Rural Communities in Crisis: Strategies to Reduce Opioid Use

John Gale, M.S.

Dakota Conference on Rural and Public Health
Grand Forks, ND
May 16, 2016

Acknowledgement

The Maine Rural Health Research Center gratefully acknowledges support for this project from the Federal Office of Rural Health Policy within the Health Services and Resources Administration.

Research Team:

Prevalence study: Jennifer Lenardson, John Gale, Erika Ziller

Strategies study: John Gale, Anush Hansen, Martha Elbaum-Williams
Complex Problem

• The good:
  ▫ A class of prescription medications providing significant benefits to patients with acute severe pain

• The bad:
  ▫ Undue influence of pharmaceutical companies
  ▫ Early failure to acknowledge the risks of prescription opioids
  ▫ Slow adoption of evidence-based prescribing guidelines
  ▫ Growing patient demand for opioids

• Complications:
  ▫ Direct linkage between prescription opioid and heroin use
  ▫ Multiple, interrelated pathways to opioid addiction

Rural Issues

• Long standing issue in rural communities
• Non-medical use of prescription opiates in rural areas
• Use of heroin as a substitute for prescription pain killers by those without health insurance – Maine
• Major initiatives–Vermont, Ohio, other rural states
• Heroin is cheap, accessible, and stronger
• Treatment & law enforcement resources are more limited
• Non-medical use is higher among rural youth, women who are pregnant or experiencing partner violence, and persons with co-occurring disorders
Methods

  • Approximately 56,000 respondents each year.
  • Rural/urban designation based on OMB’s metro/ non-metropolitan classification
  • Key informant interviews with state and community stakeholders in Indiana, North Carolina, Vermont, and Washington
  • Stakeholders included state mental health and substance use authorities, law enforcement, PDMP staff, providers, agency directors, community members

Community in Crisis: Austin, IN

• Community of 4,2000 people in rural Scott County, IN
  • Perfect storm-largest outbreak of HIV/HCV in IN history
  • 169 cases of HIV, 268 cases of HCV, 80% co-infected
  • Significant escalation of IV use of the drug Opana
  • High rates of poverty, unemployment, uninsurance
  • Governor declared a public health emergency
  • Ban on needle exchanges, moratorium on OTPs, no Medicaid coverage for MAT, no infectious disease care
  • No recovery and support services
  • Could happen elsewhere
Austin, IN (cont’d)

- Specialty substance use treatment services are not available
- Patients must travel to Indianapolis and further
- Limited access to infectious disease services
- No recovery and support services when people return to the community
- Local practice has been “stereotyped” as caring for the “those

Prevalence of Opioid Use in Past Year Slightly Higher among Urban Persons than Rural

- Rural: 4.4%
- Urban: 4.8%

Data: National Survey of Drug Use and Health, 2008-13. Residence difference significant at p<.01
Rural Persons Who Used Opioids in the Past Year Are More Likely to Have Socio-Demographic Vulnerabilities Than Urban Persons

<table>
<thead>
<tr>
<th>Category</th>
<th>Rural (%)</th>
<th>Urban (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 12-19</td>
<td>22.1%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Fair or poor health</td>
<td>16.6%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Less than high school ed.</td>
<td>21.6%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Less than $20K</td>
<td>29.3%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>29.1%</td>
<td>25.1%</td>
</tr>
</tbody>
</table>

Residence differences significant at p<.001

Rural Past Year Opioid Users Have More Vulnerabilities Than Rural Persons Who Were Not Opioid Users

<table>
<thead>
<tr>
<th>Category</th>
<th>Rural Opioid Users (%)</th>
<th>Rural Non-Opioid Users (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 19 or under</td>
<td>22.1%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Less than high school ed.</td>
<td>21.6%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Not married</td>
<td>68.6%</td>
<td>45.3%</td>
</tr>
<tr>
<td>Less than $20K</td>
<td>29.3%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>29.1%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

Differences between opioid users and non opioid users significant at p<.001
Rural Heroin Users Were Less Likely Than Urban to Perceive Risk in Trying Heroin 1-2 Times

<table>
<thead>
<tr>
<th></th>
<th>Rural Overall</th>
<th>Urban Overall</th>
<th>Rural Men</th>
<th>Urban Men</th>
<th>Rural Persons in Fair/Poor Health</th>
<th>Urban Persons in Fair/Poor Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>41.0%</td>
<td>54.4%</td>
<td>32.5%</td>
<td>52.3%</td>
<td>27.7%</td>
<td>72.3%</td>
</tr>
</tbody>
</table>

Data: National Survey of Drug Use and Health, 2008-13. Residency difference significant at p<.05.

Rural Opioid Users More Likely to Be Involved with Law Enforcement

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th>Urban</th>
<th></th>
<th>Rural</th>
<th>Urban</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever arrested / booked for breaking the law</td>
<td>42.5%</td>
<td>36.1%</td>
<td></td>
<td>41.2%</td>
<td>43.1%</td>
<td></td>
</tr>
<tr>
<td>On probation past year</td>
<td>10.6%</td>
<td>8.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driven under the influence of drugs or alcohol in past year</td>
<td></td>
<td></td>
<td></td>
<td>41.2%</td>
<td>43.1%</td>
<td></td>
</tr>
</tbody>
</table>

Rural Barriers and Challenges

- State and local inter-agency collaboration can be difficult in low resource environments
- Work force limitations – substance use
- Access to substance use services is limited
- Stigma
- View of substance use as a moral failing
- Criminalization of drug use
- Many primary care providers are not fully informed on proper prescribing practices

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
  - Peer support and recovery services
Community Strategies: Project Lazarus

- Original focus – reduce overdose deaths/needle exchanges
- Every county in NC as well as across the country
- Recognized national model
- Core components - building public awareness of opioid misuse as a community issue
  - Broad-based educational efforts
  - Use of local data to drive awareness
  - Coalition building and action
  - Data needs for planning and evaluation
  - Programs tailored to local needs
  - Process to track progress and build sustainable support

Project Lazarus (cont’d)

- Community-specific components (based on local needs)
  - Evidence-based prevention initiatives reflecting a medical & law enforcement-based, top-down public health approach
  - Community education
  - Provider education
  - Hospital emergency department policies
  - Diversion control
  - Pain patient support
  - Harm reduction
  - Addiction treatment
Community Strategies (Cont’d)

- Other projects
- Project Vision – Rutland, Vermont
- Winnebago County Heroin Task Force in Wisconsin
- Clark County Collaborative in Ohio
- Washtenaw Health Initiative Opioid Project in Washtenaw County, Michigan

State Strategies

- Multi-Level Task Force
  - Develop statewide consistent programs/policies by bringing key stakeholders to the table
  - Coordinate/integrate strategies across agencies/programs
- Example: Indiana’s Prescription Drug Task Force
  - Participants-state legislators, law enforcement, health and medical professionals, pharmacists, federal, state and local government agencies, educators, advocates and treatment providers
  - Five committees: education; enforcement; INSPECT (Indiana’s prescription drug monitoring// program); Take Back (increasing availability of disposal sites for unused controlled substances; and treatment and recovery to improve access to treatment for those with addiction
State Strategies (Cont’d)

• Agency/Program Heads
  ▫ Develops coordinated approach across state programs

• Example: Washington State
  ▫ Department of Health’s Agency Medical Directors’ Group
    • Dept of Labor & Industries, Health Care Authority, Board of Health, Dept of Health, Dept of Veteran Affairs, Office of the Insurance Commissioner, and Dept of Corrections
    • Led development/updating of prescribing guidelines, educating providers, providing tools and resources
  ▫ Interagency workgroup focused on ED prescribing practices
    • Key agency heads and hospital representatives
    • Developed ED prescribing guidelines and concept of “oxy free” zones

State Strategies (Cont’d)

• Key components of Vermont Hub and Spoke Model
  ▫ Comprehensive care management
  ▫ Care coordination and referral to local resources
  ▫ Care transitions
  ▫ Individual and family supports
  ▫ Health promotion
System Strategies: Project Echo

- Using technology to support rural providers
  - Project ECHO and telehealth
- Example: University of Washington School of Medicine
  - Project model provides technology based access to specialists for consultation and education
  - Local providers can present cases
  - Telepain program – focus on pain management
  - Project ROAM (Rural Opioid Addiction Management)
  - Successful in supporting rural providers
  - Challenge funding – grant dependent/hard to

Ongoing Challenges

- 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 – supporting services (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
The Rural Health Research Gateway provides access to all publications and projects from seven research centers funded by the Federal Office of Rural Health Policy.

Visit our website for more information: [http://www.ruralhealthresearch.org/](http://www.ruralhealthresearch.org/)

Sign up for email or RSS alerts at: [http://www.ruralhealthresearch.org/alerts](http://www.ruralhealthresearch.org/alerts)

Contact Information

Maine Rural Health Research Center
Muskie School of Public Service
University of Southern Maine
PO Box 9300
Portland, ME 04104-9300

John Gale 207-228-8246
jgale@usm.maine.edu

Jennifer Lenardson 207-228-8399
jlenardson@usm.maine.edu

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service