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Practices for better healthcare engagement for rural patients who use drugs

Department of Population Science and Policy

Jenkins WD, PhD, MPH, FACE; Vistrit Choudhary, MPP; Rebbeca Bolinski, PhD, Camille Dunkley, MD; Lauren Velten, BS, CHES

KEY FINDINGS

- **People who use drugs (PWUD) frequently report stigmatizing experiences when obtaining healthcare – significantly reducing their care utilization outside urgent/emergency circumstances.**
- **Clinician biases and inadequate knowledge and skill regarding PWUD management significantly contribute to mutually unsatisfactory healthcare experiences and poor follow up.**
- **Formal medical education and continuing education (clinical and administrative staff) regarding holistic PWUD patient management should be offered and incentivized.**

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+1 217 545 7939
psp@siumed.edu
www.siumed.edu/popscipolicy

INTRODUCTION

The United States continues to face the evolving opioid epidemic that is generally recognized to have begun in the 1990s with the rise in opioid pain pill prescriptions.[1] We are now in what is considered the 4th wave, characterized by the use of powerful synthetics such as fentanyl and co-use with stimulants such as methamphetamine.2 These evolving patterns of drug use also bring attendant risks, such as overdose, infectious disease transmission, wound care, and worsening mental health.[3, 4, 5, 6] While many of these may be to differing degrees addressable through the existing healthcare infrastructure, efficacy is predicated upon both healthcare access and utilization. Rural areas face significant disparities due to restricted capacity from widespread healthcare facilities closure and an insufficient number of addiction specialists. This diminishes the treatment options for people who use drugs (PWUD) and exacerbates the impact of stigma. [7, 8] Ultimately, individuals in need of routine healthcare feel they cannot access services in a non-biased manner.

PWUD stigmatization in healthcare

Throughout history, drug use has been considered as an manifestation of irresponsibility and immoral behavior, as posited by the moral model of addiction.[9] This perception may be particularly salient in the United States, where there has been strong legal and enforcement paradigms most visibly recognized as the 'war on drugs' which began in 1971, and other facilitators such as cultural norms and social fears.[10, 11] Given this context, that drug use is public enemy number one and people who use drugs are criminals, it is perhaps unsurprising that they experience discrimination in circumstances that have little to do with drug use (e.g., employment, housing, family regulation services).[12] Of particular concern here, many report discriminatory and stigmatizing experiences when seeking healthcare.[13, 14]

Data from our own work in southern Illinois support these reports, and we find that rural PWUD report the following reasons for not seeking medical care in the past 6-months:

- "I did not want to be seen at a medical clinic" (19%)
- "I don't trust doctors" (21%)
- "I was treated poorly at a clinic in the past" (23%)
- "I was afraid they'd treat me with disrespect since I use drugs" (46%)

Biases and lack of skills in the healthcare environment

There are substantial data to indicate that providers exhibit both implicit and explicit bias to PWUD – especially among emergency department staff.[15, 16] Explicit biases are those in which the individual is consciously aware, and are perhaps relatively addressable via training, interpersonal accountability and review, and system-level checks for equality and non-discrimination. For example, physicians are significantly less likely to offer new-patient visits to PWUD versus individuals with diabetes.[17] Implicit biases, on the other hand, are largely unconscious to the individuals but can significantly impact care. To date, no interventions regarding changing implicit bias have been effective over time, though an effective approach may be to address the corresponding discriminatory behaviors.[18] For example, there may be opportunity for individuals to take implicit bias assessments (becoming aware of their biases), engaging in role modeling, and obtaining training to reduce negative patient descriptions and stigmatizing words.

Complementary to staff bias is the issue of knowledge of multifaceted patient management and skill to utilize and organize the resources that may be available. The National Institute on Drug Abuse identified a series of wraparound services that treatment centers should provide, including: medical and mental health care; HIV/AIDS prevention and treatment; child care; educational and vocational opportunities; family counseling; housing; transportation; and financial and legal services.[19] While treatment centers on average provided less than half of these services, their identification as important to recovery indicate that successful engagement of PWUD may not be constrained to the presenting complaint.

Clinician training regarding care and management of PWUD patients may be inadequate for the growing need

Formal medical education (to include physicians, nurses, assistants and other allied health professionals) regarding both care of PWUD patient complaints but also patient management is extremely limited.[20] This lack extends into physician residency programs, where, for example, even in psychiatric residency there is only a requirement for 1 month of training – and that is specific to addiction treatment.[21, 22] The Substance Abuse and Mental Health Services Administration has recently promulgated a set of substance use curricular guidelines that address both the inconsistent education in PWUD management and a more holistic approach (to include stigma reduction).[23] There are few formal items of instruction during most medical training, and few opportunities to engage with PWUD patients. Further, such training for non-medical staff (e.g., receptionists) is essentially non-existent.

Continuing medical education (CME) is a widely implemented means to ensure clinicians are continuously engaged in learning and information refreshment/ updating through the course of professional life. States and professional societies may impose a specific number of CME credits for their members to acquire each year, and there is often substantial variety and leeway in choice of topics. While there are opportunities for CME credit for PWUD patient management (e.g., myCME.com), the degree to which they are accessed or required is largely unknown.[24, 25]

WHY SHOULD WE NOW CONSIDER BETTER MANAGEMENT OF RURAL PWUD PATIENTS?

The data continue to show that rates of drug use and drug use-related morbidity are largely holding steady or increasing.[26, 27, 28, 29] Between 2015 and 2021, drug-involved overdose deaths grew by 103 percent.30 Thus, the number of PWUD who will require medical care can also be expected to increase, especially with the increase in use of some specific drugs which are associated with increased morbidity (e.g., xylazine and persistent wounds)[31, 32] Given this context, it may be hypothesized that the number of PWUD experiencing stigmatizing healthcare experiences will also increase, leading to increased reliance upon

urgent/emergency care as they forgo more routine preventive and primary care. This hypothesis is supported by the fact that 34.2 percent of PWIDs avoided healthcare due to concerns of stigma and potential for mistreatment by providers due to drug usage.[33] A similar trend is noticed in our data from Southern Illinois where our clinical trial among rural PWUD found the following: anticipation of stigma leads to delayed care among many participants; erosion of trust in the medical system may result from stigmatizing experiences; and fear of stigma may delay medical intervention for overdose response[34]

While drug use overall is not necessarily more common in rural areas, healthcare availability is substantially less than more urban areas, and continuing to retract. Recent data indicate that 195 rural hospitals have closed or converted to emergency or outpatient care only between 2005 to 2023, and nearly all rural counties in the United States are primary care professional shortage areas.[35] Additionally, rural areas severely lack an adequate healthcare workforce. As of September 2022, 65 percent of primary care health professional shortage areas were located in rural areas.[36] The implication here is that it is even more important for the individual healthcare provider to ensure a satisfactory and respectful experience for the PWUD patient, as they may have few/no other options for care within their county, as usage of evidence-based addiction treatment is already low. In 2019, only 18 percent patients with opioid use disorder received Medication for Opioid Use Disorder (MOUD).[37] Further, the remaining rural healthcare providers may be especially stressed with high patient volume and fewer administrative resources, so adequate care coordination for PWUD patients may be disproportionately difficult to organize and manage.

WHAT CAN/IS BEING DONE?

Reducing PWUD stigmatization in healthcare

Though the overall data may appear somewhat bleak, there exist multiple avenues for better experiences. Individuals physicians are in a prime position to purposefully engage with their PWUD patients in a manner that is respectful and 'meets them where they are'. Further, healthcare organizations have an opportunity to marshal and consolidate resources into specific clinics and teams that are expressly purposeful in the same regard. Further, individual-level interventions should be supported by systemic and structural changes and purposeful staff diversity so that new paradigms may be sustained.[38]

PWUD stigmatization in healthcare

There are models whereby healthcare providers may become more proficient and fluent in caring for their PWUD patients. Examples of training in formal education include fellowship programs in addiction medicine, and continuing medical education (CME). The National Institute on Drug Abuse has developed an Addiction Medicine Toolkit for providers in training which address topics such as screening, pain management and addiction treatment.[39] Ultimately, we posit that formal education and training elements specific to PWUD care should be incorporated into all formal medical education programs, and reinforced through competency exams.

Still, considering that the vast majority of providers and staff are already in practice and not in training indicates consideration of CME as a method to address bias and increase skill. There are multiple current examples, such as promulgated by the National Institute on Drug Abuse and the American Medical Association.[40, 41] A more recently developed option is a novel Project Extension for Community Healthcare Outcomes (ECHO) course for emergency department clinicians that has been developed and piloted in southern IL 2020-2021.[42] ECHO is a structured telementoring educational model that trains community providers in specialty care. Since it is predicated upon virtual/video engagement, the modality is extremely portable and feasibly accessible in even quite remote and rural areas. The Illinois program, ECHO-Chicago: Opioid Use Disorder in the Emergency Department (ED), consisted of eight sessions covering such topics as: The role of the ED in the opioid epidemic; Legal issues and communication skills; and Medications for OUD. Participants reported that course content was acceptable, appropriate, and feasible; and there were significant increases in participant efficacy to manage PWUD patients; decreases in participant stigmatizing attitudes towards PWUD, and the majority reported changes to clinical practice (71%) and departmental

protocols (57%).[42] We propose that similar such training be: a) expanded in scope to be nationally available, b) be expanded in depth to include all types of providers and staff who engage with patients, and c) be incorporated as required aspects of CME.

New collaborations for resource management and PWUD patient follow up

While purposeful clinic and practice design, and better and increased training, are key elements to better PWUD patient engagement, they are not themselves a panacea. There remains, especially in more resource-poor rural areas, a need for knowledge of, coordination with, and follow up among, other resources and services. Healthcare organizations may be able to marshal resources sufficient for team-based care which can better serve PWUD patients.[43]

Another method may be purposeful collaboration between healthcare organizations and harm reduction organizations (HRO). Such a collaboration is being piloted in southern IL, and shows promising results regarding peer-based navigation to primary care.[44] Complementary to this might be collaboration with local health departments (LHDs). These are near-ubiquitous in all counties, often serve as a focal point for social service management, and embody a more public health-involved strategy to address substance abuse.[45] In Illinois for example, the Chicago Department of Public Health provides fentanyl tests strips, and collaborates with the Chicago Library System to provide Narcan (an opioid overdose reversal treatment).[46]

CONCLUSION

People who use drugs are at increased risk for adverse health outcomes, but less frequently utilize routine and preventive medical care services that may ameliorate these risks. Much of this care hesitancy is due to past stigmatizing experiences in healthcare, such that many only seek care in the urgent/emergency context. These circumstances may be exacerbated in rural areas where there are fewer health-care options, and opportunities for clinician training and patient wraparound services are in short supply. Still, there are means whereby the dynamic of poor routine healthcare access may be changed in rural areas. The data suggest that opportunities and incentives for healthcare staff training may do much to improve the patient experience. Further, coordination and collaboration with local resources, such as harm reduction organizations and local health departments, may provide a depth and breadth of services to better meet PWUD patient needs.

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