Maine Substance Use Disorders Learning Community

Together increasing access to OUD/SUD Care

Leveraging Quality and Process Improvement To Address Healthcare Disparities For A Vulnerable Population

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Continuing Education Credits

CME

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The Maine Medical Education Trust designates this regularly scheduled series for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity qualifies for 1 credit(s) of the 3 CME credit requirement for opioid medication education found in P.L. 2015, Chapter 488, Maine's legislation to address the opioid drug crisis.

Other

1 contact hour for social workers, licensed clinical professional counselors, and behavioral health professionals

1 Category I contact hour for psychologists. CCSME is a pre-approved sponsor and provider of Professional Education Activities for Psychologists.

1 contact hour CHES. CCSME is a designated provider of continuing education contact hours (CECH) in health education by the National Commission for Health Education Credentialing, Inc.

1 contact hour pending for alcohol and drug counselors from the Maine Board of Alcohol and Drug Counselors

Disclosures

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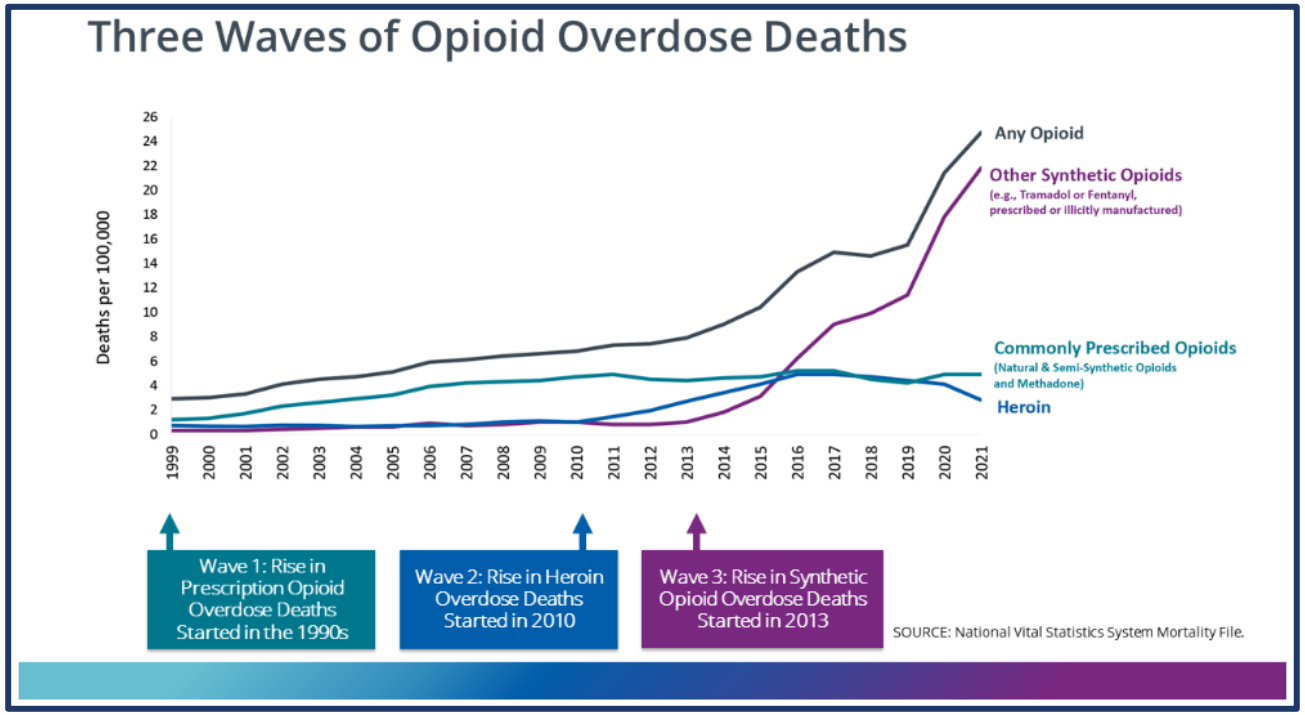
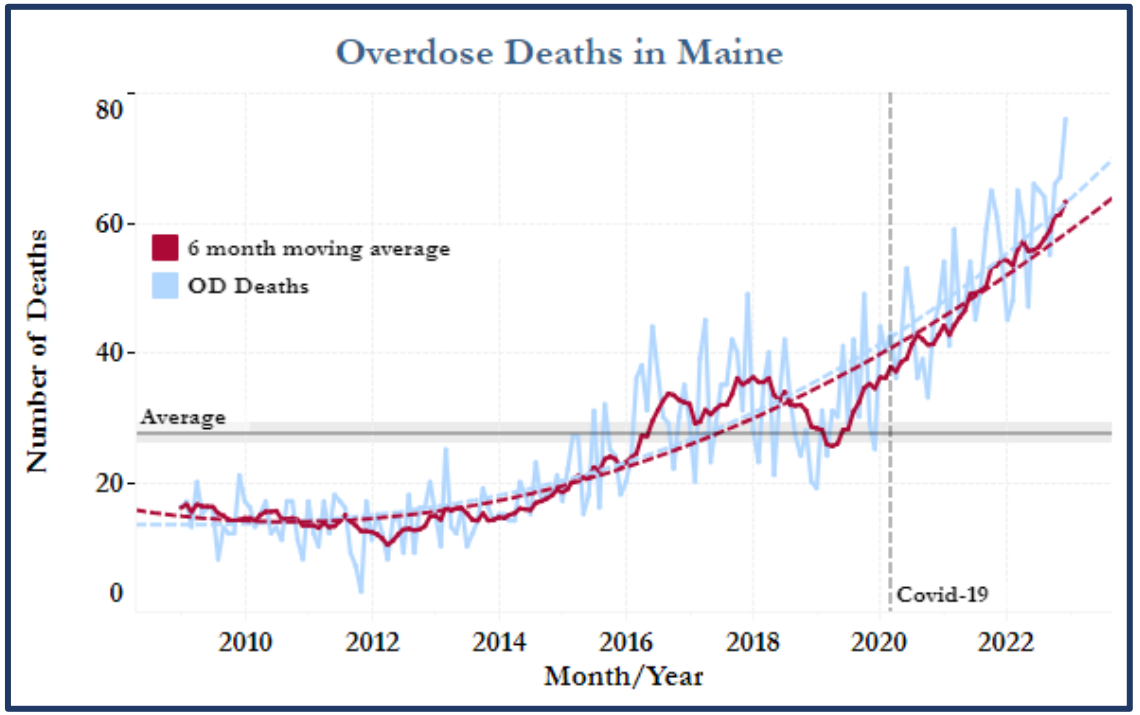
- Neither the presenters nor the program planners have any relevant financial conflicts of interest to disclose.

Learning Objectives

- Recognize and understand that substance use disorder is a complex chronic illness.
- Understand the role of stigma and bias in perpetuating healthcare inequities and poor outcomes for patients with substance use disorder.
- Demonstrate how process improvement methodology can help reduce inequities in health outcomes for a vulnerable population.
- Recognize how improved health for patients with substance use disorder leads to healthier communities overall.

Substance Use Related Deaths

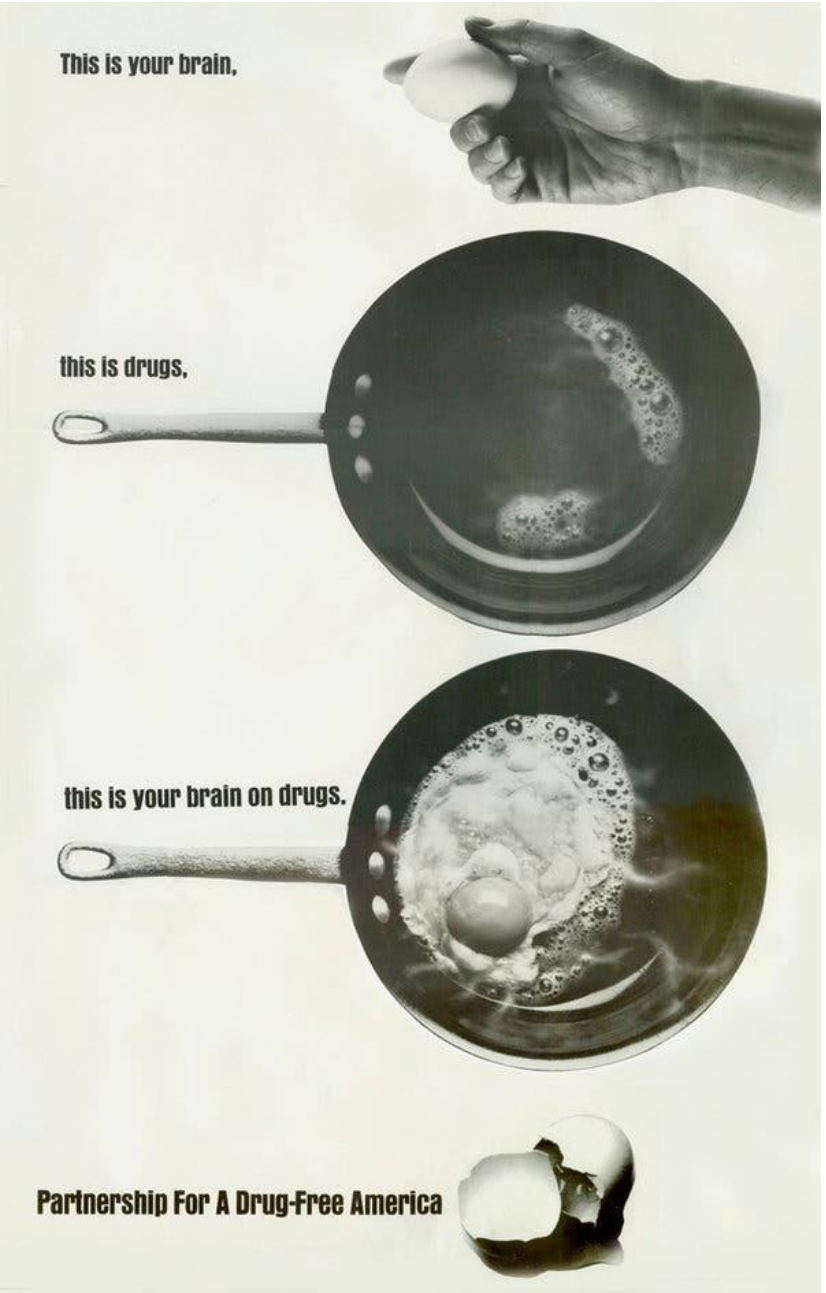




Understanding the Opioid Overdose Epidemic | Opioids | CDC

Maine Drug Death Dashboard – Maine Drug Data Hub

Substance Use - A Moral Failing?



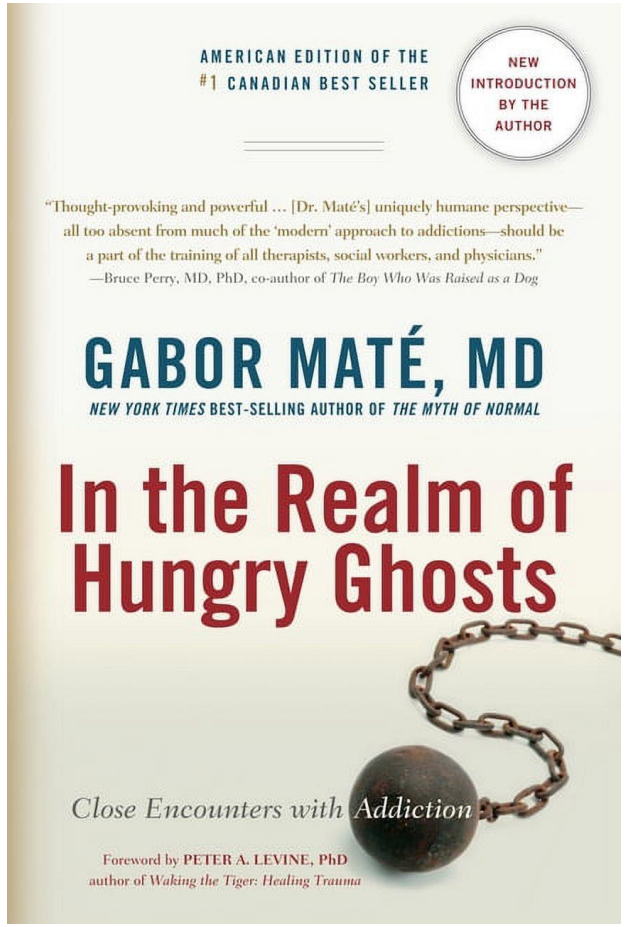
Towards A Better Understanding

- Research has uncovered how psychological traits, emotions, and behaviors are encoded in the brain; how environmental factors influence brain circuits and subsequent behavior; and how genetic and epi-genetic factors influence the development and functioning of the brain, all of which are of relevance to addiction risk and resilience.
- Adolescents are more likely than adults to experiment with drugs and to develop substance use disorders
- Adolescent brain has not completed its development and is more neuroplastic than the adult brain
- Addiction develops faster in an adolescent than in an adult, and it also explains the greater sensitivity of adolescents to environmental stimuli, such as stress, that influence drug taking

Neuroscience of Addiction: Relevance to Prevention and Treatment. Nora D. Volkow, M.D., Maureen Boyle, Ph.D. Am J Psychiatry 175:8, August 2018

Reframing Addiction

- “It is impossible to understand addiction without asking what relief the addict finds, or hopes to find, in the drug or the addictive behavior.”
- “Addiction is not a choice that anybody makes; its not a moral failure…it’s a response to human suffering.”
- “Addiction is always a poor substitute for love.”



Stigma In Medical Practices

- Adjusted response rate of 54%.
- PCPs reported high levels of stigmatizing attitudes.
- Less than 30% of PCPs reported that they were willing to have a person taking medication for OUD as a neighbor or marry into their family, even if that person was being treated with medication.
- Greater stigma was associated with an 11 percentage points lower likelihood that PCPs prescribed OUD medication and lower support for policies intended to increase access to OUD medication.
- Structural stigma – the societal and institutional policies that have led to under-resourced health and social service systems for people with OUD and other vulnerable groups.

The role of stigma in U.S. primary care physicians' treatment of opioid use disorder. Elizabeth M. Stone, Alene Kennedy-Hendricks, Colleen L. Barr, Marcus A., Bachhuber, Emma E. McGinty. Drug Alcohol Depend . 2021 April 01; 221: 108627. doi:10.1016/j.drugalcdep.2021.108627.

- What instances have you seen related to bias/stigma in your work settings?
- What can you do to reduce the bias/stigma?

How does stigma effect substance use disorder?

- **People who need care may not disclose it or seek care.**
  - Fear or actual mistreatment, stereotyping, and negative bias from society, including in healthcare settings.
  - In 2021, about 10.4% of people who felt they needed substance use treatment but did not receive it in the past year said they did not seek treatment because they feared attracting negative attitudes from their communities.
- **People receive a poorer quality of care**.
  - Health professional bias toward people with addiction may lead to failure to provide evidence-based care.

https://nida.nih.gov/research-topics/stigma-discrimination

How does stigma effect substance use disorder?

- **People may increase their substance use.**
  - Guilt and self-blame for their illness.
  - Self-stigma or adopt negative attitudes towards themselves
  - Feelings of shame and isolation may in turn reinforce drug-seeking behavior.
- **People have reduced access to health programs.**
  - Medications for substance use treatment (methadone, buprenorphine, and naltrexone) are safe and effective treatments and are often mistakenly seen as mere substitutes for illegal drugs and carry a similar stigma.
- **Harm reduction programs -** Needle exchange, supervised injection facilities
  - Help prevent risks – HIV, hepatitis, endocarditis
  - Avoided due to associated stigma
  - Misconception among general public, policy and lawmakers that they promote illicit drug use

https://nida.nih.gov/research-topics/stigma-discrimination

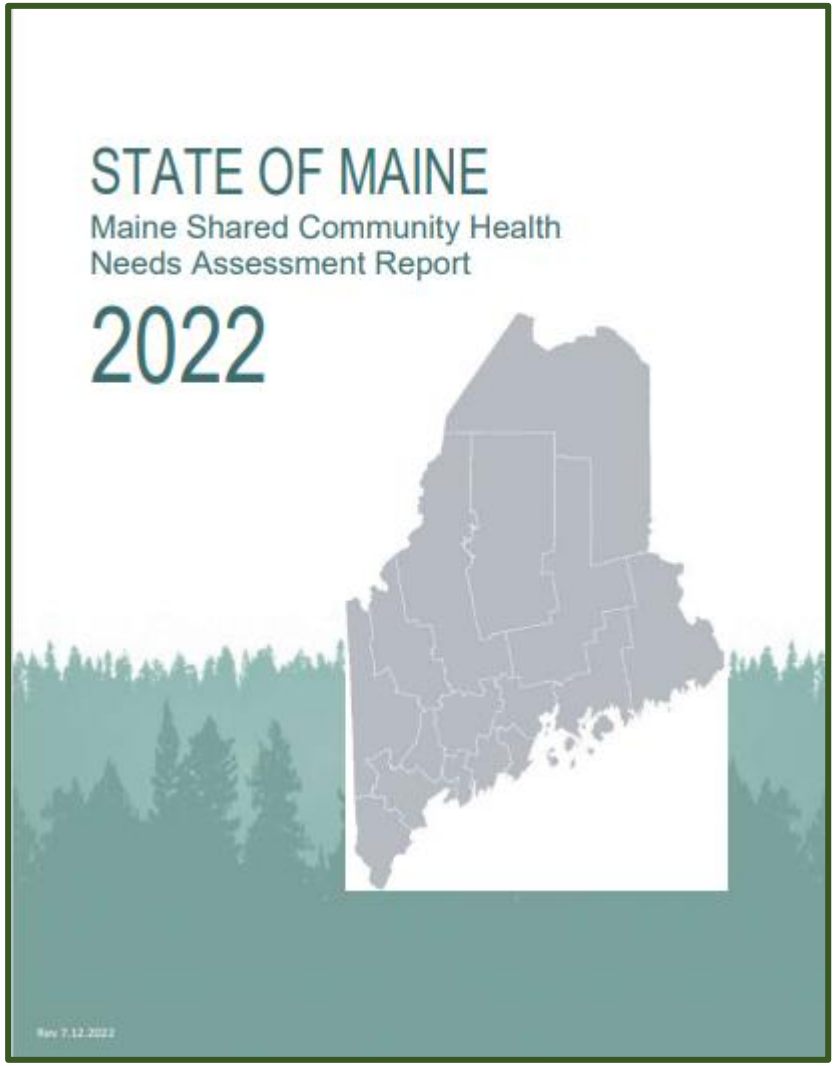
Adverse Childhood Events
CDC – Kaiser Study (1995-1997)

https://mnprc.org/wp-content/uploads/2019/01/aces-behavioral-health-problems.pdf

- **ACEs are common**
  - 28% of study participants reported physical abuse and 21% reported sexual abuse. Many also reported experiencing a divorce or parental separation or having a parent with a mental and/or substance use disorder.
- **ACEs cluster**
  - Almost 40% of the Kaiser sample reported two or more ACEs and 12.5% experienced four or more. Because ACEs cluster, many subsequent studies now look at the cumulative effects of ACEs rather than the individual effects of each.
- **ACEs have a dose-response relationship** with many health problems
  - An individual's cumulative ACE score has a strong, graded (i.e., dose-response) relationship to numerous health, social, and behavioral problems throughout their lifespan, including substance use disorders.

Maine CHNA 2022

- ACEs are a list of potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life.
- In 2019, 21.3% of Maine high school students reported experiencing four or more ACEs.



https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/documents/State%20Report%207.12.2022revision.pdf

Relationship Between ACEs and Related Behavioral Problems

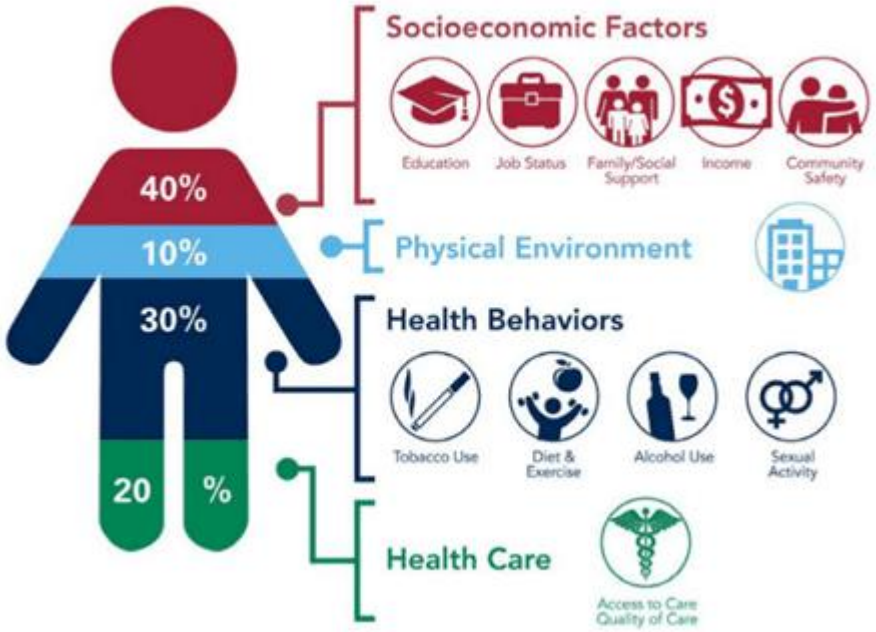
- Early initiation of alcohol use.
- Higher risk of mental and substance use disorders as an older adult (50+ years).
- Continued tobacco use during adulthood.
- Prescription drug use.
- Lifetime illicit drug use, drug dependency, and self-reported addiction.
- Suicide attempts.
- Lifetime depressive episodes.
- Sleep disturbances in adults.
- High-risk sexual behaviors.
- Fetal mortality.
- Pregnancy outcomes.
- Negative physical health outcomes.
- Poor dental health.

https://mnprc.org/wp-content/uploads/2019/01/aces-behavioral-health-problems.pdf

The Health Gap - The Challenge of An Unequal World

- “Why treat people and send them back to the conditions that make them sick?”
- “There’s good evidence that if people are disempowered, if they have little control over their lives, if they’re socially isolated or unable to participate fully in society, then there are biological effects.”

Social Drivers (Determinants) of Health (SDOH)



- Nonmedical factors that influence health outcomes
- Conditions in which people are born, grow, work, live, and age
- Driving factors in health disparities and inequities

Urban–rural variation in the socioeconomic determinants of opioid overdose

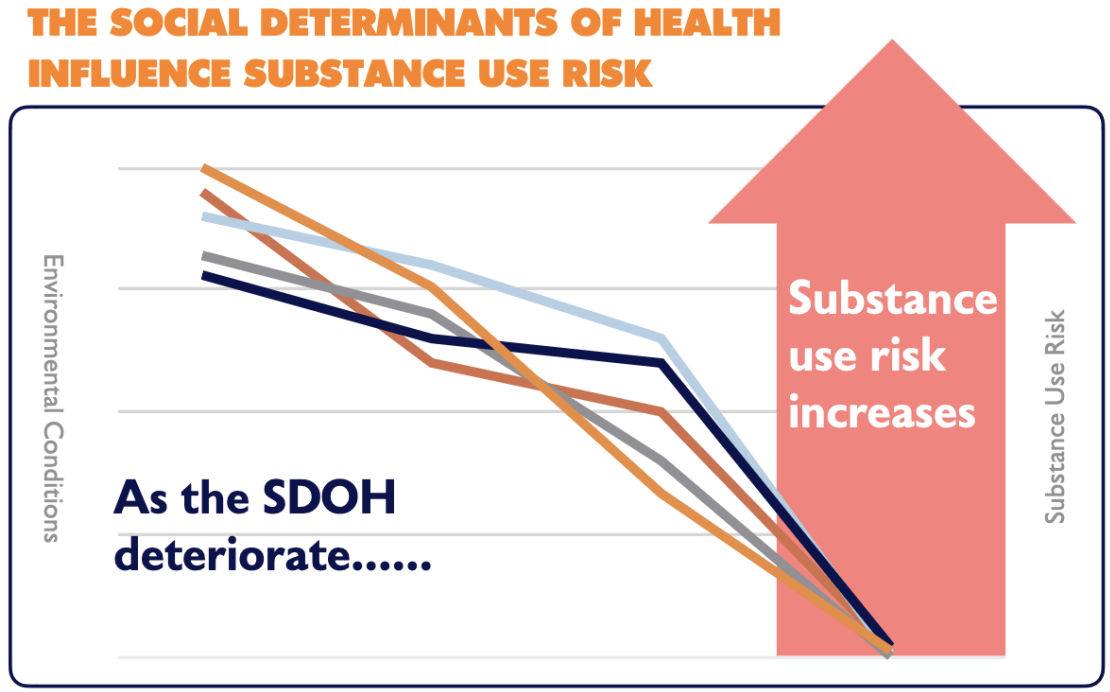
Veronica A Pear [1], William R Ponicki [2], Andrew Gaidus [2], Katherine M Keyes [3], Silvia S Martins [3], David S Fink [3], Ariadne Rivera-Aguirre [4], Paul J Gruenewald [2], Magdalena Cerdá [4]

- Opioid overdoses were concentrated in more economically disadvantaged zip codes, indicated by higher rates of poverty and unemployment as well as lower education and median household income.
- Other studies have poverty to be a risk factor for opioid overdoses, unemployment to be a risk factor for fatal heroin overdoses, and a low educational level to be a risk factor for prescription overdoses, and for overdose mortality
- Homelessness status associated with overdoses among veterans

Poverty, homelessness, and social stigma make addiction more deadly

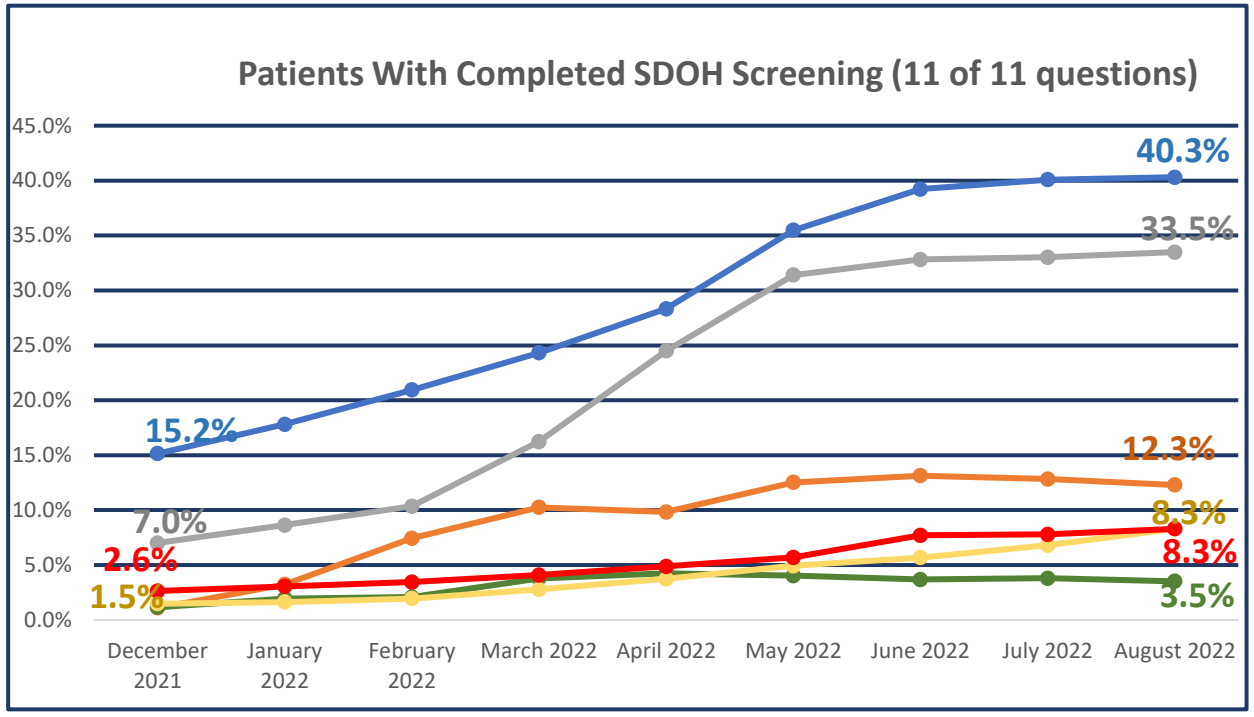
September 28, 2021

*By **Peter Grinspoon, MD**, Contributor*



Health-Related Social Needs (HRSN)

- Despite the strong links between HRSNs and health outcomes, recent evidence suggests that only one quarter of U.S. hospitals screen for these five needs (food insecurity, housing instability, a lack of access to transportation, an inability to afford utility bills, and exposure to interpersonal violence).
- CMS Hospital Inpatient Quality Reporting (IQR) Program 2023 – health equity measures
- These measures risk becoming checkboxes that increase administrative burden and waste resources if hospitals don't use sociodemographic and HRSN data to take meaningful action at the bedside and in their surrounding communities.
- Ultimately, hospital actions shouldn't be viewed as a panacea for achieving health equity, but rather as adjuvants to broader state and federal policies that improve the social conditions that drive health outcomes.

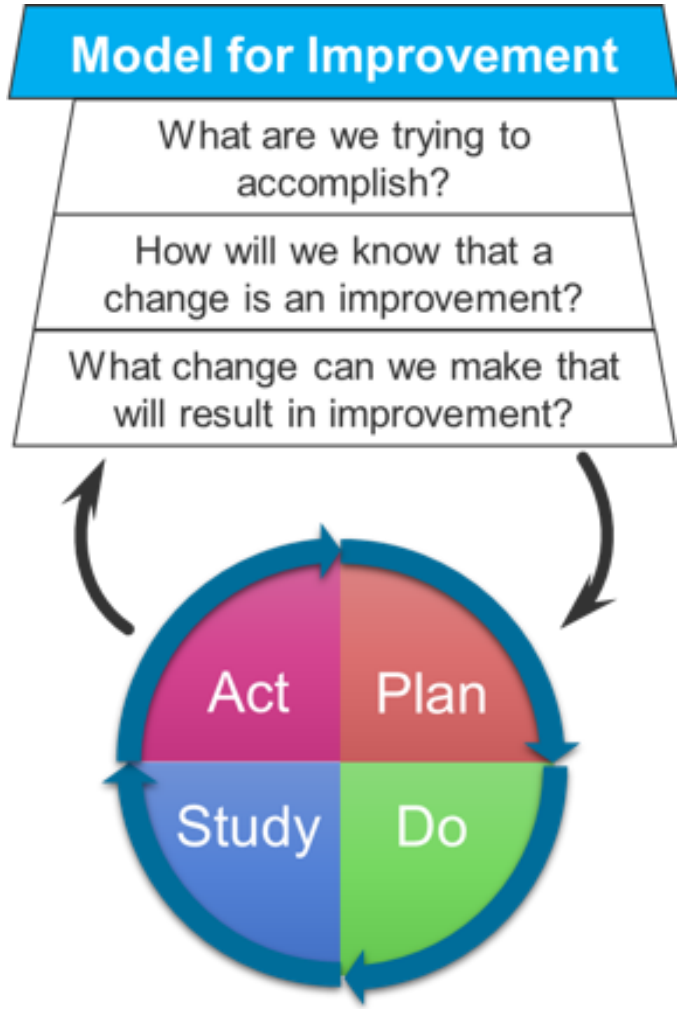


https://www.nejm.org/doi/full/10.1056/NEJMp2211648

- What methods are you employing to better understand the social drivers for patients with substance use disorder?

Quality & Process Improvement Methodology

- Understanding the problem
- Objective data
- Interpreting the data
- Voice of the patient
- Understand the process
- Data-driven - measurement
- Types of measures – process, outcome, balance



Leveraging QI to Achieve Equity in Health Care

- Adults receive only half of recommended health care services – overwhelming volume of medical knowledge, stigma, bias, other?
- Quality of health care and disparities in care are integrally linked
  - Six pillars of quality includes health equity - equitable care and outcomes
  - Initial focus on racial and ethnic minorities; other groups experiencing disparate care include immigrants, persons with disabilities, and people in lower socioeconomic status; social drivers of health.
- Health care systems will need to focus on both the elimination of disparities and on quality improvement (QI) simultaneously if we are to achieve the goal of equity in quality

https://www.elft.nhs.uk/sites/default/files/import-news/2022.06.15.Green-et-al-2010-Leveraging-Quality-Improvement-to-Achieve-Equity-in-Health-Care.pdf

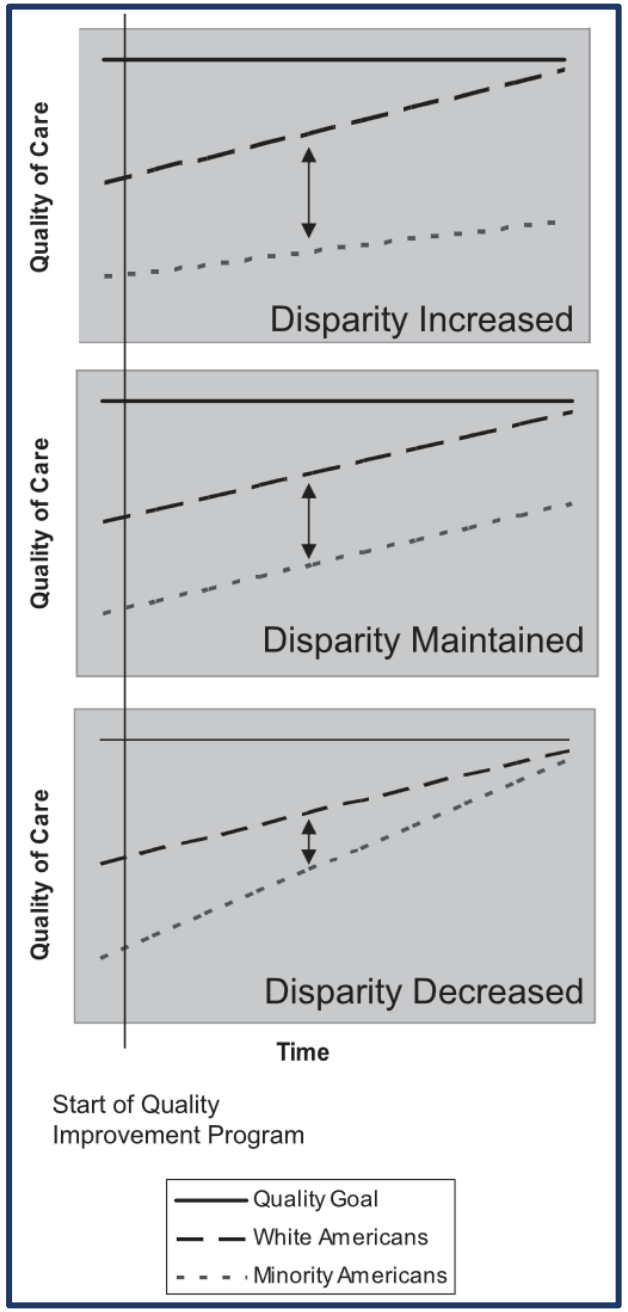
Types of QI Interventions

- **Standard QI interventions**' effect on disparities is unpredictable and variable
- **Group targeted QI interventions** selectively target specific disparity groups
  - At health care organizations that predominantly serve disparity populations
  - Target disparity groups within a general population by stratifying data by demographics and other data
- **Culturally competent QI interventions**
  - Designed to improve care for everyone with particular attention paid to disparity groups

https://www.elft.nhs.uk/sites/default/files/import-news/2022.06.15.Green-et-al-2010-Leveraging-Quality-Improvement-to-Achieve-Equity-in-Health-Care.pdf

Standard QI Interventions Can Worsen Disparities

- Three possible outcomes of standard QI interventions
- Worsening disparities may occur because of minorities' lesser access to or lesser benefit from QI programs compared with majority patients.
- Programs may also lead to unintended consequences, such as pay-for-performance initiatives causing physicians to avoid "difficult" patients.



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Standard Vs. Culturally Competent QI

- Standard QI efforts (one size fits all) may preferentially improve quality for more advantaged patients and maintain or even worsen existing disparities
- Culturally competent quality improvement:
  - Ability of individual clinicians and health care systems to provide high quality care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.
- Uses disparities data to direct tailored interventions
- Specific emphasis on addressing the unique needs of minority groups and the root causes of disparities

https://www.elft.nhs.uk/sites/default/files/import-news/2022.06.15.Green-et-al-2010-Leveraging-Quality-Improvement-to-Achieve-Equity-in-Health-Care.pdf

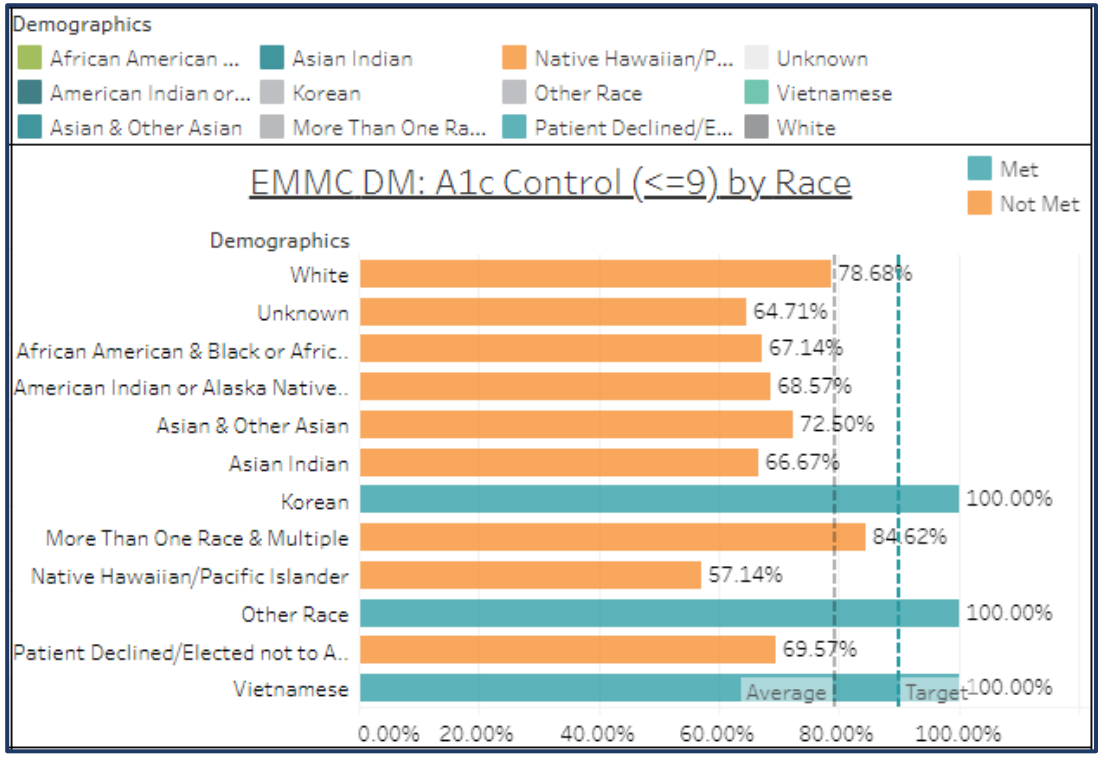
Guidelines for Culturally Competent QI

1. Identify disparities and use disparities data to guide and monitor interventions
2. Address barriers unique to specific disparity groups
3. Address barriers common to many disparity groups.

https://www.elft.nhs.uk/sites/default/files/import-news/2022.06.15.Green-et-al-2010-Leveraging-Quality-Improvement-to-Achieve-Equity-in-Health-Care.pdf

Identify disparities and use disparities data to guide and monitor interventions

- Collect demographic and SDOH data
  - In a 2006 survey of hospitals, 78% reported collecting data on race, 50% on ethnicity, and 50% on primary language. However, only 20% of hospitals used these data to stratify quality indicators to look for racial/ethnic or linguistic disparities.
- Stratify quality data
- Identify disparity conditions and populations



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Address barriers specific to disparity groups

- Many QI interventions are planned, carried out, and evaluated without ever assessing their potential effect on disparities in care
  - Engage health care teams' diverse views on unintended consequences of an intervention
  - Patient and community engagement through focus groups, interviews, or less formal discussions with community representatives or leaders.
- Helps identify potential for general QI intervention to worsen disparities
- Guide and tailor interventions to address specific cultural issues

https://www.elft.nhs.uk/sites/default/files/import-news/2022.06.15.Green-et-al-2010-Leveraging-Quality-Improvement-to-Achieve-Equity-in-Health-Care.pdf

Address Barriers Common to Disparity Groups

- **Communication barriers**: language, general literacy, and health literacy.
  - Approaches to addressing both language barriers and literacy have been shown in numerous studies to improve care
  - Health care organizations should adopt “Health Literacy Universal Precautions,” which assume that all patients are at risk of not understanding health information.
- **Difficulty accessing and navigating the health care system**
  - Disparity groups, or minority populations, may not have equal access to QI interventions.
  - tailoring QI efforts to address disparities hinge on the intervention’s ability to reach the patients who suffer from disparate care.
  - less access to resources - home computers, convenient transportation, less flexibility with their time, They may also be less likely to respond to mailed letters and other written materials.
  - Clear and simple instructions, peer support networks, and patient navigators

https://www.elft.nhs.uk/sites/default/files/import-news/2022.06.15.Green-et-al-2010-Leveraging-Quality-Improvement-to-Achieve-Equity-in-Health-Care.pdf

Address Barriers Common to Disparity Groups

- **Lack of patient-centeredness**
  - defined as care that is compassionate, empathic, and responsive to the individual patient's needs, values, and expressed preferences.
  - Central to, an overlap significantly with, culturally competent care
  - Individuals carrying out the QI interventions should receive training in culturally competent, patient-centered care
- **Conscious or unconscious biases and clinical decision-making**
  - Clinicians and others should learn to recognize their own potential for biased decision making on the basis of race, ethnicity, gender, socioeconomic status, etc.
  - Stratifying clinician performance by race/ethnicity and providing personalized feedback
  - rigorous use of evidence-based guidelines could minimize subjectivity in clinical care

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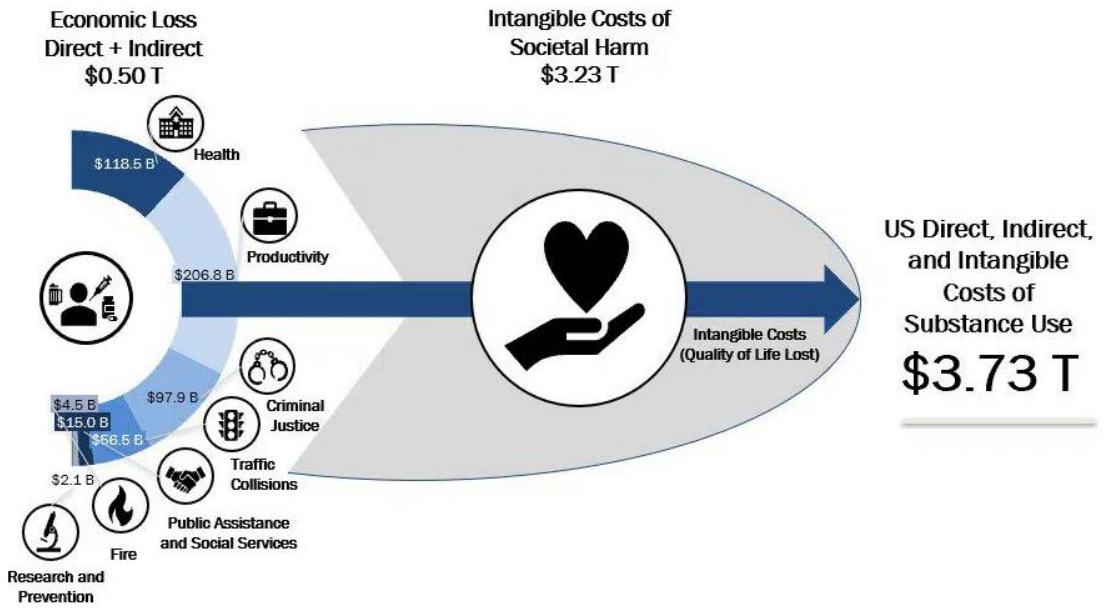
Impact of Substance Use Disorder



- Health ($118.5B)
  - Outpatient and inpatient
  - Heart disease
  - Maternal & fetal health
  - Communicable diseases – HIV, hepatitis
  - Behavioral health
- Criminal justice ($97.9B)
  - Law enforcement costs
  - Racial injustice and inequities
- Lost productivity ($206.8B)
  - Premature death, incarceration, absenteeism

Economic cost of substance abuse disorder in the United States, 2019 - Recovery Centers of America

Key Take Aways

- A society/civilization is judged by how it treats its most vulnerable, marginalized populations.
- Substance use has a complex neurobiology, should be treated as a chronic disease, with interdisciplinary team support.
- Stigma, adverse childhood events, and social drivers of health contribute to disparities in health and quality of care outcomes for patients with substance use disorder.
- Quality improvement has the potential to reduce disparities in outcomes for patients with substance use disorder by appropriately stratifying quality data.