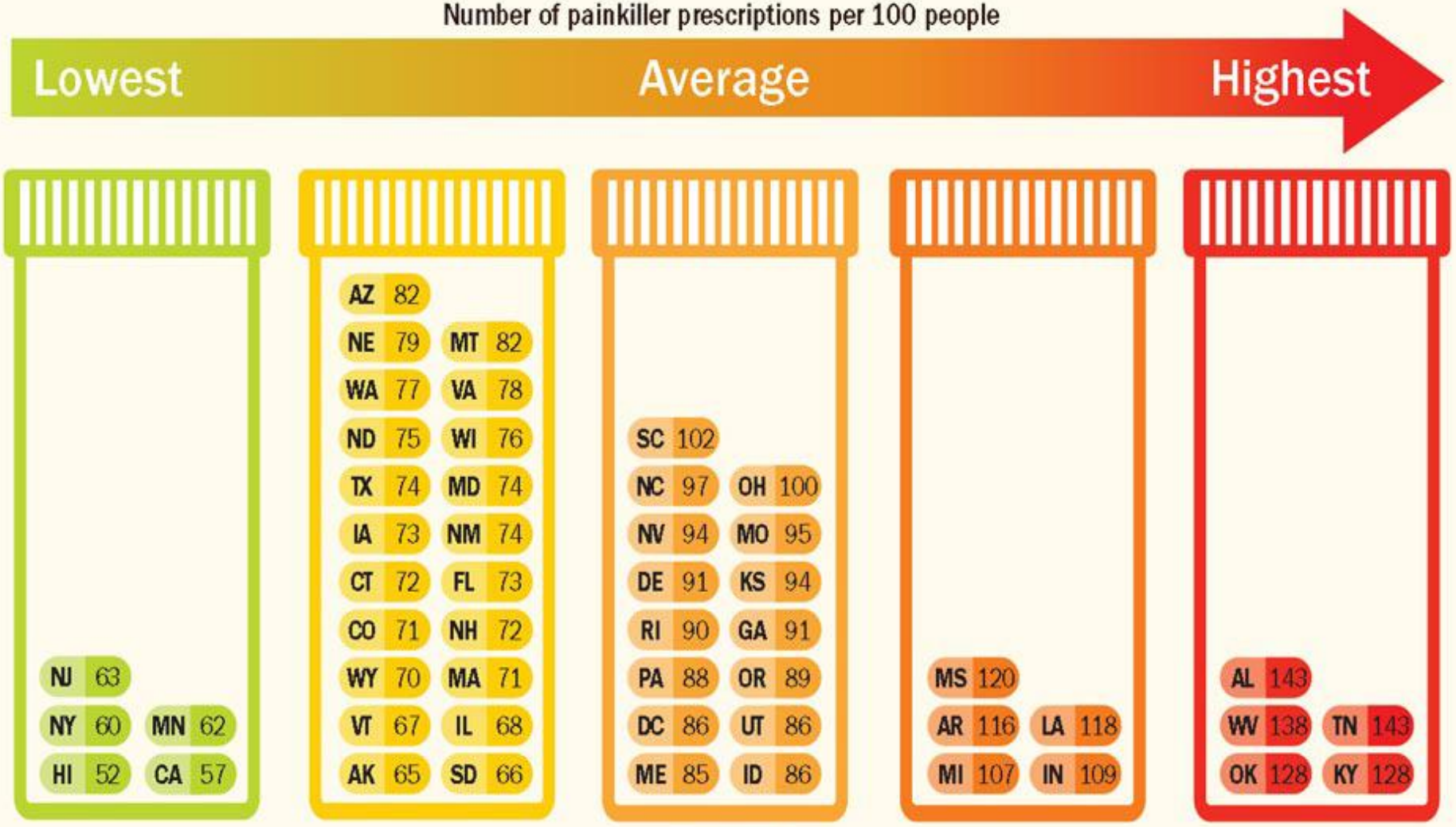
- Helping Kids PROSPER)
- Strong African American Families-Teen (SAAF-T)
- keepin’ it REAL Rural
- Madison Outreach and Services through Telehealth (MOST) Network
- 4P's Plus Pregnancy Support
- Spit It Out-West Virginia
- Mothers and Infants Sober Together
- Gloucester ANGEL Program
- Contingency Management Smoking Cessation in Appalachia

Some states have more painkiller prescriptions per person than others.



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

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

Oxy-Free Emergency Departments

- Emergency departments are a significant source of opioid prescriptions and a frequent target for those seeking opioids
- Guidelines for emergency department prescribing developed by the Washington State Department of Health in conjunction with the Washington Chapter of the College of Emergency Physicians and the Washington Hospital Association
- Included limitations on the prescription of opioids in EDs and the concept of an “oxy-free zone” (in which the ED would limit prescribing of the class of drugs that include OxyContin and replacing lost or stolen opioid prescriptions)

Oxy-Free EDs (cont'd)

- Initiative has helped to reduce the rates of ED visits by "frequent users" seeking opioid prescriptions by individuals with low-acuity diagnoses
- Washington Medicaid estimated ED savings in their non-managed care population at $33.6 million after admissions
- Evaluation shows that hospitals are pleased with this strategy but some experienced early reductions in patient satisfaction scores related to pain management

Evidence-Based Supply Management Programs

- Midcoast Maine Prescription Opioid Reduction Program
- Nevada Rural Opioid Overdose Reversal (NROOR)
- “Oxy-Free” EDs – McKenzie Health System
- Reducing Opioid Prescribing by Providing Pain Management Services- Salem Township Hospital

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

Nevada Rural Opioid Overdose Reversal Program

- Statewide partnership led by Desert View Hospital to improve access to naloxone and provide training for first responders and family off those at risk of overdose
  - Distributed naloxone to EMS agencies staffed only by basic-level EMTs
  - Enabled distribution of naloxone to at-risk individuals and family members
  - Educated healthcare providers on prescription drug use and abuse as well as legislative changes pertinent to prescribers
  - Provided public education and outreach about overdoses
- Results
  - 117 EMTs were trained on the administration of naloxone

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“Oxy-Free” EDs –McKenzie Health System

- The “oxy free” ED was developed in Washington State
- 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
- Investment was minimal, at about $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

University of Washington's Telepain Program

- UW School of Medicine's Division of Pain Management offers a TelePain program to increase primary care providers' pain management & opioid prescribing skills
- Weekly videoconferences provide didactic presentations from the UW Pain Medicine curriculum, case presentations from community clinicians, interactive consultations with pain specialists, and the use of measurement-based clinical instruments to assess treatment effectiveness and outcomes
- Benefits include increased providers access to educational and consultative support for pain management, improved patient outcomes, and enhanced patient and provider satisfaction

Treatment Strategies

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, rather than an acute, episodic condition
  - 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

Treatment and Access Realities

- Treatment access and completion is a problem
  - Less than 50% admitted to Tx complete
  - Over 50% discharged use AOD in the first year following discharge (80% of those within the first 90 days)
  - “Durability” (15% relapse rate) takes 4-5 yrs of remission
  - Professionally-directed, post-discharge continuing care can enhance recovery outcomes, but only 1 in 5 clients actually receives such care
  - Distance to services is correlated with treatment completion (longer travel distances are associated with lower rates of completion)

Barriers to MAT 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

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 drug and substance use 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 adhered
- Requires effective coordination between the criminal justice system and health and social services
- SUDs 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 drug use disorders
- Should respond to the needs of special subgroups and conditions
- Should ensure good clinical governance of treatment services and programs for drug use disorders.
- Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated

Screening for O/SUDs

- Screening, Brief Intervention, and Referral to Treatment
  - SBIRT is an evidence-based, universal public health approach used to identify, prevent, and reduce substance use disorders
  - All patients complete a brief screen (S) annually that assesses risk for problems related to substance use
  - Individuals at-risk receive a brief intervention (BI) by a medical professional on site. The BI addresses the individual's substance use and assists with establishing a plan to reduce use
  - When indicated, patients may also be referred to a specialty treatment provider for assessment (RT)

Pullman Regional Hospital Emergency Department

- A Critical Access Hospital in rural Whitman County in the State of Washington
- Active participant in a 5 year grant to implement SBIRT in urban and rural Washington settings
- Findings
  - Pullman screened 87.7% of patients receiving Medicaid funded health care at least 1 month in the year prior to SBIRT screening
  - Of this group, 10.3% received a brief intervention, 1.2% received brief treatment, 0.8% received a referral to treatment, and 14.4% had an unknown status
  - Facilities were generally successful at incorporating screening protocols into their workflows

Model Hospital-Based Treatment Programs

- Bridgton Hospital – Buprenorphine prescribing program
- 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

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

Nurse Navigator & Recovery Specialist Program

- Based in Western Pennsylvania, the program serves the residents of Armstrong, Clarion, and Indiana counties
- Consortium is made up of the Armstrong-Indiana-Clarion Drug and Alcohol Commission and 9 partners using a care coordinator/manager model to prevent and treat chronic illnesses related to O/SUDs
- Staffed by a Recovery Specialist and Nurse Navigator provider

Nurse Navigator & Recovery Specialist Program

- Services:
  - Health and resiliency education — Outreach Services
  - Physical and behavioral health planning — Case Mgt Services
  - Substance abuse treatment services — Recovery Support
  - Wellness groups and therapy sessions
- Results over three years
  - Assisted 364 clients with 2,433 client encounters
  - Reduced ED visits each year
  - Reduced clients with 1 or more hospital admissions
  - Increased client's reporting positive perceptions of their health

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

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

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