Questions from National Disparities LAN Event – Managing the Opioid Crisis: Perspectives from Rural Communities

Wednesday, March 14, 2018

Question	Answer
How are the CHW services funded?	Community Health Worker services are funded in a variety of ways. For a summary of financing sources by state, see the "Financing" tab on this webpage: https://nashp.org/state-community-health-worker-models/
In these remote areas, is telehealth available to them?	Telehealth services are available in some, but not all, remote areas. CMS has been working to expand telehealth. The final rule for the 2018 Physician Fee Schedule pays for more telehealth services than before, and makes it easier for providers to bill for these services. In some remote areas, however, access to telehealth remains impeded by poor internet and cell phone coverage. For more information about telehealth, see: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf For more information on the 2018 final rule, see: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-02.html
How are CHWs educated or trained?	For details on how CHWs are educated, trained, and certified in each state, see the "education" and "certification" tabs on this webpage: https://nashp.org/state-community-health-worker-models/
Are CHWs available in all states?	To date, CHW activity has been documented in 47 of 50 states. For details, see: https://nashp.org/state-community-health-worker-models/
What is a typical CHW case load for a typical month? What number of visits or hours do you spend on the average patient?	Our speaker, Jennifer Goulet, said that this varies greatly depending on needs and the amount of time each patient needs.
Is ECHO a telehealth program?	Not exactly. Project ECHO is a "hub and spoke" model

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	that links primary care clinicians with specialists through real-time learning made possible by inexpensive videoconferencing technology. In ECHO, clinicians have the ability to present actual cases, in a de-identified format, and receive specialist input. This makes it possible for primary care clinicians in rural and remote areas to grow their expertise and deliver high-quality specialized care to their patients. To learn more, see: https://echo.unm.edu/about-echo/ https://echo.unm.edu/nm-teleecho-clinics/opioid/ https://echo.unm.edu/nm-teleecho-clinics/opioid/curriculum/
Emergency Drug: With the new regulations, how is the emergency drug integrated into the community?	One of our participants noted: "we have naloxone available to law enforcement, some schools, and a local non-profit that is working in cooperation with the GA Council on Substance Abuse." Another participant pointed to New Mexico's Opioid State Targeted Response (STR) Initiative also known as NM Opioid Hub Program: http://newmexico.networkofcare.org/mh/content.aspx?cid=4229
We are working on a current way of contracting with our hospice patients to help prevent the diversion of drugs to friends and family with abuse issues. Any suggestions on this?	A sample patient and caregiver agreement can be found here: http://c.ymcdn.com/sites/www.virginiahospices.org/resource/resmgr/REM_Folder/Final_REM_Tool_Kit_for_elect.pdf
Is there anyone who can talk about experiences with medication assisted treatment (MAT) in rural areas? Is there a sense that MAT is more difficult in rural areas?	A call participant said she just started a MAT program in Plumas Co. California, working with the hub and spoke grant as a spoke. A call participant at Mountain Pacific Quality Health, AK, stated: "I think a large barrier to MAT in rural settings is that pharmacists who cannot get a NADEAN, were not included in the CARA. NADEAN is the X in the DEA number that allows prescribing of MAT. The CARA was the act that allowed NPs and PAs to get an X DEA number (in addition to MDs and DOs) and prescribe MAT. A call participant at the Colorado Consortium for provider education stated, "We also have free naloxone for participants in our harm reduction program and for law enforcement in our six rural counties."

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	A call participant wrote: "We have MAT courses from PCSS linked to our LMS, visit: www.learning4quality.org" Finally, another call participant wrote: "SAMHSA has some good MAT resource and training links: https://www.samhsa.gov/medication-assisted-treatment"
I'd love to hear how to continue MAT to patients that are being d/c to a nursing home or those that are in jails.	Access to MAT remains uneven in jails and nursing homes. A recent study demonstrated the benefits of MAT in jails: http://www.wbur.org/news/2018/02/14/rhode-island-study-shows-benefit-to-medication-assisted-addiction-treatment-in-jails
Local taxis and medical transport services are too expensive for our elderly/disabled population who earn just a little too much for Medicaid, plus medical transport doesn't go to drugstores or other areas - just doctor offices. Does anyone have any answers to this from a resource standpoint?	A call participant noted: Uber is moving into transportation to health related appointments, no word on costs yet. There is also a program via the TN department on aging that facilitates a volunteer program recruiting citizens to drive patients in need of rides to their appointments.
Where can a provider or caregiver go to find CHW in my community?	Visit this webpage: https://nashp.org/state-community-health-worker-models/; click on the "organizations and workgroup" and "state agency" tabs to identify existing CHWs and to request advice on training new CHWs.
Is anyone working with their local law enforcement organization regarding opioids? If so, would you please elaborate?	A call participant noted: Idaho has been making naloxone available through a grant to law enforcement and other EMS services.

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I read an editorial that the increased access to naloxone will actually increase the severity of the opioid epidemic. Any thoughts?	A recent working paper suggested Naloxone could create a "moral hazard," meaning that people might choose to engage in risky behaviors more frequently because Naloxone would protect them from the consequences of opioid abuse (see: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3135264) Several commentators noted some flaws with the paper's research methods, which may affect the validity of the authors' conclusions. Even if we assumed that the authors' conclusions were valid, however, it's not unusual to see variation in research results across studies on the same topic. For this reason, results from this one study would need to be weighed against the rest of the body of evidence to best inform Naloxone policy.
We are experiencing a shortage of inpatient treatment settings that accept Medicaid. Any suggestions?	Yes, unfortunately this is a common challenge. One option is to consult with your Medicaid office and community partners to see if you can get involved in coalition efforts to address the problem. Another option is to reduce the need for inpatient treatment by pursuing effective community-based solutions. For example, you may be able to develop or work with a community health worker program such as the one presented on the March 14, 2018 National Disparities LAN Event; participate in an ECHO to increase the ability of local primary care providers to offer medication-assisted treatment; or encourage clinicians to take online training on medication-assisted treatment, offered by SAMHSA: https://www.samhsa.gov/medication-assisted-treatment

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What are ways to make pain management more patient-centric?	1) Educate patients and caregivers about pain management options (benefits, risks, and side-effects) so that they can make informed choice based on their values and priorities. 2) Engage patients and caregivers in developing treatment plans, and check with them to make sure the plan is responsive to their values and priorities. 3) Work with community health workers to identify and address the root causes of chronic pain for individual clients. For example, our speaker Jennifer Goulet noted that one client had a broken porch railing, and fixing the railing reduced the pain and allowed her to get out of the house. 4) Close the loop on referrals. The patient who spoke on the Disparities LAN call experienced long delays in getting needed treatment for pain, because clinical staff failed to make promised referrals and follow-up appointments in a timely manner.

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