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

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

John Gale, MS

National Rural Health Resource Center
SHRT HELP Webinar
January 10, 2018
Acknowledgements

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Learning Objectives

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

• If you have seen one rural community......

• It takes a village - Community engagement and involvement are central to addressing O/SU

• Hospitals can play a central role addressing O/SU
  – Community benefit/CHNA obligations
  – Leadership role in the community
  – An important population health issue

• Models must be adapted to the geographic, resource, and cultural realities of rural areas
Important Strategy Area # 1 - Prevention

- Opioid harms extend to all users not just those using heroin or misusing prescription medications
- Discourage/delay onset of O/SU
- Focus on children, adolescents, and young adults
- Minimize related high risk behaviors
- Strategies can be external and community focused
  - Community organizing and education
- Internal, quality oriented activities
  - Reducing supply of opioids prescribed
  - Use of prescription drug monitoring programs
  - Offer alternative pain-management strategies
  - Provide opportunities to dispose of unneeded medications
Important Strategy Area # 2 - Treatment

- Implement consistent O/SU screening for all patients
  - Screening, brief intervention, and referral to treatment
- Develop referral relationships with SU/MH providers
- Explore local treatment opportunities
  - Medication assisted treatment – buprenorphine
  - Integrated behavioral health/SU/primary care services
  - Specialty substance use services
- Collaborative treatment programs – hub and spoke
- Overdose reversal programs
- Develop alternative pain management programs
- Work with law enforcement to provide a treatment alternative to incarceration
Important Strategy Area # 3 - Recovery

- The third and often overlooked strategy to address O/SU disorders
- Provide support through programs or a structured milieu to support sobriety and substance free living
- Ideally, recovery begins before treatment
- Addresses social, rehabilitation, and vocational issues
- Provides a community to reinforce sobriety
Rural O/SU in the United States

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

- Social Change
- Substance Use Disorders
- Neighbourhood Factors
- Environmental Events
- Socioeconomic Status
Barriers to Treatment in Rural Communities

- Fewer Facilities
- Geographic Barriers
- Lower Treatment Access in Rural Areas
- Limited Public Transportation
- Less Anonymity
- Stigmatization and Criminalization
## Categories of Misused Substances

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>• Beer, wine, malt liquor, distilled spirits</td>
</tr>
<tr>
<td>Illicit drugs</td>
<td>• Cocaine, including crack</td>
</tr>
<tr>
<td></td>
<td>• Heroin</td>
</tr>
<tr>
<td></td>
<td>• Hallucinogens</td>
</tr>
<tr>
<td></td>
<td>• Methamphetamines, including crystal meth</td>
</tr>
<tr>
<td></td>
<td>• Marijuana, including hashish</td>
</tr>
<tr>
<td></td>
<td>• Synthetic drugs, including K2, Spice, and “bath salts”</td>
</tr>
<tr>
<td></td>
<td>• Prescription medications used for nonmedical purposes</td>
</tr>
<tr>
<td></td>
<td>o Pain Relievers - synthetic, semi-synthetic, and non-synthetic opioid medications</td>
</tr>
<tr>
<td></td>
<td>o Tranquilizers and muscle relaxants</td>
</tr>
<tr>
<td></td>
<td>o Stimulants and methamphetamine</td>
</tr>
<tr>
<td></td>
<td>o Sedatives and any barbiturates</td>
</tr>
<tr>
<td>Over the counter drugs and other substances</td>
<td>• Cough and cold medicines</td>
</tr>
<tr>
<td></td>
<td>• Inhalants, including amyl nitrite, cleaning fluids, gasoline and lighter gases, anesthetics, solvents, spray paint, nitrous oxide</td>
</tr>
</tbody>
</table>
Rural Place as a Driver of SUDs

• Rural places suffer from a variety of health and socio-economic disparities
  – Greater sense of stigma
  – Higher sense of isolation and hopelessness
  – Lower education rates
  – Higher rates of poverty
  – Fewer opportunities for employment
  – Higher rates of chronic illnesses

• Influence of cultural, ethnic, religious differences
Why Should Hospitals Engage in O/SU initiatives?

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

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

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

• Well supported scientific evidence for robust risk and prevention factors that predict O/SU use

• Evidence-based (EB) prevention programs effectively prevent initiation, harmful use, and related problems

• Prevention is cost-effective at different stages of the lifespan from infancy to adulthood

• Communities and populations have different levels of risk, protection, and O/SU

• Communities are an important organizing force for bring effective EB prevention programs to scale

• Key: Cross sector community coalitions to assess local risk and protective factors, O/SU problems, and implement EB interventions to match local priorities
Prevention

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

- Community Organization and Engagement
- Prescriber education and behavior
- Supply reduction and diversion control
- Pain patient services and drug safety
- Drug treatment and demand reduction
- Harm reduction
- Community-based prevention education
Evidence-based community organizing models

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

• Project Vision, Rutland, VT
  – Uses a Drug Market Intervention model and community collaboration/engagement to reduce the supply of opioids

• SAMHSA’S Recovery Oriented Systems of Care

• Communities That Care
Key elements of effective community coalitions

• Understanding the community’s needs and resources
• Widely shared and comprehensive vision
• Clear and focused strategic plan
• Diverse membership: key community leaders, local government officials, and volunteers
• Strong leadership and committed partners
• Diversified funding
• Well-managed structure: organized administration, effective communication among participants, and a comprehensive evaluation plan
Project Lazarus – Hub Activities

• Hub activities are central components supporting all other activities and reflect a community-based, bottom-up public health approach
  – Build public awareness of substance use through broad-based educational efforts and the use of local data to drive awareness
  – Coalition building and action to engage a broad range of community providers, agencies, and organizations
  – Identify data needs for planning and evaluation to build awareness, tailor programs to local needs, track progress, and sustain support and funding
Project Lazarus – Spoke Activities

• Spoke activities are optional areas of evidence-based prevention initiatives that communities can select and reflect a medical and law enforcement-based, top-down public health approach
  - Community education
  - Provider education
  - Hospital emergency department policies
  - Diversion control
  - Pain patient support
  - Addressing the consequences of use
  - Addiction treatment
Project Vision – Addressing Supply Issues

• Project Vision, Rutland, VT
  – Goals: empower communities, strengthen neighborhoods, help people, change the future
  – Committees: Crime/Safety, Substance Abuse, Community/Neighborhoods/Housing
  – Use a Drug Market Intervention model and community collaboration/engagement to reduce the supply of opioids (heroin and illicitly distributed prescription opioids) in rural Rutland VT
Community Based Prevention Education

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

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

Number of painkiller prescriptions per 100 people:
- 52-71
- 72-82.1
- 82.2-95
- 96-143

SOURCE: IMS, National Prescription Audit (NPA™), 2012.
Health care providers in different states prescribe at different levels.

Number of painkiller prescriptions per 100 people

- **Lowest**
  - NJ 63
  - NY 60
  - MN 62
  - HI 52
  - CA 57

- **Average**
  - AZ 82
  - NE 79
  - MT 82
  - WA 77
  - VA 78
  - ND 75
  - WI 76
  - TX 74
  - MD 74
  - IA 73
  - NM 74
  - CT 72
  - FL 73
  - CO 71
  - NH 72
  - WY 70
  - MA 71
  - VT 67
  - IL 68
  - AK 65
  - SD 66
  - SC 102
  - NC 97
  - OH 100
  - NV 94
  - MO 95
  - DE 91
  - KS 94
  - RI 90
  - GA 91
  - PA 88
  - OR 89
  - DC 86
  - UT 86
  - ME 85
  - ID 86
  - MS 120
  - AR 116
  - LA 118
  - MI 107
  - IN 109

- **Highest**
  - AL 143
  - WV 138
  - TN 143
  - OK 128
  - KY 128

State Abbreviation: GA 91 - Number of painkiller prescriptions per 100 people
Prescriber Education and Behaviour

- One-on-one prescriber education on pain management
- Continuing medical education on pain management
- Licensing actions against criminal prescribing
- Implement and monitor evidence-based prescribing guidelines among all providers
  - CDC guidelines, state programs such as Washington state
- **Strongly** encourage use of prescription drug monitoring programs
- Think about an “oxy free” emergency department
- Harm Reduction - Naloxone and Opioid user education on overdose prevention and response
Hospital Prevention Strategies

- Participate in community-based prevention programs as part of hospital’s community benefit and/or community/population health initiatives
- Quality improvement: Focus on supply reduction
  - Prescribing guidelines
  - Encourage greater use of prescription drug monitoring programs
  - Use Project ECHO to support prescribing and pain management capacity of local providers
  - Implement an “oxy-free” emergency department
  - Engage in harm reduction strategies
Oxy-Free Emergency Departments

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

- Initiative has helped to reduce the rates of ED visits by “frequent users” seeking opioid prescriptions by individuals with low-acuity diagnoses.

- Washington Medicaid estimated ED savings in their non-managed care population at $33.6 million after admissions.

- Evaluation shows that hospitals are pleased with this strategy but some experienced early reductions in patient satisfaction scores related to pain management.
Evidence-Based Supply Management Programs

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

- Implemented opioid prescribing guidelines for dental pain in two rural EDs in Maine
- Driven by ED chairman with input from physician group
- ED patients who request refills of controlled prescriptions, have multiple controlled substance prescriptions, or have multiple previous ED visits for painful conditions
- Guidelines recommend the use of analgesic alternatives such as nerve blocks and immobilization
- Results after 12 months - reductions in rates of opioid prescriptions and visits for dental pain
Nevada Rural Opioid Overdose Reversal Program

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

- Results
  - 117 EMTs were trained on the administration of naloxone
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“Oxy-Free” EDs – McKenzie Health System

• The “oxy free” ED was developed in Washington State
• In February 2013, McKenzie Health System's ED discontinued dispensing narcotic and sedative medications for complaints of chronic pain
• Results – 60% reduction in opioid prescription abuse within a 12 month period and reduced utilization of unnecessary and costly diagnostic work-ups
• Staff met with community mental health officials, county health officials, local primary care providers, law enforcement, pharmacies to explain the initiative
• Engaged in patient education
“Oxy-Free” EDs – McKenzie Health System (con’t)

• Process:
  – Thorough medical exam to rule out medical emergencies
  – Review of patient's complete file, including internal health records, outside health records, drug screening tests
  – If patient presents with a chronic pain condition or suspected narcotics abuses, physician will inform patient of the dangers of narcotic drug abuse and may not prescribe a narcotic pain medication
  – May receive a non-narcotic pain medication and information about O/SU programs and/or pain management specialists
  – If a narcotic pain medication is prescribed after careful review by the physician, it is only for a very limited amount of pills, until the patient can be seen by his or her physician
Reducing Opioid Prescribing by Providing Pain Management Services

• Due to the limited availability of pain management services in rural communities, many providers rely on prescription opioids as a primary treatment modality

• Rural primary care providers often have limited experience with the management of chronic pain

• Strategies
  – Expand access to pain management services through contracts and/or telehealth
  – Improve the capacity of local providers to manage pain through use of program such as Project ECHO
Expanding Local Pain Management Services: Salem Township Hospital

• Salem Township recruited a pain specialist to travel an hour from Marion, Ill., twice a month to treat patients.
  – Considering expansion to three to four times a month.
• Patients are seen in one hour increments
• Provides trigger-point injections for long-term pain and promotes physical therapy and alternative treatments
• Patients continuing with opioids must agree to regular drug tests and not ask for early refills
• Over 3 to 4 months, only 3 out of 56 patients have chosen to stick with opioids
• Investment was minimal, at about $25,000 for capital equipment
Telehealth-Based Pain Management Program: Martha’s Vineyard Hospital (MVH)

• Due to its island location off Cape Cod, MVH worked with Massachusetts General Hospital’s Center for Pain Management to offer a pain service via telehealth
• MGH providers see patients in a telepain clinic 3 days per month and conduct on-site visits twice per month
• Services include initial consults and follow-up visits
• Vital signs/patients notes are recorded in a shared EHR
• An RN, trained in physical examination of pain and medical management, performs patient exams under direct physician supervision via live videoconference and also verbally announced all findings
Telehealth-Based Pain Management Program: Martha’s Vineyard Hospital (con’t)

- Physical examinations are repeated by the physician during on-site visits prior to patient intervention.
- Laboratory data and imaging studies are reviewed in the shared HER.
- Over 13 months, 49 patients participated in 238 telepain video clinics and 121 on-site interventions.
- Patients report reduced travel costs, improved access to care, and general satisfaction with the service.
- Patients rated their satisfaction with care received by telepain lower than in-person visits and thought it harder to develop a relationship with the doctor.
- This highlights the challenge of building a patient-physician relationship remotely.
University of Washington’s Telepain Program

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

• Rural residents deserve the same level of access to the full range of substance use treatment services as urban residents

• Substance use is a chronic, relapsing disease, rather than an acute, episodic condition
  – Requires ongoing level of services
  – Reflects a primary care-based system of care framework
  – Conserves resources by matching services to patient needs using a level of care criteria
Treatment and Access Realities

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

- Poor coverage for MAT services – OTPs are cash only services in some states
- Services are often clustered around urban centers – requiring long travel distances for rural residents
- Many buprenorphine providers operate below capacity
- MAT services are not enough – substance use, mental health, care coordination are needed
- Greater attention is needed on what happens after treatment – peer support and recovery services are needed to reduce likelihood of relapse
Definition of a System of Care

• An integrated spectrum of effective, community-based services and supports for rural people and their families at risk for or struggling with drug and substance use challenges
  – Organized into a coordinated network
  – Builds meaningful partnerships with individuals and their families
  – Addresses their cultural and linguistic needs, to help them function better at home, in school, in the community, and throughout life.
Structure of Treatment Services

• Use of a regional orientation/model
• Reflects the realities of rural resource limitations
  – Uses technology (e.g., telehealth, mobile phones, etc.) to address distance barriers and maldistribution of resources across urban and rural areas
• Integration across services systems:
  – Substance use,
  – Mental health, and
  – Primary care
Principals for Treatment

• Treatment must be available, accessible, attractive, and appropriate for needs
• Ethical standards must be adhered
• Requires effective coordination between the criminal justice system and health and social services
• SUDs should be viewed as a health problem rather than criminal behavior: users should be treated in the health care rather than the criminal justice system when possible
Principals for Treatment (cont’d)

- Based on scientific evidence and respond to specific needs of individuals with drug use disorders
- Should respond to the needs of special subgroups and conditions
- Should ensure good clinical governance of treatment services and programs for drug use disorders.
- Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated
Screening for O/SUDs

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

• A Critical Access Hospital in rural Whitman County in the State of Washington

• Active participant in a 5 year grant to implement SBIRT in urban and rural Washington settings

• Findings
  – Pullman screened 87.7% of patients receiving Medicaid funded health care at least 1 month in the year prior to SBIRT screening
  – Of this group, 10.3% received a brief intervention, 1.2% received brief treatment, 0.8% received a referral to treatment, and 14.4% had an unknown status
  – Facilities were generally successful at incorporating screening protocols into their workflows
Model Hospital-Based Treatment Programs

• Bridgton Hospital – Buprenorphine prescribing program

• Benefits
  – Lower regulatory/licensure barriers than methadone programs
  – SAMHSA prescribing waiver is comparatively easy to obtain
  – Can be integrated into primary care system
  – Gold standard of treatment for opioids

• Challenges
  – Buprenorphine alone is not sufficient to meet all patient needs
  – Can be difficult to incorporate into a busy practice without additional support
  – Linkages with bigger systems of care are needed
Bridgton Hospital Buprenorphine Clinic

- Coordinated efforts between Bridgton Hospital, North Bridgton Family Practice, Crooked River Counseling
  - Program has enrolled 200 patients in a rural Maine community
  - Started in 2009
  - Four physicians and two nurse practitioners prescribe buprenorphine in their primary care practice (North Bridgton)
  - Crooked River Counseling provides intensive outpatient counseling and group therapy for the patients
  - Bridgton Hospital provides comprehensive maternity care to women with OUD during their pregnancy
  - Services are interconnected and coordinated across providers
  - Key is the collaborative approach and communication
Nurse Navigator & Recovery Specialist Program

• Based in Western Pennsylvania, the program serves the residents of Armstrong, Clarion, and Indiana counties

• Consortium is made up of the Armstrong-Indiana-Clarion Drug and Alcohol Commission and 9 partners using a care coordinator/manager model to prevent and treat chronic illnesses related to O/SUDs

• Staffed by a Recovery Specialist and Nurse Navigator provider
Nurse Navigator & Recovery Specialist Program

• Services:
  – Health and resiliency education
  – Physical and behavioral health planning
  – Substance abuse treatment services
  – Wellness groups and therapy sessions

• Results over three years
  – Assisted 364 clients with 2,433 client encounters
  – Reduced ED visits each year
  – Reduced clients with 1 or more hospital admissions
  – Increased client’s reporting positive perceptions of their health
Supporting MAT and OUD Services - Vermont

- Vermont’s Hub and Spoke model supports the use of buprenorphine by primary care and community providers
  - Comprehensive care management
  - Care coordination and referral to local resources
  - Care transitions
  - Individual and family supports
  - Health promotion
  - Expands use of buprenorphine in primary care
  - Recognizes importance of mental health and traditional substance use services in treating opioid problems
  - Efficient use of scarce resources
  - Provides care in less stigmatizing settings
Vermont Hub and Spoke (cont’d)

• Regional specialty treatment centers serve as the hubs
  – Coordinate care of individuals with complex OUDs and co-occurring SU and MH disorders
  – Provide full range of OUD care and support community providers by providing consultative support to primary care and other providers prescribing buprenorphine

• Physicians prescribing buprenorphine and collaborating health and addictions professionals serve as the spokes
  – Dispense buprenorphine, monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency mgt, and case mgt services

• Funded through Medicaid waiver
Recovery Strategies
Recovery

• “Recovery is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.” SAMHSA

• Four dimensions that define a healthy life in recovery:
  – Health - Managing one’s disease(s) or symptoms; making informed choices that support physical/emotional wellbeing
  – Home – Having a safe and stable place to live
  – Purpose – Participating in meaningful daily activities and having the independence, income, resources to participate in society
  – Community – Engaging in relationships and social networks that provide support, friendship, love, and hope

• Hospitals can coordinate with local recovery programs
Recovery – Community Programs

• Does community create a supportive environment for recovery?
  – Stigma reduction – opportunities for a new start
  – Employment opportunities
  – Educational opportunities
  – Social, recreational outlets
  – Connection to cultural heritage
  – Twelve step programs
  – Peer support
Evidence-Based Recovery Programs

• Department of Veteran’s Affairs – Peer Recovery
  – Recruit veterans in recovery to support those going through the process

• Australian mental health peer support
  – Goal – avoidance of unnecessary hospitalizations

• Turning Point Center, Rutland, VT
  – Part of the Vermont Recovery Network

• Supporting Peer Recovery: The RECOVER Project, Franklin County, MA
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