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Opioid Use Disorder: Challenges and Opportunities in Rural Communities

Thoughtful strategies can improve access to high-quality care

Overview

The increasing number of drug overdose deaths in the United States has hit rural areas particularly hard. Between 1999 and 2015, overdose deaths increased 325 percent in rural counties.¹ In 2015, they surpassed the death rate in urban areas.² Additionally, nonfatal prescription opioid overdoses are concentrated in states with large rural populations.³ Helping to drive this trend in rural areas are high opioid prescription rates and challenges accessing medication-assisted treatment (MAT), the gold standard for treating opioid use disorder.⁴

This fact sheet describes some of the challenges rural communities face in providing access to evidence-based treatment and strategies used by federal and state agencies to enhance treatment capacity, including how one rural community responded to the opioid epidemic by addressing the specific needs of its residents. The policies and programs described are not an exhaustive list but are intended to be illustrative.

Medication-assisted treatment (MAT) combines behavioral therapy with one of three Food and Drug Administration (FDA)-approved medications—buprenorphine, methadone, or naltrexone— for the treatment of opioid use disorder (OUD).⁵

These medications minimize or block the euphoric effects of opioids, curtail cravings, and significantly increase a patient’s adherence to treatment.⁶

Rural treatment capacity

Compared with their urban counterparts, rural communities face significant barriers to treatment, such as fewer facilities, which may also offer more limited services, and greater distances to care.⁷

Opioid treatment programs (OTPs), which dispense methadone and may also offer buprenorphine and naltrexone, are a key component of most current opioid use disorder (OUD) treatment systems. Although a shortage of these programs exists nationally, the gap is widest in rural areas, where 88.6 percent of large rural counties lack a sufficient number of OTPs.⁸

An opioid treatment program (OTP) is a facility where patients go, usually daily, to take medications to treat their OUD under the supervision of staff and to receive counseling and other care services.

These programs are regulated and certified by the federal Substance Abuse and Mental Health Services Administration and operate in a number of care settings, including intensive outpatient, residential, and hospital locations.⁹

Another key component of an OUD treatment system is office-based opioid treatment (OBOT), which integrates opioid agonist treatment (i.e., drugs that minimize the effects of opioids) into a patient’s general medical and psychiatric regimen by allowing primary care physicians to provide MAT in their own clinical settings.¹⁰ However, OBOT is particularly limited in rural communities: 29.8 percent of rural Americans live in a county without a buprenorphine provider, compared with only 2.2 percent of urban Americans.¹¹

The shortage of treatment options in rural areas places barriers on patients who must travel farther to access MAT and, in some cases, have to rely on friends or family for transportation.¹² Numerous studies have found that those who live closer to a health care facility have better health outcomes and can more easily access care.¹³ Transportation challenges may be particularly acute for patients with OUD; a small survey of OTP patients in Vermont found that 23 percent missed at least one visit due to lack of transportation, 17 percent due to weather, and 8 percent due to costs.¹⁴ The rural treatment shortage also places burdens on payers that offer patients transportation services.¹⁵ For example, Washington state’s Medicaid program reported in 2011 that it spends \$3 million a year to transport rural enrollees of the program to urban OTPs.¹⁶

Treatment centers in rural areas are less likely than their urban counterparts to provide buprenorphine and to offer additional services, such as case management, that are shown to improve outcomes.¹⁷ Rural facilities also rely more on public funds to care for patients and support innovative programs that may improve treatment quality.¹⁸ Such limitations can contribute to decreased availability of evidence-based care, with fewer tailored treatment options and specialized providers to address complex patients.

Closing the treatment gap by expanding the provider workforce

In 2016, Congress passed legislation temporarily allowing nurse practitioners (NPs) and physician assistants (PAs) to prescribe buprenorphine after completing specified training.¹⁹ Additional legislation passed in 2018 made this allowance permanent and temporarily authorized other providers, such as clinical nurse specialists, to obtain a waiver to become buprenorphine prescribers.²⁰ This expanded prescribing authority is relevant for rural areas; in 2017, 13.8 percent of rural counties had a waived NP and 4.6 percent had a waived PA.²¹ As a result of this workforce expansion—and a 10.7 percent rise in the number of physicians with a waiver to prescribe buprenorphine—from 2012 to 2017, the number of all waived providers (e.g., physicians, NPs, and PAs) per 100,000 residents doubled in rural counties.

However, as of 2017, 28 states prohibited NPs from prescribing buprenorphine unless they are working in collaboration with a doctor who also has a federal waiver to prescribe.²² To further increase access to MAT, states may need to change laws and regulations that restrict NPs from prescribing buprenorphine.

Using technology to address physician barriers

For rural physicians, barriers to prescribing buprenorphine include time constraints and a lack of mental health or psychosocial support services for patients, specialty backup for complex problems, and confidence in their ability to manage OUD.²³ Treatment models that use technology to address these barriers have been shown to increase access in rural populations.

For example, Project ECHO (Extension for Community Healthcare Outcomes), which was launched in New Mexico, contributed to a nearly tenfold increase in buprenorphine-waivered physicians over a 10-year period.²⁴ In this model, prescribers are recruited to obtain a waiver and are provided regular opportunities for mentoring and education, thereby increasing treatment capacity in rural areas.

West Virginia's Comprehensive Opioid Addiction Treatment program is a telemedicine model that uses videoconferencing to prescribe buprenorphine and for medication management.²⁵ Patients residing hundreds of miles from the treatment center participate in virtual group-based medication management followed by in-person group therapy. Retrospective analysis of this program found that rates of treatment retention and abstinence from drug use were comparable to the rates observed when MAT is provided in person.

Developing innovative, local responses to the opioid epidemic

Strategies to address the opioid epidemic must address community needs to effectively reach and treat patients with OUD. For example, Indiana's Scott County Partnership Inc. responded to an HIV outbreak that was linked to the misuse of prescription opioids and sharing of syringes by developing a "one-stop shop" model to provide buprenorphine, mental health counseling, HIV and hepatitis C treatment, primary care, and syringe exchange in an existing mental health clinic.²⁶ Prior to this model, this rural county had no OUD or HIV treatment services.²⁷

Scott County responded to this local public health crisis by comprehensively addressing the barriers to care faced by people with OUD and HIV. In addition to health care services, patients receive clothes and meals if needed, obtain help finding a job, and have care coordinators to help them enroll in health insurance.²⁸ The partnership also transports patients to appointments and conducts outreach and education to increase the number of physicians who can prescribe buprenorphine.²⁹ Evaluations of the one-stop shop model have not been published, although Scott County's experience provides an example of a targeted response that takes specific community needs into account.

Closing the rural treatment gap

Policymakers and leaders within health care systems can ensure that effective OUD therapy is available in rural communities by implementing emerging and evidence-based practices and studying the effectiveness of these models within their states. These efforts can help close the treatment gap in rural America and save lives.

Endnotes

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