Collaborative Hospital and Community Strategies to Address Rural Substance Use

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Learning Objectives

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

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Key Take Away Messages

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

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Important Strategy Area # 1 - Prevention

- Substance use harms extend to all users not just those using illicit drugs or misusing prescription medications
- Discourage/delay onset of 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 diverted prescription medications
  - Use of prescription drug monitoring programs
  - Offer alternative pain-management strategies
  - Provide opportunities to dispose of unneeded medications

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Important Strategy Area # 2 - Treatment

- Implement consistent 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
  - 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

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Important Strategy Area # 3 - Recovery

- The third and often overlooked strategy to address 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

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Rural SU in the United States

- Overall rates of rural and urban 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

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Socioeconomic Drivers of Rural SU

Individual 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

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

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 – opioids ○ Benzodiazepines ○ 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, anesthetics, solvents, spray paint, nitrous oxide

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Barriers to Treatment in Rural Communities

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Why Should Hospitals Engage in SU initiatives?

- Problems are not limited to SUDs, but include many other health and safety problems
- Many patients treated for medical issues also have SUDs that complicate their treatment
- 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
- It provides an opportunity for collaborative action by hospitals and community stakeholders
- It is the right thing to do!

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A Comprehensive Approach Is Needed

- Enhanced SU public education and demand for more effective policies and practices to address them
- Implementation of evidence-based prevention policies and programs to prevent 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 SU services are accessible, compassionate, efficient, and sustainable

Prevention Strategies

Prevention

- Well supported scientific evidence for robust risk and prevention factors that predict 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 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, 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

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

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

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
- SAMHSA'S Recovery Oriented Systems of Care
- Communities That Care

Project Lazarus – Core Activities

- 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 – Supplemental Activities

- Optional areas of EB 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

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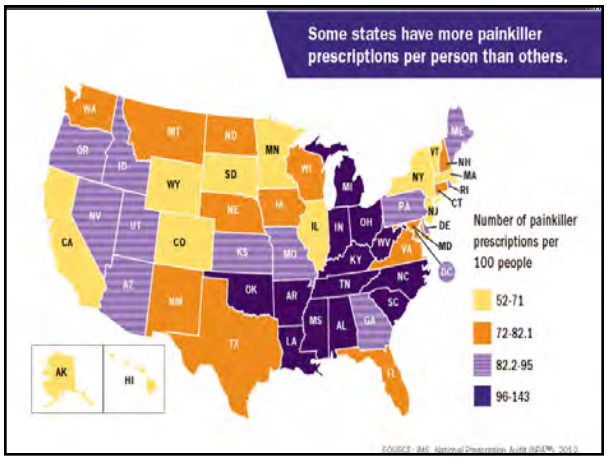
Prescriber Education and Behaviour

- 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



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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

- Significant target for drug seekers
- ED prescribing Guidelines developed by WA State Department of Health, WA Chapter of the College of Emergency Physicians, and WA Hospital Association
- Limitations on ED opioid prescriptions and creation "oxy-free zones"
- Reduced the rates of ED visits by "frequent users" with low acuity diagnoses seeking opioids
- WA Medicaid estimated ED savings in their non-managed care population at $33.6 million
- Hospitals are pleased with this strategy - some experienced early reductions in patient satisfaction scores for pain management

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 requesting opioid refills, 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 by basic-level EMTs
  - Distributed 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

"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 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 Pain Management: Salem Township Hospital

- Salem Township recruited a pain specialist to travel twice monthly from Marion, Il 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 3-4 months, 3/56 patients stayed with opioids
- Investment was minimal-$25,000 for capital equipment

Telehealth 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

Martha's Vineyard Hospital (con't)

- Physical examinations are repeated by the physician during on-site visits prior to patient intervention
- Lab data/imaging studies reviewed in the shared ER
- 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
- TelePain program increases primary care providers' pain management & opioid prescribing skills
  - Weekly videoconferences provide didactic presentations
  - Case presentations from community clinicians
  - Interactive consultations with pain specialists
  - Measurement-based clinical instruments to assess treatment effectiveness and outcomes
- Increased access to educational and consultative support for pain management, improved patient outcomes, 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 SU treatment services as urban residents
- SU 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
  - Requires integration across primary care, SU, and behavioral health

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 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 SU challenges
  - Organized into a coordinated network
  - Builds meaningful partnerships with individuals and families
  - Addresses their cultural and linguistic needs
  - Helps 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 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

- Must be available, accessible, attractive, and appropriate for needs
- Ethical standards must be adhered to
- 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 SUDs
- Responds to the needs of special subgroups and conditions
- Ensures good clinical governance of treatment services
- Treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated

Screening for SUDs

- Screening, Brief Intervention, and Referral to Treatment
  - 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 Dep't

- A CAH in rural Whitman County in Washington State
- 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
  - 10.3% brief intervention, 1.2% brief treatment, 0.8% referral to treatment, 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
  - 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 SUDs
- Staffed by a Recovery Specialist and Nurse Navigator provider

Nurse Navigator & Recovery Specialist Program

- Services:
  - Health and resiliency education
  - Outreach and case management Services
  - Physical and behavioral health planning
  - SU treatment services
  - Recovery support
  - Wellness groups and therapy sessions
- Three year results -364 clients/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

- Hub and Spoke model supports 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)

- Hubs - Regional specialty treatment centers
  - Coordinate care of complex OUDs and co-occurring disorders
  - Provide full range of OUD care
  - Support community providers by providing consultative support to primary care and other providers prescribing buprenorphine
- Spokes – Community physicians and collaborating health and addictions professionals
  - 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

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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

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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

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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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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"

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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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