Practitioner and Stakeholder Perspectives
on Opioid Use and Treatment Across Rural Northern New England

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University of Vermont Center on Rural Addiction

May 9, 2023

Disclosures

- Valerie Harder, PhD, MHS, faculty for this educational activity, has no relevant financial relationship(s) with ineligible companies to disclose.
- Julia Shaw, MPH, faculty for this educational activity, has no relevant financial relationship(s) with ineligible companies to disclose.

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

Target Audience

- The overarching goal of **PCSS** is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.

Educational Objectives

At the conclusion of this activity participants should be able to:

- Describe the **substances of highest concern** to practitioners and stakeholders in rural northern New England
- Identify the **top barriers to opioid use disorder treatment** in rural northern New England
- Discuss differences **between rural practitioner and stakeholder beliefs** about medications for opioid use disorder
- Describe **rural first responders' beliefs** about medications for opioid use disorder

UVM CORA's Mission

UVM CORA aims to expand substance use treatment capacity in rural communities by providing consultation, resources, training, and evidence-based technical assistance to healthcare providers and community partners.

PCSS Providers Clinical Support System

UVM CORA's Objective

Leverage expertise in evidence-based practices for treating OUD and other SUDs to:

- **IDENTIFY** real-time needs of rural communities and science-supported methods for effectively addressing substance use treatment needs.
- **DELIVER** ongoing technical assistance and workforce training to support the effective use of best practices for assessing and treating rural patients.
- **DISSEMINATE** education and resources on evidence-based treatment and prevention to rural providers and policymakers.

UVM CORA Priority Areas

KEY

= Maine Rural Counties

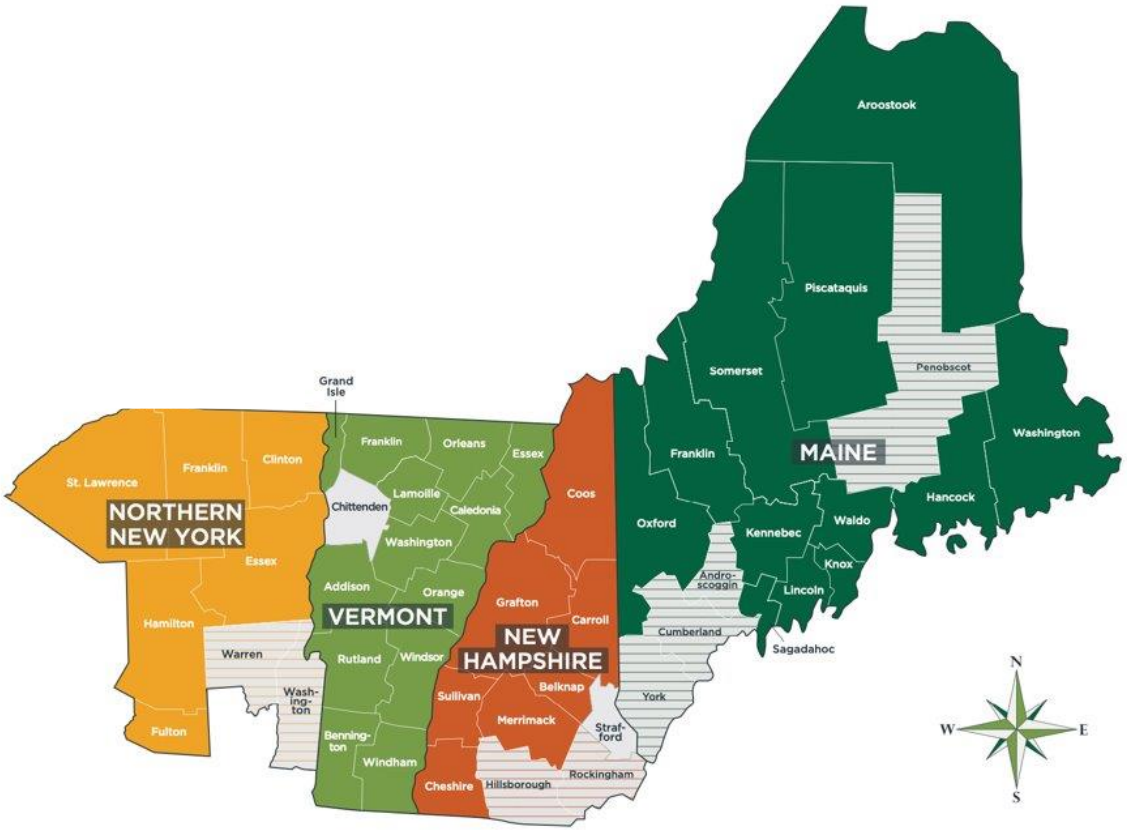
= New Hampshire Rural Counties

= Vermont Rural Counties

= Northern NY Rural Counties

*The University of Vermont Center on Rural Addiction focuses its work on HRSA-designated rural counties in Vermont, New Hampshire, Maine, and northern New York, but the Center is also designed to provide services to non-rural counties and nationally.

Stripes indicate county is partially rural.



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UVM CORA's Four Cores

SURVEILLANCE & EVALUATION

- Conducts baseline needs assessments to identify real-time needs and barriers in rural communities
- Monitors drug use patterns in rural communities
- Disseminates data to rural practitioners and community partners

BEST PRACTICES

- Provides technical assistance to support rural practitioners and community partners in implementing evidence-based practices
- Provides supplies, resources, and training in new and expanded models of care and delivery

EDUCATION & OUTREACH

- Develops and disseminates resources on effective treatment and prevention
- Provides presentations and educational resources to rural practitioners and community partners
- Produces Community Rounds Workshop Series

CLINICAL & TRANSLATIONAL

- Provides clinical expertise and consultation in evidence-based treatment and patient-centered care coordination
- Administers scholarship program for rural practitioners and staff
- Facilitates clinician office hours to support rural practitioners

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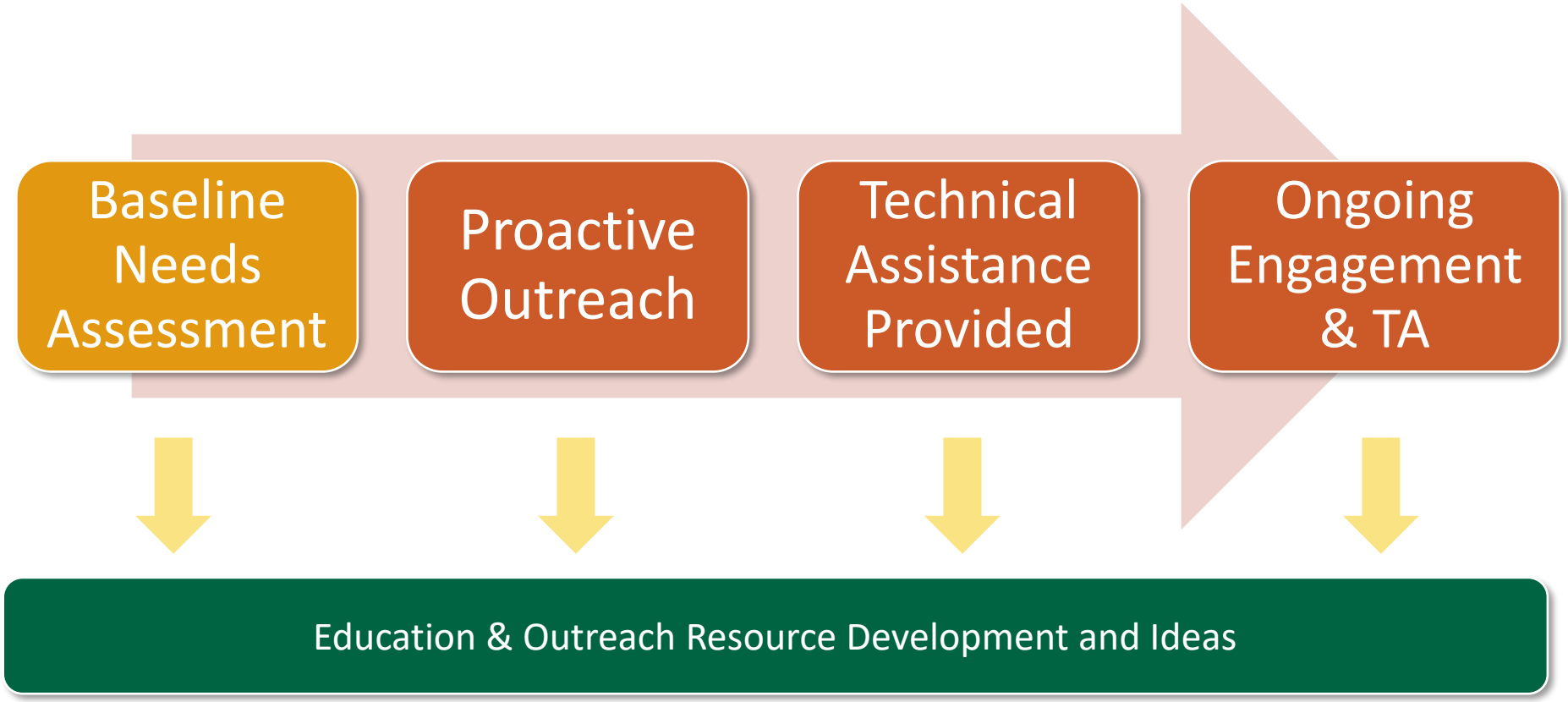
UVM CORA: STATE BY STATE



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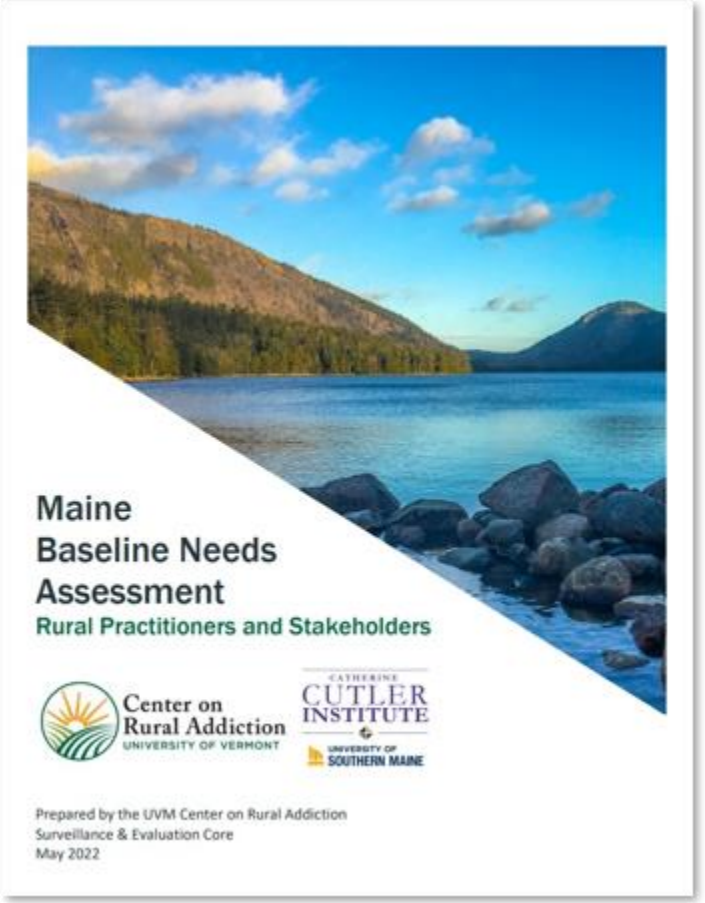
Surveillance & Evaluation Core

- Identifies substance use treatment needs and barriers in rural communities
- Gathers insights from practitioners, community stakeholders, and people and families affected by OUD through quantitative and qualitative data collection
- Monitors drug use patterns in rural communities
- Disseminates data to rural practitioners and partners
- Evaluates and informs UVM CORA technical assistance and outreach

Baseline Needs Assessments

- Statewide surveys in **Vermont** (2020), **New Hampshire** (2020-2021) and **Maine** (2021)
- **Northern New York** survey in the field (2023)
- Areas Addressed:
  - Substance use concerns
  - Barriers to treatment
  - Comfort treating substance use disorders
  - Beliefs about treatment
  - Impacts of COVID-19 on substance use
  - UVM CORA Resources that would be useful to practitioners
- Data reports: **uvmcora.org/resources**



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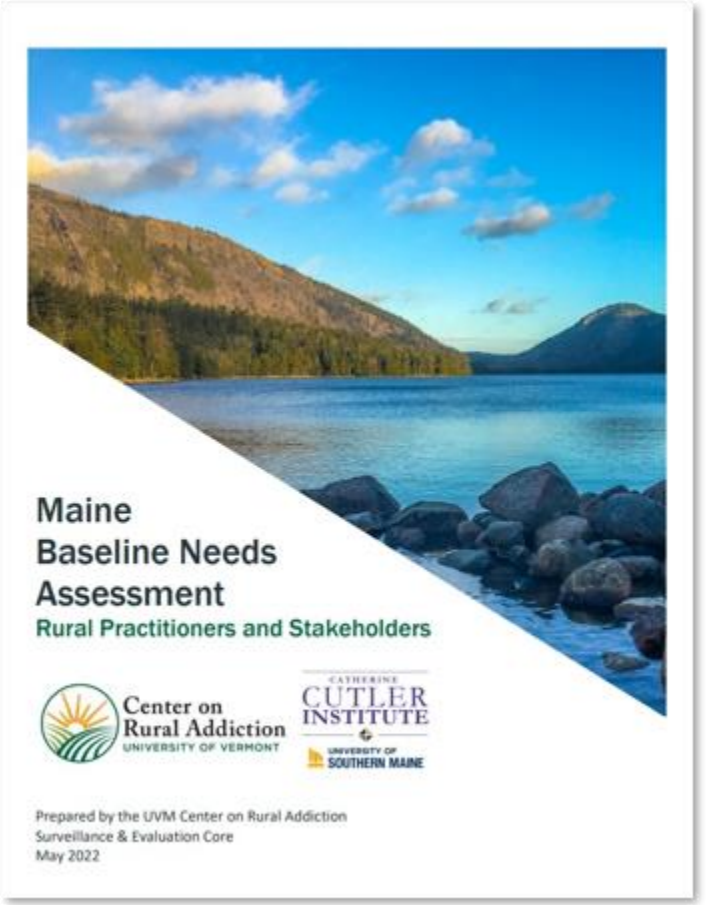

Needs Assessment Respondent Roles

Practitioners

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurses
- Pharmacists
- Counselors

Stakeholders

- Emergency Medical Technicians
- Firefighters
- School Nurses
- State Agency Staff
- Healthcare Organization Staff
- Mental Health Organization Staff
- Legislators

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Needs Assessment Methods

Vermont

Survey Administration:

- April – May 2020
  Primarily rural
- July – August 2020
  Primarily non-rural

Response Rate:

- Practitioners: 26%
- Stakeholders: 29%

New Hampshire

Survey Administration:

- Oct 2020 – March 2021
  Rural and non-rural

Response Rate*:

- Practitioners: 65%
- Stakeholders: 70%

Maine

Survey Administration:

- April – June 2021
  Rural and non-rural

Response Rate:

- Practitioners: 30%
- Stakeholders: 13%

***Note:** In New Hampshire, we used a contact survey rather than email distribution lists. New Hampshire response rates are calculated using valid contact survey respondents as the denominator.

Rural Respondents

	Vermont	New Hampshire	Maine	Total
All Rural Practitioners	202	81	174	**457**
Prescribing clinicians (e.g., MD, NP)	198	28	160	364
Buprenorphine-waivered	70	15	149	234
Non-waivered	102	9	8	119
Unknown waiver status	16	4	3	23
Non-prescribing clinicians (e.g., RN)	4	11	8	43
Counselors	0	42	6	48
All Rural Community Stakeholders	92	74	138	**304**
First responders (e.g., EMS)	41	3	60	104
Other (e.g., school staff, policymakers)	51	71	78	200
				761

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Substance Concern Questions

Practitioners: How concerned are you about use of the following substances among your patients or in your practice?

Stakeholders: How concerned are you about use of the following substances in the community in which you work?

Scale: 0-10 0: Not at all concerned 10: Extremely concerned

Opioids
- Heroin
- Prescription opioids
- Fentanyl/synthetic opioids

Stimulants
- Cocaine
- Methamphetamine
- Prescription stimulants

Sedatives
- Benzodiazepines and other sedatives

Common Substances
- Alcohol
- Cannabis
- Tobacco/e-cigarettes

Other Drugs
- Other street drugs
- Misuse of over-the-counter or other prescription medications

Combinations
- Opioids and alcohol
- Opioids and sedatives
- Opioids and stimulants

Concern About Substances

Rural Practitioners (n=457)		Rural Stakeholders (n=304)	
Top substances of concern	**Mean**	**Top substances of concern**	**Mean**
Opioids + alcohol	7.4	Fentanyl	7.8
Tobacco or e-cigarettes	7.2	Heroin	7.5
Opioids + benzodiazepines	7.2	Opioids + alcohol	7.5
Alcohol	7.1	Prescription opioids	7.3
Fentanyl	7.1	Opioids + stimulants	7.2

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Fentanyl	7.1	Opioids + stimulants	7.2

Concerns About Substances

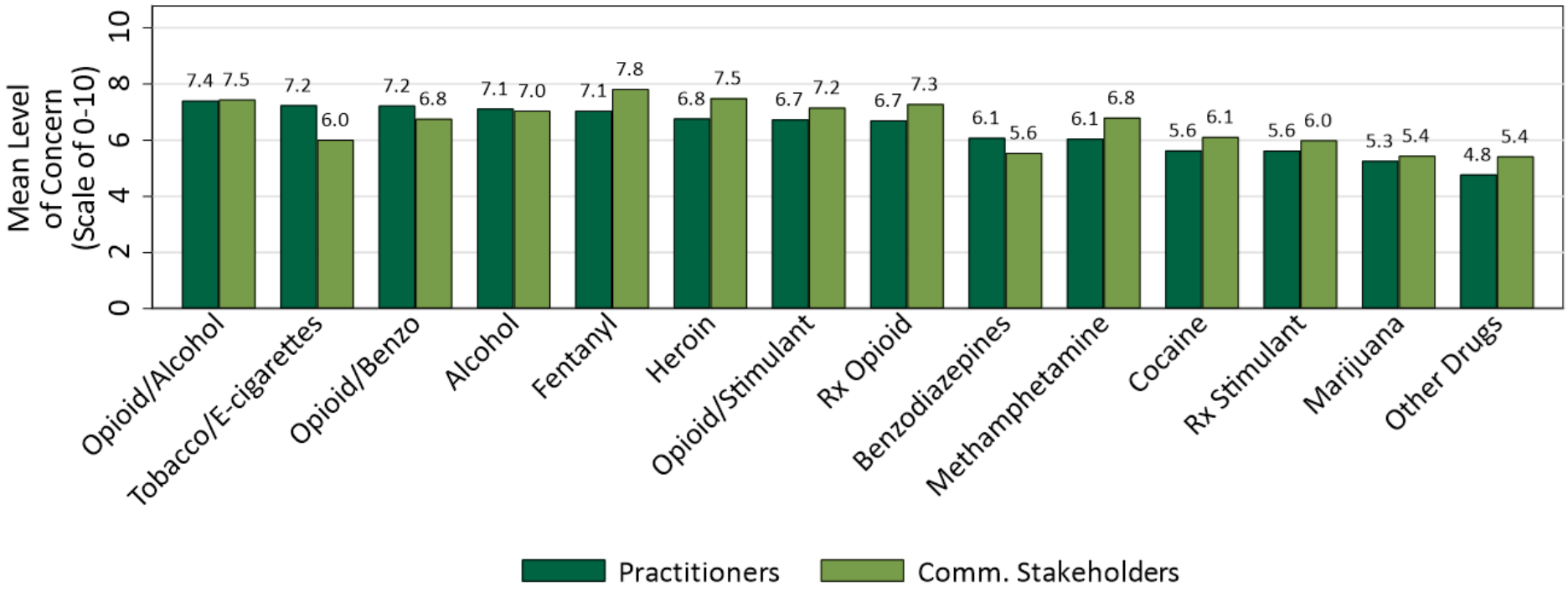

Figure 1. Mean level of concern regarding patient use of substances among practitioners (n=457) and community stakeholders (n=304) working in rural Vermont, New Hampshire, and Maine.

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Concerns

"Mixing of prescription drugs and alcohol."
– NH Stakeholder

"There has been an increase in poly-substance use [during COVID-19]."
– NH Stakeholder

"Alcohol is still the most abused substance."
– VT Stakeholder

"[We are] seeing a lot more crystal meth use in the last year."
– ME Practitioner

"[We are] seeing a lot more crystal meth use in the last year."
– ME Practitioner

Barriers and Challenges

Practitioners

Question 1:

Please rank the top three responses you view as **patient-related** barriers to receiving treatment for their opioid use disorder in your practice.

Question 2:

Please rank the top three **provider-related** barriers to treating patients with opioid use disorder in your practice.

Stakeholders

Question 1*:

Please select the three areas you see as the greatest challenges to treating opioid use disorder in the community in which you work.

*Response options included **patient-** and **practitioner-related** barriers.

Barriers to Opioid Use Disorder Treatment

Rural Practitioners (n=438)				**Rural Stakeholders** (n=273)	
Patient-related Barriers	**n %**	**Practitioner-related Barriers**	**n %**	**Stakeholder-identified Challenges**	**n %**
Time, transportation, or housing	358 82%	Time or staffing constraints	232 53%	Time, transport, childcare	139 51%
Stigma	236 54%	Medication diversion concerns	203 47%	Not enough care coordination	105 38%
Insurance issues	164 37%	Patient management concerns	161 37%	Difficulty with treatment adherence	97 36%
Concerns about treatment or health issues	163 37%	Organizational or clinic barriers	156 36%	Not enough treatment capacity	91 33%
Parenting or family demands	129 29%	Lack of training or experience	149 34%	Stigma	87 32%

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Other Research

THE AMERICAN JOURNAL OF DRUG AND ALCOHOL ABUSE
2020, VOL. 46, NO. 3, 273–288
https://doi.org/10.1080/00952990.2019.1694536

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REVIEW

OPEN ACCESS Check for updates

A systematic review of rural-specific barriers to medication treatment for opioid use disorder in the United States

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[a]School of Social Work, Rutgers University, New Brunswick, NJ, USA; [b]School of Medicine, Department of Psychiatry and Behavioral Neurosciences, Wayne State University, Detroit, MI, USA; [c]School of Social Work, University of Michigan, Ann Arbor, MI, USA; [d]Department of Psychology, Wayne State University, Detroit, MI, USA; [e]Department of Psychiatry, University of Michigan, Ann Arbor, MI, USA

ABSTRACT

Background: Opioid-related deaths have risen dramatically in rural communities. Prior studies highlight few medication treatment providers for opioid use disorder in rural communities, though literature has yet to examine rural-specific treatment barriers.
Objectives: We conducted a systematic review to highlight the state of knowledge around rural medication treatment for opioid use disorder, identify consumer- and provider-focused treatment barriers, and discuss rural-specific implications.
Methods: We systematically reviewed the literature using PsycINFO, Web of Science, and PubMed databases (January 2018). Articles meeting inclusion criteria involved rural samples or urban/rural comparisons targeting outpatient medication treatment for opioid use disorder, and were conducted in the U.S. to minimize healthcare differences. Our analysis categorized consumer- and/or provider-focused barriers, and coded barriers as related to treatment availability, accessibility, and/or acceptability.
Results: Eighteen articles met inclusion, 15 which addressed consumer-focused barriers, while seven articles reported provider-focused barriers. Availability barriers were most commonly reported across consumer (n = 10) and provider (n = 5) studies, and included the lack of clinics/providers, backup, and resources. Acceptability barriers, described in three consumer and five provider studies, identified negative provider attitudes about addiction treatment, and providers' perceptions of treatment as unsatisfactory for rural patients. Finally, accessibility barriers related to travel and cost were detailed in four consumer-focused studies whereas two provider-focused studies identified time constraints.
Conclusions: Our findings consistently identified a lack of medication providers and rural-specific implementation challenges. This review highlights a lack of rural-focused studies involving consumer participants, treatment outcomes, or barriers impacting underserved populations. There is a need for innovative treatment delivery for opioid use disorder in rural communities and interventions targeting provider attitudes.

ARTICLE HISTORY
Received 14 July 2019
Revised 22 October 2019
Accepted 14 November 2019

KEYWORDS
Rural; opioid; medication treatment; barriers; United States; review

Background

Between 2015 and 2016, the synthetic opioid death rate doubled in the United States, and from 2010 to 2016, heroin-related deaths increased 400% (1). These concerning trends mirror rises in overdose-related deaths in other countries like Australia and Canada (2,3). Within the United States, these issues are particularly pronounced in rural communities, where overdose-related deaths increased most dramatically, and by 2015 surpassed the urban overdose-death rate (4). As a result, the White House declared a Public Health Emergency (5), identifying a critical need for expanded availability of medication treatment for opioid use disorder (OUD) in rural communities (6). Similar messages have been put forth across the international literature, documenting the need to expand access to medication treatment and emergency opioid-overdose reversal medications, particularly in rural areas (7–10).

Medication treatment, the gold-standard approach for treating OUD (11–13), uses medications (buprenorphine, methadone, or naltrexone) alongside concurrent psychosocial treatment (14,15). However, the availability and implementation of medication treatment in rural U.S. communities is limited (16). This treatment gap is consistent with research demonstrating the limited availability of other evidence-based treatments in the rural U.S., including mental and behavioral health treatments (17) and services sought in specialty hospital settings (18).

In addition to the limited availability of medication treatment in rural communities, prior research reveals rural residents are more likely (than urban) to

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A 2020 systematic review by Lister *et al.* describes patient and provider opioid treatment barriers in the following categories:

- **Availability**
- **Accessibility**
- **Acceptability**

Lister, J *et. al.* (2020) A systematic review of rural-specific barriers to medication treatment for opioid use disorder in the United States, The American Journal of Drug and Alcohol Abuse, 46:3, 273-288, DOI: 10.1080/00952990.2019.1694536

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Other Research

Table 5. Barrier domains focused on consumers and providers.

	% (n)	Most common barrier type	Other barriers
Consumer-Focused Barrier Domains (N = 15 articles)			
Availability	66.7 (10)	• Rural areas consistently more likely (than urban) to lack available medication treatment clinics and waivered practitioners	• Rural areas less likely to have concurrent psychosocial services for consumers in medication treatment
Accessibility	26.7 (4)	• Rural consumers more likely than urban to have travel hardships (further distance, longer travel, cross-state commute)	• Rural providers perceived their rural consumers would view medication treatment as a cost burden
Acceptability	20.0 (3)	• Rural consumers offered medication treatment less than urban, perhaps due to concerns treatment wouldn't work well for rural consumers	• Rural providers perceived their rural consumers would view medication treatment for OUD as unsatisfactory
Provider-Focused Barrier Domains (N = 7 articles)			
Availability	71.4 (5)	• Rural providers cited limited capacity and infrastructure, e.g., lack of staff, specialty backup, and office space	• Lack of coordination, i.e., non-family medicine rural clinics less likely to provide BMT
Accessibility	28.6 (2)	• A lack of time for rural providers to deliver medication treatment	• No other findings
Acceptability	71.4 (5)	• Negative provider attitudes: a lack of belief in medication treatment, too complex, view people with SUDs as mistrustful and unmotivated	• Regulatory concerns if providing treatment, e.g., audit issues or inability to meet DEA regulations

Barriers

"We have no treatment centers within our community, so having even one would be an improvement."

– ME stakeholder

"Transportation is a huge issue. We have no reliable public transport."

– ME practitioner

"[We need] more MAT providers in primary care settings."

– NH stakeholder

"[We need] consistently accessible community resources for counseling/ social work support, especially for un/under-insured patients"

– NH practitioner

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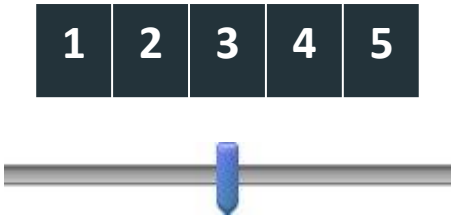
Beliefs about MOUD

Zoom Poll

To what extent do you agree with the following statement?

Scale: 1-5 (1: Strongly Disagree, 5: Strongly Agree)

Medications (like methadone, buprenorphine, and naltrexone) are the most effective way to treat people with opioid use disorder.



Beliefs about MOUD
Rural Practitioners and Community Stakeholders

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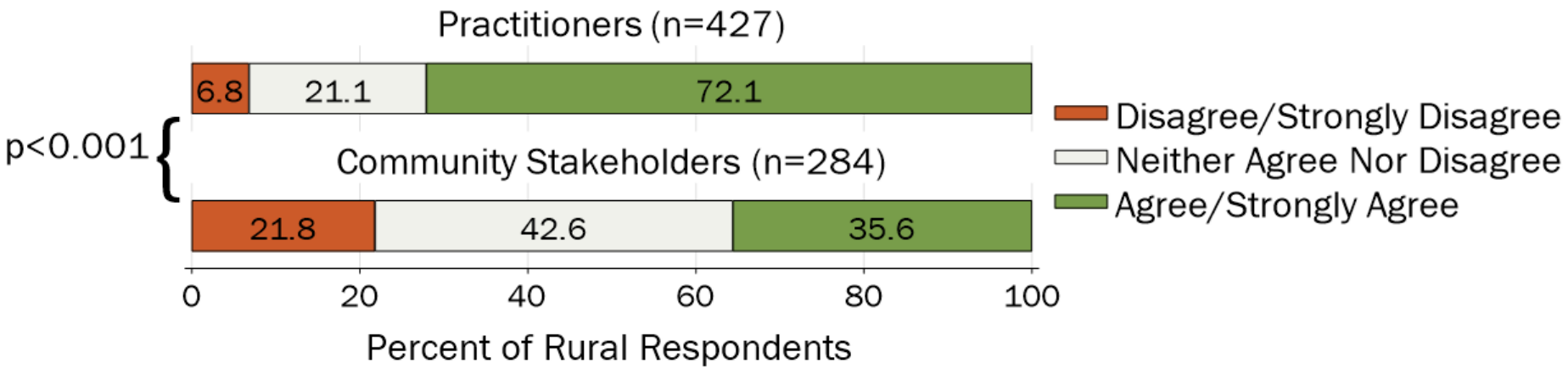


Efficacy of MOUD

MOUD are safe, evidence-based, and the most effective way to treat people with opioid use disorder.

- **Buprenorphine**, **methadone**, and **naltrexone** are safe and FDA-approved for treatment of OUD.
- Randomized clinical trials have demonstrated that MOUD are more effective for treatment of OUD than treatment without MOUD.

https://nida.nih.gov/videos/medications-opioid-use-disorder-video

Treatment with **methadone** or **buprenorphine** also **reduces the risk of death from opioid overdose.**

For more information*:*

UVM CORA MOUD Resource Guide

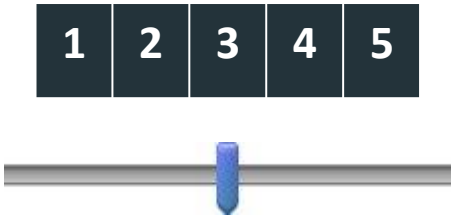
Beliefs about MOUD

Thought Question

To what extent do you agree with the following statement?

Scale: 1-5 (1: Strongly Disagree, 5: Strongly Agree)

Medications given to treat people with opioid use disorder (specifically methadone and buprenorphine) replace addiction to one kind of drug with another.



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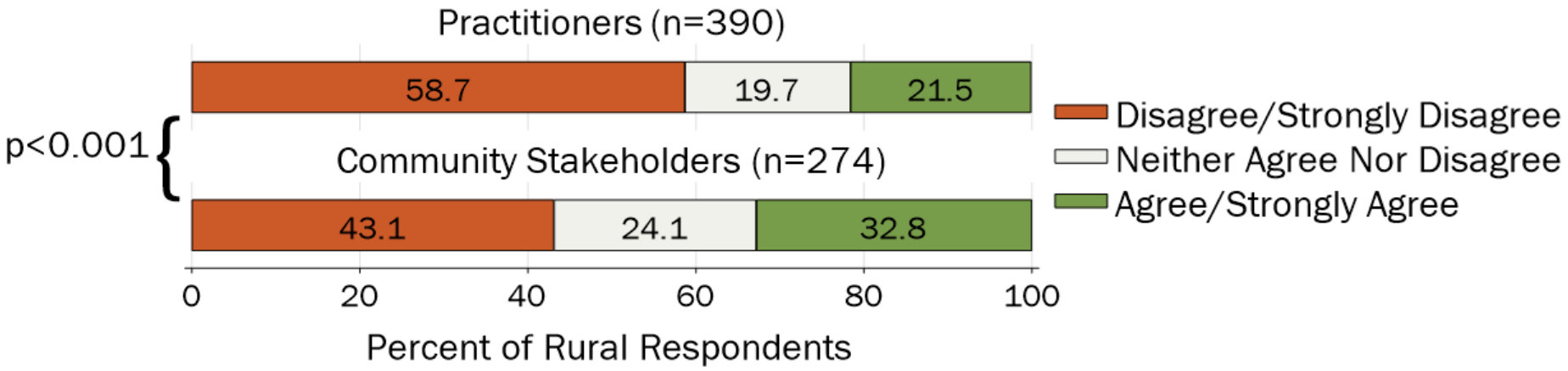

Is MOUD Use an Addiction?

Thought Question

How would you define **Addiction?**

"**Addiction** is… "

Is MOUD Use an Addiction?

Addiction is "*a chronic, relapsing disorder characterized by compulsive drug seeking and use* ***despite adverse consequences***."

(Adapted by NIDA from DSM-5)

Is MOUD Use an Addiction?

Addiction is "*a chronic, relapsing disorder characterized by compulsive drug seeking and use* ***despite adverse consequences***."

Illicit Opioids: Safety

- Unknown contents/adulterants
- Irregular dosage, frequency, timing, duration of use
- Unsafe administration is likely (e.g., self-injection, smoking)
- Inconsistent access
- Substantial risk of overdose
- Physiological dependence

Prescribed MOUD: Safety

- Known active ingredient(s); quality control
- Dosage, frequency, timing, duration of use determined in a clinical setting
- Safe administration is likely (e.g., oral, sub-lingual, injection by medical staff)
- Consistent, predictable access
- Negligible risk of overdose
- Physiological dependence

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Is MOUD Use an Addiction?

Addiction is "*a chronic, relapsing disorder characterized by compulsive drug seeking and use* ***despite adverse consequences***."

- **Physiological dependence** (i.e., medication tolerance, withdrawal symptoms) in the context of appropriate medical treatment **is not** a diagnostic criterion for substance use disorder.

  https://www.ncbi.nlm.nih.gov/books/NBK565474/table/nycgsubuse.tab9/

- Research shows that initiation of treatment with MOUD **improves physical, psychological, and social quality of life.**

  https://pubmed.ncbi.nlm.nih.gov/35430522/

Beliefs about MOUD
Rural Practitioners and Community Stakeholders

"Methadone needs to be taken away."
– ME stakeholder

"[The] most important improvements are in policy and legislation—buprenorphine should be free of cost and access not restricted by X-waiver requirements."
– NH practitioner

"We need to think of treatment in combination with prevention, intervention, harm reduction, and recovery. Just focusing on one of these will never solve the issues at hand."
– VT stakeholder

"With lifelong methadone maintenance or Suboxone use, the patient is just enslaved to another system, this time the medical system for their entire life."
– VT practitioner

Beliefs about MOUD
First Responders and Other Stakeholders

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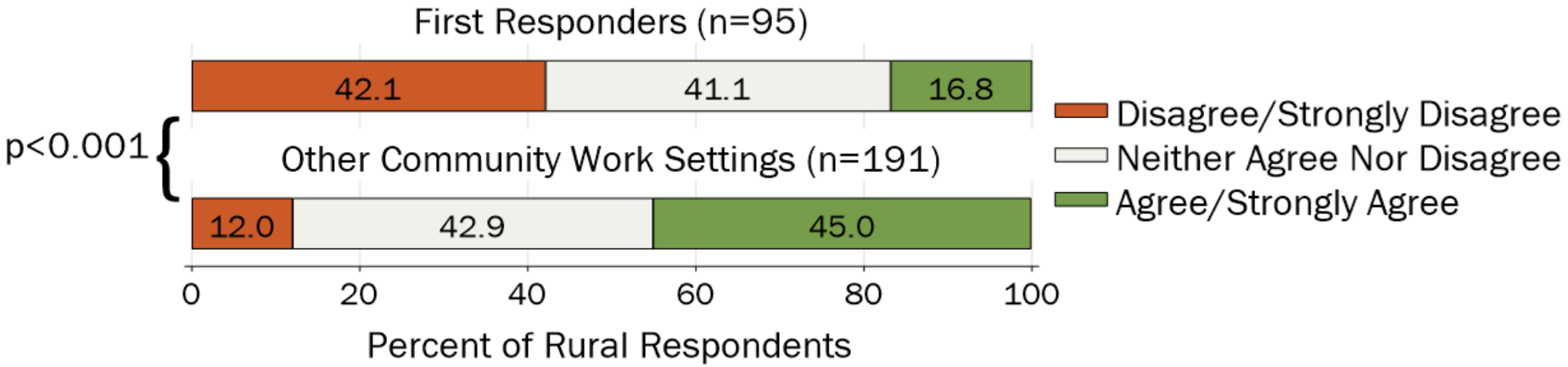

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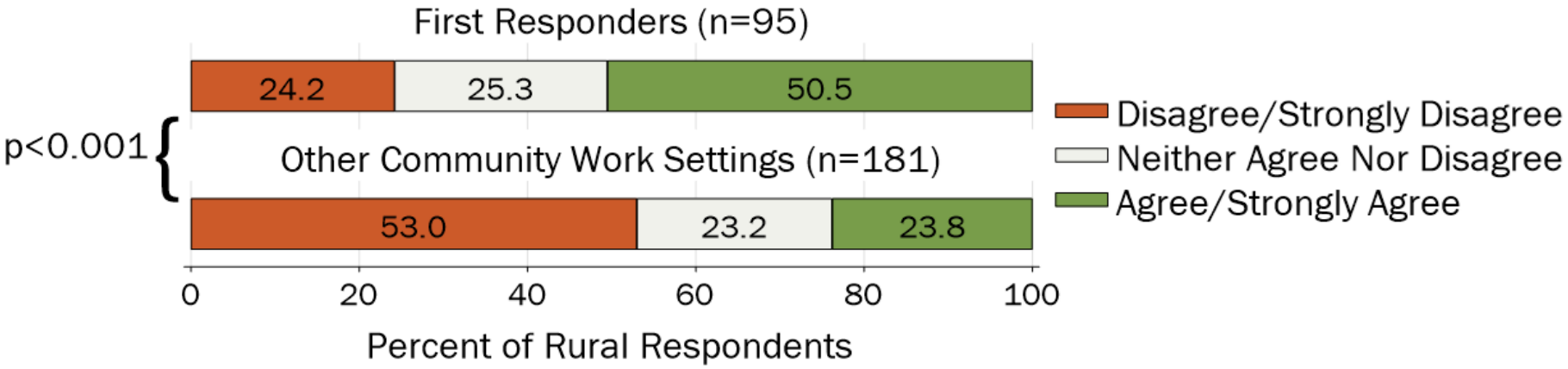

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Beliefs about MOUD
First Responders and Other Stakeholders

"Vermont needs to support EMS with Narcan [to] give away to addicts."
– VT first responder

"First responders need more education about opioid/ substance abuse and its treatment."
– ME stakeholder

"My awareness is by 'crisis' situations when responding with ambulance."
– ME first responder

"Inadequate access to treatment and the continuation of inappropriate prescribing of opiates is destroying our communities."
– ME first responder

"[We need] a collaborative approach involving tribal & regional health systems, EMS & law enforcement."
– ME stakeholder

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Most Important Improvement
to Increase OUD Treatment Access

Thought Question

Please respond in the chat.

What would you recommend as the SINGLE most important improvement to increase access to opioid use disorder treatment in your community?

Please note your profession and whether you primarily work in a rural or non-rural area.

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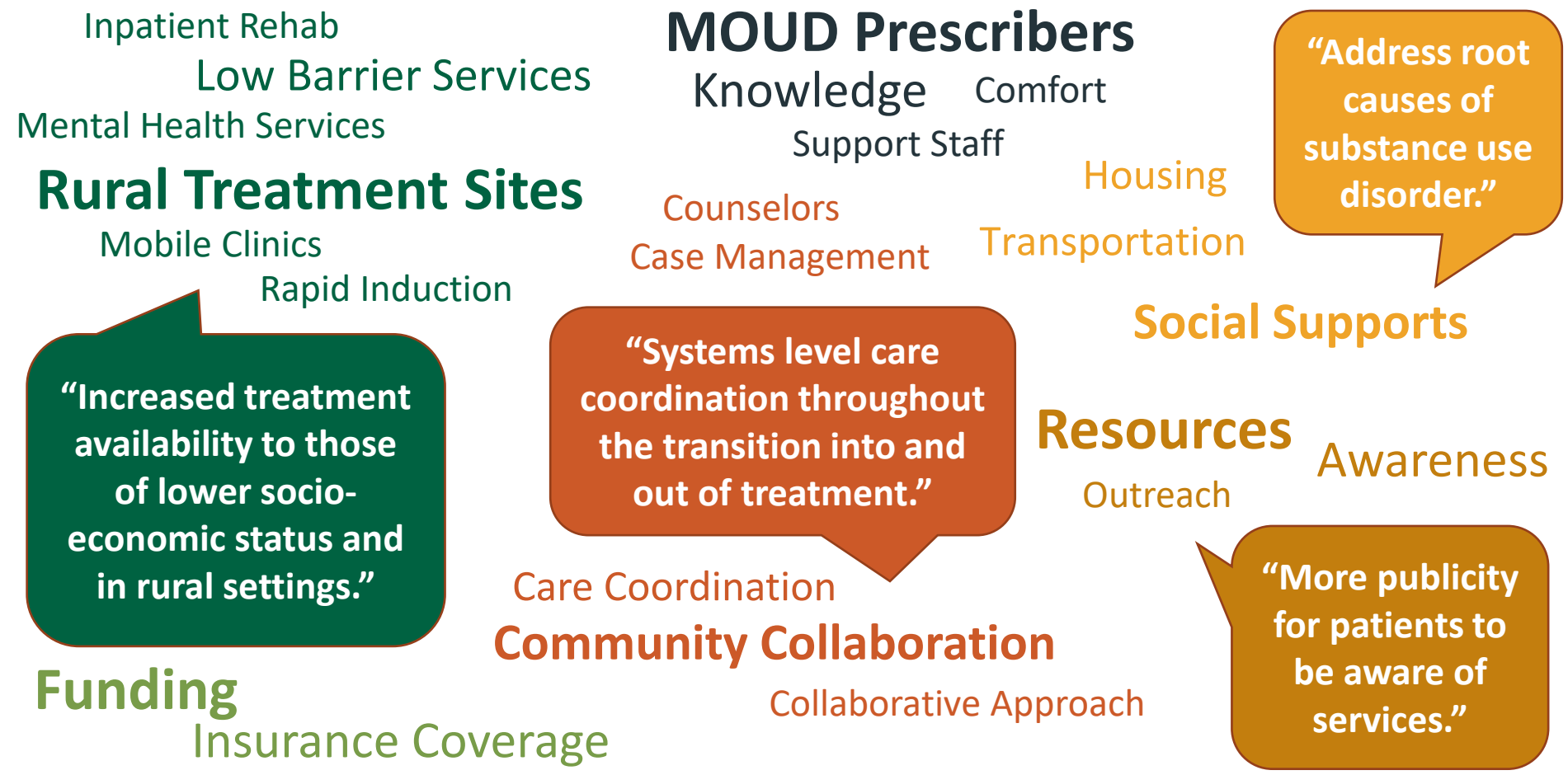
Most Important Improvement
to Increase OUD Treatment Access



Themes

Social Determinants

Transportation Housing Insurance Childcare

Stigma

Polysubstance Use

Fentanyl Sedatives Stimulants Alcohol Tobacco

Capacity

Providers Staff Care Coordination

Inpatient Outpatient Detox

Knowledge

Theme: Stigma

Barrier reported by:

- Practitioners
- Stakeholders

Beliefs of:

- Practitioners
- Stakeholders
- First Responders

Center on Rural Addiction
UNIVERSITY OF VERMONT

Identifying Substance Use Disorder Bias and Addressing Stigma in the Clinical Setting

Peter Jackson, MD
Recording + Slides

Pregnancy, Parenting, and Substance Use: Stigma, Fear, and a Call for Improved Messaging

Marjorie Meyer, MD
Recording + Slides

UR MEDICINE
Recovery Center of Excellence
Taking Action

National Rural Substance Use Disorder Health Equity and Stigma Summit

Information + Recordings

PCSS Providers Clinical Support System

Changing Language to Change Care: Stigma and Substance Use Disorder

Sarah E. Wakeman, MD, FASAM

Link

Theme: Polysubstance Use

Opioids plus:

- Alcohol
- Sedatives
- Stimulants

Fentanyl

Alcohol

Tobacco/

e-Cigarettes

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Panel: Alcohol Use Disorder in the Primary Care Setting: Best Practices for Rural Communities
Recording + Slides

Treatment of Stimulant Use Disorders
Rick Rawson, PhD
Recording + Slides

SBIRT for Unhealthy Alcohol Use
Gail Rose, PhD
Recording + Slides

Contingency Management
Provider Training Video

PCSS Providers Clinical Support System

Management of Other Substance Use Co-occurring with Opioid Use Disorder: Benzodiazepines, Cocaine and Amphetamines, and Cannabis; Pharmacotherapy for Alcohol Use Disorder
Edward V. Nunes, MD
Link

Pharmacotherapy for Alcohol Use Disorder
Larissa Mooney, MD
Link

Theme: Social Determinants

Patient barriers:

- Stable housing
- Transportation
- Technology for telehealth

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Social Determinants of Mental Health and Substance Use

Brady Heward, MD

Recording + Slides

Technical Assistance

uvmcora.org/request-support/

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Opioid Use Disorder and Social Determinants of Health

Rachel Talley, MD, and Jessica Isom, MD

Link

Theme: Capacity

Treatment Barriers:

- Treatment capacity
- Care coordination
- Co-occurring conditions

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Telehealth for Substance Use Disorders and Considerations for Rural Regions
Allison Lin, MD, MSc
Recording + Slides

Use of Sustained Release Buprenorphine (SRB) in the Outpatient Setting
John Brooklyn, MD
Recording + Slides

Treatment and Assessment of Co-occurring PTSD and SUDs
Kelly Peck, PhD
Recording + Slides

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Managing Common Psychiatric Conditions in Primary Care

John A. Renner, Jr., MD

Link

Theme: Knowledge

Barrier:

- Training and support

Desire for:

- Training
- Mentorship
- Resources
- Support

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Clinician Office Hours

Scholarship Program – Fall 2023

Other Resources

Community Rounds Webinars, Resource Guides, Research Spotlights, Data Reports

uvmcora.org/resources

PCSS Providers Clinical Support System

Provider's Clinical Support System

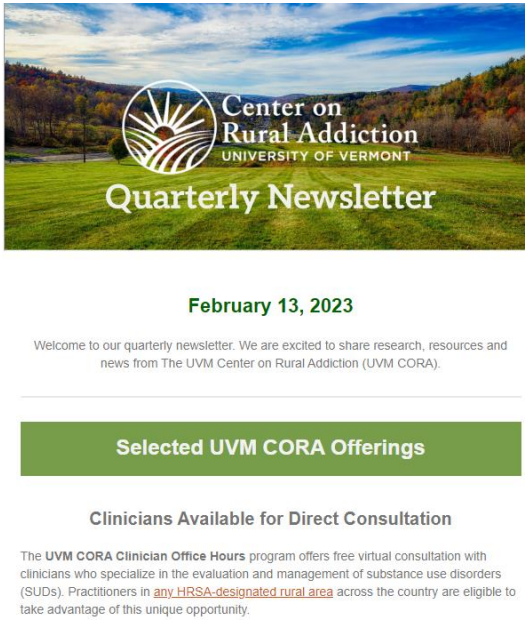
https://pcssnow.org/

Takeaways

- Rural practitioners and stakeholders reported **high concern about substance use**, particularly opioids, polysubstance combinations, alcohol, and tobacco.
- **Patient barriers** to OUD treatment in rural northern New England include lack of transportation, childcare, and stable housing; stigma; and insufficient capacity of the treatment system.
- **Provider barriers** to providing OUD treatment include time and staffing constraints, concern about patient management and treatment adherence, and lack of training or experience.
- While most rural practitioners believe that **MOUD are the most effective way to treat people with OUD**, some practitioners and many stakeholders do not.
- Half of rural first responders, a quarter of other stakeholders, and more than 15% of practitioners reported **believing that MOUD replace one addiction with another**.

Thank you!

Questions



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PCSS Providers Clinical Support System

PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

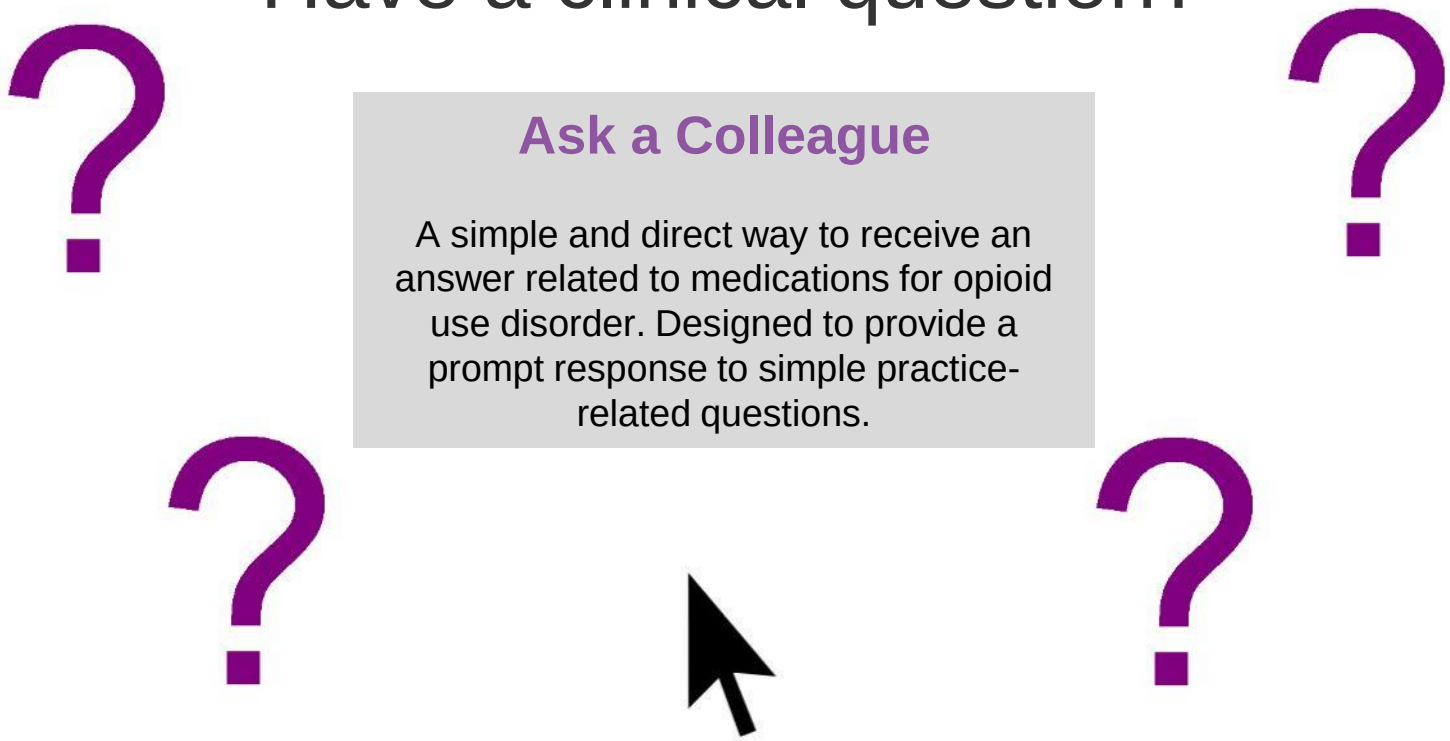
For more information visit:

https://pcssNOW.org/mentoring/

PCSS Providers Clinical Support System

PCSS Discussion Forum

Have a clinical question?



Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register

PCSS Providers Clinical Support System

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PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

Addiction Technology Transfer Center	American Society of Addiction Medicine
American Academy of Family Physicians	American Society for Pain Management Nursing
American Academy of Pain Medicine	Association for Multidisciplinary Education and Research in Substance use and Addiction
American Academy of Pediatrics	Council on Social Work Education
American Pharmacists Association	International Nurses Society on Addictions
American College of Emergency Physicians	National Association for Community Health Centers
American Dental Association	National Association of Social Workers
American Medical Association	National Council for Mental Wellbeing
American Osteopathic Academy of Addiction Medicine	The National Judicial College
American Psychiatric Association	Physician Assistant Education Association
American Psychiatric Nurses Association	Society for Academic Emergency Medicine

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