# Implementing and Sustaining Medication for Opioid Use Disorder in Michigan Emergency Departments

## Barriers and Potential Solutions

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Michigan Opioid Partnership | Community Foundation FOR SOUTHEAST MICHIGAN


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# Executive Summary

The Michigan Opioid Partnership (MOP) is a public-private collaborative focused on decreasing opioid overdoses and deaths in Michigan. The MOP includes the State of Michigan and key philanthropic organizations. Since its inception in 2018, the partnership has supported the implementation of medication for opioid use disorder (MOUD) programs in Michigan emergency departments (EDs) through grant funding and technical assistance. With changes in available funding occurring in 2024, the MOP was no longer able to provide grant support to hospitals. However, the MOP continued to offer technical assistance to EDs implementing MOUD programs and started exploring systems-level strategies to promote sustained statewide implementation.

The Community Foundation for Southeast Michigan, which is home to the MOP, engaged Public Sector Consultants (PSC) to help identify pervasive barriers to MOUD in EDs and potential high-impact solutions to those barriers. To identify and prioritize barriers and solutions to implementing and sustaining MOUD in Michigan EDs, PSC engaged stakeholders through one-on-one conversations, a survey, and small group discussions.

PSC's research occurred between January and September 2024 in three distinct phases:

- **Phase one:** Identify barriers to initiating and/or sustaining programs to provide MOUD in EDs
- **Phase two:** Prioritize the barriers identified in phase one
- **Phase three:** Identify solutions to address high-priority barriers

Numerous barriers were identified through an initial set of stakeholder conversations and a survey. Three overarching barriers then emerged from a small group discussion with key stakeholders to prioritize the identified barriers.

1. Stigma, staff resistance, and a lack of hospital leadership buy-in create significant barriers to implementing and sustaining a MOUD program.
2. Hospitals often implement and track the MOUD protocol in a siloed manner that creates variation across the state, making statewide analysis and monitoring difficult.
3. There is inadequate peer integration due to difficulties associated with reimbursement of peer services and patient access to these services.

Additional conversations and small group discussions with stakeholders led to the following proposed solutions.

### Mandate and Incentivize MOUD in EDs

All stakeholders agreed that mandating and incentivizing the use of MOUD in hospitals and pharmacies would have a significant impact on the high-priority barriers. Stakeholders stated that Michigan and the U.S. have reached a point where mandating MOUD is likely to be more widely accepted by legislators, advocates, and healthcare providers. As opioid settlement funds are being distributed and utilized and as the opioid crisis is gaining national attention, they said the time is ripe for Michigan to mandate MOUD within hospitals and pharmacies.

### Establish MOUD Trainings and Resources for Hospital Staff

Stakeholders agreed that establishing a statewide incentivized MOUD training program for new and experienced healthcare workers along with resources, such as marketing tools and role-specific training for hospital staff, would significantly reduce barriers to MOUD program implementation. Stakeholders believe that stigma against people with opioid use disorder/substance use disorder (OUD/SUD) and providing MOUD in medical settings has significantly reduced over the last ten years, in part due to national-level opioid epidemic reporting and elimination of the Drug Addiction Treatment Act (DATA) waiver, or X-waiver, in 2023.[1] However, they acknowledge that stigma and misconceptions still exist and could be further reduced with more training and resources.

### Integrate Peers into MOUD Programs

Throughout the process, stakeholders asserted that peer recovery coaches are vital to MOUD program success and patient navigation. They averred that policies that better integrate peers into hospital MOUD programs would ultimately save the lives of OUD patients by ensuring they get the help they need in the way that they require. They recommend allowing hospitals to bill for peer services directly through insurance providers, creating a formal reimbursement model for peer services, and reimbursing for peer services at a competitive rate compared to similar positions to eliminate barriers to directly hiring peers as hospital staff.

Implementing the solutions above will require dedicated stakeholders to work collaboratively and, likely, through a more formalized structure. Key stakeholders could come together to develop an action plan that includes overarching objectives, strategies, and tactics; a detailed timeline; and responsible entities. Some proposed solutions will require the State of Michigan, state legislators, and statewide organizations to promote and enact policy changes to motivate and incentivize hospitals to implement MOUD and better utilize peers to support successful patient uptake of MOUD. The State will also need to collaborate with Michigan hospitals and clinical champions to improve educational resources for MOUD staff and establish a more robust career pathway for peer recovery staff. Now is the time for Michigan to ensure that all citizens have access to the lifesaving medication of MOUD.

[1] Practitioners seeking to prescribe buprenorphine outside of a treatment program for OUD were required to obtain a "X-waiver" to do so. Obtaining the waiver entailed participation in a daylong training, which discouraged doctors from obtaining the waiver, thereby limiting access to MOUD.

# Introduction

The MOP is a public-private collaborative focused on decreasing opioid overdoses and deaths in Michigan. The MOP includes the State of Michigan and key philanthropic organizations, such as the Community Foundation for Southeast Michigan (Community Foundation), which serves as the home of the MOP, as well as Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of Michigan Foundation, Ethel and James Flinn Foundation, The Jewish Fund, Michigan Health Endowment Fund, and Superior Health Foundation.

Since its inception in 2018, the MOP aims to increase access to evidence-based treatment for individuals with opioid use disorder. The partnership has supported the implementation of medication for opioid use disorder programs in EDs across Michigan through grant funding and technical assistance. With funding from the Michigan Department of Health and Human Services (MDHHS), Vital Strategies, and others, ED MOUD participation grew from six hospitals in 2019 to 75 hospitals in 2023, representing approximately half of Michigan's EDs, all ten prepaid inpatient health plan (PIHP) regions, and most major health systems. With changes in available funding occurring in 2024, the ED MOUD initiative concluded its grant program, continued its technical assistance, and started exploring systems-level strategies to encourage sustained statewide implementation.

The Community Foundation engaged PSC to help identify pervasive barriers to ED MOUD and potential high-impact solutions to those barriers. To identify and prioritize barriers and solutions to implementing and sustaining MOUD in Michigan EDs, PSC engaged stakeholders through one-on-one conversations, a survey, and small group discussions. Participating stakeholders included clinical champions, which are emergency medicine providers who are advocates for, and experts in, MOUD, including physicians, nurses, and pharmacists, and peer recovery coaches; PIHPs and commercial insurance representatives; and statewide and national experts. In total, 32 stakeholders participated in a range of engagement activities. A full list of stakeholders can be found in Appendix A.

PSC's research occurred between January and September 2024 in three distinct phases:

- **Phase one:** Identify barriers to initiating and/or sustaining programs to provide MOUD in EDs
- **Phase two:** Prioritize the barriers identified in phase one
- **Phase three:** Identify solutions to address high-priority barriers

A detailed description of the research phases is provided below.

# Phase One: Identifying Barriers

Understanding what barriers exist to implementing sustainable, successful MOUD programs in hospital EDs was crucial to laying a foundation for the rest of the work. PSC began the process of identifying ongoing barriers by reviewing several resources provided by the Community Foundation, including several bulletins related to Michigan Medicaid policy, a 2022 Vital Strategies program evaluation report, and MOUD educational and training resources. PSC also reviewed the MOP medication-assisted treatment (MAT) initiative interim report from December 2020 and the original work plan from this initiative. A full list of the documents PSC reviewed is available in Appendix B.

## Conversations

During phase one, PSC conducted one-hour video call conversations with 16 stakeholders who interact with MOUD programs at different points in the healthcare system, including clinical champions (physicians, a registered nurse, and a

pharmacist), peer recovery coaches, statewide experts, and representatives from PIHPs and private insurance. The Community Foundation identified these participants from ongoing MOUD-related projects, and several peer recovery coaches were selected based on clinical champion recommendations.[2]

PSC asked participants to describe the MOUD intake, treatment, and discharge process; where challenges arise; and how the Community Foundation has supported or can better support this work. Additionally, PSC asked about challenges in ED, pharmacy, and outpatient procedures; with hospital leadership buy-in and billing and reimbursement; and with PIHPs and statewide policy. The conversation guide can be found in Appendix C.

## Emerging Themes

During the one-on-one conversations, stakeholders identified a wide range of barriers to MOUD implementation in EDs, which largely fit into the following categories:

- Lack of buy-in from hospital leadership
- Staff resistance to culture change in EDs
- Siloed and varied MOUD program development
- Not enough referral options or care coordination following ED visits
- Inadequate integration and reimbursement of peer recovery coaches
- Inadequate relationship building with PIHPs and pharmacies
- Loss of financial and champion cohort supports
- Disjointed patient navigation

An overview of specific barriers identified within each category are provided below. Additional detail can be found in Appendix D.

### Lack of Buy-In from Hospital Leadership

- **Stigma limits hospitals' willingness to implement MOUD programs—**Hospital leadership and other physicians may be unwilling to create programs for people with OUD if they view OUD as a choice rather than a medical issue or disease.
- **MOUD programs are not profitable compared to other types of medical interventions—**Patients treated with MOUD are often transferred out of the hospital into a separate recovery program. If MOUD and recovery treatments are not seen as profitable, hospitals may not prioritize it as a treatment option.
- **Contract issues prevent MOUD programs from being established—**When hospital administrators refuse to sign contracts needed to initiate MOUD programs, the programs cannot be funded, resulting in some hospitals discontinuing their MOUD efforts.
- **MOUD program success depends on physician buy-in—**Physicians can act as leaders and advocates within hospital systems, and advocates are necessary for MOUD to launch and sustain.

### Staff Resistance to Culture Change in EDs

- **OUD intake adds to ED staff workload—**EDs have lengthy triage checklists for each patient, and MOUD intake can be seen as one more task in addition to the already time-consuming intake process.

[2] PSC reached out to clinical champions at hospitals with varying levels of MOUD program implementation in northern Michigan and the Upper Peninsula, but they did not respond to the request or participate in the research.

- **Stigma among hospital staff limits their willingness to treat patients with OUD—**Staff's negative experiences treating patients with OUD may impact their willingness to treat OUD as they would any other illness or medical emergency; some hospital staff view behaviorally difficult patients as very time consuming and challenging to assess and treat.
- **Lack of consistent, ongoing education inhibits staff willingness and ability to administer MOUD protocols—**Assessing OUD and administering MOUD requires frequent education and training, but some ED staff lack the required ongoing education and training.
- **Longer-tenured staff find culture change difficult—**Newer doctors and residents tend to have a more progressive understanding of how to treat OUD and are willing to participate in implementing MOUD programs.

## Siloed and Varied MOUD Program Development

- **Having only one champion per hospital system exacerbates program burden—**MOUD program success relies on a program champion, but building buy-in within their hospital, educating fellow staff, and introducing the necessary screening protocols can be difficult for only one person to manage. In hospitals with successful MOUD programs, there are champions in multiple departments.
- **Champions are working alone despite cross-regional expertise—**Despite many MOUD champions having expertise in addiction treatment, dispensing MOUD, and establishing ED protocols, lacking a formal network means individual hospital sites must create their own protocols, which is time consuming and burdensome, given competing ED needs.
- **MOUD protocol in EDs is not consistently implemented or tracked—**MOUD is implemented differently everywhere, so initiation, screening, and prescribing processes differ from hospital to hospital, making MOUD protocol difficult to track—both within the hospital and statewide.
- **Integration of peer recovery coaches varies among hospitals—**MOUD programs incorporate peer recovery coaches in different ways and to varying degrees across the state, which can lead to differing uptake and outcomes for patients.

## Not Enough Referral Options or Care Coordination Following ED Visits

- **Hospitals do not trust the quality of outpatient OUD services—**The quality of outpatient service providers varies and is sometimes unknown to providers, which can inhibit OUD patients' recovery success.
- **EDs do not have a functioning follow-up mechanism—When** referral organizations are not integrated into the larger hospital system, doctors do not have a way to know whether the patient referral was successful (i.e., whether treatment occurs, prescriptions are picked up, or both) unless they make a point to call the patient or the organization to which the referral was made.
- **Rural locations lack access to referral organizations—**Hospitals in more rural areas, especially in northern Michigan, may not have many (or any) outpatient organizations to refer patients to.

## Inadequate Integration and Reimbursement of Peer Recovery Coaches

- **Lack of peer support access creates patient backlog or drop-off—**With already long ED wait times, waiting even longer to see a peer recovery coach because a peer is not immediately available can result in patients leaving before they get the help they need.
- **Current peer support policy makes reimbursement difficult—**It is currently required that all billing for peer services go through a PIHP, creating an extra reimbursement step that requires a collaborative working relationship between the PIHP and hospital.

## Inadequate Relationship Building with PIHPs and Pharmacies

- **Quality of relationships with PIHPs varies across the state—**Many hospitals partner with PIHPs to contract peer recovery coaches, but not all hospitals currently coordinate with their local PIHP, and some were unaware of this option.
- **Pharmacies refuse to fill electronic MOUD prescriptions—**Some pharmacies will not fill an electronic MOUD prescription, either because the pharmacist does not know the prescribing provider or because the pharmacy refuses to stock medications like buprenorphine.
- **Rural locations do not have access to dependable pharmacies—**Like the potential lack of outpatient treatment services in more rural areas, there tend to be fewer pharmacies willing to dispense MOUD, which may result in fewer options for accessing MOUD in rural areas.

## Disjointed Patient Navigation

- **Stigma can prevent patients from seeking help—**Patients may not believe they have a problem with substances or may associate SUD with being a "junkie" or other harmful stereotypes that could limit their willingness to seek treatment.
- **Lack of transportation poses barriers to treatment—**A lack of transportation becomes a profound barrier when clients must travel long distances to pick up a prescription or attend a recovery program.
- **Unreliable communication devices can hinder care coordination—**It can be difficult to contact patients who struggle to maintain a consistent phone number or device due to economic challenges.
- **Uninsured status can result in longer wait times and additional expenses—**Patients who are uninsured have to pay out of pocket for MOUD treatment while they are waiting to be enrolled in Medicare or Medicaid.
- **Patients may not trust ED staff—**Patients might not feel safe divulging information to hospital staff (namely doctors) for fear of getting in trouble, being treated differently from other patients, and/or being denied care.
- **Patients may resist OUD treatment—**Some patients may not be ready to address their SUD, including committing to picking up and taking medication and participating in a treatment plan. Regardless of readiness for treatment, sometimes patients' other financial or health priorities take precedence over addressing OUD.
- **Rural patients may perceive a lack of confidentiality—**In smaller, more rural communities, patients may feel less inclined to share candidly with their providers if they know each other or have acquaintances in common due to a perceived lack of confidentiality.

## Loss of Financial and Champion Supports[3]

- **Loss of peer recovery coach support significantly impacts program success—**Unless coaches can be paid for through other programs or grants, or reimbursement policy is changed at the federal level, hospitals may struggle to retain peer recovery coaches.
- **Lack of financial support makes it harder to justify the program expense—While** established MOUD programs may have self-sustaining protocols in place, staff regularly working to address SUD and prescribe MOUD still need to devote adequate administrative and training time, which is an ongoing, significant cost.

[3] These barriers were ultimately not included in the prioritization survey nor any further feedback opportunities because they could not be solved due to the grant cycle being complete.

- **Loss of champion peer communication hinders problem-solving**—Grant-funded, formalized communication allowed champions to compare processes and share ideas, which helps prioritize MOUD programming. The loss of grant funding has led some MOUD programs to be paused or discontinued.

# Phase Two: Prioritizing Barriers

Following the conversations, PSC engaged the same group of stakeholders through a brief survey and a 90-minute virtual meeting to prioritize the identified barriers and determine the most urgent ones. Key findings from these activities are presented below, followed by detailed findings from the survey and facilitated meeting. A copy of the survey can be found in Appendix E, and a copy of the workgroup session results can be found in Appendix F.

## Survey

Survey respondents were asked to rank the eight barrier categories from most- to least-significant impact on MOUD implementation and then to indicate whether each subbarrier was or was not a barrier. Ten stakeholders completed the survey. Most respondents (60 percent) were physicians, one was a peer recovery coach, one was a PIHP representative, one was an insurance representative, and one was a registered nurse.

### Barrier Category Rankings

Survey respondents ordered the eight barrier categories based on the level of impact the barrier has on implementing MOUD programs, where the top-ranked category has the greatest impact and the lowest-ranked category has the least impact. Survey respondents' average rankings of each barrier category's impact level are below (the lower the average, the greater the impact) (Exhibit 1).

**EXHIBIT 1.** Barrier Category Ranking by Level of Impact

| Barrier Category | Average Impact Ranking (one for greatest impact and eight for lowest impact) |
|---|---|
| Not enough referral options or care coordination following ED visits | 3.5 |
| Lack of buy-in from hospital leadership | 3.6 |
| Inadequate integration and reimbursement of peer recovery coaches | 3.7 |
| Staff resistance to culture change in EDs | 4.3 |
| Disjointed patient navigation | 4.6 |
| Loss of financial and champion cohort supports | 5.0 |
| Siloed and varied MOUD program development | 5.2 |
| Inadequate relationship building with PIHPs and pharmacies | 6.1 |

### Subbarrier Significance

Within each barrier category, there was a list of associated subbarriers. For the subbarriers within those categories, respondents indicated whether each subbarrier was not a barrier, was a moderate barrier, or was a significant barrier (Exhibit 2). Appendix E includes the results of the subbarrier survey questions.

EXHIBIT 2. Barrier Significance

| Barrier Categories and Subbarriers | Significant Barrier | Moderate Barrier | Not a Barrier |
|---|---|---|---|
| **Not enough referral options or care coordination following ED visits** | | | |
| Rural locations lack access to referral organizations | 60% | 40% | 0% |
| EDs do not have a functioning follow-up mechanism | 50% | 40% | 10% |
| Hospitals do not trust the quality of outpatient OUD services | 10% | 50% | 40% |
| **Lack of buy-in from hospital leadership** | | | |
| MOUD program success depends on physician buy-in | 60% | 40% | 0% |
| Stigma limits hospital leadership's willingness to implement MOUD programs | 50% | 30% | 20% |
| MOUD programs are not profitable compared to other types of medical interventions | 20% | 70% | 10% |
| Contract issues prevent MOUD programs from being established | 20% | 40% | 40% |
| **Inadequate integration and reimbursement of peer recovery coaches** | | | |
| Current peer support policy makes reimbursement difficult | 70% | 20% | 10% |
| Lack of peer support access creates patient backlog or drop-off | 40% | 50% | 10% |
| **Staff resistance to culture change in EDs** | | | |
| Lack of consistent, ongoing education inhibits staff willingness and ability to administer MOUD protocols | 60% | 40% | 0% |
| Stigma among hospital staff limits their willingness to treat patients with OUD | 60% | 40% | 0% |
| Longer-tenured staff find culture change difficult | 50% | 50% | 0% |
| OUD intake adds to ED staff workload | 0% | 80% | 20% |
| **Disjointed patient navigation** | | | |
| Lack of transportation | 70% | 20% | 10% |
| Lack of trust in ED staff | 60% | 40% | 0% |
| Stigma around OUD | 60% | 40% | 0% |
| Not able to prioritize addressing OUD over other financial or health issues | 40% | 60% | 0% |
| Not being ready/willing to address OUD | 40% | 60% | 0% |
| Lack of insurance coverage | 40% | 50% | 10% |
| Difficulty contacting for follow-up | 30% | 70% | 0% |
| Lack of confidentiality in rural areas | 0% | 90% | 10% |
| **Siloed and varied MOUD program development** | | | |
| Integration of peer recovery coaches varies among hospitals | 70% | 20% | 10% |
| MOUD protocol in EDs is not consistently implemented or tracked | 50% | 40% | 10% |
| Champions are working alone despite cross-regional expertise | 40% | 40% | 20% |
| Having only one champion per hospital system exacerbates program burden | 20% | 80% | 10% |
| **Inadequate relationship building with PIHPs and pharmacies** | | | |
| Quality of relationships with PIHPs varies across the state | 44% | 56% | 0% |
| Rural locations do not have access to dependable pharmacies | 33% | 67% | 0% |
| Pharmacies refuse to fill MOUD prescriptions | 11% | 56% | 33% |

# Workgroup Discussion

PSC facilitated a 90-minute virtual workgroup session to review the survey results, confirm prioritization criteria, and continue prioritizing the identified barriers by assessing the urgency with which they should be addressed. Four people participated in the workgroup discussion, including two clinical champions for MOUD programs, a statewide addiction expert, and a PIHP representative.

## Barrier Category Ranking

The workgroup reviewed the survey results, starting with the ranking of the barrier categories' impact on MOUD program implementation. PSC shared the impact rankings (Exhibit 1 above) and confirmed with the group that the top four categories (outlined below) are the most salient to address.

- Not enough referral options for care coordination following ED visits
- Lack of buy-in from hospital leadership
- Inadequate integration and reimbursement of peer recovery coaches
- Staff resistance to culture change in EDs

## Subbarrier Prioritization

PSC presented the subbarrier survey results and worked with the meeting participants to prioritize the subbarriers based on the survey findings. PSC proposed that barriers with at least 40 percent of respondents saying they were "significant" barriers and at least 70 percent of respondents saying they were either "moderate" or "significant" barriers should be considered high priority and advanced for solution identification. Workgroup participants agreed with the proposed criteria.

The subbarriers that met the proposed prioritization criteria and/or were otherwise selected for inclusion as high-priority barriers are in the table below (Exhibit 3). Most subbarriers that met the proposed criteria were advanced "as is" for solution development. In a few cases, however, workgroup participants modified the wording of a barrier, determined a barrier should not be advanced, or elevated a barrier that did not meet the prioritization criteria for advancement to solution development. A few barriers that did not meet the criteria were advanced for solution development when group members determined they were important barriers to address.

**EXHIBIT 3.** Subbarriers Advanced for Solution Development

| Subbarriers | Percentage Significant | Percentage Significant and Moderate Combined |
|---|---|---|
| Rural locations lack access to referral organizations | 60% | 100% |
| EDs do not have a functioning follow-up mechanism | 50% | 90% |
| MOUD program success depends on physician buy-in | 60% | 100% |
| Stigma limits hospital leadership's willingness to implement MOUD programs | 50% | 80% |
| MOUD programs are not equitably reimbursed compared to other interventions[4] | 20% | 90% |
| Current peer support policy makes reimbursement difficult | 70% | 90% |

[4] Revised from original barrier wording, which was MOUD programs are not profitable compared to other types of medical interventions.

| Subbarriers | Percentage Significant | Percentage Significant and Moderate Combined |
|---|---|---|
| Lack of peer support access creates patient backlog or drop-off | 50% | 90% |
| Lack of consistent, ongoing education inhibits staff willingness and ability to administer MOUD protocols | 60% | 100% |
| Stigma among hospital staff limits their willingness to treat patients with OUD | 60% | 100% |
| OUD intake adds to ED staff workload[5] | 0% | 80% |
| Integration of peer recovery coaches varies among hospitals | 70% | 90% |
| MOUD protocol in EDs is not consistently implemented or tracked | 50% | 90% |
| Champions work alone despite cross-regional expertise | 40% | 80% |
| Quality of relationships with PIHPs varies across the state | 44% | 100% |

## Barrier Urgency

After reviewing the survey results and confirming the high-priority barriers, PSC worked with the participants to identify the barriers that most urgently need to be addressed. To begin, participants were asked to define "urgent." The group agreed that to be ranked as high urgency a barrier should be one that "needs to be addressed now to reduce the event of death." With this definition in mind, participants discussed the prioritized subbarriers and categorized them as not urgent, somewhat urgent, or highly urgent.

The workgroup identified the subbarriers in the table below as highly urgent and also began to group them into larger themes (Exhibit 4).

**EXHIBIT 4.** Highly Urgent Barriers and Themes

| Theme | High-Priority Barriers |
|---|---|
| **Stigma, staff resistance, and lack of leadership buy-in** | Stigma among hospital staff limits their willingness to treat patients with OUD |
| | Stigma limits hospital leadership's willingness to implement MOUD programs |
| | MOUD programs are not equitably reimbursed compared to other types of medical interventions |
| | MOUD program success depends on physician buy-in |
| **Siloed and varied MOUD programs** | MOUD protocol in EDs is not consistently implemented or tracked |
| **Inadequate peer and referral utilization** | Current peer support policy makes reimbursement difficult |
| | Lack of peer support access creates patient backlog or drop-off |
| | EDs do not have a functioning follow-up mechanism |
| | Quality of relationships with PIHPs varies across the state |
| | Rural locations lack access to referral organizations |

[5] Barrier added to priorities even though it did not meet prioritization criteria.

# Phase Three: Identifying Solutions

With high-priority barriers identified, PSC engaged additional stakeholders through conversations and small group discussions to identify solutions to barriers deemed highly urgent. PSC first conducted one-hour conversations with stakeholders who had been engaged in the first two phases of the work as well as out-of-state experts to ask how the barriers should be addressed. PSC then conducted two small group conversations—one with MOUD clinical champions and one with MDHHS representatives—to refine the solutions identified through the conversations, discuss feasibility, and begin to identify potential entities responsible for their implementation.

## Conversations

PSC conducted one-hour conversations with ten stakeholders who interact with MOUD programs at different points in the healthcare system, including physician clinical champions, a peer recovery coach, a commercial insurance representative, and experts from inside and outside of Michigan. The Community Foundation identified these participants from previous and ongoing MOUD-related initiatives in Michigan and other states.

PSC presented the high-priority barriers to each participant and asked them to consider the barriers' root causes as well as potential solutions. National experts were also asked to describe efforts to solve these issues in other states. PSC also asked all participants to help categorize solutions as those that could be advanced through policy, training, or advocacy. The conversation guide can be found in Appendix G.

## Small Group Discussions

Following the conversations, PSC compiled a list of solutions to address barriers related to stigma, peers, and siloed programs to use as a foundation for two iterative small group discussions, one with six clinical champions (all physicians) and one with four MDHHS representatives. During the small groups, PSC shared a project overview and sought feedback and input on the potential solutions in each conversation. The first conversation was conducted with clinical champions, who were asked whether any solutions were missing, needed to be reworded, or should be removed; which solutions were most important; and which entities might be responsible for implementing each solution. Based on their feedback, PSC refined the solutions list and presented a refined list to the MDHHS group, who were asked whether the assembled solutions are already being addressed or align with ongoing initiatives; how feasible each of the solutions are; and which entities might be responsible for implementing each solution.

# Proposed Solutions

Many barriers were identified during the data collection process, and three overarching barrier themes arose during prioritization. Stakeholders shared that stigma, staff resistance, and a lack of hospital leadership buy-in create significant barriers to implementing and sustaining MOUD programs. Additionally, stakeholders noted that hospitals often implement and track MOUD protocol in a siloed manner, resulting in varied implementation across the state, making statewide analysis and monitoring difficult. Finally, peer recovery coaches provide an essential service in Michigan EDs. Yet, there remains inadequate peer integration due to difficulties associated with reimbursement of peer services and patient access to these services.

**The final set of proposed solutions can be organized into three categories:**

**Mandate and incentivize MOUD in EDs**

**Establish MOUD trainings and resources for hospital staff**

**Integrate peers into MOUD programs**

Most solutions must be initiated at the state level and coordinated with MOUD champions at the local level. Other solutions need to originate at the local (i.e., hospital) level. All the possible solutions under "mandating and incentivizing MOUD in EDs" require policy change and are solutions needing state-level action. Solutions under "establishing MOUD trainings and resources for hospital staff" require development by hospitals and champions before they are shared with and distributed at the state level. Solutions under "integrating peers into MOUD programs" require a combination of responsible entities (e.g., the State, hospitals, PIHPs, and clinical champions) to work together to integrate peer recovery coaches' expertise into hospitals and the MOUD process.

## Mandate and Incentivize MOUD in Emergency Departments

This set of solutions addresses high-priority barriers related to:

- Stigma, staff resistance, and lack of leadership buy-in
- Siloed and varied MOUD programs

The identified solutions include:

- Mandating the use of MOUD protocols in all hospitals
- Mandating that all pharmacies carry buprenorphine
- Creating a statewide hospital incentive program in coordination with insurance companies and Medicaid

All stakeholders agreed that mandating and incentivizing the use of MOUD in hospitals and pharmacies would have a significant impact on the related identified high-priority barriers. Stakeholders stated that Michigan and the U.S. have reached a point in time where mandating MOUD is likely to be more widely accepted by legislators, advocates, and healthcare providers. As the opioid settlement funds are being distributed and utilized and as the opioid crisis is gaining national attention, the time is ripe for Michigan to mandate MOUD within hospitals and pharmacies.

### Previous Attempts to Mandate

Though Michigan medical practitioners and state legislators previously attempted to mandate implementing MOUD, that bill has yet to be adopted. House bill 5163 (2021) proposed changes to the Public Health Code that would require:

1. A hospital that treats 50 or more patients per year in its ED for opioid-related overdose to implement an emergency-based MAT program
2. Require MDHHS to develop and implement a grant program to support MAT programs
3. Require a hospital to agree to comply with certain requirements as a condition of receiving grant funding

According to discussion participants, the State should also incentivize the use of MOUD and a common protocol. Stakeholders advised that Michigan should build an incentive program in partnership with commercial insurers and Medicaid to reduce resistance and promote MOUD adoption within hospitals and pharmacies across the state. The aim in partnering with medical insurers is not to increase the cost of MOUD, but to standardize it. By offering an incentive, the State would acknowledge the significant time investment and resources required to launch and maintain MOUD programs. A similar mandate and incentive program in the maternal-infant health space has seen success and is currently under way in Michigan. MDHHS shared that hospitals are motivated to adopt new mandates when that requirement is tied to ongoing funding that builds from year to year.

> "A lot of the way you get consistency is through incentives. If you're not paying well for MOUD, how can you expect [implementation and tracking] to be consistent?" — Phase three conversation participant

Stakeholders posited that the lack of buy-in among hospital administration and ED staff will gradually fade through mandating MOUD. They said staff resistance and lack of physician buy-in could become moot with state mandates and incentives because the decision to implement MOUD programs would no longer hinge upon provider and staff enthusiasm. Additionally, incentive programs would include standards and expectations for MOUD programs, which will increase consistent implementation of protocols, procedures, and data collection across the state.

It is important to note that for MOUD to be adopted statewide, mandating and incentivizing must occur in tandem as a coordinated, statewide effort. To mandate without an incentive or to incentivize without a mandate will likely result in hospitals continuing to choose not to provide MOUD.

## Establish MOUD Trainings and Resources for Hospital Staff

This set of solutions addresses high-priority barriers related to:

- Stigma, staff resistance, and lack of leadership buy-in
- Siloed and varied MOUD programs

The identified solutions include:

- Developing a statewide stigma reduction and MOUD training program, which should include:
  - Providing financial incentives or reimbursement for training attendance
  - Providing onsite and personalized technical assistance by staffing role based on sites' needs
- Advocating for medical schools to partner with and place students with SUD-focused organizations and addiction specialists
- Developing a clinical toolkit to encourage standardization, which may include low-barrier implementation guidance for hospitals with fewer resources and shared MOUD marketing tools

Stakeholders agreed that establishing MOUD training and resources for hospital staff would significantly reduce the burden of launching, evaluating, and sustaining an MOUD program. Stakeholders believe that stigma against people with OUD/SUD and providing MOUD in medical settings has significantly improved over the last ten years, in part due to national-level opioid epidemic reporting and the Drug Addiction Treatment Act (DATA) waiver, or X-waiver's, elimination[6]

[6] Substance Abuse and Mental Health Services Administration. 2023. "Waiver Elimination (MAT Act)." *Substance Abuse and Mental Health Services Administration.* https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act

in 2023. However, stigma and misconceptions still exist and could be further reduced through an incentivized statewide training program for new and experienced healthcare workers.

The intention of the incentivized training is to acknowledge people's misunderstandings about MOUD and SUD/OUD by directly challenging stigma and misconceptions. Incentivizing or reimbursing staff for training emphasizes the importance of this work and helps ensure staff attendance. It's also important to note that statewide coordinated training may relieve the pressures that hospitals experience when developing and conducting their own SUD/OUD trainings. During the conversations and small group sessions, stakeholders shared that advocating for medical schools to partner with SUD-focused organizations can continue to hone incoming healthcare workers' understanding of the importance of treating OUD with MOUD.

**Stakeholders suggested many potential training program topic areas, including:**

- One-on-one persuasive communication
- Debunking MOUD myths
- Stories from people with lived experience
- MOUD effectiveness and related health outcomes
- Sharing MOUD program case studies to demonstrate their cost benefit
- Evidence-based information about how peers support MOUD uptake to increase hospital leadership buy-in and public knowledge

> "How do you create culture change? It feels like you need bottom-up and top-down. You find and incentivize champions at all levels. You have to free up people's calendars and make room for the additional push needed [to get the work done]. Leadership can influence only so much." —Phase three conversation participant

Since 2018, the Community Foundation and clinical champion physicians have provided onsite technical training to hospitals as they developed their MOUD programs. Stakeholders shared that this resource was imperative to recruiting and supporting new hospitals. However, it's vital to ensure that technical assistance is provided according to staffing roles (e.g., nurse to nurse, pharmacist to pharmacist) since they will be able to address role-specific protocol questions. Additionally, providing role-specific technical support ensures that MOUD is championed within a hospital not only by physicians, but by all staffing levels, a critical element in sustaining MOUD programs.

> "Each person that becomes the champion is doing three million other jobs, so you're dealing with someone already overloaded. Give them a tool." —Phase three conversation participant

While MOUD programs have found success in multiple hospital systems in Michigan, their siloed and varied nature makes them challenging to implement and sustain without statewide support. Stakeholders recommended developing standardized toolkits to ensure a shared statewide protocol for MOUD program implementation and to avoid individual hospitals bearing the brunt of creating and implementing a new program without guidance. Training, marketing toolkits, and onsite technical assistance provide hospitals with the tools required to implement and sustain MOUD programming.

## Integrating Peers into MOUD Programs

The third solution addresses the barriers related to:

- Inadequate peer and referral utilization

The identified solutions include:

- Creating policies and procedures to adjust billing for peer services, including:
  - Allowing hospitals to bill for peer services directly through Medicaid and commercial insurance providers (remove PIHP requirement)
  - Creating a reimbursement model for peer services
  - Providing competitive reimbursement rates for peer services
- Identifying ways to share peers across a larger region
- Professionalizing the peer role and services, including:
  - Changing the peer recovery coach title to "peer navigator" to emphasize follow-up as a key element of the peer role
  - Providing financial support for peer training programs
  - Developing a career pathway with a living wage and career advancement opportunities

Stakeholders throughout this project asserted that peer recovery coaches and their role are vital to MOUD program success and patient navigation. They shared that policies that better integrate peers into hospital MOUD programs ultimately save the lives of OUD patients by ensuring they get the help they need in the way that they require. Allowing hospitals to bill for peer services directly through insurance providers, creating a formal reimbursement model for peer services, and reimbursing for peer services at a competitive rate compared to similar positions will eliminate barriers to directly hiring peers as hospital staff.

> "[Michigan] should share a peer across community settings, especially in rural areas." —Phase three conversation participant

In more rural Michigan regions, where the need for peer recovery coaches and their services onsite at every hospital is less pronounced, stakeholders have suggested that hospitals and the state consider sharing peers among several organizations, counties, or community settings to develop a rotating on-call system. This innovative approach could ensure that multiple sites have access to several peers, thereby better serving their community's needs and fostering peer-supported MOUD programs in these areas.

> "Peers [need to] earn a living wage and have a real career trajectory." —Phase three conversation participant

Supporting peer recovery coaches' career development will help hospitals attract and retain qualified, dedicated individuals to sustain MOUD program success. Stakeholders recommended changing the peer recovery coach title to "peer navigator" to signal the importance of helping OUD patients navigate the hospital MOUD process as part of the peer services role—further navigation and follow-up is often overlooked as a crucial part of MOUD program success. They also emphasized the need to support peers as they develop in their careers, including covering required training costs to increase equity among those in the profession. Because peers fill a unique niche and are in recovery from OUD themselves, their professional development resources may be limited—supporting their initial training can be

instrumental in ensuring they enter and thrive in this profession. Finally, developing a formal career pathway will help improve peer recruitment and retention by providing peers with career advancement options, which would encourage them to gain additional training and remain in this crucial field.

> "Using the term 'navigator' is important. Peers should have a mechanism for continued patient follow-up. It would make a huge difference [for patients] under the influence of a substance since they can struggle to know what to do." —Phase three conversation participant

# Conclusion

Through a comprehensive, iterative engagement process, including conversations, a survey, and small group discussions, PSC supported the Community Foundation in identifying salient barriers to implementing and sustaining MOUD programs in hospital EDs along with potential solutions for addressing those barriers.

Ensure all Michiganders have access to MOUD, a lifesaving OUD medication and ED intervention.

Implementing the proposed solutions will require dedicated stakeholders to work collaboratively and, likely, through a more formalized structure. PSC recommends pulling key stakeholders together to develop an action plan based on these proposed solutions, which may include overarching objectives, a detailed timeline, benchmarking metrics, and responsible entities. Some identified solutions will require the State of Michigan, state legislators, and statewide organizations to enact policy changes to motivate and incentivize hospitals to implement MOUD and better utilize peers to support successful patient uptake of MOUD. The State will also need to collaborate with Michigan hospitals and clinical champions to improve educational resources for MOUD staff and establish a more robust career pathway for peer recovery staff. Now is the time for Michigan to ensure that all citizens can access MOUD, a lifesaving medication and ED intervention.

# Appendix A: Stakeholder Organizations

# Stakeholder Organizations

The stakeholders who participated in the research, while employed by their respective organizations, reflect their individual experiences and perspectives. Their insights do not represent the views or positions of their organizations.

- Blue Cross Blue Shield of Michigan
- Bronson Healthcare
- California Bridge
- Corewell Health West Michigan (formerly Spectrum Health)
- Covenant HealthCare
- Detroit Medical Center
- Face Addiction Now (formerly Families Against Narcotics)
- Henry Ford Hospital
- Hurley Medical Center
- Michigan Department of Health and Human Services (MDHHS), State of Michigan
- Michigan Department of Licensing and Regulatory Affairs, State of Michigan
- Michigan Health & Hospital Association Keystone Center
- Michigan Health Endowment Fund
- Munson Healthcare
- Northern Michigan Regional Entity (Prepaid Inpatient Health Plan)
- Office of Strategic Partnerships & Medicaid Administrative Services, MDHHS, State of Michigan
- Opioid Overdose Response Program at Integrated Services of Kalamazoo
- Substance Abuse and Mental Health Services Administration
- Trinity Health Michigan, Grand Rapids location
- Vital Strategies

# Appendix B: Literature Review List

# Providing Medication for Opioid Use Disorder in Emergency Departments

## Literature Review Document List

To learn about the challenges hospital emergency departments (EDs) face in initiating medications for opioid use disorder (MOUD) for people with opioid use disorder (OUD), Public Sector Consultants (PSC) reviewed resources, including documents and video recordings, provided by the Community Foundation for Southeast Michigan (Community Foundation) and the Michigan Opioid Partnership (MOP). PSC also reviewed Michigan Department of Health and Human Services (MDHHS) policies and bulletins and additional documents and websites described below.

- American College of Emergency Physicians, Medication Assisted Treatment (MAT) FAQs
- California Bridge, CA Bridge Resources Page
- Community Foundation, Championing Medication for Opioid Use Disorder with a Large Hospital System
- Community Foundation, Community Foundation Training Series (2022)
- Community Foundation, Fact or Fiction? The Truth About Medication for Opioid Use Disorder
- Community Foundation, Michigan Opioid Partnership Impact Report
- Community Foundation and MOP, ED MOUD Initiative Workplan
- Community Foundation and MOP, September 2023 Symposium: Billing and Sustainability Considerations
- Community Foundation and MOP, September 2023 Symposium: Harm Reduction Services Panel Discussion
- Community Foundation and MOP, September 2023 Symposium: Inpatient MOUD Services and Addiction Consult Services
- Community Foundation and MOP, September 2023 Symposium: Peer Recovery Coach Services Panel Discussion
- Community Mental Health Association of Michigan, What is a PIHP?
- Dima Qato, Jonathan Watanabe, Kelly Clark, et al., Federal and State Pharmacy Regulations and Dispensing Barriers to Buprenorphine Access at Retail Pharmacies in the US
- Kathryn Hawk, Jason Hoppe, Eric Ketcham, et al., Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department
- MDHHS, Michigan Medicaid Policy (MMP) Bulletin 23-49
- MDHHS, MMP Bulletin 23-61
- MDHHS, MMP Bulletin 23-74
- MOP, Program—Michigan Opioid Partnership

# Appendix C: Identifying Barriers Conversation Guide

# Providing Medication for Opioid Use Disorder in Emergency Departments

## Conversation Guide—Identifying Barriers

## Background

The Michigan Opioid Partnership (MOP), led by the Community Foundation for Southeast Michigan (CFSEM), has been supporting hospitals to implement medications for opioid use disorder (MOUD) programs in emergency departments across Michigan. With funding, participation in the ED MOUD initiative grew from six to 75 hospitals—representing approximately half of Michigan's emergency departments and all ten prepaid inpatient health plan regions. With changes in available funding, the ED MOUD initiative is entering a new phase that shifts away from directly funding individual hospitals and towards identifying and addressing underlying barriers that prevent hospitals from initiating and/or sustaining their program to provide MOUD in the ED.

CFSEM has partnered with PSC to lead this research. This winter, we are conducting one-on-one conversations with a variety of stakeholders representing hospital programs at different levels of implementing MOUD in their ED, including clinical consultants and peer recovery coaches, as well as statewide government and insurance experts. In discussing MOUD launch and implementation, we'd like to explore what works well, where challenges arise, and where improvements can be made.

We appreciate you taking time today to share your thoughts. Please feel free to speak candidly from your perspective and experience. Your participation is voluntary; if there are any questions you do not want to answer, you are not required to do so. Your feedback will not be attributed to you personally. Do you have any questions before we begin?

| Stakeholder Perspective | 1—Building Rapport | 2—Emergency Departments | 3—Hospital Leadership | 4—State- level Policy | 5—CFSEM | 6—Closing |
|---|---|---|---|---|---|---|
| Clinical Consultants | X | X | X | X | X | X |
| Other Clinical Champions | X | X | X | X | X | X |
| Peer Recovery Coaches | X | X | X | | | X |
| State/Government | X | | | X | | X |
| PIHPs | X | | | X | | X |
| Hospital Administration | X | X | X | X | X | X |
| Private Insurance | X | | | X | | X |

# Questions

## One—Building Rapport

1. To start, can you tell me about your role(s) within your current organization(s)?
    a. How does or did your role support or influence ED MOUD?
    b. [If part of direct services/implementation] What made you decide this program was worth bringing to/engaging in at your hospital?
2. [If a physician] How would you describe the status of your hospital's MOUD in the ED program?
    i. *Working on implementing a program now*
    ii. *Previously implemented a program, but no longer a part of our ED's process*
    iii. *Previously implemented a program and working to continue and sustain it*
    iv. *Previously implemented a program and it is fully operational*

## Two—Emergency Departments

### Process Burden

3. When this program is running successfully, what does that look like?
    a. Can you describe any obstacles in setting up a successful program?
    b. In your ED, is this process seen as a burden (too time-consuming and/or difficult to carry out) compared to other screenings and treatments? Is there pushback in instituting this program because of its challenges?
4. Can you describe how stigma surrounding opioid-related programs has affected MOUD in EDs programming?

### [Physicians Only] Program Champions and Staff Turnover

5. We want to learn more about how support from champions helps establish and sustain an MOUD program. What was your experience [working as a champion/working with a champion]?
    a. Typically, what departments are champions part of? Does this vary by location?
        i. What challenges accompany being a champion in this type of department?
        ii. What works well about this champion placement?
6. How has staff turnover affected implementing and sustaining this program?
    a. How can champions better prepare team members to sustain this work even after they leave?
    b. How can mentorship be built in or improved? (probe: Do you know where/who to turn to when you have questions about the work? Do you feel there are resources readily available?)
7. Does your ED have an onboarding guide for new hires, including residents, nurses, APPs, staff physicians?

a. [If yes] Does it describe your ED MOUD process? Tell me more about that.
b. [If no] Do you think an onboarding guide would be helpful to sustain an ED MOUD program? Why or why not?

### MOUD is a Lower Priority in ED

8. We know the ED setting is a demanding space already. Where does MOUD fall in your ED's priorities? Tell me more about that.
9. Where in the diagnosis process/at what stage of admission is the MOUD process considered?

    a. Who determines that the MOUD process should happen?

### Outpatient Landscape and Referrals

10. We've heard that referrals can require navigating a complex process. What is the importance of having a referral process in place for ED MOUD?

    a. Where are there successes in the current referral process both for the specific site and the ecosystem as a whole?
    b. Where are there challenges to creating/completing successful referrals both for the specific site and the ecosystem as a whole?

### Pharmacy Challenges

11. We've heard that coordinating with pharmacies to fill medication orders can sometimes prove challenging. What obstacles have you noticed with filling MOUD orders?

    a. [If familiar with rural areas] We've also heard that responses to MOUD programs may differ across Michigan—for example, pharmacies won't fill orders through telehealth or from providers they don't know. Have you heard of this happening? Do you know why that is?
    b. Have you experienced any issues with keeping adequate stock of medications like buprenorphine?

## Three—Hospital Leadership

### Leadership Buy-in

We're hoping to understand how leadership is involved in sustaining MOUD in EDs.

12. How would you describe the level of hospital leadership buy-in to the MOUD program?

    a. What strategies have worked well with gaining administration buy-in?

        i. What are some challenges that have come up when getting their buy-in (probe: financials, budgeting, stigma, etc.)?
        ii. What efforts were made to address the stigma related to MOUD?

    b. What about other ED staff? What strategies have worked well with gaining buy-in among ED staff and medical providers?

    i. What are some challenges that have come up when getting their buy-in (probe: extra staff/capacity, time required, stigma, etc.)?
    ii. What efforts were made to address the stigma related to MOUD?

13. Overall, what has been the biggest obstacle to achieving leadership or ED buy-in?

### Billing and Reimbursement

14. We heard about a lower reimbursement for this program—is that an issue mostly for financial/administrative folks?
15. Does the current billing code setup hinder or enhance the MOUD work being done? How so? (probe: dispensing/administration of medication, care management/coordination, peer recovery coaches, etc.)

    a. Is G-code typically used?

16. If the program you're familiar with has peer recovery coaches, are they (or the hospital/clinic) able to bill and collect for the services they provide? If yes, what does that process look like?
17. [If state/government] What impact might having peer recovery coach services outsourced through community organizations reimbursed by PIHP add to existing stigma related to OUD? For example, why is this person not an employee of the hospital when every other person I interact with for my care is an employee?
18. [If a PIHP or private insurance provider] Do you perceive that well-functioning ED MOUD programs improve care and are cost effective? Tell me more about that.

## Four—State-level Policy

### Policy Challenges

19. Now, I'd like to zoom out and consider state-level policy. What are the current policies in place that support MOUD and wraparound services?

    a. Where do you think policy needs to be improved to sustain MOUD/wrap around services?
    b. Where are there are gaps in understanding Michigan policies related to MOUD programs?
    c. Describe how hospital programs track, interpret, and implement policy changes. Which step (tracking, interpreting, or implementing) has proven the most difficult? Why?

20. How can CFSEM better support programs to track, interpret, and implement policy changes?

    a. How have past or existing Medicaid bulletins helped or hindered the billing process?

### Prepaid Inpatient Health Plans (PIHPs)

21. Specifically related to PIHPs, which policy issues have impeded or slowed the implementation of this program?

    a. Have there been issues with reimbursement that got in the way of implementing this program? If so, tell me more about that.

        i. Are there specific issues related to getting reimbursed for peer support?

22. [If a PIHP or private insurance provider] Have you had experience working with EDs and their MOUD programs?

    a. If yes:

        i. Can you describe any barriers that you've experienced?
        ii. Can you describe any issues with outpatient referrals?
        iii. Can you describe whether there have been issues when billing MOUD programs?
        iv. What strategies does your PIHP/private insurance use when funding peer recovery coaches?
        v. Has there been any movement with the ability to bill peers through the hospital system?

# Five—CFSEM Program Management

## Marketing and Communications

23. In thinking about how MOUD programs are established and implemented, what tools has CFSEM provided for your hospital to implement/sustain this program and track its progress?

    a. How can the CFSEM tools be improved?
    b. What marketing and communications-focused materials have been helpful in implementing this program?

        i. What materials would be helpful that don't currently exist?

## Loss of Financial Incentive

We know that some MOUD programs were impacted by a loss of funding in September.

24. Can you describe how access to MOUD-specific funding impacted your program?
25. Can you describe how the loss of grant funding impacted how your MOUD program?

# Six—Closing

26. If you could wave a magic wand, what improvements can be made to better implement this program?
27. Are we asking the right questions? Based on your understanding of barriers in MOUD hospital programs, are there any important topics missing from what we've covered today?
28. Is there anything else you would like to share before we wrap up?

Thank you so much for participating and sharing your perspective today. PSC will compile the information we've gleaned through these conversations and provide a summary to CFSEM. The next step in our research will be bringing a group of people together to prioritize the barriers that have been identified. Would you be open and interested in staying involved as we continue our research?

Thank you again. If you have any additional feedback, please feel free to reach out to us at elammers@publicsectorconsultants.com.

# Appendix D: Identifying Barriers Emerging Themes

# Providing Medication for Opioid Use Disorder in Emergency Departments

## Identified Barriers

In one-on-one conversations, stakeholders identified a wide range of barriers to medication for opioid use disorder (MOUD) implementation in emergency departments (EDs). While several barriers were consistently raised by participants, they represent a starting point to enhance understanding of the barriers that hospitals and patients face within Michigan's recovery ecosystem and should not be viewed as comprehensive. This summary presents themes that emerged around respondents' observed barriers to MOUD in EDs.

### Hospital Leadership

#### Barrier Location: Hospital

- **Stigma limits hospitals' willingness to implement MOUD programs**—Physicians shared that stigma is the foundation of resistance to implementing and following MOUD protocols in their hospital. Hospital leadership and physicians may be unwilling to create programs for people with opioid use disorder (OUD) if they view OUD as a choice rather than a medical issue or disease. Participants explained that hospital leaders are also concerned offering MOUD and other OUD treatment options will result in their hospital being labeled as the type of hospital that caters to people with OUD rather than to the general population.
- **MOUD programs are not profitable compared to other types of medical interventions**—Participants shared that hospitals' bills for MOUD are not comparable to other reimbursable medical procedures. When someone is treated with MOUD, they are often transferred out of the hospital into a separate recovery program. Consequently, MOUD/recovery is not as profitable as other forms of care (e.g., cancer, diabetes), so hospitals may not prioritize MOUD.
- **Contract issues prevent MOUD programs from being established**—Some participants described establishing an MOUD ED program, confirming alignment among staff, and drafting the Community Foundation for Southeast Michigan (CFSEM) grant contract, only for the contract to not be signed by hospital administration. Without signature, the program cannot be funded, which has led some hospitals to discontinue their MOUD efforts.
- **MOUD program success depends on physician buy-in**—Participants described how physicians can act as leaders and advocates within hospital systems. If a physician chooses a program to be a priority, with support from hospital leaders, they have the authority to ensure it happens. Participants noted that a physician advocate is necessary for MOUD to launch and sustain.

### ED Culture Change

#### Barrier Location: Hospital

- **OUD intake is one more thing for ED staff to do**—EDs are structured with lengthy triage checklists. According to participants, potential nurse pushback might be related to having one more thing to do in addition to the already lengthy checklist they must cover for every patient.

- **Stigma among hospital staff limits willingness to treat patients with OUD—**According to participants, staff's negative experiences treating patients with OUD may impact their willingness to treat OUD as they would any other illness or medical emergency. Participants described many ways in which stigma among hospital staff creates barriers to treatment. Participants shared that some nurses, ED physicians, and even pharmacists believe promoting OUD treatment options could encourage people with OUD to seek help and overwhelm their ED. Some staff believe an ED or pharmacy becoming known for dispensing MOUD could attract people with OUD, especially those in active addiction or withdrawal. Participants shared that people with OUD, especially those in withdrawal, can be rude to hospital staff or exhibit unpredictable behaviors because of the intense pain they experience. Some hospital staff view behaviorally difficult patients as very time consuming to assess and treat. Participants noted some staff may be burned out treating people with OUD—if OUD is seen as a choice, frequent visitors may be perceived as beyond or not worth helping.
- **Lack of consistent, ongoing education inhibits staff willingness and ability to administer MOUD protocols—**Some ED staff lack the education and training needed to assess OUD and administer MOUD despite having received previous training. Assessing OUD may be a less-frequent ED need than other medical conditions, so it is possible that staff forget the steps or feel more comfortable enlisting staff with more OUD experience to support assessment and administering MOUD. Past policies, like the X waiver, can lead to misunderstanding around what medication can be prescribed, staff authority to prescribe medication, and what processes should be followed.
- **Older staff find culture change difficult—**Participants shared that doctors fresh out of medical school know more about the realities of OUD compared to before this program began. Newer doctors and residents tend to have a more progressive understanding of how to treat OUD and are willing to participate in implementing MOUD programs. Older generations of doctors and nurses tend to have outdated knowledge about OUD and some push back against treating it, believing that promoting MOUD treatment will entice people with OUD to visit and use up valuable ED staff resources. According to participants, staff with this perception worry they will be treating repeat visitors who may not be interested in meaningfully addressing their OUD.

## Program Development

### Barrier Location: Hospital

- **Having only one champion per hospital system exacerbates program burden—**Participants emphasized how MOUD program success relies on an MOUD program champion, someone who advocates for programming to address OUD and rallies colleagues to support this effort. Champions are necessary because they help build buy-in within their hospital, educate fellow staff, and introduce the necessary screening protocols. Unless someone in a leadership position encourages MOUD work, champions are usually doctors and directors of EDs. Hospital sites often have only one champion to promote this work due to both stigma among hospital staff and competing priorities in the ED and the larger hospital system. Participants observed that in hospitals where MOUD is most successful, there are champions in multiple hospital departments, outpatient services, and other locations within the recovery ecosystem.
- **Champions are working alone despite cross-regional expertise—**According to participants, people responsible for implementing MOUD programs do not have a broader regional or statewide cohort with which to share ideas. Despite many MOUD champions having expertise in addiction treatment, dispensing MOUD, and establishing ED protocols, lacking a formal network means

individual hospital sites must create their own protocols, which is time consuming and burdensome, given competing ED needs.

- **MOUD protocol in EDs is not consistently implemented or tracked**—Participants shared that many hospital programs do not track whether ED staff consistently follow MOUD intake procedure(s). For example, questions related to substance use disorder (SUD) may not be triage requirements or can be avoided if staff have the option to select "patient refused to answer" when they do not feel comfortable asking about substance use or are unsure about next assessment steps. Screening processes may be initiated by intake staff—which could occur when a patient enters the ED or once they are seen by a nurse or doctor—or by peer recovery coaches situated in the ED to support patients presenting with SUD symptoms. Once patients have reached the prescribing phase, hospitals use prescription orders to indicate whether MOUD is being prescribed, but this is not something that is being monitored statewide or consistently within hospital systems. Champions must also account for their own hospital system's regulations, which can result in different requirements (and different results and uptake) within each program.
- **Integration of peer recovery coaches varies**—While many participants lauded the importance of peer recovery coach intervention, MOUD programs incorporate peer recovery coaches in different ways and to varying degrees across the state. Differing peer recovery coach integration can lead to differing uptake and outcomes for patients. Some hospitals ask everyone who comes into their ED about OUD, while others rely on individual staff discretion to determine whether to bring in a peer recovery coach. Most hospitals contract peer recovery coaches through local prepaid inpatient health plans (PIHPs) or other outside organizations, though some hire their own coaches. Onsite peer recovery coaches seem to have more robust processes to communicate when their support is required. Outside organizations that provide peer recovery coaches are often on call 24/7 but, depending on the day and time, there can be a lengthy delay between when the hospital calls the organization and when the peer recovery coach arrives at the hospital.

## Referrals and Follow-up Coordination

### Barrier Location: Recovery Ecosystem

- **Hospitals may not trust the quality of outpatient SUD services**—MOUD program champion participants shared that the quality of outpatient service providers varies. Successful referrals to these providers are often based on personal relationships between hospital staff and outpatient staff and knowledge of how outpatient centers support their patients. If outpatient centers are not affiliated with the hospitals that discharge patients, doctors cannot vouch for the quality or suitability of their services. Participants shared that there are residential recovery organizations that require abstinence for a certain number of days before they approve an admission, which creates a barrier for patients when they are in active withdrawal or use. Discrepancies between a progressive ED standard of care and abstinence-focused recovery organizations can inhibit OUD patients' recovery success. Some organizations' regulations and practices related to standards of care, like prohibiting smoking and vaping on campus premises or requiring negative drug screen results, can unintentionally filter out otherwise eligible and committed patients.
- **EDs typically do not have a functioning follow-up mechanism**—ED staff typically do not check in with patients after they are referred out of the ED. When referral organizations are not integrated into the larger hospital system, doctors do not have a way to know whether the patient referral was successful (whether treatment occurs, prescription is picked up, or both) unless they

make a point to call where they referred the patient. Because of competing emergent needs in EDs, the busy nature of working in a hospital, and doctors not being required to check in after patients leave, this follow-up does not always occur.

- **Rural locations may lack access to referral organizations**—Hospitals in more rural areas, especially in northern Michigan, may not have many (or any) outpatient organizations to refer patients to. According to participants, outpatient organizations more than 30 miles away can be a barrier for patients with limited access to transportation.

## PIHP/Insurance Integration

### Barrier Locations: Recovery Ecosystem and State Policy

- **Lack of peer support access can create patient backlog or drop-off**—While peer recovery coaches are onsite and ready to support walk-in patients at some EDs, for other programs, coaches are a 20- to 30-minute drive away and come to the hospital ED when paged. With already long ED wait times, waiting even longer to see a peer recovery coach can result in patients leaving before they get the help they need.
- **Current peer support policy makes reimbursement difficult**—Hospitals have historically not been able to receive reimbursement for peer recovery coach services due to (federal) Medicaid limitations. Without allowable reimbursement, hospitals potentially lose money employing peer recovery coaches. Without MOUD program grant funding, coaches are often cut due to budget constraints. Program champion participants bemoaned the loss of peer recovery coaches because they are integral to the success of the program, including capturing accurate patient information and successfully navigating the referral process. Participants across stakeholder categories agreed peer recovery coach retention is vital to ensuring the success of MOUD programs—inadequate pay is a significant barrier for retaining qualified, dedicated coaches. It is important to note that the State of Michigan's draft fiscal year 2025 budget currently includes funding for peer recovery coaches in hospitals, which would allow hospitals to directly bill for this service.
- **Quality and relationships with PIHPs vary across the state**—Due to reimbursement barriers, participants said many hospitals partner with PIHPs to contract peer recovery coaches to support patients seeking SUD treatment. This partnership requires a strong existing relationship between a hospital and PIHP, which varies across the state. Not all hospitals currently coordinate with a local PIHP for this service, and some participants were unaware of this option.
- **Without trusting relationships with providers, pharmacy technicians may not fill prescriptions**—Some pharmacies will not fill an electronic prescription if they do not know the prescribing provider. Several participants detailed the administrative burden they must navigate to call a pharmacy directly and rely on, or develop, a relationship with the pharmacist(s) to ensure their prescriptions get filled. In some cases, insurance providers are tied to a specific pharmacy (Meridian is an example of an insurer with this practice). ED doctors prefer to call in MOUD prescriptions to pharmacies they know will fill the prescriptions without wait or hassle. Some insurers have pharmacy lock-in programs, which require patients considered at risk for misuse of certain drugs to obtain and fill prescriptions from predesignated pharmacies and prescribers. The time it can take to add the ED doctor as a provider in the pharmacy's system to fill the prescription for the patient can result in losing patients, who get burned out navigating this system and waiting for MOUD. This results in patients not picking up the prescription and not returning communications.

- **Pharmacies can refuse to fill MOUD prescriptions**—According to participants, some pharmacies do not consistently fill MOUD prescriptions and/or do not have them in stock. Many participants attributed this refusal to supply and fill MOUD orders to the ongoing stigma against providing MOUD and addressing SUD. Pharmacy issues seem to be site-specific and not generalizable to regions in Michigan.
- **Rural locations may not have access to dependable pharmacies**—Similar to the potential lack of referral organizations in more rural areas, there may be fewer pharmacies willing to dispense MOUD. The limited willingness combined with fewer pharmacies may translate to fewer options for accessing MOUD in rural areas. One participants in northern Michigan described the prevalence of pop-up prescription clinics, which have the reputation of being profitable more than they help patients. These locations may fill an access gap for areas with few other options, but they often close down within months of opening because of their questionable practices.

## Patient Navigation

### Barrier Locations: Hospital and Recovery Ecosystem

- **Stigma can prevent patients from seeking help**—Many participants described stigma among ED patients as a remaining barrier to getting the support they need in addressing their SUD. Patients may not feel or understand they have a problem with substances or may associate SUD with being perceived as a "junkie" or other harmful stereotypes that could limit their care options.
- **Lack of transportation poses barriers to treatment**—Participants shared that access to transportation may be limited for patients with a history of SUD, especially if they have lost their driver's license. A lack of transportation becomes a profound barrier when clients must drive long distances to pick up their prescription or attend a recovery program. According to participants, this is another example of a point in the MOUD program where peer recovery coach intervention is key. Helping patients secure transportation to their next location, be it housing, an inpatient or outpatient setting, or a pharmacy, is critical to the patient securing MOUD.
- **Unreliable communication supports/devices can hinder care coordination**—Patients need to have access to a personal phone for follow-up and related communications to be successful. Participants highlighted the difficulty in attempting to contact patients who struggle to maintain a consistent phone number or device due to economic burdens caused by addiction. Doctors, nurses, pharmacists, and peer recovery coaches cannot contact someone who loses access to their phone unless those hospital staff have a secondary contact on file—that contact person must be considered an emergency contact due to HIPAA laws.
- **Noninsured status can result in extra waiting and expenses**—While some uninsured patients may be eligible for Medicare or Medicaid, it can take time to enroll them. The wait time until they are enrolled means patients would have to pay for MOUD and other treatment out of pocket, which is expensive.
- **Patients may not trust ED staff**—Patients may not feel comfortable sharing details related to opioid/substance use, especially when not in a private environment due to an overcrowded ED. Participants shared that some patients also might not feel safe divulging information to hospital staff (namely doctors) for fear of getting in trouble, being treated differently than other patients, and/or being denied care.

- **Patients may resist OUD treatment—**Some patients may not be ready to address their SUD. Participants described the importance of patients consenting to treatment, including committing to picking up and taking medication and participating in a care plan.
- **Other financial or health priorities may take precedence over addressing OUD—**If patients have several social determinants of health (nonmedical factors that influence health outcomes) impacting their daily life, they may not be willing or able to prioritize the financial burden of traveling to and attending appointments and paying for MOUD. Participants described how other medical conditions may take precedence over patients' SUD, especially if they are concerned about cost and are uninsured (or privately insured).
- **Rural patients may perceive a lack of confidentiality—**In smaller, more rural communities, patients may feel less inclined to share candidly with their providers if they know each other or have acquaintances in common due to a perceived lack of confidentiality.

## CFSEM Supports

### Barrier Location: Hospital

- **Loss of peer recovery coach support significantly impacts program success—**Some participants shared that after losing grant funding for MOUD programs, there has been a drop in hospital integration of peer recovery coaches. Unless coaches can be paid for through other programs or grants, like through outside grant funding, or the reimbursement policy is updated at the federal level, hospitals may not retain peer recovery coaches.
- **Lack of financial support makes it harder to justify the program expense—**The heavy lift for initial and ongoing coordination between the many partners and departments (within and outside of the hospital) is an ongoing cost. While established MOUD programs may have self-sustaining protocols in place, several participants shared that staff regularly working to address SUD and prescribe MOUD still need to devote adequate administrative and training time.
- **Loss of champion peer communication hinders problem-solving—**Several program champions explained MOUD grant funding allowed them to communicate with champion counterparts at other hospital systems. This formalized communication allowed champions to compare processes and share ideas. Hospital physicians have especially hectic schedules, so additional funding for cross-system communication helps prioritize MOUD programming.

# Appendix E: Prioritizing Barriers Survey

# Providing Medications for Opioid Use Disorder in Emergency Departments

## Survey—Prioritizing Barriers

### Introduction

Thank you for your continued participation in the Community Foundation for Southeast Michigan's (CFSEM's) effort to identify and address barriers that prevent hospitals from initiating and/or sustaining programs to provide medications for opioid use disorders (MOUD) in hospital emergency departments (EDs). CFSEM partnered with Public Sector Consultants (PSC) to conduct one-on-one conversations with a variety of stakeholders representing MOUD programs at different levels of implementation and interaction.

Based on information gathered in those conversations, PSC identified barriers to hospitals sustaining MOUD programs. We would like your input to prioritize the barriers most fundamental to these programs' success as we move toward developing solutions. The following survey should take less than five minutes to complete.

### Questions

1. Please select your role in relation to addressing opioid use disorder (OUD) and implementing MOUD:

    a. Physician
    b. Peer recovery coach
    c. Pharmacist
    d. Insurance representative
    e. Prepaid Inpatient Health Plan (PIHP) representative
    f. Statewide/government/policy representative
    g. Other (please describe)

2. From your perspective, **which barriers have the largest impact on implementing and sustaining MOUD programs** in EDs? Rank the barriers below from largest to smallest impact.

    a. Lack of buy-in from hospital leadership
    b. Staff resistance to culture change in EDs
    c. Siloed and varied MOUD program development
    d. Not enough referral options or care coordination following ED visits
    e. Inadequate integration and reimbursement of peer recovery coaches
    f. Inadequate relationship-building with PIHPs and pharmacies
    g. Loss of financial and champion cohort supports
    h. Disjointed patient navigation

3. How significant of a barrier is **lack of buy-in from hospital leadership** when providing MOUD in EDs? [Not at all a barrier, a moderate barrier, a significant barrier]

a. Stigma limits hospital leadership's willingness to implement MOUD programs
b. MOUD programs are not profitable compared to other types of medical interventions
c. Contract issues prevent MOUD programs from being established
d. MOUD program success depends on physician buy-in

4. How significant of a barrier is **staff resistance to culture change in EDs** when providing MOUD in EDs? [Not at all a barrier, a moderate barrier, a significant barrier]

   a. Opioid use disorder (OUD) intake adds to ED staff workload
   b. Stigma among hospital staff limits their willingness to treat patients with OUD
   c. Lack of consistent, ongoing education inhibits staff willingness and ability to administer MOUD protocols
   d. Longer-tenured staff find culture change difficult

5. How significant of a barrier is **siloed and varied MOUD program development** when providing MOUD in EDs? [Not at all a barrier, a moderate barrier, a significant barrier]

   a. Having only one champion per hospital system exacerbates program burden
   b. Champions are working alone despite cross-regional expertise
   c. MOUD protocol in EDs is not consistently implemented or tracked
   d. Integration of peer recovery coaches varies among hospitals

6. How significant of a barrier is **not enough referral options or care coordination following ED visits** when providing MOUD in EDs? [Not at all a barrier, a moderate barrier, a significant barrier]

   a. Hospitals do not trust the quality of outpatient OUD services
   b. EDs do not have a functioning follow-up mechanism
   c. Rural locations lack access to referral organizations

7. How significant of a barrier is **inadequate integration and reimbursement of peer recovery coaches** when providing MOUD in EDs? [Not at all a barrier, a moderate barrier, a significant barrier]

   a. Lack of peer support access creates patient backlog or drop-off
   b. Current peer support policy makes reimbursement difficult

8. How significant of a barrier is **inadequate relationship-building with PIHPs and pharmacies** when providing MOUD in EDs? [Not at all a barrier, a moderate barrier, a significant barrier]

   a. Quality of relationships with PIHPs vary across the state
   b. Pharmacies refuse to fill MOUD prescriptions
   c. Rural locations do not have access to dependable pharmacies

9. During one-on-one conversations, we heard that people with OUD experience many barriers that impact MOUD. How significant are the following **patient navigation barriers** when providing MOUD in EDs? [Not at all a barrier, a moderate barrier, a significant barrier]

   a. Stigma around OUD
   b. Lack of transportation

c. Difficulty contacting for follow-up
d. Lack of insurance coverage
e. Lack of trust in ED staff
f. Not being ready/willing to address OUD
g. Not able to prioritize addressing OUD over other financial or health issues
h. Lack of confidentiality in rural areas

10. Conversation participants identified six core elements for a successful MOUD program. Please rank these elements according to how important they are to creating a successful MOUD program. Reorder the following options from most to least important.

    a. Robust referrals and transition options
    b. Champions who train future champions
    c. Access to supportive pharmacies
    d. Integrated peer recovery coaches
    e. Intentional follow-up care
    f. Growth fueled by data analysis

11. As we move toward prioritizing these barriers, is there anything else we should know? [text box]

## Thank You and Confirmation Page

Thank you for your time. All answers will remain anonymous and will be combined with other responses.

# Appendix F: Prioritizing Barriers Summary

# Providing Medication for Opioid Use Disorder in Emergency Departments

## Summary—Prioritizing Barriers

## Introduction

The Community Foundation for Southeast Michigan engaged Public Sector Consultants (PSC) to identify and prioritize barriers to implementing successful medication for opioid use disorder (MOUD) programs in hospital emergency departments (EDs) to better address opioid use disorder (OUD). PSC first identified barriers through one-on-one conversations with a diverse group of stakeholders engaged at all levels of MOUD implementation. Using the findings from the 16 conversations, PSC then engaged the same group of stakeholders through a survey and a subgroup of those stakeholders in a 90-minute virtual meeting to prioritize the identified barriers and determine which barriers are most urgent to address. Key findings from these activities are presented below, followed by detailed findings from the survey and facilitated meeting.

## Key Findings

In all, ten people responded to the pre-session survey. The barriers identified as particularly significant by survey respondents provided a foundation for the virtual meeting. Four people participated in the discussion, including two clinical champions for MOUD programs, a statewide addiction expert, and a Prepaid Inpatient Health Plan (PIHP) representative. PSC led the group through a review of the survey results and facilitated a discussion to identify which barriers are most urgent to address. Those barriers are provided in the table below. Meeting participants began to group the barriers by theme, including stigma and peer utilization. The meeting ended before themes were identified for the remaining barriers.

**EXHIBIT 1.** Barriers by Theme

| Theme | Highly Urgent Barriers |
|---|---|
| Stigma | Stigma among hospital staff limits their willingness to treat patients with opioid use disorder |
| | MOUD program success depends on physician buy-in |
| Peer utilization | Current peer support policy makes reimbursement difficult |
| | Lack of peer support access creates patient backlog or drop-off |
| | EDs do not have a functioning follow-up mechanism |
| | Quality of relationships with PIHPs vary across the state |
| | Rural locations lack access to referral organizations |
| Theme not identified | MOUD protocol in EDs is not consistently implemented or tracked |
| | Stigma limits hospital leadership's willingness to implement MOUD programs |

| Theme | Highly Urgent Barriers |
|---|---|
| | MOUD programs are not equitably reimbursed compared to other types of medical interventions |

PSC will use the results of this prioritization process as the basis for a series of additional one-on-one conversations and small group discussions aimed at identifying potential solutions to these barriers.

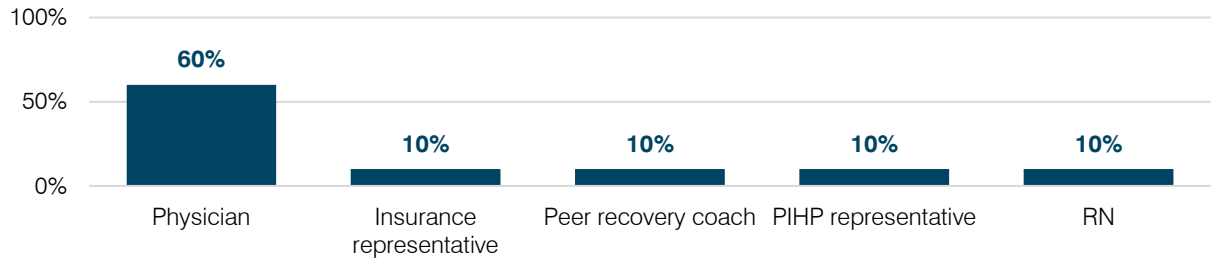
# Survey

To begin the process of prioritizing barriers to implementing MOUD in EDs, PSC surveyed stakeholders who had participated in the identifying-barriers conversations. From the conversations, PSC identified eight categories of barriers and several specific subbarriers that fell within each category. Survey respondents were asked to rank the eight barrier categories from most to least significant impact on MOUD implementation and then to indicate whether each subbarrier was (1) not a barrier, (2) a moderate barrier, or (3) a significant barrier.

## Survey Respondents

Ten stakeholders completed the survey. Most respondents (60 percent) were physicians, one was a peer recovery coach, one was a PIHP representative, one was an insurance representative, and one was a registered nurse (RN).

**EXHIBIT 2.** Percent of Respondents by Role




N = 10

## Barrier Category Rankings

Survey respondents ordered the eight barrier categories based on the level of impact the barrier has on implementing MOUD programs, where the top ranked category (1) has the greatest impact and the lowest ranked category (8) has the least impact. Survey respondents' average rankings of each barrier category's impact level are below (the lower the average, the greater the impact).

**EXHIBIT 3.** Barrier Category Ranking by Level of Impact

| Barrier Category | Average Impact Ranking |
|---|---|
| Not enough referral options or care coordination following ED visits | 3.5 |
| Lack of buy-in from hospital leadership | 3.6 |
| Inadequate integration and reimbursement of peer recovery coaches | 3.7 |
| Staff resistance to culture change in EDs | 4.3 |
| Disjointed patient navigation | 4.6 |
| Loss of financial and champion cohort supports | 5.0 |
| Siloed and varied MOUD program development | 5.2 |
| Inadequate relationship building with PIHPs and pharmacies | 6.1 |

## Subbarrier Significance

Within each barrier category, there was a list of associated subbarriers. For the subbarriers within those categories, respondents indicated whether each subbarrier was (1) not a barrier, (2) a moderate barrier, or (3) a significant barrier. The following charts show how stakeholders responded to the subbarrier survey questions.

**EXHIBIT 4.** Barrier Significance Within Not Enough Referral Options or Care Coordination Following ED Visits

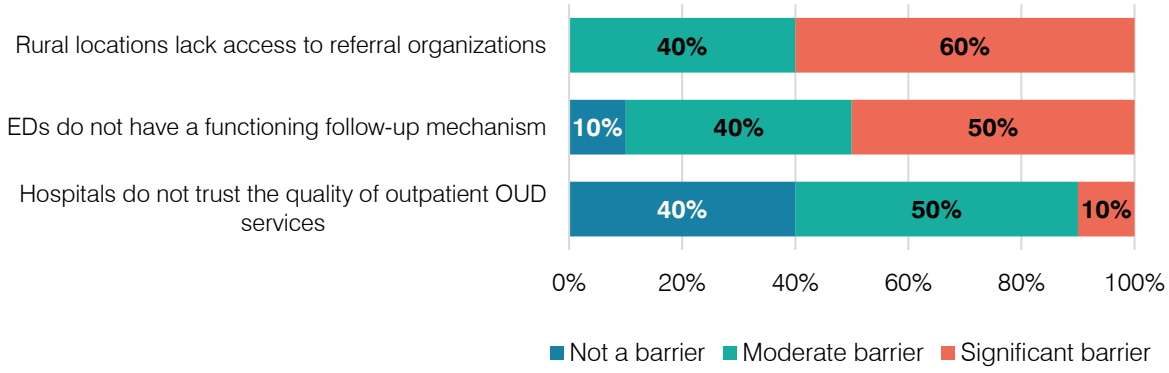


**EXHIBIT 5.** Barrier Significance Within Lack of Buy-in from Hospital Leadership

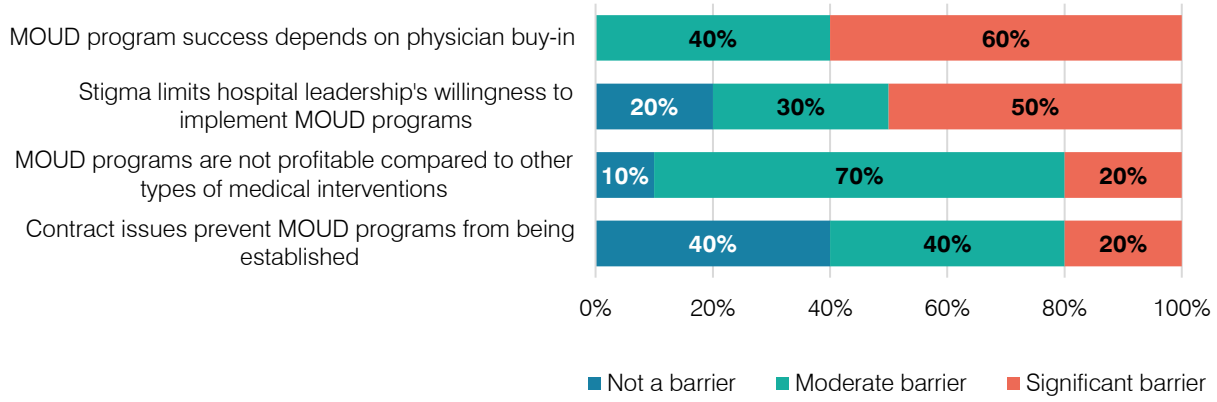



**EXHIBIT 6.** Barrier Significance Within Inadequate Integration and Reimbursement of Peer Recovery Coaches

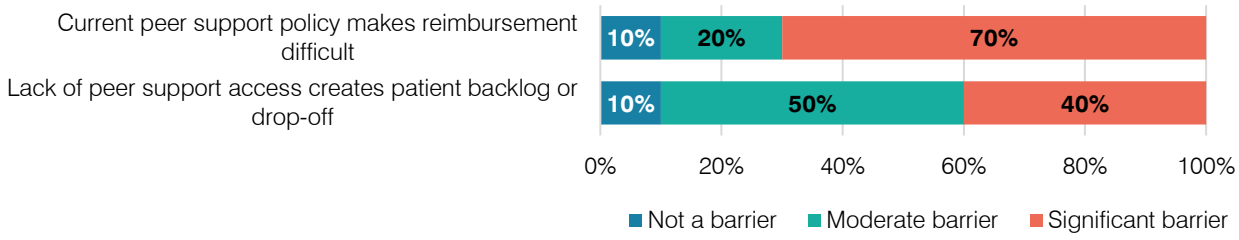



**EXHIBIT 7.** Barrier Significance Within Staff Resistance to Culture Change in EDs

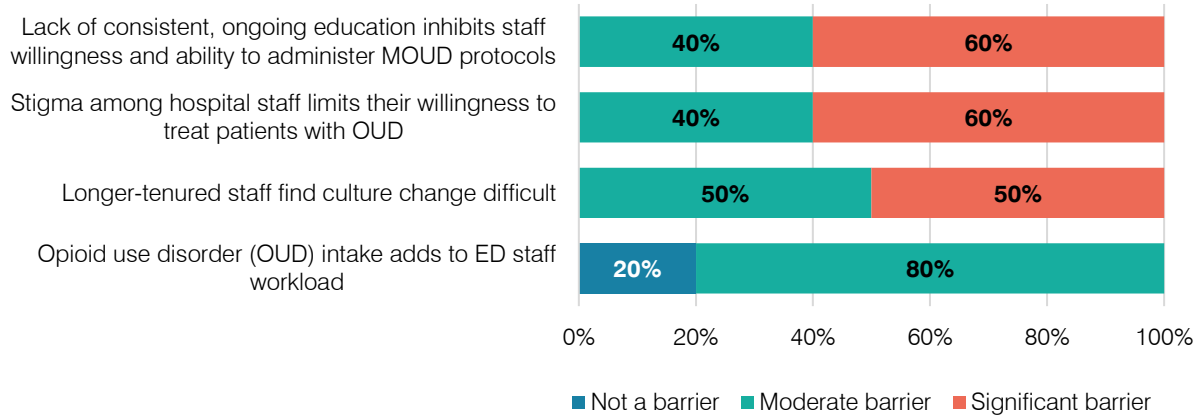


**EXHIBIT 8.** Barrier Significance Within Disjointed Patient Navigation

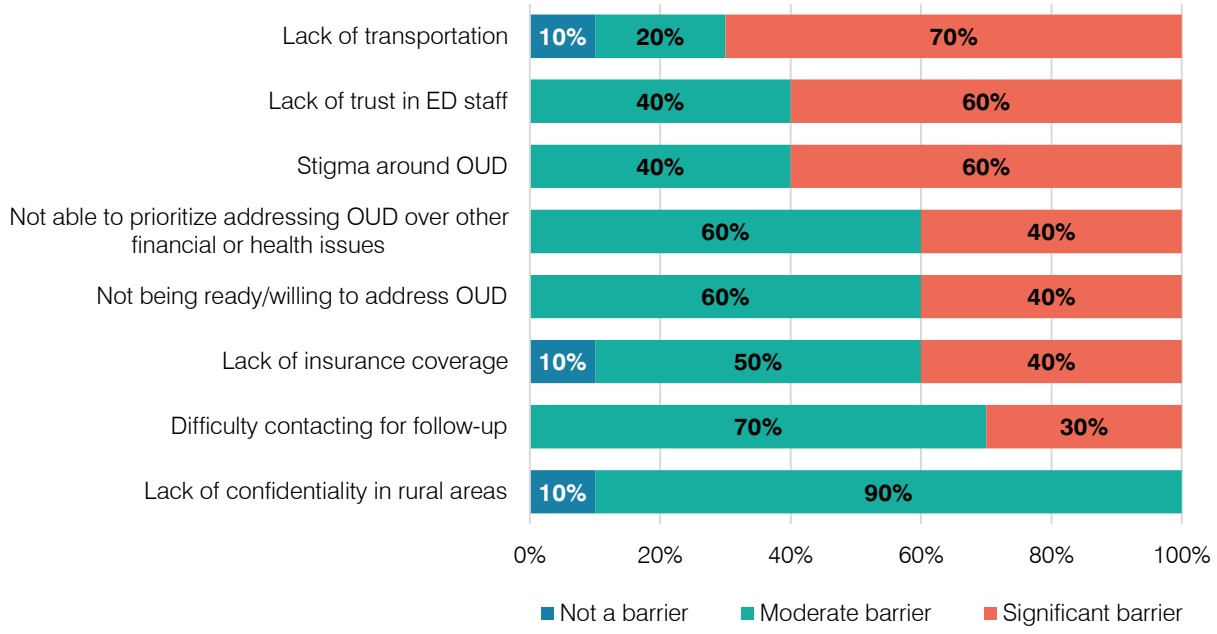



**EXHIBIT 9.** Barrier Significance Within Siloed and Varied MOUD Program Development

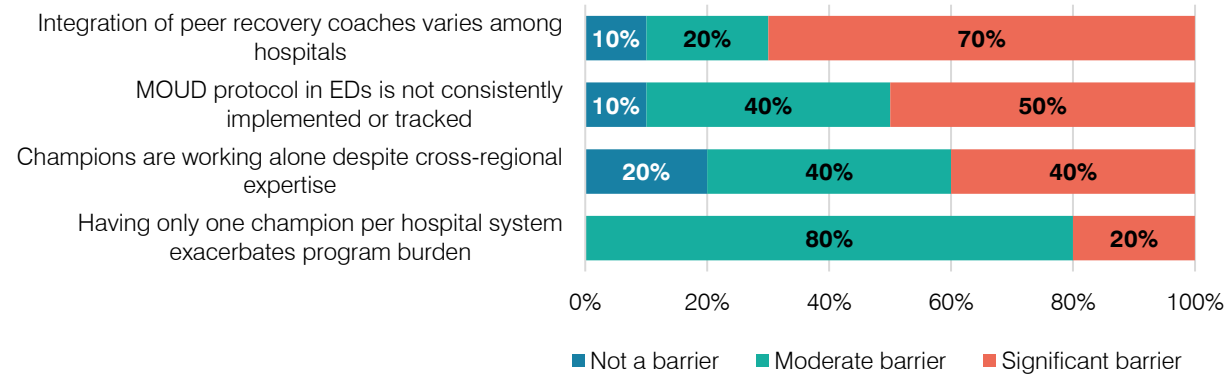
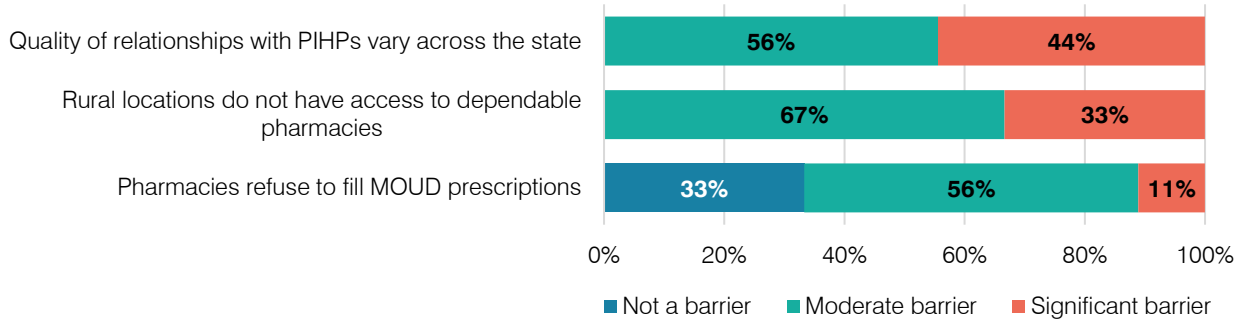


**EXHIBIT 10.** Barrier Significance Within Inadequate Relationship Building with PIHPs and Pharmacies




# Facilitated Workgroup Session

A subset of conversation and survey participants joined a 90-minute virtual facilitated workgroup session designed to review the survey results, confirm prioritization criteria, and continue prioritizing the identified barriers by assessing the urgency with which they should be addressed. Workgroup attendees were:

- Dr. Cara Poland, statewide addiction expert
- Dr. Maureen Ford, MOUD program clinical champion, Bronson Healthcare
- Dr. Christina Eickenroth, MOUD program clinical champion, Munson Medical Center
- Branislava Arsenov, PIHP representative, Northern Michigan Regional Entity

## Discussion and Prioritization

### Barrier Category Ranking

The workgroup reviewed the survey results, starting with the average ranking of the barrier categories' impact on MOUD program implementation. PSC shared the average impact rankings (presented above) and suggested that the group focus on the top four categories for the purpose of prioritizing barriers, which are outlined in Exhibit 11. The participants agreed, saying these barriers aligned with their own understanding of and experience with MOUD program implementation.

**EXHIBIT 11.** Barrier Categories by Average Impact Ranking

| Barrier | Average Impact Ranking |
|---|---|
| Not enough referral options or care coordination following ED visits | 3.5 |
| Lack of buy-in from hospital leadership | 3.6 |
| Inadequate integration and reimbursement of peer recovery coaches | 3.7 |
| Staff resistance to culture change in EDs | 4.3 |
| Disjointed patient navigation | 4.6 |
| Loss of financial and champion cohort supports | 5.0 |
| Siloed and varied MOUD program development | 5.2 |
| Inadequate relationship building with PIHPs and pharmacies | 6.1 |

Smaller average = higher impact ranking
Larger average = smaller impact ranking
N = 10

## Subbarrier Prioritization

PSC presented the subbarrier survey results and worked with the meeting participants to prioritize the subbarriers based on the survey findings. PSC proposed that barriers with at least 40 percent of respondents saying they were "significant" barriers or at least 70 percent of respondents saying they were either "moderate" or "significant" barriers should be considered high priority and advanced for solution identification. During the facilitated session, participants assessed the barriers against these criteria and determined whether they agreed with prioritizing the barriers and/or suggested alternate wording or other changes.

The subbarriers that met the proposed prioritization criteria and/or were otherwise selected for inclusion as high-priority barriers are in the table below. Most subbarriers that met the proposed criteria were advanced "as is" for solution development. Occasionally, however, workgroup participants modified the wording of a barrier, determined a barrier should not be advanced, or elevated a barrier that did not meet the prioritization criteria for advancement to solution development. These changes are also presented in the table.

**EXHIBIT 12.** Barrier Category/Subbarriers Significance and Workgroup Changes

| Barrier Category/Subbarriers | Percentage Significant | Percentage Significant and Moderate Combined | Changes the Workgroup Made, If Any |
|---|---|---|---|
| **Not enough referral options or care coordination following ED visits** | | | |
| Rural locations lacking access to referral organizations | 60% | 100% | |
| EDs not having a functioning follow-up mechanism | 50% | 90% | |
| **Lack of buy-in from hospital leadership** | | | |
| MOUD program success depends on physician buy-in | 60% | 100% | |
| Stigma limits hospital leadership's willingness to implement MOUD programs | 50% | 80% | |
| MOUD programs are not profitable compared to other types of medical interventions | 20% | 90% | Changed the language to read, "MOUD programs are not equitably reimbursed compared to other interventions" |
| **Inadequate integration and reimbursement of peer recovery coaches** | | | |
| Current peer support policy makes reimbursement difficult | 70% | 90% | |
| Lack of peer support access creating patient backlog or drop-off | 50% | 90% | |
| **Staff resistance to culture change in EDs** | | | |
| Lack of consistent, ongoing education inhibiting staff willingness and ability to administer MOUD protocols | 60% | 100% | |
| Stigma among hospital staff limiting their willingness to treat patients with OUD | 60% | 100% | |
| Longer-tenured staff find culture change difficult | 50% | 100% | Removed barrier |
| OUD intake adds to ED staff workload | 0% | 80% | Added barrier |
| **Siloed and varied MOUD program development** | | | |
| Integration of peer recovery coaches varying among hospitals | 70% | 90% | |
| MOUD protocol in EDs not consistently implemented or tracked | 50% | 90% | |
| Champions working alone despite cross-regional expertise | 40% | 80% | |
| **Inadequate relationship building with PIHPs and pharmacies** | | | |
| Quality of relationships with PIHPs varying across the state | 44% | 100% | |

There were four changes to the barriers initially presented for prioritization.

1. The workgroup changed "MOUD programs are not profitable compared to other types of medical interventions" to "MOUD programs are not equitably reimbursed compared to other interventions." The workgroup felt that lack of equitable reimbursement for the amount of work and staffing required to effectively run an MOUD program within an ED better represents the issue than profitability.

2. The workgroup removed the barrier "longer-tenured staff find culture change difficult" as they were worried that the emphasis on longer-tenured staff might be viewed as targeting older staff.

3. The workgroup chose to include "OUD intake adds to ED staff workload," which had an 80 percent moderate barrier survey result, and seemed more able to be addressed than culture change with longer-tenured staff.

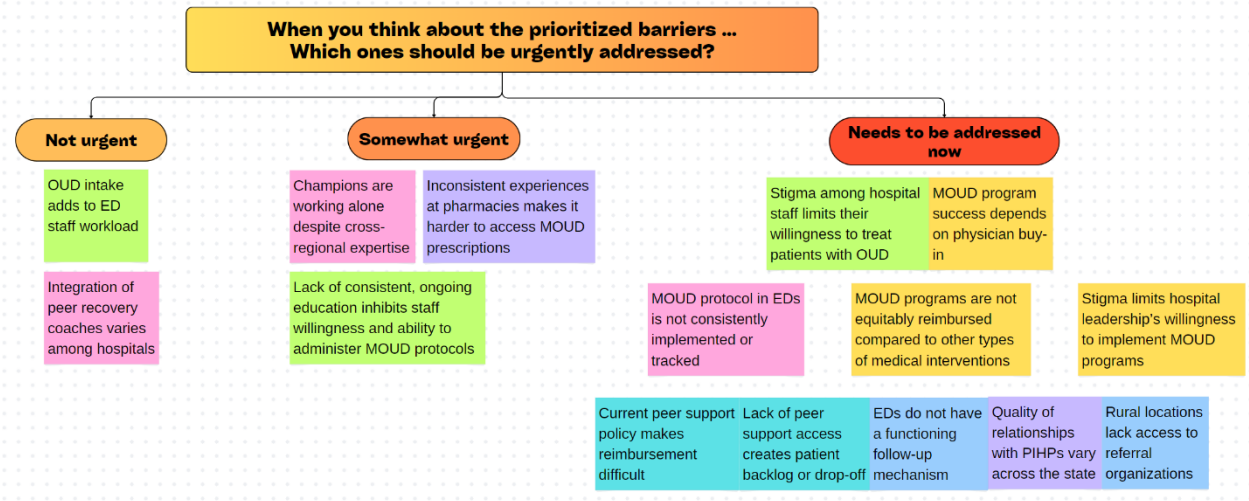
4. One of the barrier categories identified in the survey was "disjointed patient navigation." Although this barrier category includes significant barriers that patients experience that should be addressed, the subbarriers are systemic and will need to be solved at multiple implementation levels. As a result, and with the group's agreement, the barrier category "disjointed patient navigation" was removed to focus on which subbarriers hospitals could address now.

After examining the survey results together, PSC asked session participants what surprised them about the findings and what resonated with their understanding of the barriers. All four participants agreed that they were not surprised by the results of the survey and felt comfortable with how the barriers were defined after making changes to some of the wording.

## Barrier Urgency

After reviewing the survey results and confirming the high-priority barriers, PSC worked with the participants to identify barriers that should be urgently addressed. To begin, participants were asked to define "urgent." The group agreed that to be ranked as high urgency a barrier should be one that "needs to be addressed now to reduce the event of death." With this definition in mind, participants discussed the prioritized subbarriers and categorized them as either: (1) not urgent, (2) somewhat urgent, or (3) needs to be addressed now. The results of the exercise are in the graphic below.

**EXHIBIT 13.** Barrier Urgency Prioritization




The workgroup identified the subbarriers in the table below as needing to be addressed now. They also began to group them according to larger themes, noting that for each grouping a single solution would resolve all of the barriers in the group.

**EXHIBIT 14.** Highly Urgent Barriers and Themes

| Theme | Highly Urgent Barriers |
|---|---|
| Stigma | Stigma among hospital staff limits their willingness to treat patients with OUD |
| | MOUD program success depends on physician buy-in |
| Peer utilization | Current peer support policy makes reimbursement difficult |
| | Lack of peer support access creates patient backlog or drop-off |
| | EDs do not have a functioning follow-up mechanism |
| | Quality of relationships with PIHPs vary across the state |
| | Rural locations lack access to referral organizations |
| Theme not identified | MOUD protocol in EDs is not consistently implemented or tracked |
| | Stigma limits hospital leadership's willingness to implement MOUD programs |
| | MOUD programs are not equitably reimbursed compared to other types of medical interventions |

The group connected the top two barriers because both relate to MOUD program growth and success being inhibited by stigma. They said addressing stigma would solve both barriers. The next five barriers were grouped by their connection to peer utilization. The workgroup said peers play an essential role in hospital MOUD programs by connecting patients to referral organizations and providing dependable follow-up with patients after they leave the ED. They shared that removing barriers to peer utilization and

billing will solve all five peer barriers. The meeting concluded before the workgroup could group the remaining three barriers.

Following this session, PSC will review and continue to group the “needs to be addressed now” subbarriers in preparation for the next phase of the project. In the next phase, PSC will facilitate one-on-one conversations and small group discussions with additional stakeholders to identify solutions to the prioritized barriers.

# Appendix G: Identifying Solutions Conversation Guide

# Providing Medication for Opioid Use Disorder in Emergency Departments

## Conversation Guide—Identifying Solutions

## Background

The Michigan Opioid Partnership (MOP), led by the Community Foundation for Southeast Michigan (CFSEM), has been supporting hospitals to implement medications for opioid use disorder (MOUD) treatment programs in emergency departments across Michigan. Since the program's inception, participation in the ED MOUD initiative grew from six to 75 hospitals—representing approximately half of Michigan's emergency departments and all ten prepaid inpatient health plan regions. With changes in available funding, the ED MOUD initiative is entering a new phase that shifts away from directly funding individual hospitals and towards research that identifies and addresses underlying barriers that prevent hospitals from initiating and/or sustaining programs to provide MOUD in the ED.

CFSEM has partnered with PSC to lead this research.

- Earlier this year, we conducted one-on-one conversations with stakeholders to identify barriers to implementing MOUD in EDs.
- Last month, we conducted a pre-survey and workgroup meeting to prioritize the barriers and identify those that are most urgent to address. The workgroup defined an urgent barrier as one that "needs to be addressed now to reduce the event of death."
- During the workgroup session, participants began to group barriers by their potential solution, which led to the identification of three sets of barriers.
- Today, we'd like to share with you the grouped barriers the workgroup identified as urgent and begin to identify possible solutions to those barriers.

We appreciate you taking time today to share your thoughts. Please feel free to speak candidly from your perspective and experience. Your participation is voluntary; if there are any questions you do not want to answer, you are not required to do so. Your feedback will not be attributed to you personally. Do you have any questions before we begin?

## One—Lack of Leadership Buy-in, Stigma, Staff Resistance

The first set of barriers is how stigma impacts program interest, implementation, reimbursement policy, and sustainability. The workgroup felt that this group would have a similar set of solutions and solving these barriers would lead to less patient deaths. I'd like to review each of the barriers, answer any questions that you may have and begin to identify possible solutions together.

**Lack of Buy-in from Hospital Leadership**

- MOUD program success depends on physician buy-in
- Stigma limits hospitals' willingness to implement MOUD programs
- MOUD programs are not equitably reimbursed compared to other types of medical interventions

**Staff Resistance to Culture Change in EDs**

- Stigma among hospital staff limits their willingness to treat patients with OUD

1) What are possible root causes of this set of barriers? The root causes can vary, they don't necessarily need to have the same root cause.
2) From your perspective when considering these barriers to providing MOUD in EDs, what are some possible solutions that would potentially address the root causes and solve these issues?
   a) Are there policy solutions?
   b) Are there hospital procedure solutions?
   c) Are there training solutions?
   d) Are there advocacy solutions?
3) Who might be responsible for these solutions? E.g. federal, state, local, hospital, physician, peer
4) When considering these possible solutions, which is the most feasible for Michigan to implement?
5) Are you aware of any other states that have attempted to or solved these barriers to providing MOUD in EDs?
   a) What strategies did they use?
   b) Who was responsible for the solution?
   c) Is there anything similar happening in Michigan?
6) Do you have anything else to add?

# Two—Peers and Referrals

The second set of barriers is how peers are integrated into the crisis system and support referrals after an individual leaves the ED. The workgroup felt that this group would have a similar set of solutions and solving these barriers would lead to less patient deaths. I'd like to review each of the barriers, answer any questions that you may have and begin to identify possible solutions together.

**Not Enough Referral Options or Care Coordination Following ED Visits**

- Rural locations lack access to referral organizations
- EDs do not have a functioning follow-up mechanism

**Inadequate Integration and Reimbursement of Peer Recovery Coaches**

- Current peer support policy makes reimbursement difficult
- Lack of peer support access creates a patient backlog or drop-off

**Inadequate Relationship Building with PIHPs and Pharmacies**

- Quality of relationships with PIHPs vary across the state

1) What are possible root causes of this set of barriers? The root causes can vary, they don't necessarily need to have the same root cause.
2) From your perspective when considering these barriers to providing MOUD in EDs, what are some possible solutions that would potentially address the root causes and solve these issues?
    a) Are there policy solutions?
    b) Are there hospital procedure solutions?
    c) Are there training solutions?
    d) Are there advocacy solutions?
3) Who might be responsible for these solutions? E.g. federal, state, local, hospital, physician, peer
4) When considering these possible solutions, which is the most feasible for Michigan to implement?
5) Are you aware of any other states that have attempted to or solved these barriers to providing MOUD in EDs?
    a) What strategies did they use?
    b) Who was responsible for the solution?
    c) Is there anything similar happening in Michigan?
6) Do you have anything else to add?

# Three—Siloed and Varied Programs

This final barrier was not paired with other barriers since the workgroup did not feel that it shared a solution with other barriers. I'd like to review this barrier, answer any questions that you may have and begin to identify possible solutions together.

**Siloed and Varied MOUD Program Development**

- MOUD protocol in EDs is not consistently implemented or tracked

1) What are the possible root causes of this barrier?
2) From your perspective when considering this barrier to providing MOUD in EDs, what are some possible solutions that would potentially address the root causes and solve these issues?
    a) Are there policy solutions?
    b) Are there hospital procedure solutions?
    c) Are there training solutions?
    d) Are there advocacy solutions?
3) Who might be responsible for these solutions? E.g. federal, state, local, hospital, physician, peer
4) When considering these possible solutions, which is the most feasible for Michigan to implement?
5) Are you aware of any other states that have attempted to or solved these barriers to providing MOUD in EDs?
    a) What strategies did they use?
    b) Who was responsible for the solution?
    c) Is there anything similar happening in Michigan?
6) Do you have anything else to add?

# Six—Closing

1) Is there anything else you would like to share before we wrap up?

Thank you so much for participating and sharing your perspective today. PSC will compile the information we've gleaned through these conversations and provide a summary to CFSEM. The next step in our research will be bringing a group of people together to review our strategies and reports. Would you be open and interested in staying involved as we continue our research?

Thank you again. If you have any additional feedback, please feel free to reach out to us at elammers@publicsectorconsultants.com.



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