# National Rural Health Association Position Paper

## Substance Use Disorder in Rural Areas

**Policy recommendations**

The most successful treatment programs nationally have prioritized expanding the provider workforce and patient access to care. In 2016, Congress passed the Comprehensive Addiction and Recovery Act, which allowed nurse practitioners (NPs) and physician assistants to prescribe buprenorphine after completing training. After this workforce expansion, the number of waivered providers per 100,000 residents doubled in rural counties from 2012 to 2017. However, 28 states currently prohibit NPs from prescribing buprenorphine unless they are working in collaboration with a doctor who also has a federal waiver, which only serves to decrease access to MAT.[i] Further, other components of MAT models of care, such as counseling and community interventions, need to be available and closely coordinated for rural patients.

While creating the infrastructure for substance use treatment is paramount, successful programs included funding for campaigns to spread awareness of opioid use disorders and available treatment options. Developing community strategies to address the opioid epidemic and supporting community collaborations remain critical to treating and preventing addiction going forward. Rural areas need access to telemedicine to connect with specialists for counseling as one component of a successful care model. Significantly, social determinants of health and issues of under- and un-insurance must be considered so individuals have access to other aspects of health care in addition to overcoming addition.

- Make MAT an option in all rural communities by removing barriers to treatment
  - Continue to allow NPs and PAs to prescribe buprenorphine with training and support
  - Ease unnecessarily restrictive licensing standards
  - Educate community members to reduce opposition to MAT programs
- Improve the availability of MAT prescribers and mental health professionals in rural areas
  - Strongly promote pain management, behavioral health, and addiction education in all U.S. allopathic and osteopathic medical schools through accreditation requirements
  - Fund telemedicine consultation services for addiction and pain management
  - Identify MAT deserts and target training and treatment availability in those areas
- Support availability of inpatient and outpatient treatment in rural communities
  - Allow patients to be induced on buprenorphine while in inpatient settings to improve continuity between inpatient and outpatient treatment
  - Improve availability of outpatient mental health, recovery, and peer recovery services in rural settings
  - Improve availability of rural inpatient facilities that treat substance use disorders
- Provide funding for research on treatment of opioid issues specifically in rural settings, focusing on provider supply; treatment availability and its variation depending on geography; outcomes of specific treatment models in rural settings; outcomes of educational models and provider support programs; and the impact of treatment services per dollar spent

**Recommended action**

- Support *S. 586 and HR 3259: The NOPAIN Act* to establish Medicare coverage of pain management treatments that are able to replace or reduce prescription opioid consumption.

- Support *S. 2796 and HR. 2985: Rural Opioid Abuse Prevention Act* to provide for the eligibility of rural community response pilot programs for funding under the Comprehensive Opioid Abuse Grant Program.

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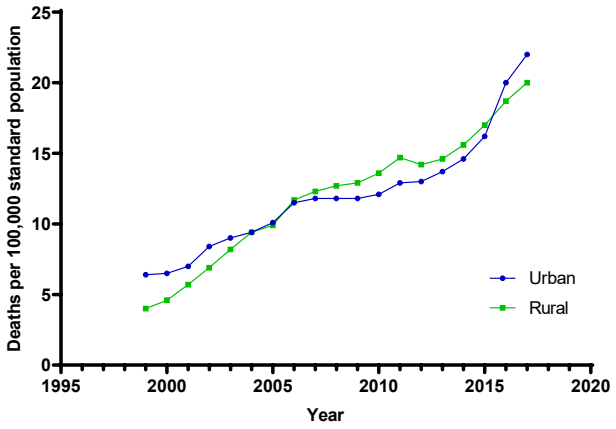
## Overview

Rural areas have been particularly hard hit by substance use disorder (SUD). Alcohol is the most commonly used substance nationally, with higher use rates among rural populations.[ii] Rural communities per capita have an opioid overdose rate 45% higher than urban areas.[iii] Further, many rural areas also have high rates of methamphetamine use.[1]

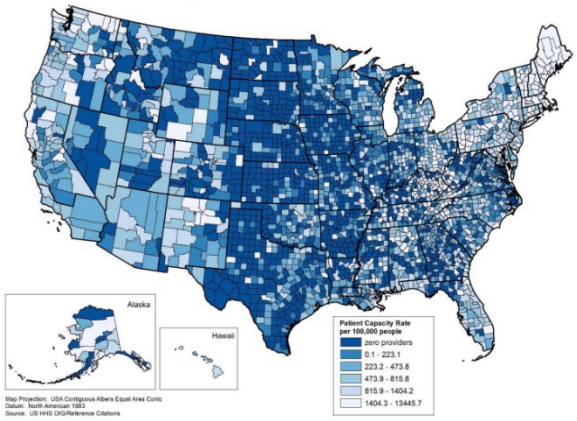
**Age-adjusted rates of drug overdose deaths (CDC, 2019)**




The SUD crisis in rural communities is incredibly complex and will not be solved easily. At one level is the direct cost to individuals suffering from SUD including ongoing health problems, high rates of overdose deaths, greater risk of homelessness, exposure to HIV and hepatitis C, and incarceration.[2] The second level involves social problems affecting the community including poverty; increased criminal behavior to support drug habits; higher rates of domestic violence, child neglect, sexual trafficking, and prostitution; and greater demands on the health care, social service, and criminal justice systems.[iv][v][vi]

## Rural OUD treatment capacity

Exhibit 3: Rates of Patient Capacity in the United States by County, 2018




Treatment of opioid use disorders is necessary to return dependent patients to normal functioning and quality of life.[vii] Treatment also reduces mortality in these patients by 50%.[viii] While treatment is necessary and effective, there are many barriers to its provision. Education about treatment of pain and addiction only occupies 0.3% of the formal curriculum in U.S. medical schools, leaving graduates underprepared.[ix] Physicians must obtain a waiver from the Drug Enforcement Agency to prescribe the most common medication-assisted treatment (MAT), buprenorphine, but only 2.2 % of practicing U.S. physicians are approved to use it.[x] Of these physicians, 90% practice in urban counties, leaving 30 million people living in counties where treatment is unavailable.[xi] Moreover, in 2016, 41.3% of rural counties that did have a waivered provider had only one, making the county vulnerable to losing the service. One of the biggest obstacles facing providers is the restriction of using telemedicine to access SUD patients to provide the full range of needed services.

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