The Center for Health Affairs

CLINICAL OPIOID EDUCATION NEEDS ASSESSMENT

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Introduction

As the leading advocate for Northeast Ohio hospitals, The Center for Health Affairs focuses its efforts on areas that benefit from a regional approach. From collaborating on community health needs assessments, to serving as the regional coordinator for hospital emergency preparedness, and housing the Northeast Ohio Hospital Opioid Consortium, The Center serves as the voice of Northeast Ohio hospitals and brings members and stakeholders together to enhance the healthcare community.

When Cuyahoga County applied for the Centers for Disease Control and Prevention Overdose Data to Action (CDC OD2A) grant, The Center was a natural partner given its longstanding relationships with hospital membership and the Northeast Ohio Hospital Opioid Consortium. The Consortium is a physician-led collaborative, with core partners consisting of Cleveland Clinic, The MetroHealth System, St. Vincent Charity Community Health Center, University Hospitals, the VA Northeast Ohio Healthcare System, Southwest General, and the Academy of Medicine of Cleveland and Northern Ohio. Established in 2016, the work of the Consortium focuses on mitigating the impact of the opioid crisis through expanded access to opioid treatment and naloxone, improved pain management and prescribing practices, and the creation of educational tools and resources for healthcare providers. Today, the Consortium has broadened its collaborative to include city and county health departments, federally qualified health centers (FQHCs), and other stakeholders.

This work is supported through funding by Cuyahoga County Board of Health, made possible by the CDC's Overdose Data to Action (OD2A) Grant.

Executive Summary

In 2022, between April and July, 22 key stakeholder interviews were conducted to identify gaps in education relative to substance use disorder (SUD) treatments with a primary focus on opioid use disorders (OUD) in Cuyahoga County. Questions focused on the current challenges of treating patients with opioid and polysubstance use disorders, existing educational opportunities, and gaps in related clinical training. See Appendix A for interview questions.

Key stakeholders were identified by The Center based on involvement in the SUD treatment space in Cuyahoga County. Interviewees included doctors, social workers, nurses, clinicians who directly treat people who use drugs, individuals who manage direct service providers, a periodontist, and people who oversee the provision of mental health and substance use services in the county. Interviewees have direct experience with various aspects of existing training opportunities and the knowledge gaps that remain in practical treatment settings.

Key findings that emerged from the interviews are highlighted below:

- ✓ In-person, peer-to-peer education is valued by clinicians and may lead to improved knowledge retention.
- ✓ Clinician stigma toward people who use drugs is nuanced and complex.
- ✓ Multi-disciplinary education for treating OUD and medications for opioid use disorders (MOUD) may expand the reach and efficacy of MOUD – particularly in primary care settings.
- ✓ Clinician and patient treatment success stories are impactful educational offerings and may motivate prescriber participation in SUD treatments
- ✓ Practical information on creating and implementing MOUD programs is needed to enable and encourage more facilities to establish treatment protocols.
- ✓ Uncomplicated accessibility along the full continuum of care, including access to appropriate community resources, is critical.
- ✓ Federal and state regulations relative to SUD treatment and insurer requirements can make caring for patients with SUD extremely cumbersome and time consuming.
- ✓ Early inclusion of addiction medicine curricula in medical school may normalize SUD screening and treatment and serve to mainstream SUD treatment across the continuum of care.

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Key Findings & Discussion

In-person, peer-to-peer education is highly valued and retained.

Opportunities to connect and learn from peers, especially in the same room, are seen as particularly valuable to learning and knowledge retention. Interviewees shared feelings of trust toward colleagues who can directly relate with and teach through shared experiences and perspectives. Dedicated, in-person time to learn from peers may also increase understanding, knowledge retention, decrease compassion fatigue, and allow for the establishment of ongoing, supportive, mentoring relationships.

- ✓ Peer-to-peer coaching or mentoring, "would be revolutionary for us."
- ✓ "...if you say, 'This happened in my practice," or 'I had this patient, and this happened,' or even an actual patient story, like a patient telling their story, that's very engaging."
- ✓ "I like peer-to-peer. The doctor that's an addictionologist, he's on my team and he's been super-great at teaching everybody about the medications and pharmacy and prescribing...So that's why I utilize him a lot, because I think that it is helpful to have a one-on-one with him, and he can go over some questions, especially when you first start."
- ✓ "...what seems to work well is people coming to us, mainly because a lot of people can't get away [from their work]."

Based on this input, future efforts should focus on the development of in person education and networking opportunities that allow for meaningful peer-to-peer discussions, peer connection, and relationship building. In addition to hosted events, targeted outreach to ambulatory clinics and federally qualified health centers that wish to host in-house training sessions responsive to specific gaps and needs is recommended.

Clinician stigma toward people who use drugs is nuanced and complex.

Stigma is defined as "a set of negative and unfair beliefs that a society or group of people have about something"[1] and impacts access to care for people seeking treatment. Interviewees described a great breadth of contributing factors associated with medical stigma toward people with SUDs and, while there are a variety of tactics to dismantle stigma, it is a very personal and nuanced struggle.[2] Decades of research have detailed the disease model of SUD, yet when people display the behaviors associated with this brain disease, they may be perceived as morally haggard or failures in society.

Barriers to treatment and other social determinants of health can also contribute to the complexity of caring for patients with SUD. When unaccustomed to treating behaviorally and socially complex patient cases, unintentional stigma or bias may create a rift in the provider-patient relationship.[3] Furthermore, prescribers have been under intense scrutiny related to opioid prescribing and the laws related to treatment for OUD continue to change. Finally, the system of care is complex and difficult to navigate. Providers may not have a treatment plan or referrals for patients with SUD and this lack of accessibility to smooth care transitions may contribute to medical stigma and roadblocks that patients encounter when seeking help from a medical setting.

- ✓ "[Make] sure that everybody is practicing within the idea that we are treating people and they are worthy of our treatment . . ."
- ✓ ". . . even if you tell somebody it's a brain disease, that isn't quite enough to fix the stigma, because I still think that people have their opinions, like 'Okay, they might have a brain disease, but they're liars and cheaters and untrustworthy,' which some of that stuff is absolutely true, but usually it's true when you're in active addiction, not when you're well."
- ✓ "Can we all be trauma-informed and help patients, meeting them where they're at and understanding this is a health problem? It starts with that."
- ✓ ". . . there is definitely the stigma where people just say like, 'This isn't something I want to deal with.' With all the issues with opioids in the last few years, I think a lot of people try to stay away from that topic in general."
- ✓ "There's two big problems: one is stigma and the second problem is lack of infrastructure to treat addiction."
- ✓ "Probably a focus more on how a patient who is an SUD patient is a patient . . . They're a patient who happened to have a disease that could be an alcohol use disorder, opioid use disorder, etc. I think just making that clear, because even when you read in the news or on TV, people still talk about this as a moral failing or a poor choice, and it's not. It's a disease."

Addressing medical stigma will require multipronged approaches that include humanizing patient struggles and highlighting treatment successes, solidifying medical opinions about SUD as a brain disease, and empowering clinicians to use the continuum of care and available referral resources for patients with SUD. Peer-to-peer conversations or education that share the stories and perspectives of treatment success stories can be utilized to combat compassion fatigue and empower clinicians to holistically treat and refer patients for care.

[1] https://www.merriam-webster.com/dictionary/stigma, accessed 6/27/23.
[2] Volkow, Nora D., M.D., Stigma and the Toll of Addiction, https://www.nejm.org/doi/full/10.1056/NEJMp1917360?query=recirc_curatedRelated_article, accessed 6/27/23.
3 Cornuțiu, G. (2013). The Doctor-Patient Relationship and Self-Stigma. Psychology, 4, 506-509. doi: 10.4236/psych.2013.46071.

Key Findings & Discussion (Continued)

Clinician and patient treatment success stories are impactful educational offerings and may motivate prescriber participation in SUD treatments.

Interviewed clinicians who have long been treating people with SUDs shared patient recovery success stories where they altered the trajectory of countless lives including patients, family members, employers, and neighbors. They spoke passionately about their roles in changing lives for the better and ending cycles of addiction, pain, and trauma but shared that conversations and education often focus on negative behaviors. Relapse during treatment is common and should be a realistic part of the discussion related to recovery, however stories of hope and healing hold great value in motivating positive change across sectors. Furthermore, sharing messages that underscore professional fulfillment and positive feelings can serve to combat compassion fatigue related to burnout and secondary traumatic stress, which is prevalent in clinicians treating patients with SUD.

- ✓ "When you have someone in recovery educating people on recovery, it's very effective."
- ✓ "I bring a person in...from recovery and [fellows] get to ask them questions and all that, super-powerful. That's good stuff, and that makes a person think differently."
- ✓ "Positive stories build a desire to continue to do more. Having success stories, watching success stories, makes people more engaged and more willing to continue."
- ✓ "We have a lot of exposure to people that are sick, very, very sick, like at the end of the rope sick, but then we don't have a lot of exposure to people that are actually in recovery."

Future education should strive to humanize people with SUDs and include the perspective of people in recovery from SUD who are willing to share their journey with clinicians, including relapse and success stories. When possible, education offerings should be tailored to convey the impact and far-reaching value of treating people with SUD and highlight successful treatment stories.

Multi-disciplinary education for treating OUD and using medications for opioid use disorders (MOUD) may expand the reach and efficacy of MOUD – particularly in primary care settings.

Interviewees repeatedly discussed the large gaps around clinician experience prescribing MOUD or referring patients for MOUD. Primary care physicians are critical to the SUD treatment continuum of care and interviewees identified systemic gaps in the primary care system that may discourage these providers from participating in SUD treatments. Reasons identified included the limited amount of time providers have with each patient, fear of becoming involved in socially complex situations, and established routines that do not yet include SUD treatment protocols. Furthermore, the ever-changing landscape of legal requirements relative to prescribing MOUD can be daunting, particularly for clinicians who already have full patient panels.

- ✓ "If you think you don't see [substance use disorders], you're missing it; it's everywhere."
- ✓ ". . . I don't think enough primary care physicians are doing assessments to even determine whether the patients they're seeing have a substance use disorder, or family history of substance use disorder, or any indication of that."
- ✓ "A lot of the providers that are in primary care, they only have 20 minutes to see patients and, as a result, they don't think that they can manage one more condition, when it's not their specialty, and deal with the problems associated, should there be a risk in sobriety or a relapse."
- ✓ "...there's a lot of education that still needs to be done [in primary care], because our patients a lot of times get stigmatized because they're on [medications for opioid use disorder]."
- ✓ "I think more education [is needed] about all of the forms [of MAT]. Not just Suboxone and Subutex, but all of the other forms of medication-assisted treatment (MAT), and where they're available and where we, as primary care doctors, would be able to utilize those other forms."
- ✓ "...patients are like 'Oh, my primary care doctor can prescribe this?' 'Yes. Yes, they can.' Sometimes for them, that relieves stress of not one more doctor they have to go to, and it gets them closer to sobriety and harm reduction and living a healthier life."

Targeted outreach to federally qualified health centers and primary care clinics is recommended. Equipped academic detailing and education teams can respond to needs and gaps identified by each organization with sessions tailored to the specific learning goals identified by clinic leaders. Topics may include the science of addiction, pharmacology of MOUD, laws and regulations related to prescribing, withdrawal management and tapering, and community linkages to care, and ways to address clinician bias and stigma.

Key Findings & Discussion (Continued)

Practical information on creating and implementing MOUD programs is needed for more facilities to establish treatment protocols.

In addition to practical training on MOUD prescribing and management, interviewees called out gaps in educational tools to help clinics or primary care offices to implement office-based treatment programs. Interviewees who launched newer programs shared struggles with program implementation. In addition to the process, policies, and lessons learned (successes and pitfalls), it was recommended that organizational culture is also addressed when seeking to implement MOUD protocols. Implementation tools that address clinic employees' biases toward MOUD or patients with SUD may be particularly practical.

- ✓ "...understanding the nuances...What do we want to be doing here? And then building in policies and procedures and workflows that make sense . . ."
- ✓ "Almost like a case study or how other places have done it, or best practices . . ."
- ✓ "How do other organizations do this, if this is not their main population that they see?"
- ✓ "...sometimes there's a webinar and technical assistance for 'helping a practice become ready to provide office-based opioid therapy.' I've seen a few of those...and I feel like they're fine, except maybe they missed the piece of changing a culture of an organization."
- ✓ "We can offer Sublocade now, but I will tell you the hoops you have to jump through in order to get that, and we essentially had to navigate that ourselves."

Organizations interested in establishing MOUD programs should develop relationships and leverage the collective experience and lessons learned by organizations with successful programs.

Federal and state regulations relative to SUD treatment and insurer requirements can make caring for patients with SUD extremely cumbersome and time consuming.

Both seasoned providers and those who are new to treating SUD may find the regulatory landscape particularly cumbersome due to the varied and ever-changing local, state, and federal requirements. Government regulations and insurance companies dictate many details of the doctor-patient cadence and treatment plans, including the frequency of follow-up appointments, urine drug screening requirements, prescription refills, and myriad other considerations. Around the time of this report, sweeping federal changes eliminated the X-waiver, previously required for outpatient buprenorphine prescriptions specific to OUD treatment.

- ✓ "...trying to keep up with all [the policies] would be good to have refreshers for staff."
- ✓ "I like the idea of having education about the laws and things like that, and what's going on federally, state, local, so people are aware..."
- ✓ "I know it's a necessary step [to have a level of care assessment for insurance], but I don't really understand...what it entails and what...it enables."
- ✓ "I have someone that has seven years [in recovery], but I still have to have her screen every three months, and it's like 'Can we just let her live her life? I'll be able to tell if something's up. She'll present differently.'"
- ✓ "I spent 24 minutes trying to fix a prior authorization problem...on one of my patients who's been on the same Suboxone dose for over five years, and she went without her medicine this weekend because of a glitch in the system."

To address the rapidly changing landscape, training events and offerings that provide information on policies relative to MOUD and opioid prescribing and related regulations for SUD treatment should be held regularly. Opportunities to build relationships with contacts at regulatory bodies and insurance companies may add value to peer-to-peer training opportunities and events. Reliable and easily accessible electronic mail and social media resources may also empower providers with regulatory updates.

Key Findings & Discussion (Continued)

Uncomplicated accessibility along the full continuum of care, including access to appropriate community resources, is critical.

In addition to the complexities of working with insurance companies and keeping up with regulatory requirements, another gap that interviewees identified was that of accessibility and knowledge of SUD treatment protocols and the system of care available for people seeking treatment for SUDs in Cuyahoga County. Physician practices are often siloed and disconnected from the treatment services and SUD expertise available in the community. Creating a care plan for a patient with SUD can be confusing when clinicians are not well-versed in these resources. Even more complex can be addressing the social determinants of health (i.e., food insecurity, stable housing, employment, transportation, etc.) that often accompany medical diagnoses like SUD. Still, physicians can help ensure long-term recovery by caring for the whole person, including the social hurdles to recovery.

- ✓ Need to "understand levels of care that are available," in addition to "motivational interviewing and understanding stages of change."
- ✓ "You want to ask all the questions to reduce the barrier so you can give them what they need so they're not just calling a list and hitting a wall, because that's very discouraging, especially if they're ready to make a change."
- ✓ "I feel like I'm a little fuzzy about the local resources, and then also about the legal requirements for prescribing."
- ✓ "We look at social services in siloes."
- ✓ "That could be as simple as an email...spelling out the different categories of resources and contact people at those various sites. I know that so much of this [treatment connection] is handled at the social work level, but just to better understand when a person tells me they're at Hitchcock, what does that mean...that could be email, probably something where you could file it away and pull it up when you needed it as a reference."
- ✓ "It's the work that goes with these patients, which has to deal with their psychosocial issues. The housing problem was the big one...and then a lack of financial resources, lack of transportation, all of those kinds of psychosocial issues which, if those aren't addressed in some meaningful way, the patients are not gonna be able to consistently get the treatment that they need because of those barriers, and that is labor-intensive and a big turnoff in the primary care clinics...because we don't have the resources or the people to address those issues in an ongoing, successful way."

In response, collaboration could be improved across the county to provide clinicians with easily accessible SUD treatment and service tools and connections. Providers may be polled on the most effective way for them to access the information when it is needed, including search terms and methods. Resources to address the social determinants of health, guidance on levels of care assessments and corresponding treatments, and a bench of local resources and information that is easily accessible to providers when they are meeting with patients may be created. Information for clinical practices and teams to access real-time can be developed and tailored. Additionally, resources that are already available can be tailored for clinical practice and utilized. Convening a group to map the system of care and determine effective ways to share the information and pathways, and ways to discuss options with patients, may address this gap.

Early inclusion of addiction medicine curricula in medical school may normalize SUD screening and treatments and serve to mainstream SUD treatment across the continuum of care.

Beyond education for currently practicing clinicians, the expansion of addiction medicine education within medical schools was discussed as a gap and an important way to normalize SUD care across medical disciplines. It is common for practitioners to leave medical school without learning about SUD, yet the need for SUD treatment is not expected to wane.

- ✓ ". . . what we can do, what other organizations can do to encourage dental schools, or for that matter, any school that allows their graduates to apply for a DEA so that they can prescribe, to mandate having a substance abuse education program."
- ✓ ". . . I think that giving education on substance use disorders, on the treatment, on what to look for, on how to recognize, on including addiction screenings, especially before prescribing, if that's built into the education before their move into their clinicals and then it's paired with experience and then put into practice, I think that will build a longer-term, more successful education strategy."

Building a pipeline of knowledgeable and compassionate clinical teams will open more pathways to recovery and may eliminate treatment barriers that currently exist. Groups that have strong relationships with medical and dental schools and related professional organizations can be powerful advocates for curricula changes to include the science of addiction, SUD screening and treatments, levels of care, drug interactions, opioid tapering, and MOUD training.

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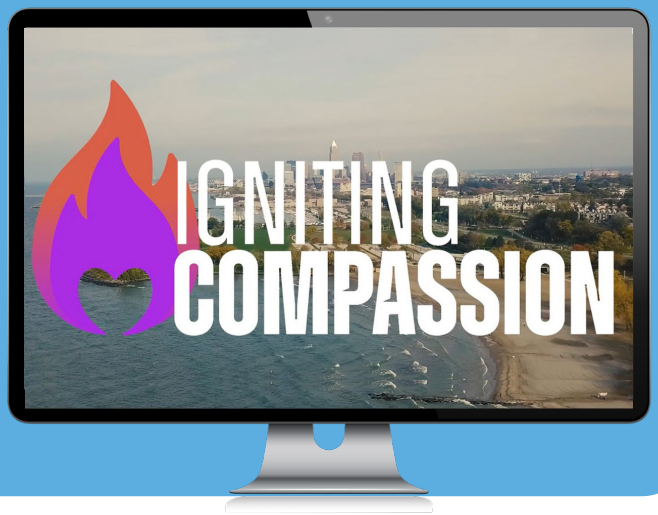
Postscript

According to SAMHSA's 2021 National Survey on Drug Use and Health, 16.5% of the population aged 12 or older met the DSM-5 criteria for SUD and 94% of this same group did not receive any treatment.[4] In Cuyahoga County, medical examiner data predicts around 800 drug poisoning deaths in 2023, which is an average of approximately two deaths each day and would be the highest number since 2017.[5] One way to fight against these deaths is to respond to gaps in the education of clinicians and to improve access to effective of substance use disorder treatments. Clinicians with the tools to practice the art and science of addiction medicine will be equipped to navigate the system of care and help patients through personalized recovery journeys.

In response to some of the key findings discussed, The Center for Health Affairs filmed and produced a documentary called ***Igniting Compassion***. This film weaves together stories of physicians, nurses, people in recovery, and family members to dismantle medical stigma toward substance use and to encourage the active listening and creative solutions needed to help people seeking treatment for substance use.

YouTube **Click to Watch**



More efforts to normalize substance use treatment and education across medical sectors are necessary to stem the tide of the opioid epidemic that is ravaging the lives of our neighbors now more than ever. To collaborate on these efforts, please contact The Center for Health Affairs.

[4] https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html#:~:text=Drug%20Use%20and%20Substance%20Use,drugs%20in%20the%20past%20year.

[5] https://cuyahogacms.blob.core.windows.net/home/docs/default-source/me-library/heroin-fentanyl-cocaine-deaths/2023/july2023-heroinfentanyl.pdf?sfvrsn=2f34d179_3

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Appendix A

Premise: Education and training is needed for clinicians (medical physicians, nurses, pharmacists, behavioral health providers) at county hospitals, FQHCs, outpatient and mental health facilities and community/peer support organizations who are treating and supporting individuals with OUD/SUD/Polysubstance abuse. Information gathered on gaps in education and training will be used to inform new and innovative opportunities for professionals that are responsive to their identified needs.

1. Could you talk about the current challenges / issues you're facing when treating patients with OUD/SUD/Polysubstance abuse that you'd like more education and training on? What do you still need to learn to most effectively serve this patient population?
    a. Would education about policies governing OUD/SUD/Polysubstance treatment at various levels (e.g., within your organization, or at the state and federal level) be useful? If so, in what way specifically?
    b. If you are involved in Medication-Assisted Treatment (MAT), are there specific areas of education and training that you feel you still need? (e.g., gaps in clinical knowledge related to MAT treatment initiation or maintenance)?
2. What do you think are the most important/pressing aspects of OUD/SUD/Polysubstance abuse treatment that clinical professionals need to know about today? In the future?
    a. Could you talk about the policies governing OUD/SUD/Polysubstance abuse treatment (e.g., pain management contracts) that you feel are useful, out-of-date, or unnecessary and in need of revision (if any)?
3. We'd like to learn more about the existing OUD/SUD/Polysubstance abuse educational and training opportunities that are available to you through your employer or professional organizations.
    a. First, do you know of any? And, if so, what are they?
        i. What format(s) does your employer use to convey clinical information/education/training on OUD/SUD/Polysubstance abuse to clinicians? (e.g., online live webinars, pre-recorded courses, grand rounds/expert speakers, staff meetings, peer-to-peer mentoring/coaching)
        ii. What formats do you find most engaging?
    b. Do you participate or take advantage of these existing opportunities and resources? Why or why not? (Are you actually interested or is participation due to compliance?)
        i. (If they do…) How would you describe their quality?
        ii. (If they do OR don't…) Are they relevant to your specific needs? Please explain.
            1. Have these educational / training opportunities caused you to change your clinician practice? If so, how?
            2. Do you ever find that the material presented is impractical or impossible to implement given the reality of your clinical practice? Please explain.
        iii. What are some of the barriers you face to accessing them? (e.g., time constraints/scheduling, funding, delivery format, learning about them/hearing about them in advance)
4. Next, we'd like some feedback about what the ideal education and training on OUD/SUD/Polysubstance abuse would look like for you.
    a. What format is most preferable? Why?
        i. MetroHealth is piloting a new one-to-one technique for opioid education that is proving successful (explain it); do you think your health system would be interested in education techniques like this?
    b. What other disciplines do you think need OUD/SUD/Polysubstance abuse education?
5. Can you share names (and contact information) of individuals from your organization or network that you feel should participate in an upcoming focus group on this topic?
6. Is there anything else that we haven't talked about that you'd like to share before we end today?