Pacific Southwest
RURAL OPIOID TECHNICAL
ASSISTANCE REGIONAL CENTER

# The Impact of Opioid Use on Rural Communities and Effective Treatment Approaches and Recovery Supports Part 1

Thomas E. Freese, PhD, and Beth A. Rutkowski, MPH
Pacific Southwest Addiction Technology Transfer Center

UCLA Integrated Substance Abuse Programs

June 8, 2023

# SAMHSA Disclaimer



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# A Focus on Opioids

## (Part 1, June 2023 Webinar Series)

**Thomas E. Freese, PhD, and Beth A. Rutkowski, MPH**
Pacific Southwest Addiction Technology Transfer Center
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# What Do We Hope You Learn Today?

- Patterns and trends in opioid use in rural communities.
- Overdose and overdose prevention strategies.
- Service system needs in rural communities to address opioid use

# Disclosure

The speaker does not have relevant financial relationships with commercial interests.

# Overview

- The Impact of Stigma
- Opioids
- Medications for Opioid Use Disorders
- Opioids in Rurual Communities

# Imagine…

- You are visiting with your sister after a recent visit to the doctor for numbness and tingling in her feet.
- She says that her doctor told her that she has diabetes and that she is stupid for letting her diet get so out of control.
- The doctor's recommendation is that she see a dietician and gain some self control.  Once she does that, he will consider treating her diabetes directly with medicine.
- The doctor tells her that treatment with insulin will not do her any good unless she really is ready and he will know that is true when she loses some weight.
- The doctor tells her to come back when she really wants to change.  No follow-up appointment is scheduled.

# What impact might this have?

- For the patient
- For her family
- For the doctor and health care team

**Addiction may be most stigmatized condition in the US and around the world: Cross-cultural views on stigma**

Across 14 countries and 18 of the most stigmatized conditions…

Illicit drug addiction ranked 1st

Alcohol addiction ranked 4th

**Stigma, social inequality and alcohol and drug use**

ROBIN ROOM

*Centre for Social Research on Alcohol and Drugs, Stockholm University, Stockholm, Sweden*

- **Sample:** Informants from 14 countries
- **Design:** Cross-sectional survey
- **Outcome:** Reaction to people with different health conditions

Room, R., Rehm, J., Trotter, R. T. II, Paglia, A., & Üstün, T. B. (2001). Cross-cultural views on stigma valuation parity and societal attitudes towards disability. In T. B. Üstün, S. Chatterji, J. E. Bickenbach, R. T. Trotter II, R. Room, & J. Rehm (Eds.), *Disability and culture: Universalism and diversity* (pp. 247–291). Seattle, WA: Hofgrebe & Huber.

# Studies have shown that…

**SUD is more stigmatized** compared to other psychiatric disorders

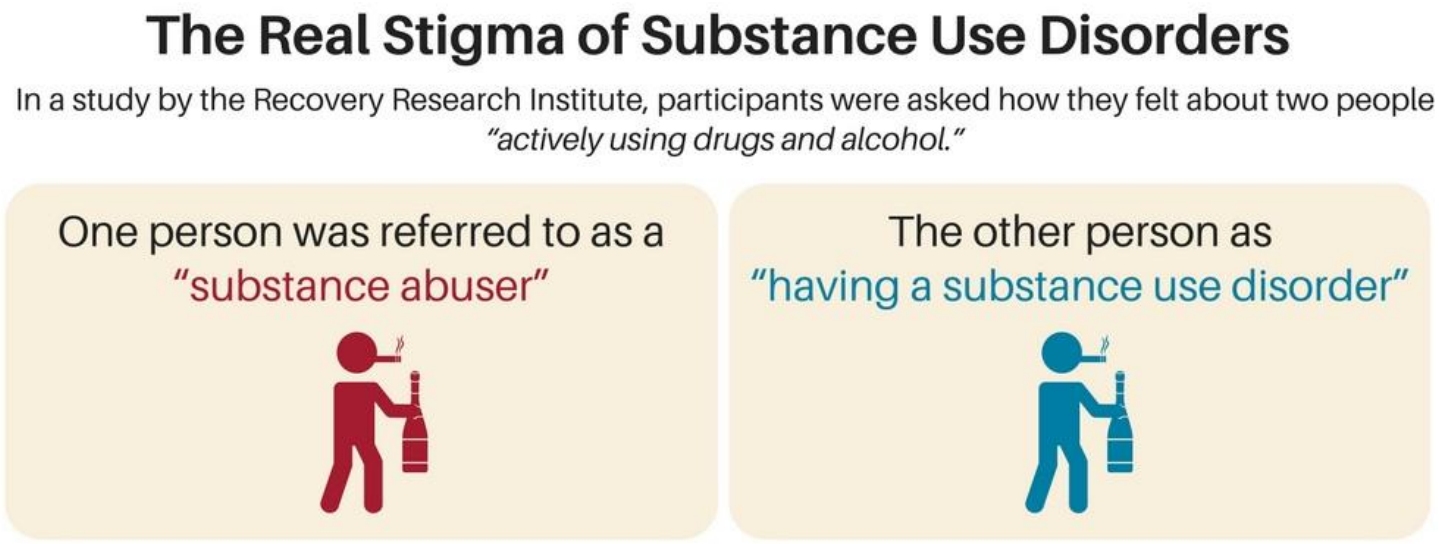
Compared to other psychiatric disorders, **people with SUD are perceived as more to blame** for their disorder

**Describing SUD as treatable helps**

Patients themselves who hold **more stigmatizing beliefs** about SUD **less likely to seek treatment; discontinue sooner**

**Physicians/clinicians** shown to hold stigmatizing **biases against those with SUD**; view SUD patients as unmotivated, manipulative, dishonest; **SUD-specific education/training helps**

Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy, 21*(3), 202–207. doi:10.1016/j.drugpo.2009.10.010




**"Substance Abuser"**

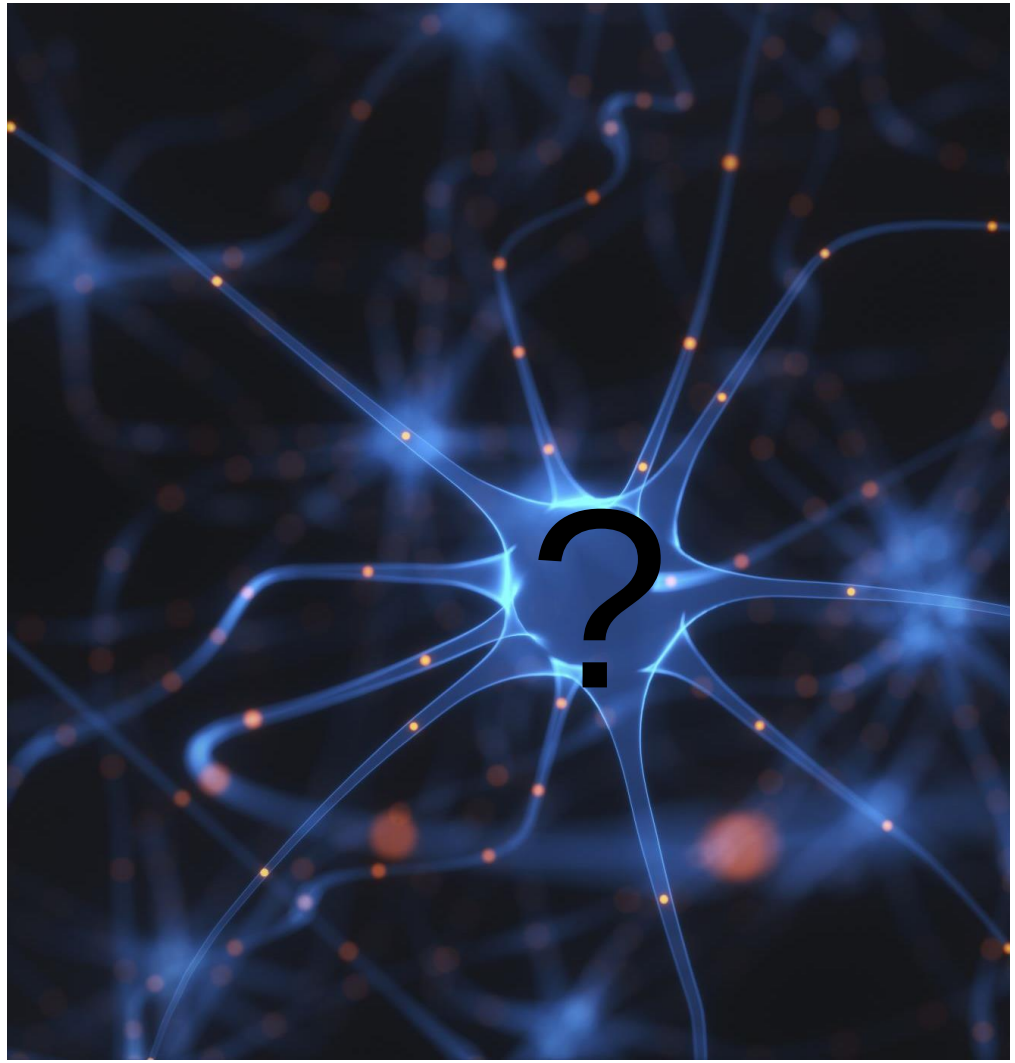
Mr. Williams is a substance abuser and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs…

**"Substance Use Disorder"**

Mr. Williams has a substance use disorder and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs…

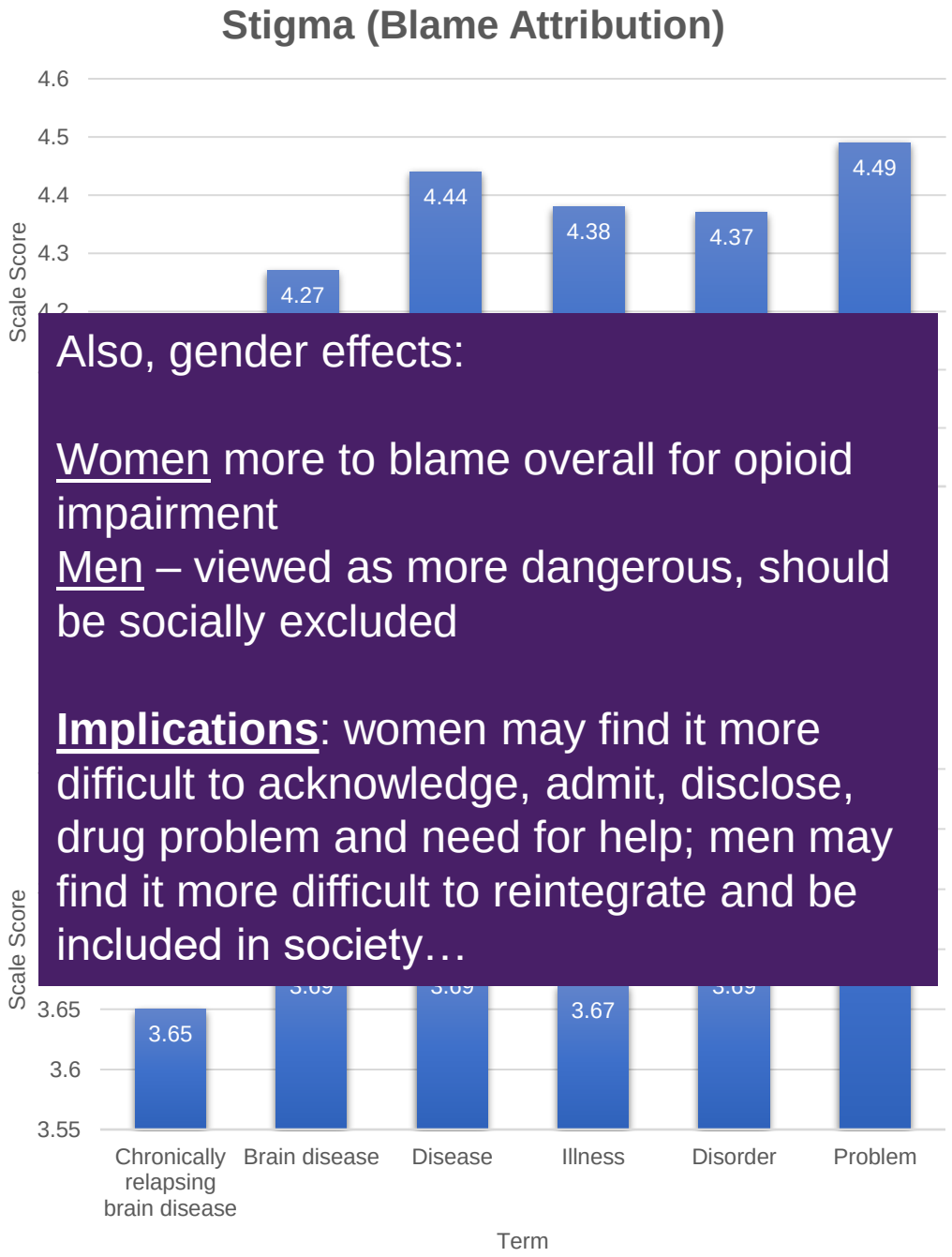
**Terminology:**
What's the best way to describe drug-related impairment to reduce stigma/discrimination?

- Chronically relapsing brain disease
- Brain disease
- Disease
- Illness
- Disorder
- Problem




Kelly, J. F., Greene, M. C., & Abry, A. (2020). A U.S. national randomized study to guide how best to reduce stigma when describing drug-related impairment in practice and policy. *Addiction,* [Epub ahead of print]. doi: doi.org/10.1111/add.15333


IS THIS BETTER?
... NOT REALLY
BRAIN
RELEASE
DOUGHAN




Opposite effects of the same terminology on different aspects of stigma:

- More medical terminology reduced blame the most but increased perceived danger, social exclusion, and decreased perceptions that the person could recover
- Less medical terminology increased blame the most but decreased perceived danger, social exclusion, and increased perceptions regarding likelihood of recovery
- Thus, clinical/public health communication messaging may need to be tailored to context and goal

Kelly, J. F., Greene, M. C., & Abry, A. (2020). A U.S. national randomized study to guide how best to reduce stigma when describing drug-related impairment in practice and policy. *Addiction,* [Epub ahead of print]. doi: doi.org/10.1111/add.15333

# How do patients respond to stigma?

- Secrecy (concealing the stigmatized condition)
- Educating others about the condition
- Challenging others about stigmatizing attitudes
- Avoiding healthcare

# How do people who inject drugs respond to stigma?

- “When it comes down to it, a lot of the times that I need to get medical attention, **I put it off and put it off and put it off**, because I don’t want to face the embarrassment that they make me feel, and that’s not fair. It’s not.”

- Instead of accessing needed healthcare services, Stacey and others decided to delay care as long as possible, often until they required emergency services.

Biancarelli DL et al. Strategies used by people who inject drugs to avoid stigma in healthcare settings. Drug Alcohol Depend. 2019

# Opioid Basics

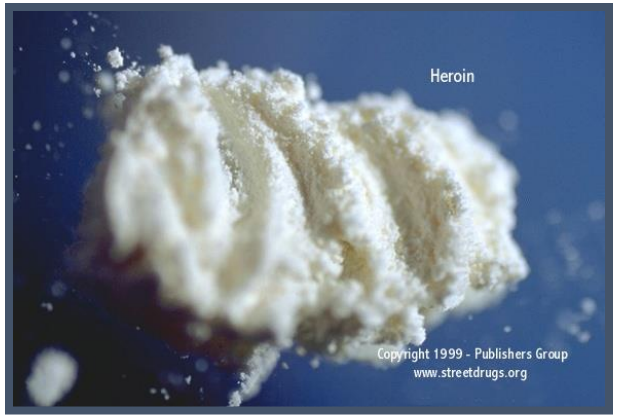
- Opioids target **mu receptor** (“opioid receptor”)
- Natural vs. synthetic
- Ex’s: *heroin, fentanyl, hydrocodone, oxycodone, methadone, morphine, hydromorphone…*
- Cause euphoria, sleepiness, slowed breathing & mentation

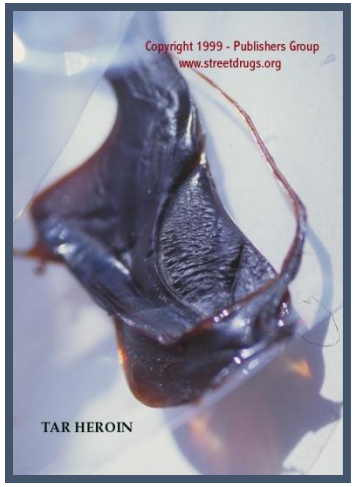
Opium plant. Image from https://stock.adobe.com/

# Opioids


Opium
Copyright 1999 - Publishers Group
www.streetdrugs.org


C-II
ENDO PHARMACEUTICALS
2.5
5
2.5 mg/325 mg
5 mg/325 mg
7.5
7.5 mg/325 mg
7.5 mg/500 mg
10
10 mg/325 mg
10 mg/650 mg
Percocet®
(oxycodone HCl/acetaminophen, USP)


Heroin
Copyright 1999 - Publishers Group
www.streetdrugs.org


Copyright 1999 - Publishers Group
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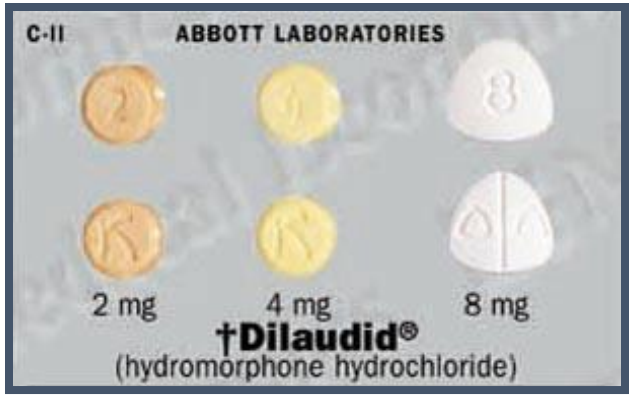
TAR HEROIN


C-II
ABBOTT LABORATORIES
2
4
8
2 mg
4 mg
8 mg
†Dilaudid®
(hydromorphone hydrochloride)


C-III
KNOLL LABORATORIES
VICODIN
Vicodin®
(hydrocodone bitartrate, acetaminophen)
5 mg/500 mg

# What are Opioids?

Opiate: derivative of opium poppy

- Morphine
- Codeine
- Opium
- Semisynthetics
  - Heroin (derived from morphine)
  - Hydrocodone
  - Hydromorphone
  - Oxymorphone
  - Buprenorphine

Opioid: any opium-like compound that binds to opiate receptors

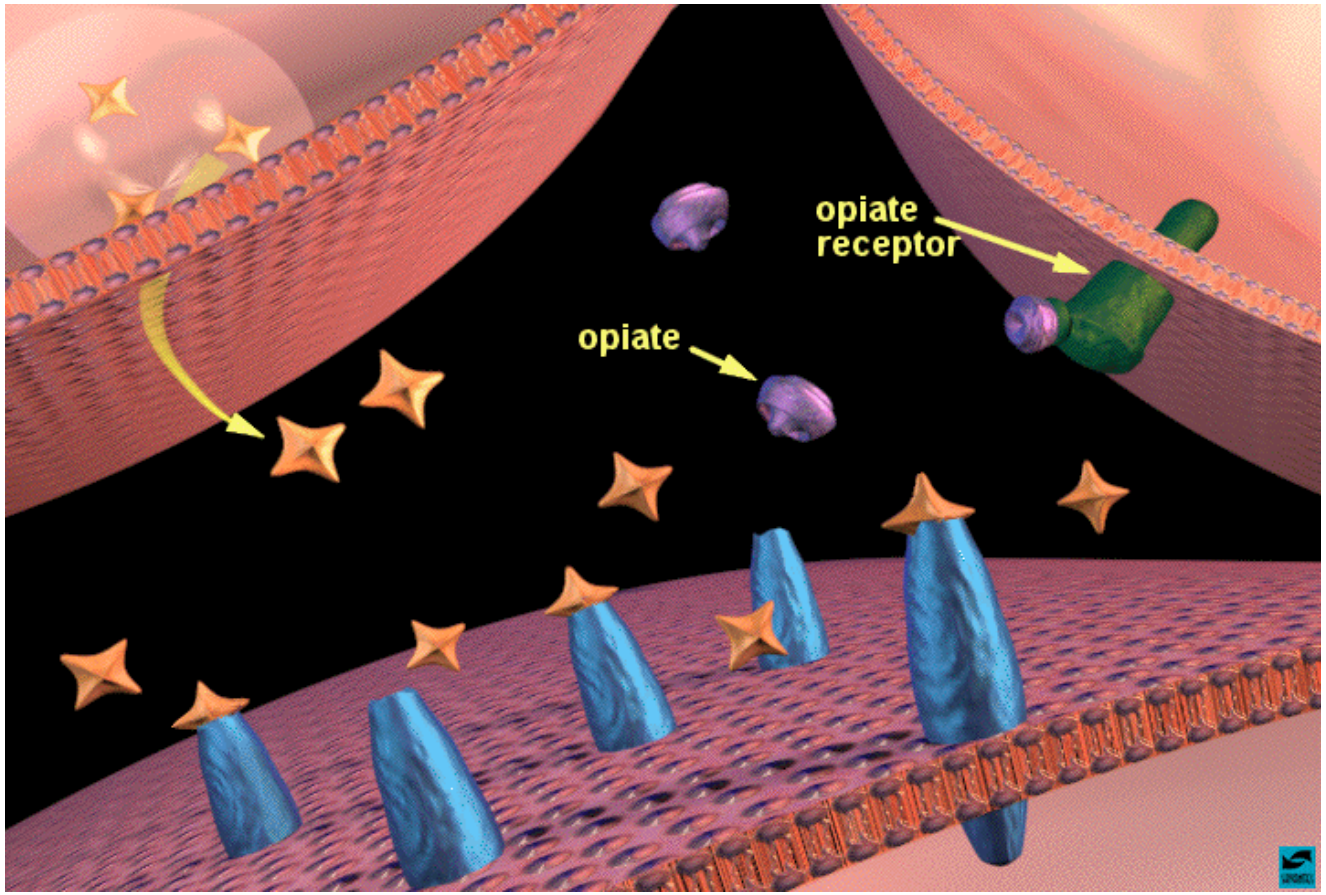
- All Opiates
- Synthetic pain medications
  - Methadone
  - Fentanyl
  - Tramadol
  - Meperidine
  - Dextropropoxyphene

Route of Administration: Oral, transdermal, intravenous, nasal inhalation, rectal insertion, and implantable formulations

# What Do Opioids Do?

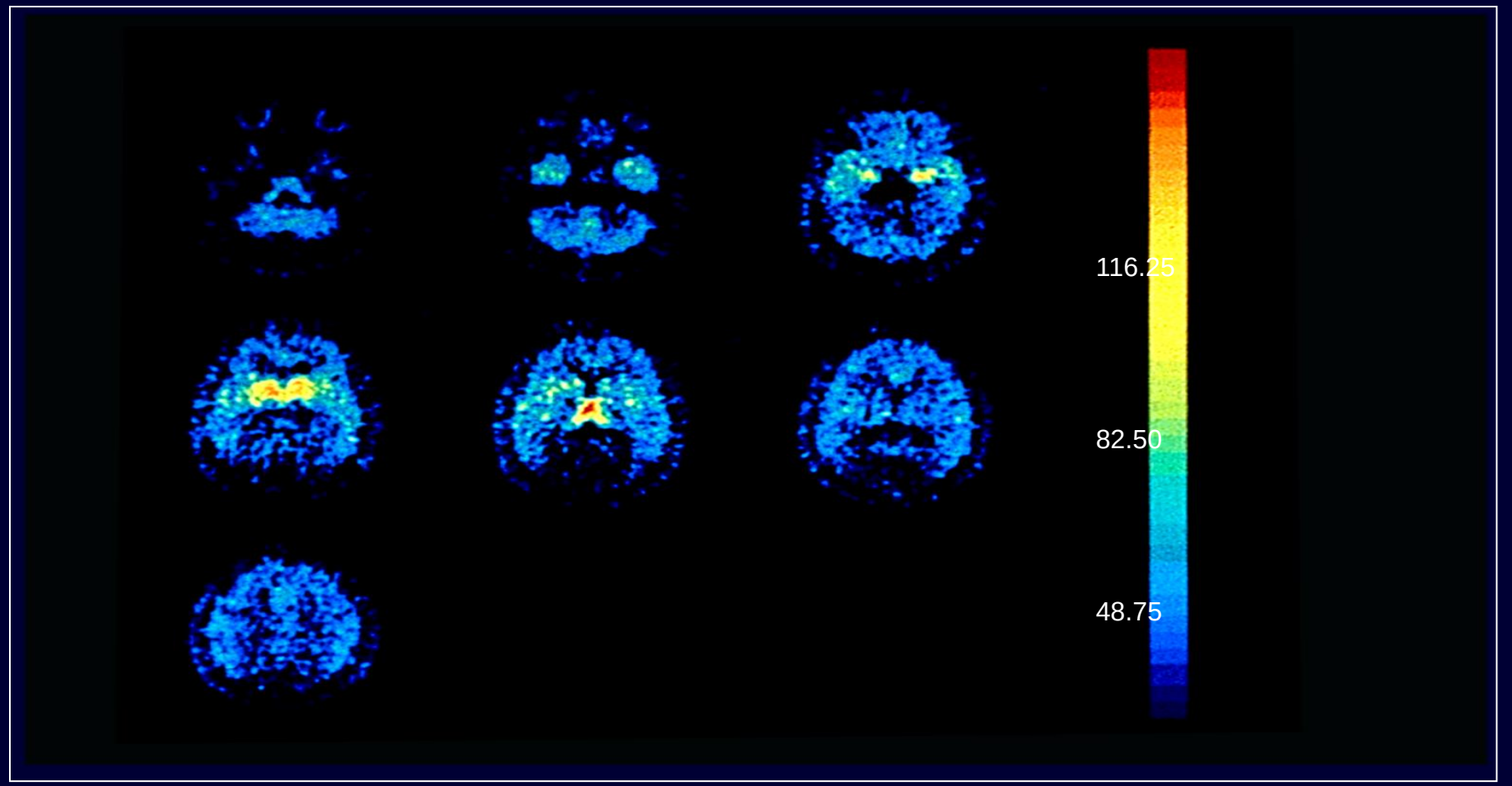
- Opioids act on many places in the brain and nervous system, including:
  - The limbic system, which controls emotions. Opioids can create feelings of **pleasure**, **relaxation**, and **contentment**.
  - The spinal cord, which receives sensations from the body before sending them to the brain. Opioids **decrease feelings of pain**, even after serious injuries.
  - The brainstem, which controls things your body does automatically, like breathing. Opioids can **slow breathing**, stop coughing, and reduce feelings of pain.

# Opioids and Reward




- Opioids bind to opioid receptors in the nucleus accumbens: increased dopamine release

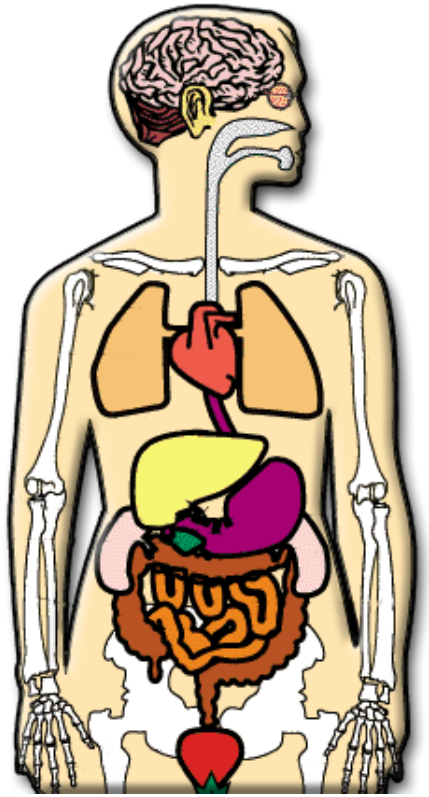
# [$^{18}$F] Cyclofoxy (a Selective Opioid Antagonist) Binding in Human Brain: Normal Volunteer PET Study - NIH



# Acute Opioid Effects

- Pupil constriction
- Slurred speech
- Impaired attention/memory
- Constipation
- Urinary retention
- Nausea
- Confusion, delirium
- Seizures
- Slowed heart rate
- Euphoria
- Sedation
- Pain Relief
- Suppresses Cough
- Warm flushing of the skin
- Drowsiness and lethargy
- Sense of well-being
- Histamine release
- Respiratory depression

# Long-Term Effects of Opioids



- Fatal overdose
- Collapsed veins (intravenous use)
- Infectious diseases
- Higher risk of HIV/AIDS and hepatitis
- Infection of the heart lining and valves
- Pulmonary complications & pneumonia
- Respiratory problems
- Abscesses
- Liver disease
- Low birth weight and developmental delay
- Constipation
- Cellulitis

# Opioid Withdrawal

- All opioids produce similar withdrawal symptoms when stopped abruptly
  - Severity varies with the amount and duration of use
- Timing of withdrawal symptoms depends on the opioid:
  - With longer-acting opioids, symptoms usually begin later and last longer:

| opioids used | onset of withdrawal | symptoms peak | duration of withdrawal |
|---|---|---|---|
| short-acting opioids (e.g. heroin, oxycodone) | 6-12 hours | 36-72 hours | about 5 days |
| long-acting opioids (e.g. methadone) | 36-48 hours | ~ 72 hours | up to 3 weeks |

SAMHSA, 2018

# Symptoms of Opioid Withdrawal

- Dysphoric mood
- Nausea or vomiting
- Diarrhea
- Tearing or runny nose
- Dilated pupils
- Muscle aches
- Goosebumps
- Sweating
- Yawning
- Fever
- Insomnia

# Can you name somebody who…?

# Can you name somebody who…?

Yes, you can.
We all can.

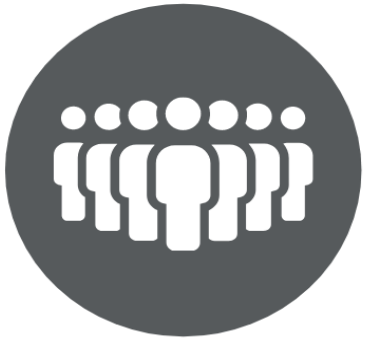
# The Opioid Epidemic

**107,622**

people died from drug overdose during 2021 (1)

**9.3 million**

people misused prescription opioids in 2020 (2)



**2.7 million**

people had an opioid use disorder in 2020 (2)

**902,000**

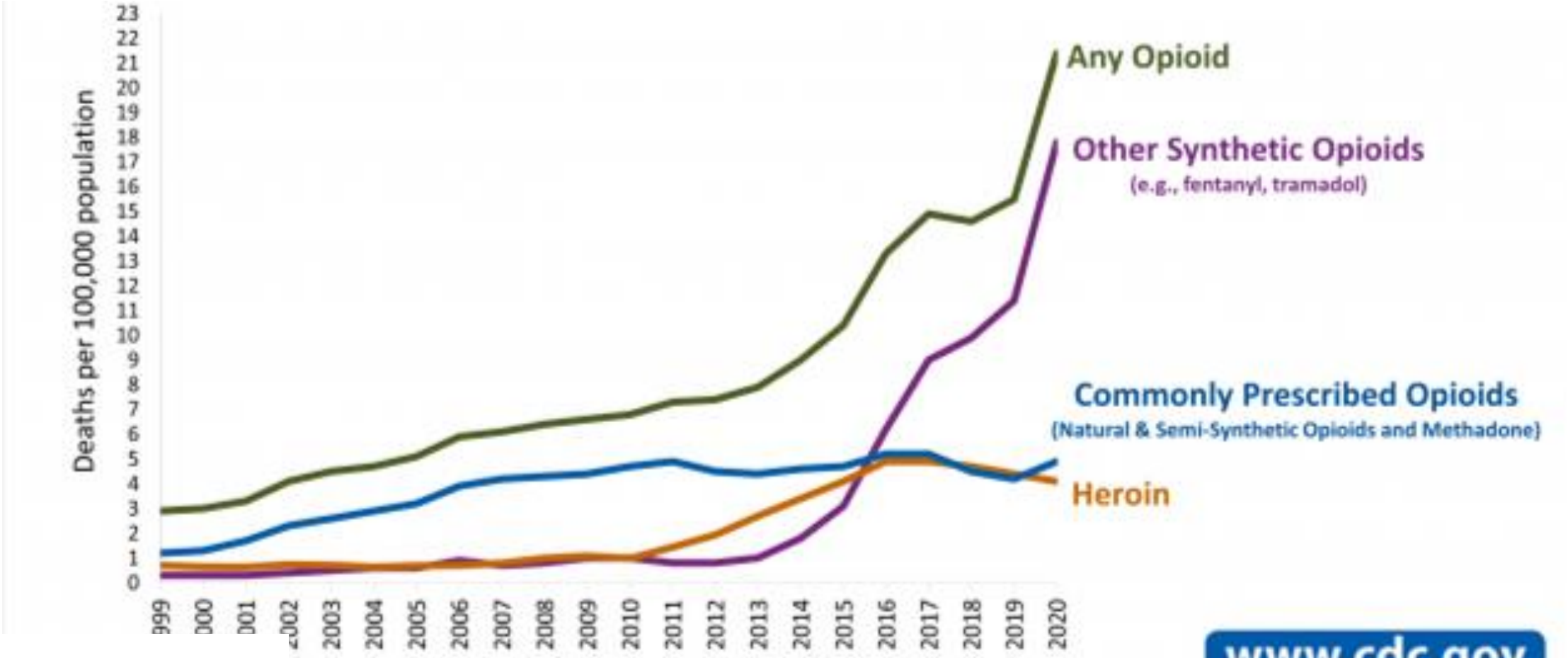
people used heroin in 2020 (2)

**Sources**


(1) Provisional data from CDC, National Center for Health Statistics

(2) 2020 National Survey on Drug Use and Health, 2021

# Overdose Death Rates Involving Opioids, by Type United States, 1999-2020

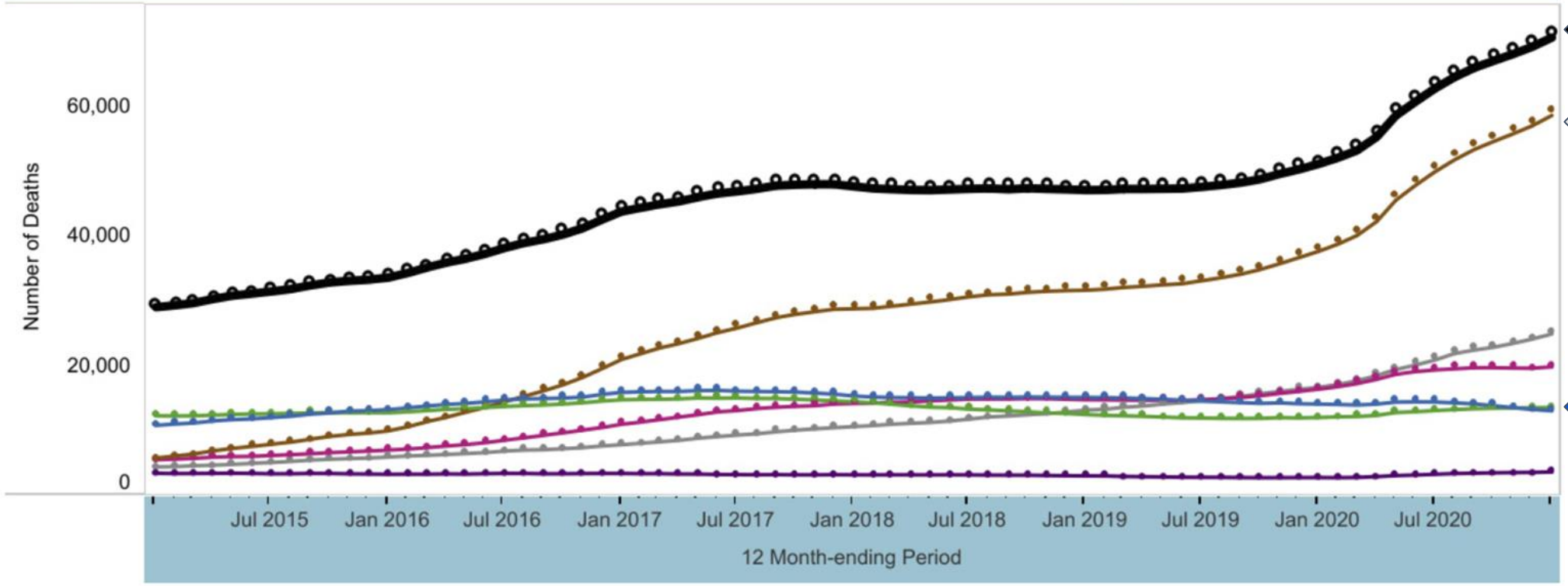


**Based on data available for analysis on:** **8/1/2021**

**Select Jurisdiction**
United States

**Select specific drugs or drug classes**
Multiple values

## Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States




**Legend for Drug or Drug Class**

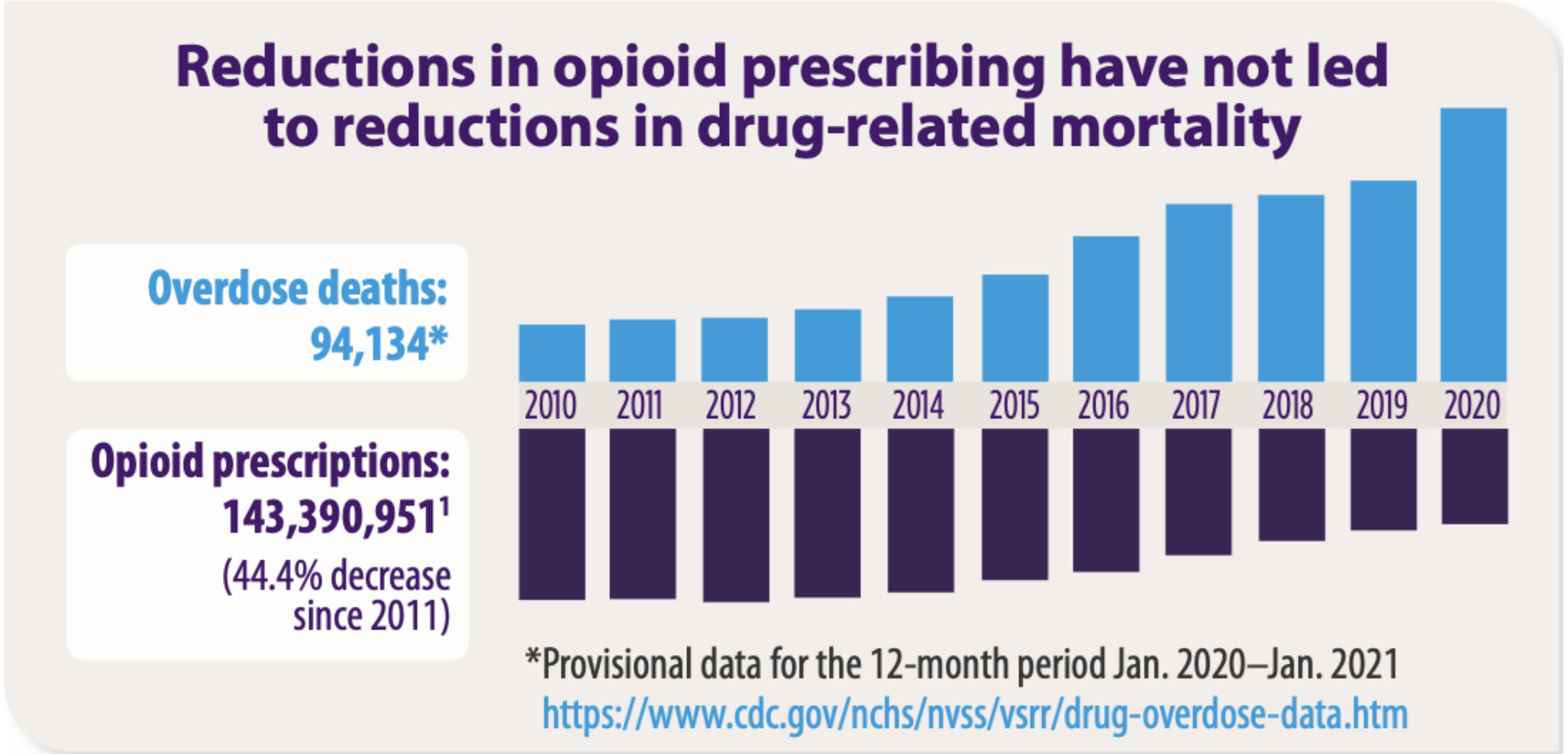
- Opioids (T40.0-T40.4,T40.6)
- Heroin (T40.1)
- Natural & semi-synthetic opioids (T40.2)
- Methadone (T40.3)
- Synthetic opioids, excl. methadone (T40.4)
- Cocaine (T40.5)
- Psychostimulants with abuse potential (T43.6)

---- Reported Value

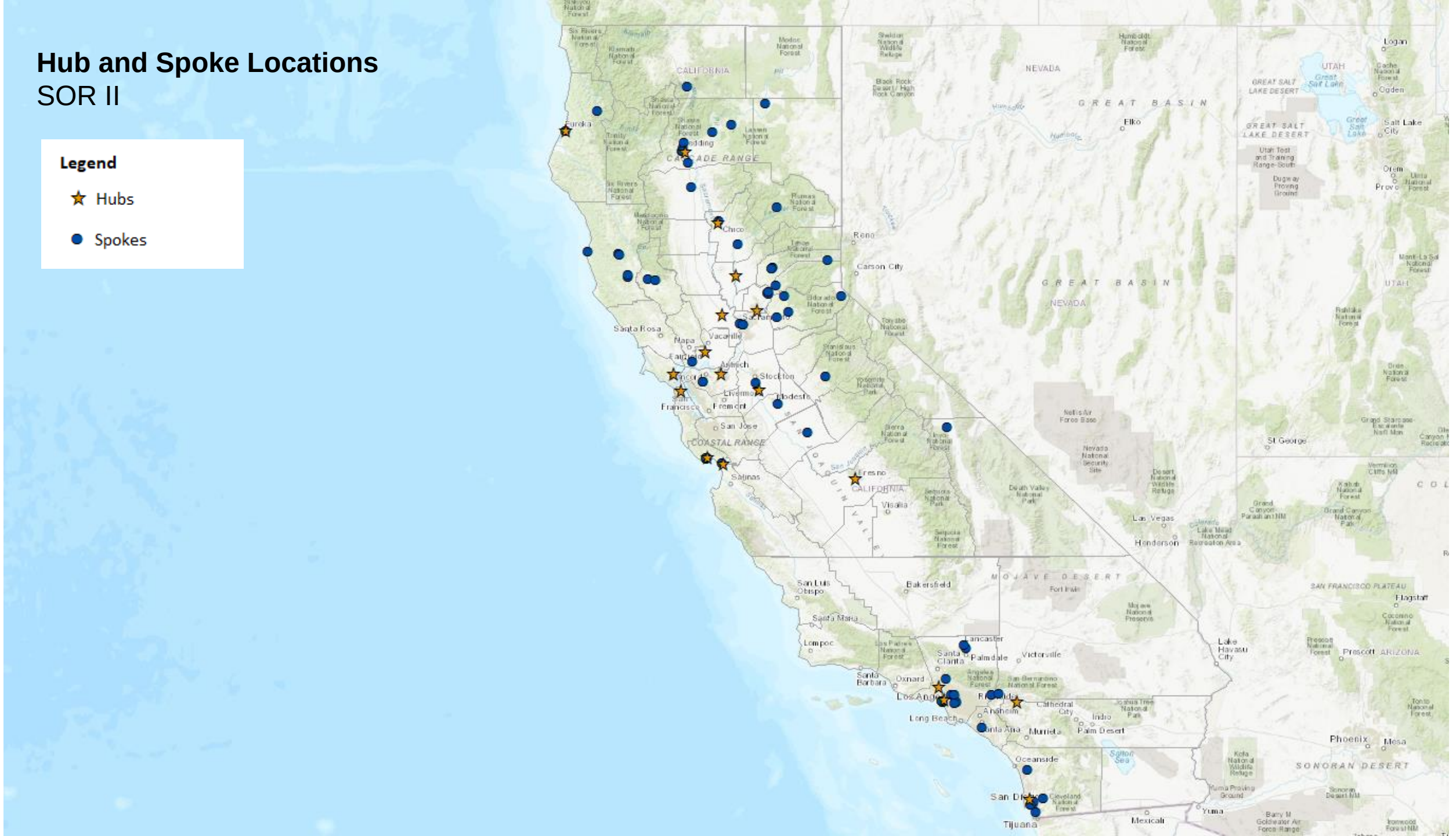
○ Predicted Value

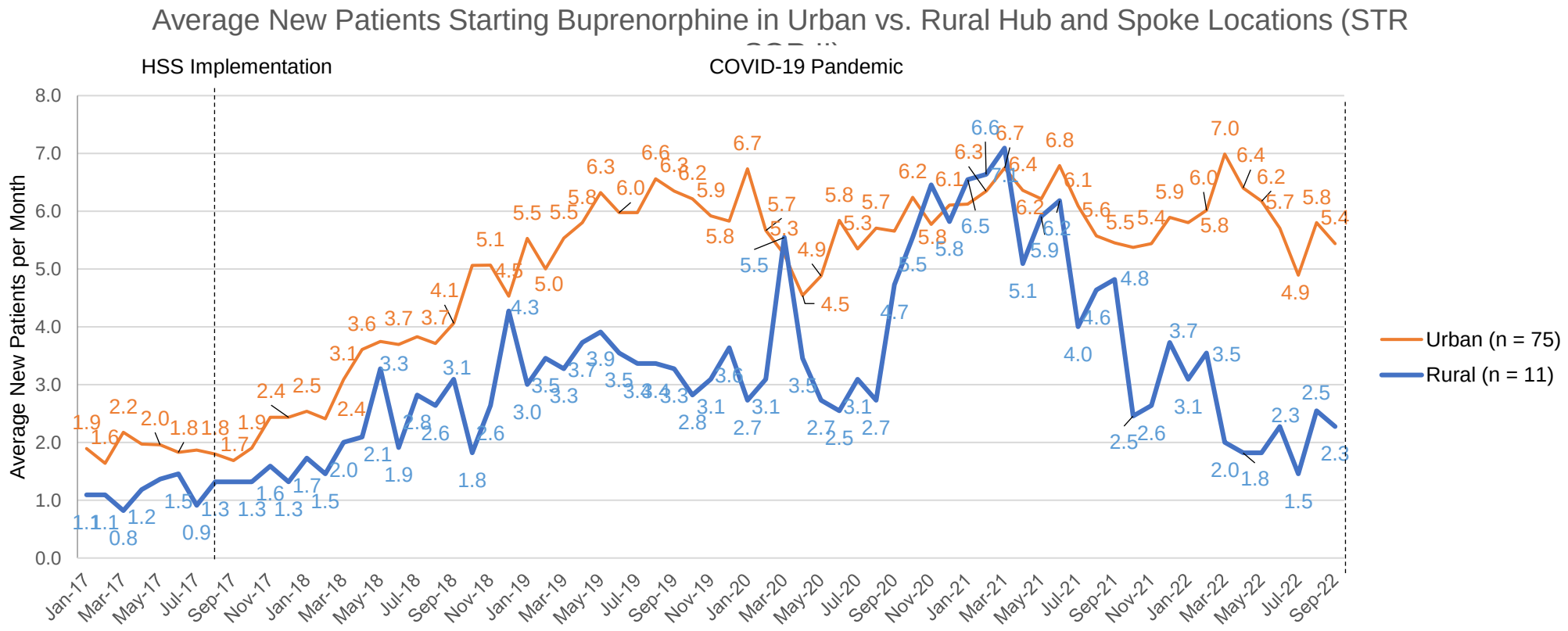
*CDC VITAL STATISTICS RAPID RELEASE (8/1/2021) https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm*

# As Opioid Prescribing Decreased, Overdose Deaths Increased



# Hub and Spoke Locations
SOR II




Average New Patients Starting Buprenorphine in Urban vs. Rural Hub and Spoke Locations (STR
HSS Implementation
COVID-19 Pandemic
Average New Patients per Month
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
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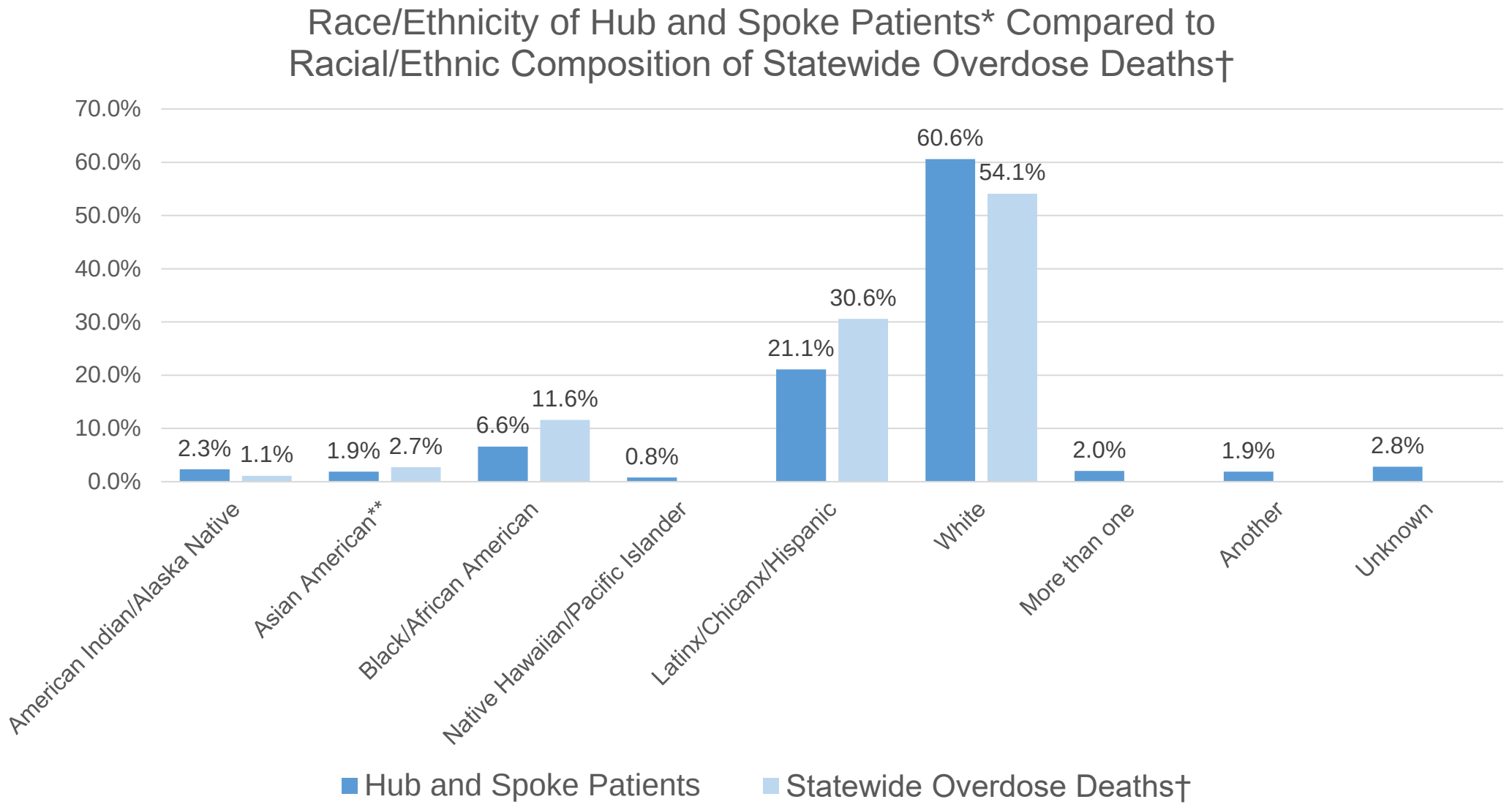
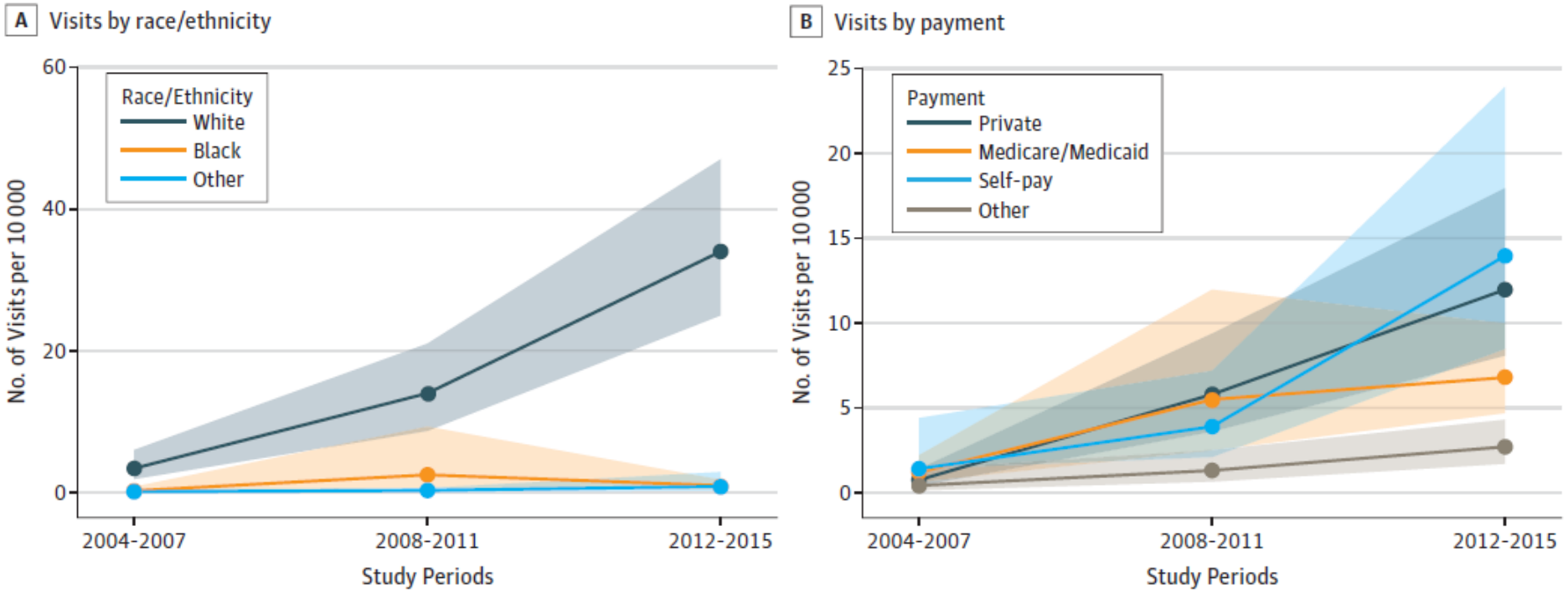
Jul-22
Sep-22
Urban (n = 75)
Rural (n = 11)




*As of September 2022
** Statewide data combine Asian and Pacific Islander into one category
†Data source: California Overdose Surveillance Dashboard, 2021

# Buprenorphine by Race and Payment Method




Lagisetty, P.A., et al. (2019). JAMA

# What's the deal with Fentanyl?

- **Synthetic opioid** = lab designed → ***stronger, more effective***
- **Higher receptor affinity & potency** → higher "high"(more addictive)
  *…and higher risk of OD*
- Can **build up in fat stores over time** → longer time to withdrawal

- ***Does not reliably show up on routine urine toxicology screen*** (there *are* specific fentanyl tests – not available in every lab)

# Fentanyl

## Fentanyl

- A **synthetic** (man-made) opioid **50x** more potent than heroin and **100x** more potent than morphine.
- **Prescribed** in the form of transdermal patches, tablets, lozenges, or nasal sprays.
- Can also be **illegally** made (**illicitly manufactured fentanyl**) and mixed into other drugs like heroin or cocaine.

## Illicitly Manufactured Fentanyl (IMF)

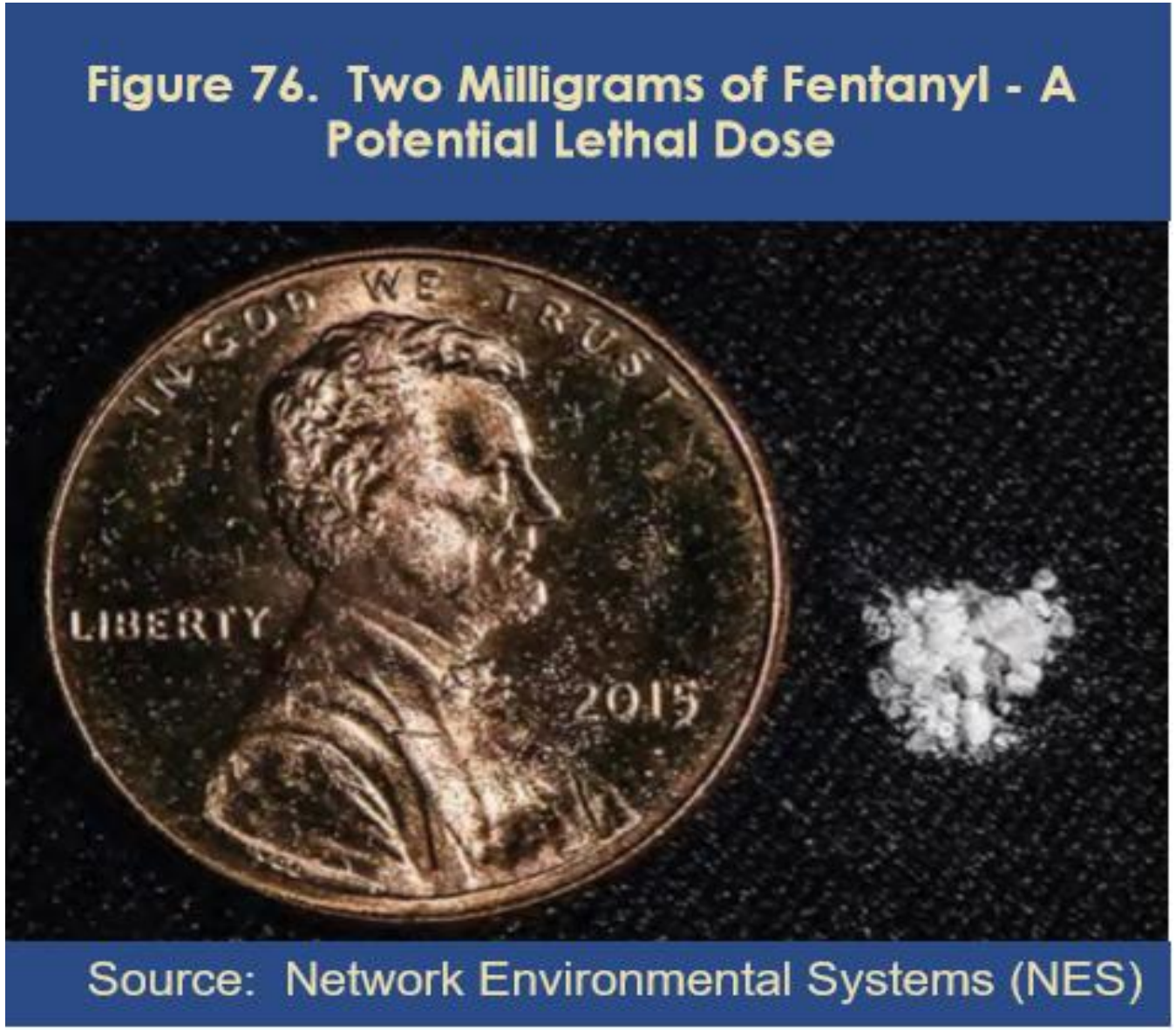
- **Illegally sold** for its heroin-like effect, and linked to recent increases in **overdose deaths**.
- Often pressed into **counterfeit pills** or **mixed** with **heroin** or **cocaine**, with or without the user's knowledge.
- **Fentanyl analogs** are drugs that are **chemically related** to fentanyl and mimic the effects of the drug.

Source: CDC, "Synthetic Opioid Overdose Data," 2020

# What's the deal with Fentanyl?

- **Fentanyl gets mixed with other drugs – e.g. heroin, methamphetamine, cocaine**
- **DEA analysis of counterfeit pills showed 0.02 to *5.1mg of fentanyl/tablet* (>*2x lethal dose!*)**
  - **42% of pills tested contained ≥2mg**
  - **Medical dose 50-200*mcg* = 0.05-0.2*mg***
  - **Drug trafficking is by the *kg***
  - **1kg of fentanyl can kill *500,000 people***

Image credit: DEA.gov




A lethal dose of carfentanil 1/100th of the amount shown next to the penny.

# Potential Lethal Dose
# Heroin, Fentanyl and Carfentanil


Comparing the size of lethal doses of heroin, fentanyl, and carfentanil. The vials here contain an artificial sweetener for illustration. (New Hampshire State Police Forensic Laboratory)

# Fentanyl testing required by CA law!

State of California—Health and Human Services Agency
**California Department of Public Health**

**TOMÁS J. ARAGÓN, M.D., Dr.P.H.**
*State Public Health Officer & Director*

**GAVIN NEWSOM**
*Governor*

November 29, 2022

AFL 22-25

**TO:** General Acute Care Hospitals (GACHs)

**SUBJECT:** Senate Bill (SB) 864 – Fentanyl Screening in GACHs

**AUTHORITY:** Health and Safety Code (HSC) section 1259.3

## All Facilities Letter (AFL) Summary

This AFL notifies GACHs of the passage of SB 864 (Chapter 169, Statutes of 2022) requiring a GACH that is conducting a diagnostic urine drug screening to also include testing for fentanyl, until January 1, 2028.

Effective January 1, 2023, SB 864 establishes "Tyler's Law" that requires a GACH to include testing for fentanyl if conducting a urine drug screening to assist in diagnosing a patient's condition. The bill defines urine drug screening to mean a chemical analysis intended to test patients for the presence of multiple drugs, including cocaine, opioids, and phencyclidine. The requirements of the bill remain in effect until January 1, 2028.

If you have any questions about this AFL, please contact your respective district office.

CDPH's failure to expressly notify facilities of statutory or regulatory requirements does not relieve facilities of their responsibility for following all laws and regulations. Facilities should refer to the full text of all applicable sections of HSC and the California Code of Regulations to ensure compliance.

# What's the deal with Fentanyl?

**Fentanyl fear causes lots of uncertainty surrounding treatment**

- ***What about MAT? Can I still use buprenorphine?***
- ***How can I safely start treatment?***
- ***What about precipitated withdrawal?***
- ***What about narcan?***
- ***What do I do?!***

# Non-fatal & Fatal Overdose

- 46-92% of people who misuse opioids witness or experience a non-fatal or fatal overdose (OD)
  - ➢ More than 17% of overdoses are estimated to be intentional
- Witnessing an OD is a traumatic experience (Winstanley 2020)
  - ➢Children may witness their parent OD
  - ➢People OD while driving
- Experiencing a non-fatal OD, could experience:
  - ➢Neurocognitive impairments & brain injuries Acute amnestic syndrome

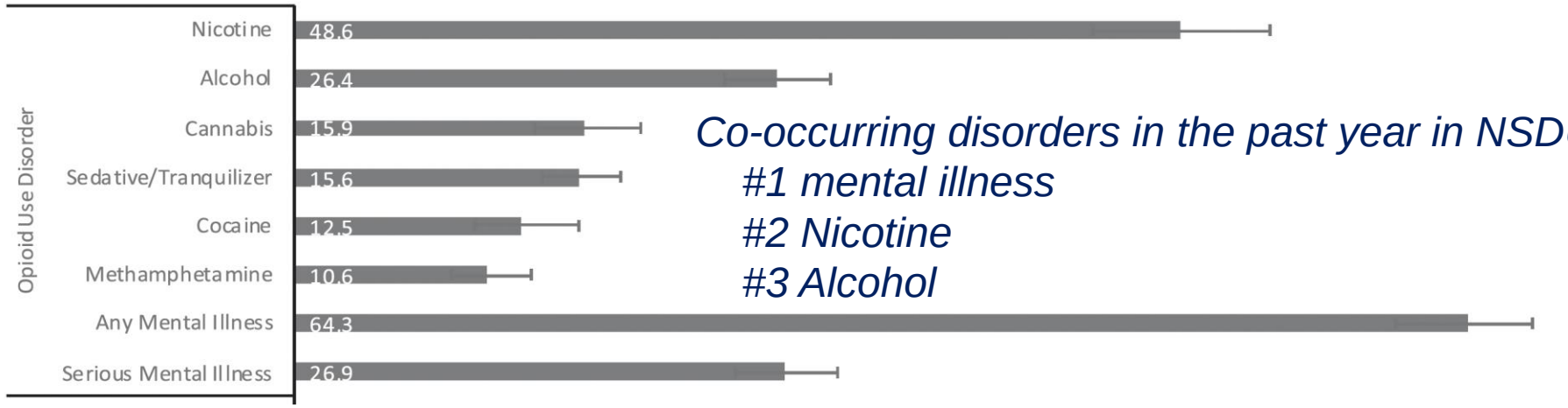
SOURCES: Winstanley et al (2021); Barash et al. 2018

# Infectious Diseases

- Approximately 42%-81% of patients seeking treatment for an OUD develop chronic viral hepatitis
- Approximately 18% of people who inject drugs (PWID) in addiction treatment have HIV
  - Range 1-37% depending on geographic area
- Approximately 62% of people in addiction treatment have at least one sexually transmitted infection
- Injection drug use is associated with risk of serious bacterial infections, such as endocarditis, visceral and nervous system abscesses, and osteomyelitis

SOURCES: Jimenez-Trevino et al. 2011; Hser et al. 2006; Wejnert et al. 2009; Hwang et al. 2000

# Co-Morbid SUD & MH




*Co-occurring disorders in the past year in NSDUH:*

*#1 mental illness*

*#2 Nicotine*

*#3 Alcohol*

*Among patients with OUD in treatment (past month drug use):*

- *More methamphetamine use in rural areas*
- *More prescription stimulant use in rural areas*
- *Less cocaine use in rural areas*

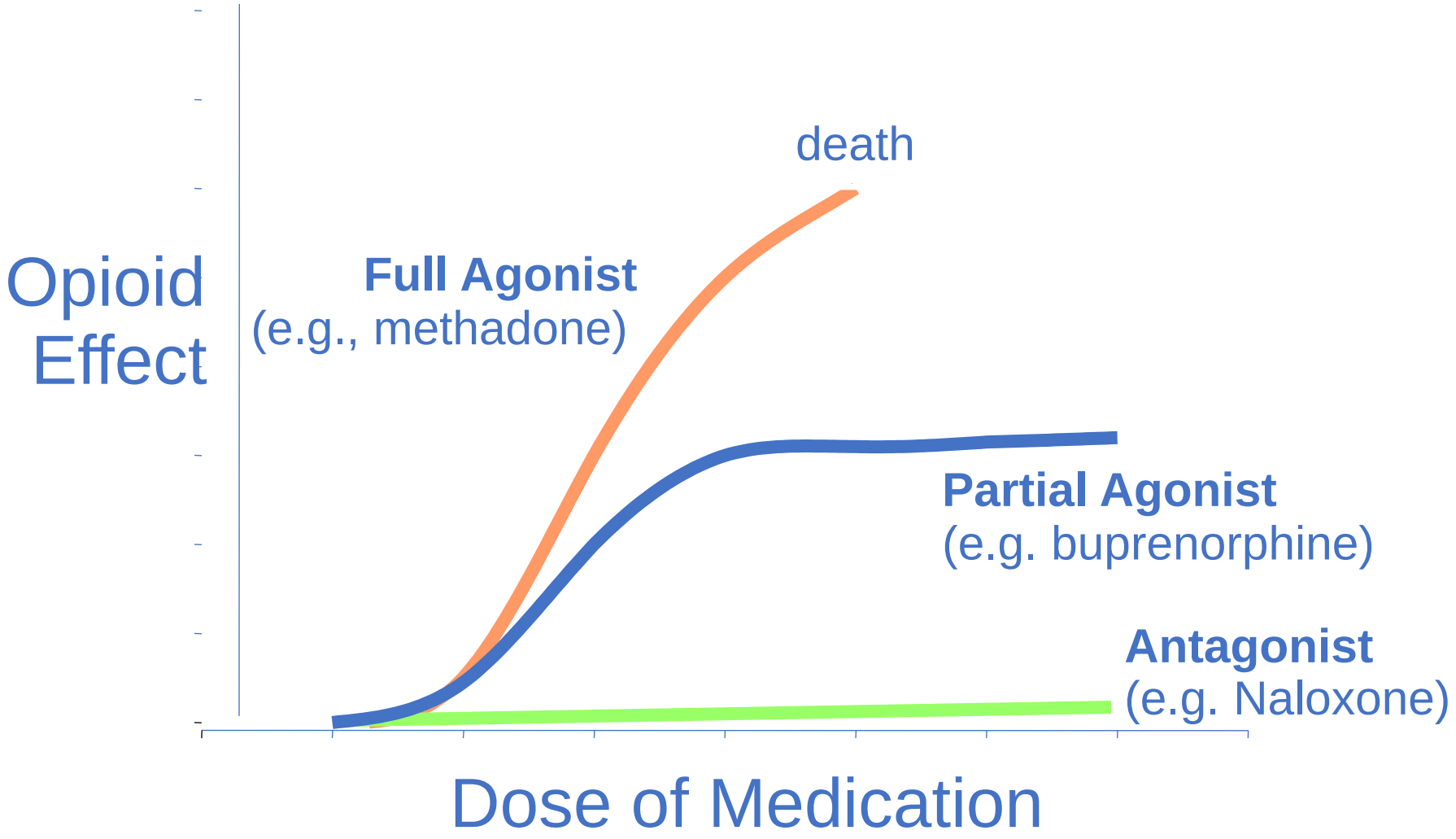
| Past-month non-opioid use | Rural | Urban | P value |
|---|---|---|---|
| Nicotine/tobacco | 82.4% | 83.0% | 0.467 |
| Marijuana | 50.4% | 50.6% | 0.845 |
| Alcohol (>4 times in one day) | 34.6% | 36.2% | 0.097 |
| Methamphetamine | 35.4% | 30.9% | <0.001 |
| Anxiolytics | 42.5% | 46.1% | <0.001 |
| Crack/cocaine | 25.4% | 34.5% | <0.001 |
| Muscle relaxants | 22.5% | 22.7% | 0.780 |
| Antidepressants | 18.0% | 19.1% | 0.140 |
| Prescription stimulants | 20.7% | 18.4% | 0.024 |
| Prescription sleep medications | 17.6% | 18.4% | 0.307 |
| Hallucinogens | 8.4% | 9.4% | 0.074 |
| MDMA | 9.8% | 11.8% | 0.001 |

SOURCES: Jones & McCance-Katz (2019); Ellis et al. (2021)

# The Gold Standard for OUD: Medications for OUD (MOUD)

Methadone
Buprenorphine
Naltrexone

# Interacting with the Opioid Receptor



# Purpose of Medication for OUD

- **Control** symptoms of opioid withdrawal
- **Restore** emotional and decision-making capacities
- **Suppress** opioid cravings
- **Block** the reinforcing effects of ongoing opioid use
- **Promote** and facilitate engagement in recovery-oriented activities
- **Couple** with behavioral interventions
  - Enhance the salience of natural, healthy rewards
  - Reduce stress reactivity and negative emotional state
  - Improve self-regulation
  - Increase avoidance of relapse triggers

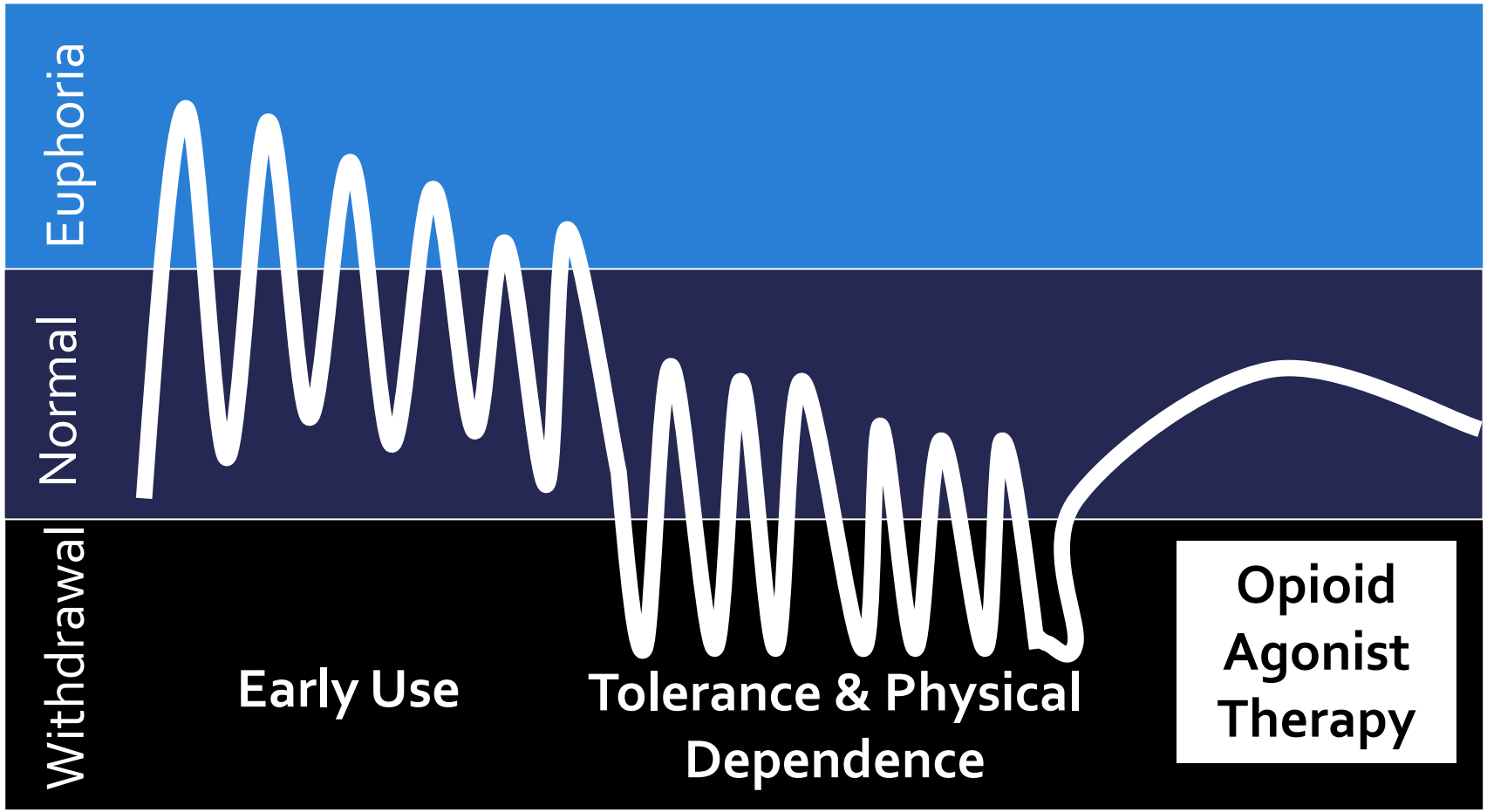
Volkow, et al, NEJM. 2016
ASAM National Practice Guideline, June 1, 2015.

# Goals of Medication for OUD

- **Reduce** mortality. (Save lives!)
- **Reduce** associated morbidity
  - Transmission of blood-borne viruses
  - Infectious complications from IV drug use
- **Reduce** opioid use
- **Reduce** substance-related crime
- **Increase** retention in treatment
- **Improve** general health and well-being

Volkow, N, Chang, L, et al.(2001) *Loss of dopamine transporters in methamphetamine abusers recovers with protracted abstinence. J Neurosci* 21:9414-8

# Staying well




ASAM American Society of Addiction Medicine

# Methadone

- Dolophine ®  Methadose ®


Buprenorphine

Buprenorphine/
Naloxone


Subutex ®

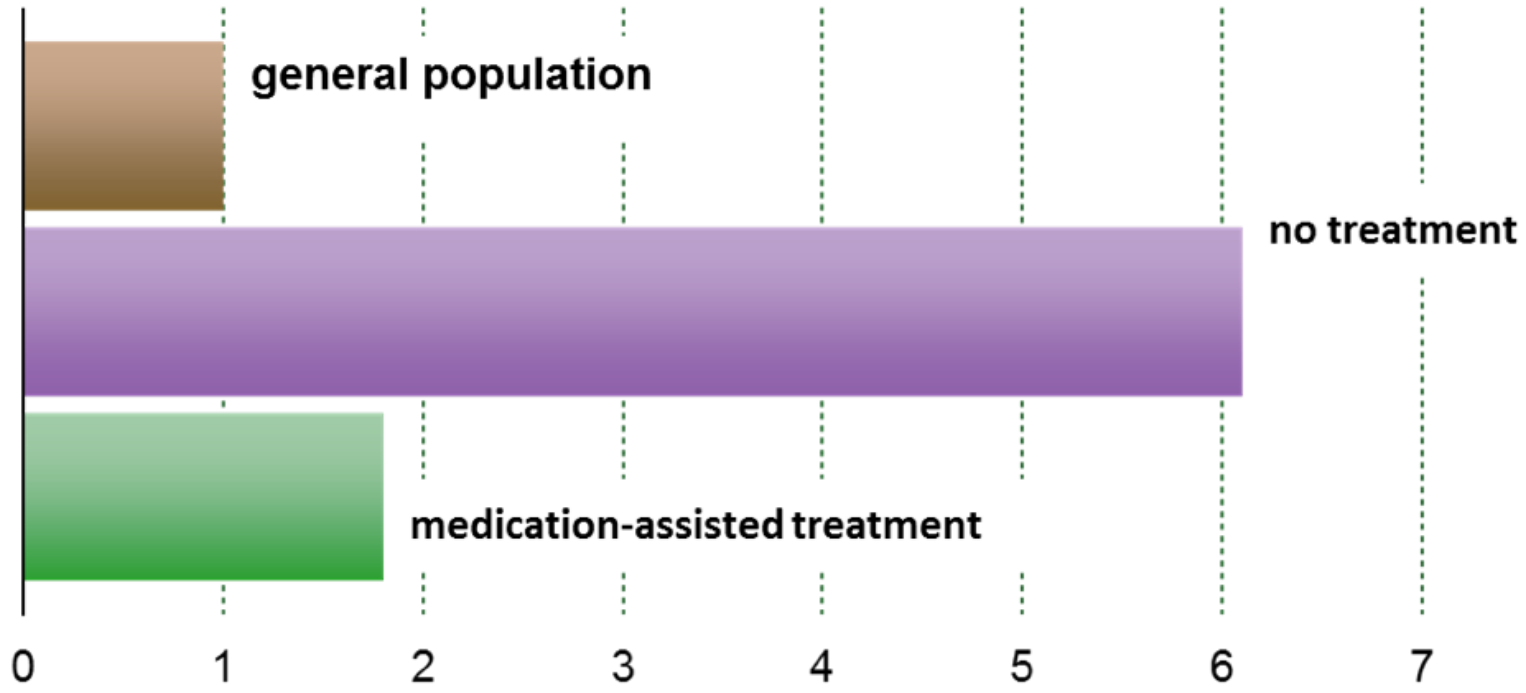
Suboxone ®

# Naltrexone and Long Acting Injectable Naltrexone

Vivitrol®

# Benefits of MAT: Decreased Mortality

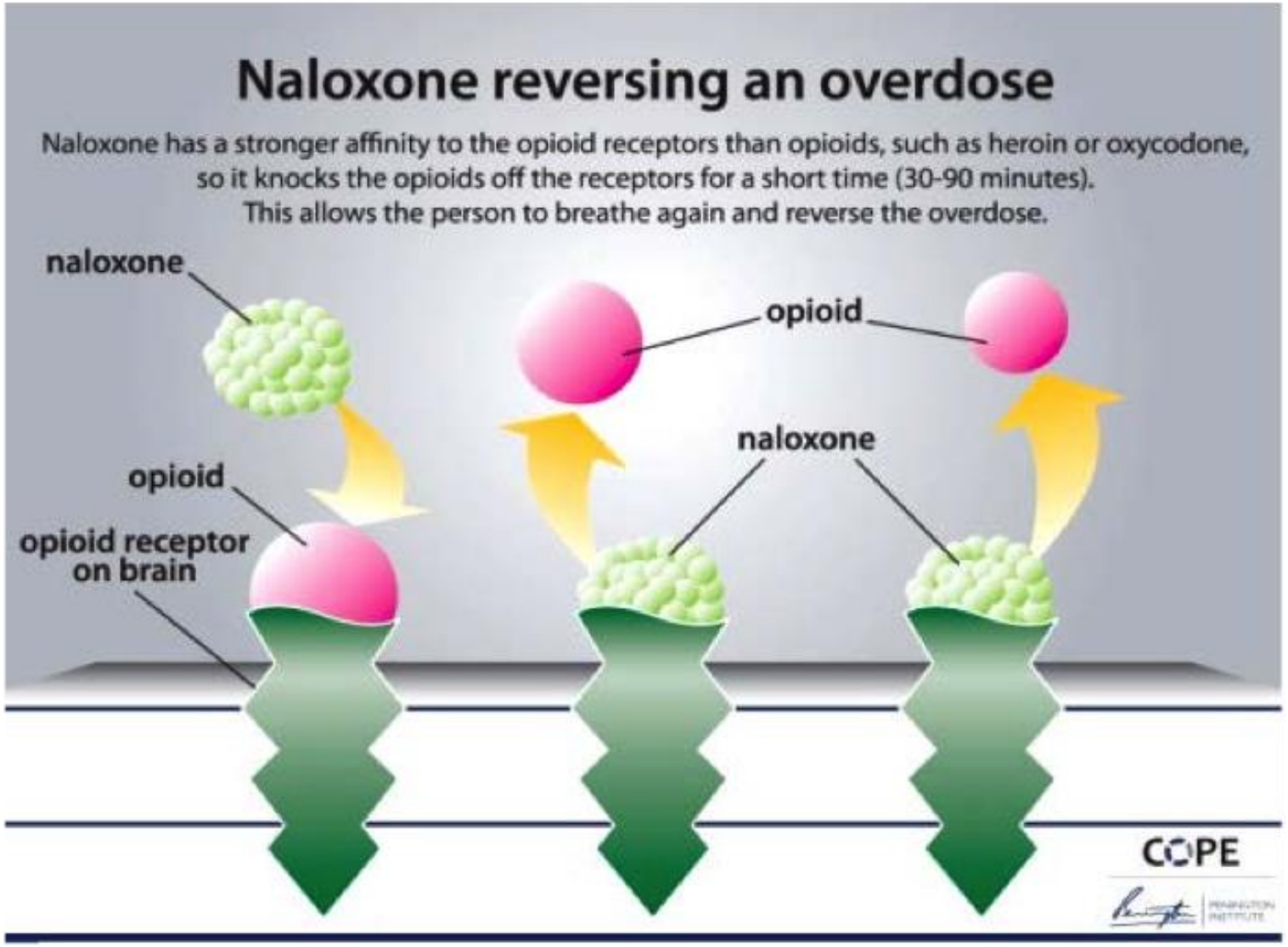
**Death rates:**




Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

# Naloxone for Opioid Overdose

# How Naloxone Reverses an Overdose



# Naloxone

- Full opioid antagonist; rapidly displaces opioid agonist molecules (e.g. heroin), which is why it is used in the event of overdose
- Reverses the CNS and respiratory depression caused by opioids
- Takes effect in 2-5 minutes
- Available as nasal spray (Narcan) or auto-injector (Evzio)
- Distributed to first responders around the country
- Wears off in 20 – 90 minutes.

Source: Ryan & Dunne, 2018

# Is Naloxone Safe?

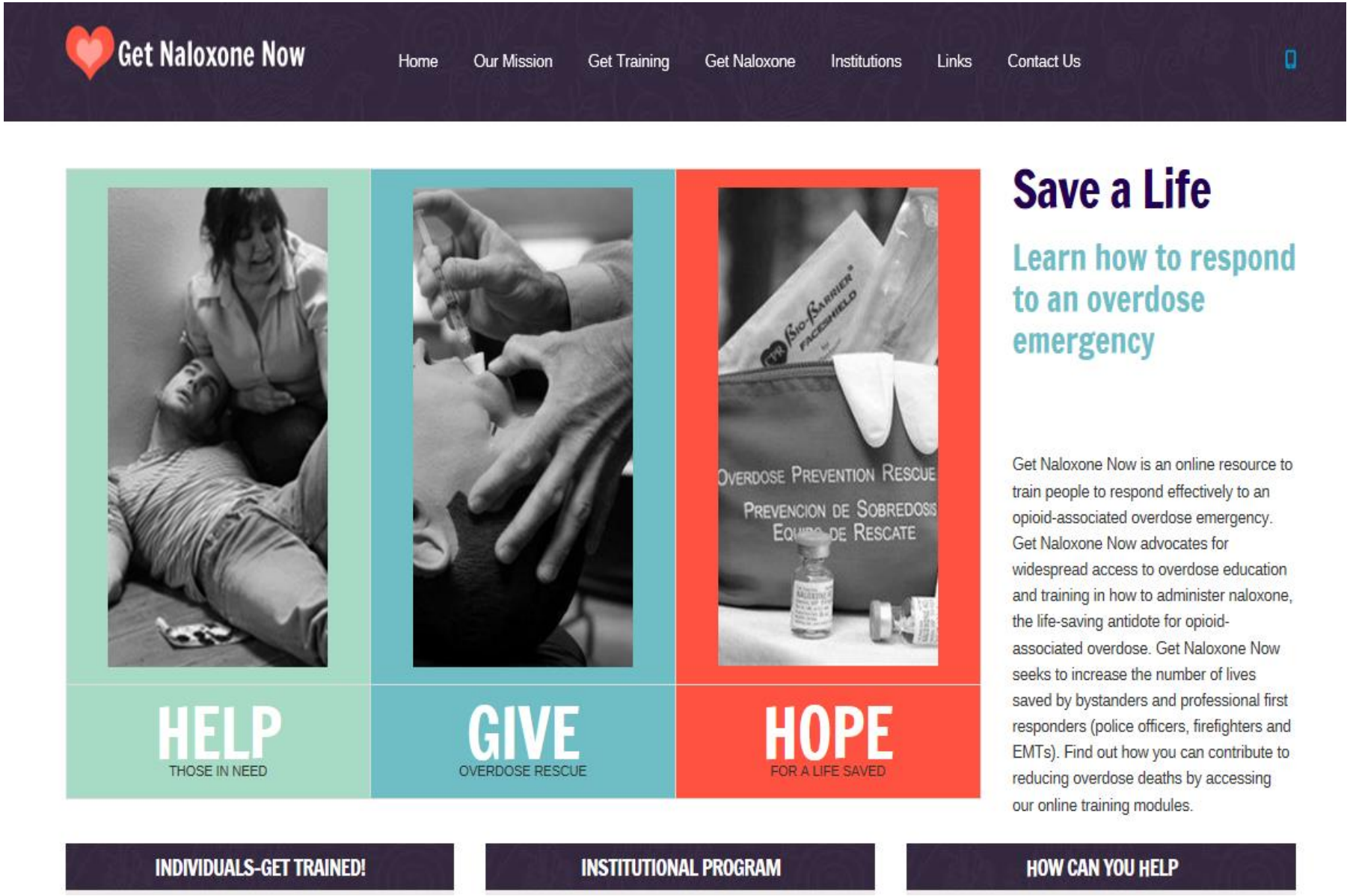
- Cannot be misused
- Has no effects in absence of opioids
- Restores breathing
- Does not increase substance use risk

# Narcan Nasal Spray


- Partnership through the Clinton Health Matters Initiative-
- Free to all high schools and colleges in the U.S.

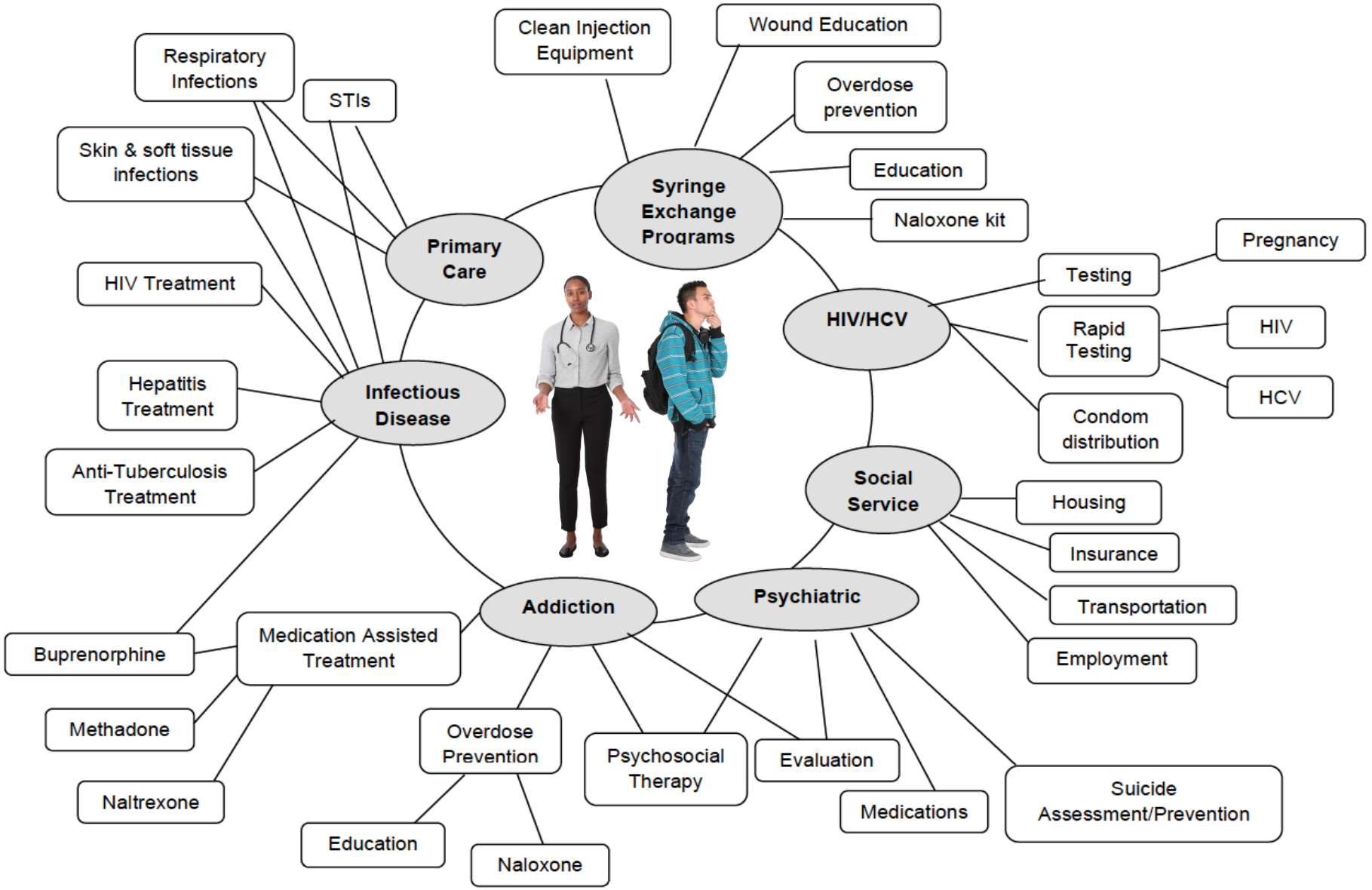
# Naloxone: Important Considerations

- **Not a replacement for emergency medical treatment**
  - After using the pen, client must **immediately** seek medical care
- Many opioids are long-acting, and naloxone may not last as long as the opioid
  - If overdose symptoms return, a second dose may be needed
- As the potency of opioids increases (e.g., fentanyl, carfentanil), higher doses and multiple doses of naloxone will be necessary.




www.getnaloxonenow.org

# Potential Service Needs



# Summary of Barriers in Rural Areas

Built environment:

- Insufficient addiction treatment system capacity
- Limited access to high-speed internet
- Lack of integrated services
- Transportation (limited or no public transportation)
- Delays in emergency response times/naloxone administration
- Broadband infrastructure

Social/Political:

- Lack of understanding of addiction as a chronic relapsing brain disease
- Stigma associated with addiction
- Limited financial resources for prevention & treatment

Economic:

- Recruiting highly qualified health professionals
- Difficulty of real-time surveillance
- Scaling-up services in rural areas

# Health Care in Rural Areas

- Rural residents have **less access** to health care:
  - Fewer hospital beds, in particular ICU beds; hospitals continue to close in rural areas
  - Fewer addiction treatment programs & Syringe Exchange Programs
- Rural residents may be **less likely to use preventative** services
- Due to stigma, individuals with SUD **may be reluctant** to seek health care
- COVID-19 caused **reductions** (or cessation) in SUD services in rural areas:
  - MOUD regulations require frequent in-person visits

SOURCES: Peters (2020) *Journal of Rural Health;* Karim & Chen (2020) *Journal of Rural Health;* Murphy et al. (2020) *Journal of Substance Abuse Treatment;* Ostrach et al. (2020) *Journal of Rural Health*

# Care Delivery Models

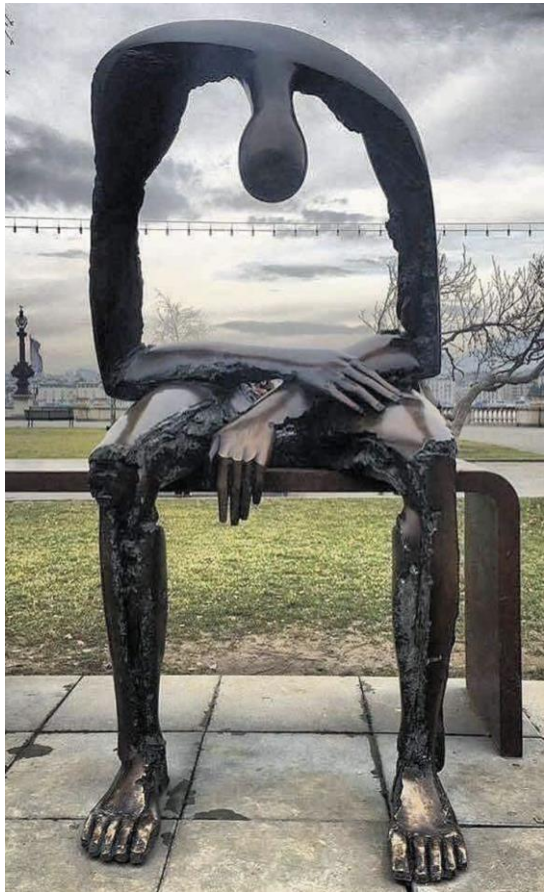
- Hub & spoke model to expand specialty services in rural areas
- Bridge Clinics
- Low threshold using collaborative practice agreements
  - Syringe Exchange Programs
  - Pharmacy-based services
- Telehealth

# Strengths of Rural Areas During the COVID-19 Pandemic

- Creative & adaptive
- Personal connections
- Decentralized
- Regional distribution
- Partnerships


# Compassion Fatigue

- Compassion fatigue (CF) is a reduction in empathy or distress that results from exposure to traumatic events
- Overdoses are traumatic events whether directly witnessed or indirectly
- High rates of overdoses & low access to prevention services may increase community-level CF in rural areas
- COVID-19 may exacerbate CF in rural areas hardest hit by the overdose epidemic, particularly among behavioral health care providers

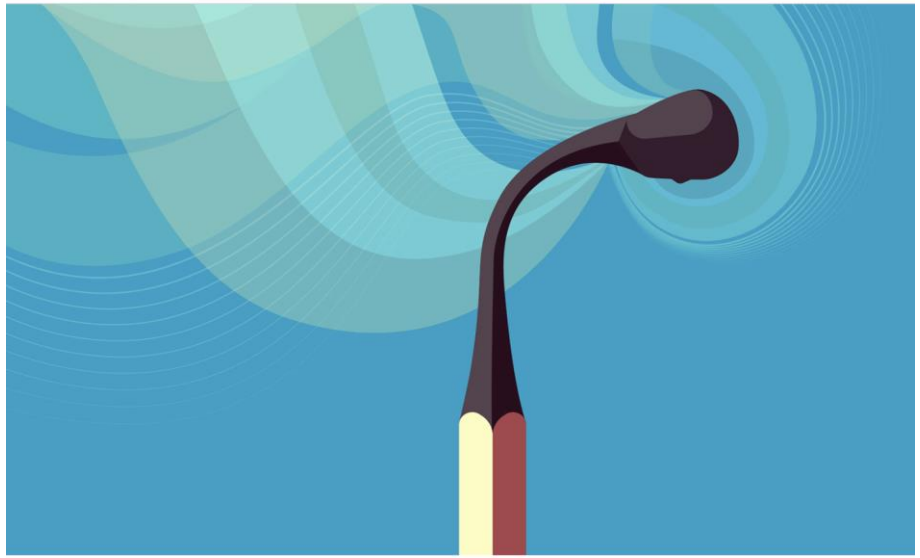


Melancholy by Albert György

SOURCE: Winstanley (2020) *International Journal of Drug Policy*

Harvard Business Review

The Big Idea Series / The Burnout Crisis



od/Folio Art

Managing People

# Beyond Burned Out

Chronic stress was rampant even before the pandemic. Leaders can't ignore it any longer. by Jennifer Moss

February 10, 2021

1. Unsustainable workload
2. Perceived lack of control
3. Insufficient rewards for effort
4. Lack of a supportive community
5. Lack of fairness
6. Mismatched values and skills

The New York Times

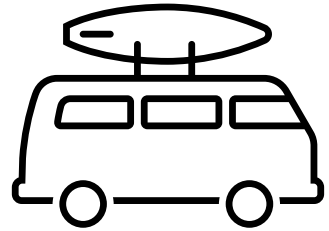
# There's a Name for the Blah You're Feeling: It's Called Languishing

The neglected middle child of mental health can dull your motivation and focus — and it may be the dominant emotion of 2021.

1252

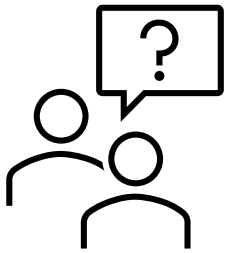
# Other Potential Solutions

- Mobile methadone/MOUD
  - San Francisco General Hospital's Opiate Treatment Outpatient Program (OTOP) offers mobile methadone & buprenorphine (Dr. Brad Shapiro)
  - Collaboration between San Francisco Dept. of Health & UCSF



- Street Psychiatry & other models of medical care outreach for people that are unhoused or for patients with serious mental illness

- Extender models to improve knowledge of effective services & share information on how to access such services



# Evidence-Based Practices and Personal Beliefs

# Evidence-Based Practices (EBPs) and Personal Beliefs

- Clinicians are ethically bound to provide the services that give the client the best chance of success
- For both MH and SUD, this means using EBPs whenever they exist
- Personal belief and clinical practice may come into conflict (E.g., “I don’t believe in using medicines in addiction treatment.”)
- Engaging clients with empirically-based choices is essential

# *Staff & Patient Perspectives on the MOUD Continuum of Care from 7 Rural Primary Care Clinics*

## *We talked with staff and patients at 7 rural primary care clinics; 4 in Washington State and 3 in Maine*

- **Clinic leadership (n = 7)**
  - 7 virtual interviews
- **Prescribing Providers (n = 30)**
  - 7 virtual focus groups, 1 virtual interview
- **Non-prescribing Providers (n = 37)**
  - 8 virtual focus groups, 1 virtual interview
- **Clinic patients who have received MOUD (n = 16)**
  - 16 virtual interviews

# Identification & Screening

## Key Themes

- Screening has workflow implications
- Patients may not answer questions truthfully because they are not ready to disclose treatment or worry about consequences of disclosing
- Successful identification of patients requires time and a variety of methods and approaches

*"Well, you know, we had to cut [universal screening] back because it was so disruptive of our schedules. So we started doing it just on principal exams. So, basically, if someone's come in for routine visits or something, they're not getting screened, which is a problem. But if they could get them here 20 minutes early for their appointment, that would be okay." (Provider)*

*personal experience has been times in which organically, like difficult problems have come ation or as a side note, 'Hey, listen, you know, day, and, yeah, I noticed your opioid screening rug screen…those kind of settings where it's been more organic have yielded better results with individuals than screening tools have." (Provider)*

# Diagnosing OUD

## Key Theme

- Diagnosis coding for OUD is inconsistent and may be inaccurate

*"…coding appropriately, probably not, but they just kind of throw in a vague opiate dependence or stimulant use, whatever. … and then, —when I do a MAT intake, you know, we're kinda going through the whole DSM and tryin' to get them the most appropriate diagnosis for that." (Provider)*

# INITIATE MOUD, SUPPORT RECOVERY

## Key Themes

- Transportation issues, limited community resources and poverty impede access to MOUD and ancillary treatment
- MOUD implementation can be challenging for frontline staff
- Patients are ambivalent about OUD treatment due to stigma, mistrust and readiness for treatment

*"I think for staff—I mean, it's- the patients in the program, some days, patients will upset and angry, and you know, they' (Administrator)*

*"I didn't wanna do Suboxone only because I assumed that, once you're on Suboxone, and every doctor that you go to, you know, if you see that you're on Suboxone, then they're gonna assume you had a drug problem and nix you. So that was my biggest hurdle was I didn't want to have Suboxone on my medical record." (Patient)*

# Referral to and Coordination with an External TM Provider

**Themes**

- TM referral and coordination can expand access to treatment for OUD patients by reducing overflow burden and expanding capacity
- TM referral and coordination can benefit patients by giving them grater privacy, flexible scheduling, ease of access, more access to behavioral health and pain providers
- There could be workflow implications for clinic providers, such as unexpected workload issues and logistical complications
- Patients may prefer receiving care from known providers
- Technological and communication barriers may impede implementation

# Referral to and Coordination with an External TM Provider

*"For us, I definitely think that it is because it has given us an avenue to treat these patients that we weren't treating before. You know, there may have been some conversations with patients. But I mean, until we had this program, we didn't even have opioid use disorder as something that we even charted. And so it's definitely given us—made us aware and given us an avenue to treat our patients." (Staff)*

*"I do feel that would take some of the load off of the provider, 'cause family practice providers are pulled in so many directions. You know, and they're not experts on everything. And so if they have some help, and I think they're totally fine with having places to have people get the help they need."*

*"'Cause it eliminates the biggest problem, which is the getting to and from wherever you need to be. If you can do it from your own home—I mean, people are more likely to do something if they don't have to go and put a lot of huge effort into going somewhere. You know?" (Patient)*

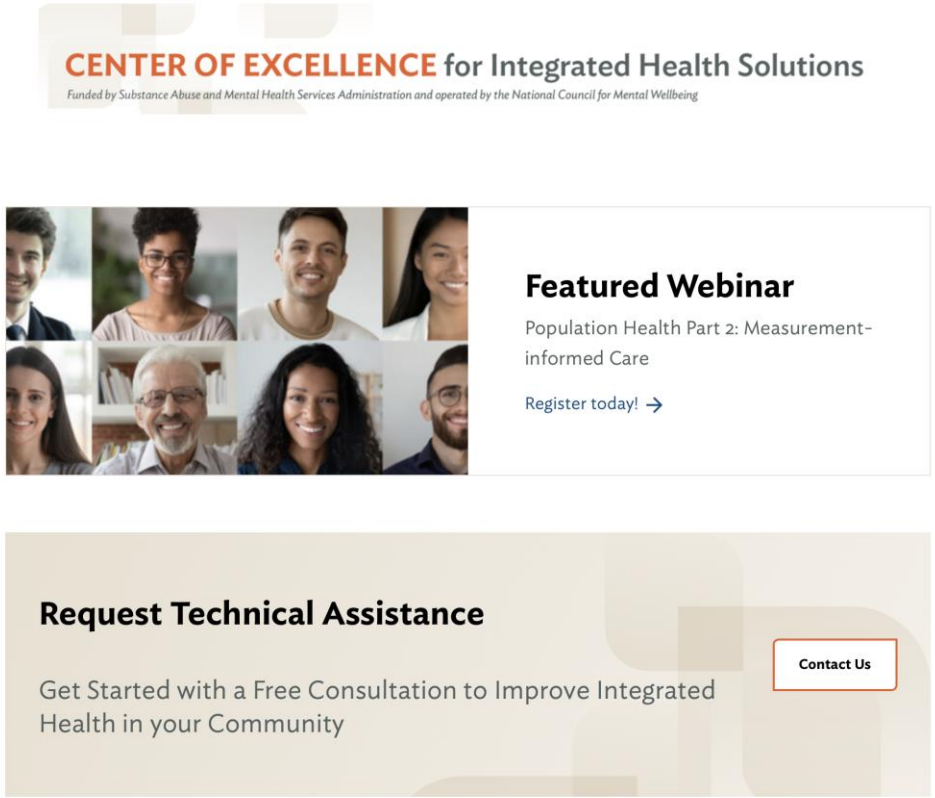
# Discussion

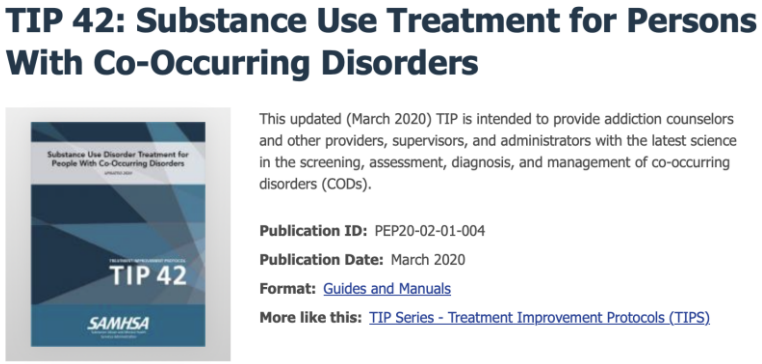
# How can today's discussion inform strategies for addressing MOUD implementation & workforce challenges?

- Diversify OUD patient identification and screening strategies
  - Conduct targeted screening
  - Further assess patient screening preferences and adapt screening tools
  - Engage community service providers in patient identification and referral
- Engage clinic staff in creating a vision, planning and preparing
- Adapt the MOUD workflow to fit clinic capacity and resources
- Prepare the workforce through clinic-wide engagement meetings and trainings to improve MOUD knowledge, reduce stigma and improve understanding of MOUD
- Consider the right model for your clinic – could referral patients to an external TM vendor support increasing access to MOUD for our patients?


Meit & Knudson, 2017

# Resources

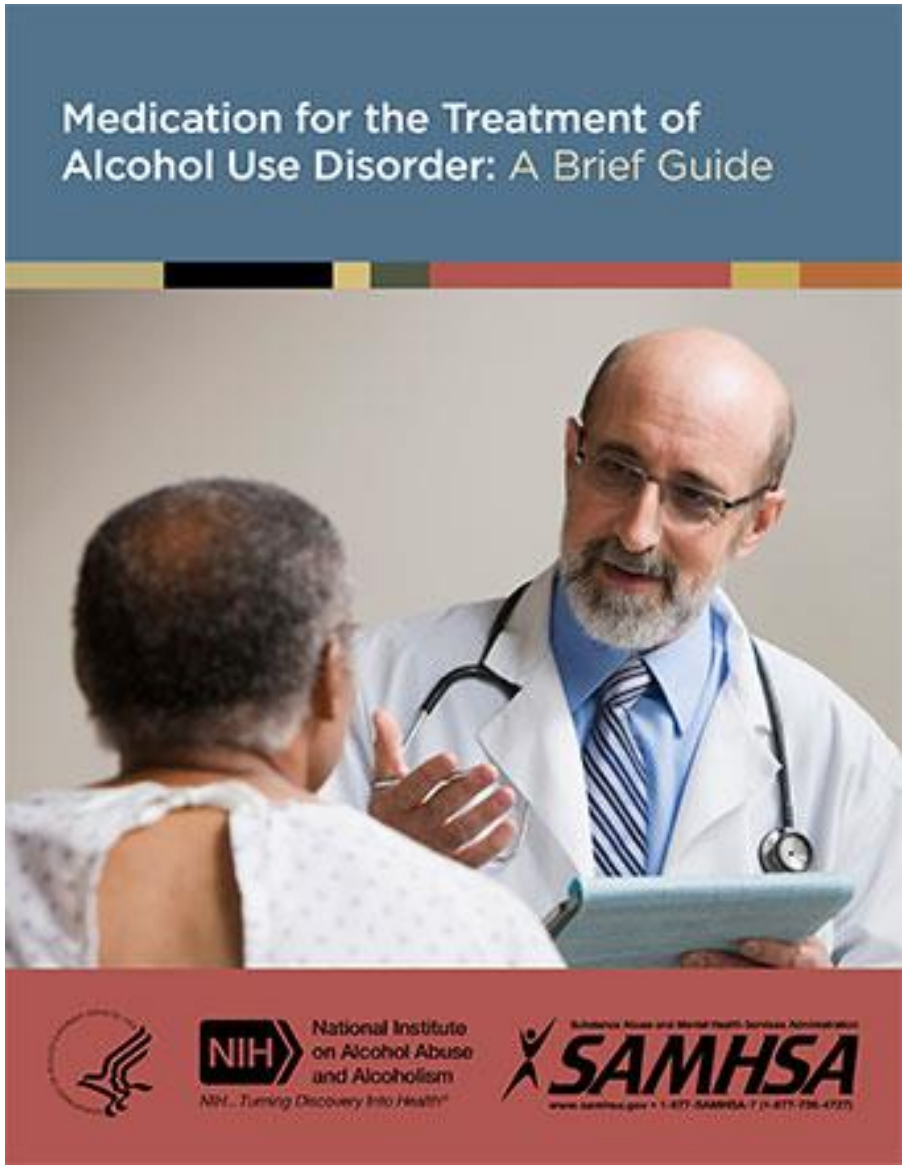



SOURCE: https://www.thenationalcouncil.org/program/center-of-excellence/

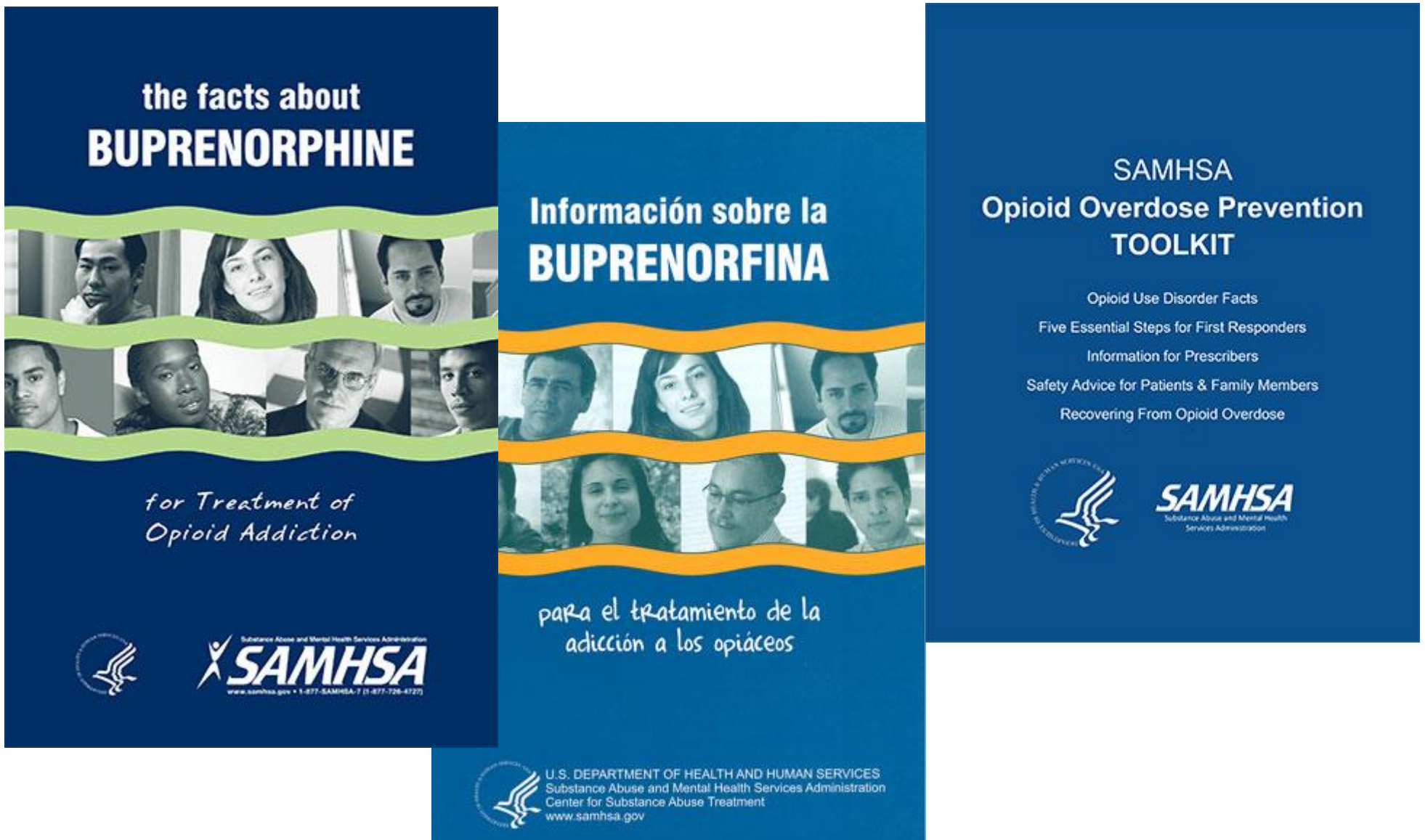
# SAMHSA


Medications for Opioid Use Disorder
For Healthcare and Addiction Professionals, Policymakers, Patients, and Families
TREATMENT IMPROVEMENT PROTOCOL
TIP 63
SAMHSA


Medication for the Treatment of Alcohol Use Disorder: A Brief Guide
NIH
National Institute on Alcohol Abuse and Alcoholism
SAMHSA

# SAMHSA

buprenorphine.samhsa.gov



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*This product was funded under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CASAT) (Grant Number H79TI085586).* 