The Michigan Opioid Collaborative:

Increasing access to medications to treat opioid use disorder

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Abstract

Addressing gaps in access to medication treatment for opioid use disorder (OUD) is critical to the response to the rise in opioid-related mortality in the United States. Here we describe the establishment of the Michigan Opioid Collaborative (MOC), a statewide program that supports clinicians and clinics to prescribe medications for opioid use disorder (MOUD). MOC offers several services: (a) Behavioral Health Consultants (BHCs) located within communities to conduct outreach to clinicians and provide direct clinic support with referrals to treatment and other community resources; (b) technical assistance to support clinics to start prescribing MOUD treatment; (c) same-day case consultation by addiction specialists; and (d) providing education to clinicians and communities to improve OUD treatment. MOC provides timely and remote consultation to clinicians to increase access to MOUD and improve care for patients with OUD across Michigan.

Introduction

Opioid use disorders (OUD) are associated with overdose and suicide, and effective treatment for OUD is essential to addressing these two public health problems (1). Medications for opioid use disorder (MOUD), including buprenorphine and methadone, are associated with reduced risk of fatal and non-fatal overdose as well as suicide mortality (2, 3, 4). At a community level, opioid-related mortality is associated with a lack of availability of clinicians prescribing buprenorphine (5). However, despite compelling evidence of these medications' efficacy for the treatment of OUD, there remains a lack of access to MOUD (6).

Treatment of OUDs with methadone and buprenorphine is tightly regulated. It was not until the Drug Addiction Treatment Act of 2000 (DATA 2000) that physicians were permitted to prescribe buprenorphine for the treatment of OUD in general medical settings. To meet the DATA 2000 criteria, clinicians were required to complete an 8-hour "DATA 2000 waiver" training course. Clinicians could then apply for a Drug Enforcement Agency (DEA) "X-license" which is needed to prescribe buprenorphine for the treatment of OUD.

The Comprehensive Addiction and Recovery Act passed in 2016 and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act passed in 2018 extended prescriptive authority to nurse practitioners, physician assistants, and advanced practice registered nurses. These advanced practice providers were required to complete 24 hours of training to satisfy DEA requirements.

In 2021, in response to the growing evidence that buprenorphine decreases fatal and non-fatal overdoses, the Department of Health and Human Services simplified the process to receive an X-license by eliminating the educational requirements. Clinicians can now file a Notice of Intent and receive an X-license which allows them to prescribe buprenorphine for the treatment of OUD for up to 30 patients without additional training.

Decreased educational requirements for buprenorphine prescribing will hopefully lead to an increase in the number of providers offering treatment. However, treating over 30

patients continues to require completion of the DATA 2000 waiver training course and additional regulatory restrictions and burden. Furthermore, many clinicians who have an X-waiver are not prescribing buprenorphine. In a 2016 survey of rural physicians with X-waivers, 53% of respondents were not treating any patients with buprenorphine (7).

As drug overdose fatalities continue to rise, addressing gaps in access to MOUDs is critical. In 2017, drug overdose fatalities in Michigan (MI) were 14th in the nation with a rate of 27.7 per 100,000 (8). In Michigan in 2012, the estimated prevalence of OUD was 9.2/1000 residents and treatment capacity was 5.3/1000 (based on the assumption that every waivered clinician has a 100 patient panel, likely an overestimate) (9).

As a response to a lack of accessible MOUD treatment in Michigan, the Michigan Opioid Collaborative (MOC) was created in 2017. It is a statewide program with an interdisciplinary team that aims to increase access to evidenced-base care via MOUD throughout Michigan by supporting clinicians, health care organizations, and communities.

Michigan Opioid Collaborative: Program Description

MOC was developed in partnership with the Michigan Department of Health and Human Services (MDHHS). It has been funded by MDHHS with funds originating from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Interdisciplinary team

MOC is comprised of a team of addiction physicians and researchers, behavioral health consultants (BHC), communication experts, data analysts, program coordinators, and a peer support specialist.

The addiction physician specialists and researchers have had training in public health, psychiatry, emergency medicine, internal medicine, family medicine and hepatology with expertise in primary care, obstetrics, rural medicine, pain management, professional monitoring programs (health professional recovery program in Michigan), unhoused healthcare, and treatment of hepatitis C.

BHCs are masters-level mental health clinicians, regionally located to support all counties in Michigan. Prior to the COVID-19 pandemic, many BHCs were provided office space within offices of key stakeholders in their area, such as Community Mental Health clinics. The local presence of the BHCs allows them to identify and respond to community needs in a tailored way.

Geographic Coverage

MOC was originally established within the Community Mental Health Partnership of Southeast Michigan in Lenawee, Livingston, Monroe, and Washtenaw counties. During the program's second year, it expanded to Calhoun, Kalamazoo, and all fifteen counties of the Upper Peninsula. These regions were chosen for expansion because they had a limited number of buprenorphine prescribers.

In 2020, additional funding from Blue Cross Blue Shield of Michigan (BCBSM) supplementing MDHHS funds allowed MOC to expand services to the entire state **(Figure 1).**

Figure 1. Michigan Opioid Collaborative expansion by year.

Services offered

MOC was initially comprised of four major components: (1) patient case consultations; (2) clinician and community training and education; (3) community referrals; and (4) community and clinician outreach to increase interest and acceptance of MOUD treatment.

1. **Patient case consultations**. On-call MOC addiction physician specialists provide same-day advice for patient case consultations.

2. **Clinician training and education**. MOC hosts webinars and trainings on various addiction-related topics as well as organizes and teaches frequent DATA 2000 waiver trainings. As the waiver training requirements have changed, we now also offer a condensed buprenorphine training in addition to the official DATA 2000 eight-hour training course.

After each educational event, BHCs contact attendees to offer logistical support and assistance with the X-waiver application process as they start prescribing MOUD. When clinicians or clinics request additional clinical or logistical support, addiction physicians and BHCs from MOC provide additional trainings to address the specific needs of individual clinic and clinician group. **(Table 1)**

MOC also receives training requests from clinicians who have their X-license but are not prescribing buprenorphine and clinics requesting guidance to prescribe extended-release naltrexone, an FDA-approved treatment for alcohol use disorder or OUD.

3. **Community referrals for clinicians**. BHCs work with the current resources of each community to optimize recovery support services. They help identify specialty services that are available including psychiatric and SUD treatment, including medication and psychotherapy treatment. They also become experts on locally available options for legal aid, supportive housing, and food assistance to address social determinants of health that could affect an individual's ability to engage in treatment. BHCs work with clinicians and community organizations to build smooth connections for patient care

Table 1. Training topics and technical support areas
Patient screening, assessment, and diagnosis
Clinic workflow
Urine drug screen interpretation and utilization
Sample forms/documentation- patient consent and agreement, patient tracking for regulatory requirements, unsupervised buprenorphine induction patient guides
Support staff and/or Nurse training- Utilizing opiate withdrawal scales, follow-up, patient tracking, buprenorphine initiation, administration of XR-naltrexone
Polysubstance use and treatment of co-occurring SUDs
Treatment of co-occurring psychiatric conditions
Pain management and/or peri-operative management for patients receiving MOUD
Treating chronic hepatitis C
Reducing stigma faced by patients with substance use disorder
Management of pregnant people with SUD

transitions such as from the emergency department to aftercare clinicians or from a primary care setting to an outpatient treatment program.

4. **Community and clinician outreach**. BHCs outreach to clinics and individual clinicians to proactively engage them in prescribing MOUD. Examples of BHC outreach include calling primary care clinics currently not prescribing buprenorphine to inform them of MOC services, presenting on stigma to individual clinics or at community events; working with individual clinics to assist with protocols for MOUD prescribing; conducting individual clinic staff trainings; assisting residency programs to incorporate MOUD prescribing within residency clinics; and providing educational presentations on addiction and MOUD to staff at drug courts and jails.

Expansion of services

During the first year of the program, most clinician consultation requests were for general education or logistics of prescribing MOUD in outpatient clinical setting rather than questions about patient cases, as had been expected. After evaluating themes in the consult requests from year 1, the MOC team subsequently increased its capacity to provide technical assistance on providing MOUD in primary care practices.

MOC focused on providing practical clinical advice and promoting evidenced-based harm reduction practices in the care of patients with substance use disorders, e.g., encouraging clinicians to offer MOUD treatment without requiring mandatory counseling, continuing to treat patients with buprenorphine who continue to use other substances, and counseling providers on how to safely do unsupervised initiations.

Over time, the program evolved in response to clinician and community needs by adding services and projects, including:

(a) Hepatitis C treatment patient case review and clinical case conferences.

(b) Outreach to pharmacies that do not dispense buprenorphine to inform them of best practices.

(c) Outreach to substance use disorder treatment programs that do not admit patients being treated with buprenorphine to encourage them to accept this evidenced-based medication treatment.

(d) An 8-session telehealth-delivered cognitive behavioral psychotherapy intervention for patients on MOUD to increase retention in treatment.

(e) A one-year multistage randomized trial evaluating the effectiveness of different outreach models to X-waivered clinicians who were not prescribing buprenorphine.

(f) A telehealth-delivered mentoring program which provided ongoing mentorship and support to enrolled clinicians.

(g) A coordinated care model of SUD treatment and primary care for pregnant and parenting persons.

(h) Information on changing guidelines including telehealth and controlled substance prescribing during the COVID pandemic; state Medicaid reimbursement policies, and insurance incentive programs.

MOC growth and outcomes

Since the program's inception in October 2017, MOC has trained 944 clinicians in 35 DATA 2000 waiver training events. The number of consultations has also increased dramatically **(Figure 2).**

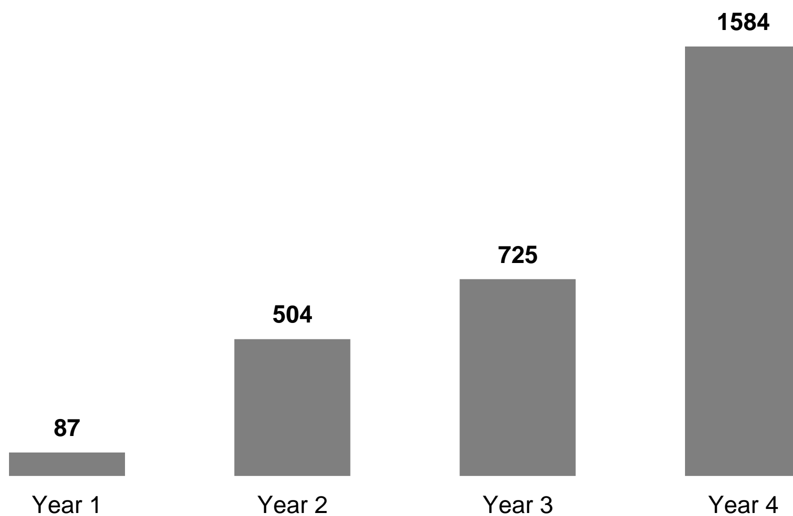
Funding, Collaborations, and Partnerships

The Michigan Opioid Collaborative (MOC) was initially funded in 2017 by the State Targeted Response (STR) from the Michigan Department of Health and Human Services with funds that originated from Substance Abuse Mental Health Services Administration (SAMHSA) (10). The STR grant program has awarded states almost 1 billion dollars in

funding since May 2017 to expand access to MOUD, reduce unmet treatment needs, and reduce opioid related overdose deaths.

MOC later received funding from the State Opioid Response to offer telehealth-delivered cognitive behavioral psychotherapy for patients with OUD ("tele-counseling")

Figure 2. Michigan Opioid Collaborative consults by year.



and with subsequent funding, to expand services including to improve care for patients with other comorbid substance use disorders (e.g., stimulant or alcohol use disorder), hepatitis C treatment, chronic pain and other goals.

In Michigan, lawmakers had expanded Medicaid access in 2015 under provisions of the Affordable Care Act through the "Healthy Michigan Plan" (11). Thus, by having improved *coverage* for OUD treatment, the focus of STR programs in Michigan, which included MOC among others, was to expand *capacity* for OUD treatment and prevention.

In fall of 2019, BCBSM announced clinician organization and clinic financial incentives for clinicians to obtain their (then required) DATA 2000 waiver and prescribe

MOUD through the Physician Group Incentive Program with the goal of increasing MOUD prescribing in Michigan.

BCBSM began funding MOC in 2020 to expand services to the entire state, hold monthly waiver trainings in different geographic areas throughout the state in 2020-2021, and provide ongoing support to new prescribers of MOUD. Due to the COVID-19 pandemic, the trainings were switched to a virtual format in March of 2020.

MOC works collaboratively across Michigan to include community stakeholders to address unique treatment gaps in different communities. MOC works in partnership with the Michigan Department of Health and Human Services, Blue Cross Blue Shield of Michigan, the University of Michigan Department of Psychiatry, the University of Michigan Department of Anesthesiology, the University of Michigan Injury Prevention Center and the Michigan State University Department of Obstetrics, Gynecology and Reproductive Health. MOC also partners with the Michigan Opioid Prescribing Engagement Network (OPEN) (12) and the Michigan Emergency Department Improvement Collaboration (https://medicqi.org).

Conclusion

MOC seeks to increase and improve access to MOUD in Michigan by providing support to existing clinicians prescribing MOUD, organizing buprenorphine trainings, including DATA 2000 waiver trainings to train new MOUD clinicians, addressing patient barriers to treatment engagement that result from social determinants of health and health disparities, and improving linkage to treatment services by employing BHCs that are engaged with organizations that oversee existing community health services.

The sharp increase in the number of consultations over the program's existence suggests that many clinicians are interested in using these supports to expand access to MOUDs. This interest may also reflect improved openness to MOUD in recent years due to increased public awareness of drug overdose fatalities and the effectiveness of MOUD.

Part of MOC's success can be attributed to flexibility, as the program shifted focus to respond to clinicians' needs. The program emphasizes meeting clinicians "where they are at"

to combat stigma and gain acceptance of managing substance use disorders as chronic conditions. As a result, MOC has worked with many clinicians, even those who initially declined to prescribe MOUD.

However, many challenges remain. Clinicians cite many barriers to prescribing buprenorphine including insufficient knowledge about substance use disorder treatment, time constraints; lack of institutional, peer, and psychosocial support; lack of specialty backup for complex problems; regulatory concerns; issues with reimbursement and concerns about attraction of patients with substance use disorders to their practices (6,13).

There are many barriers to prescribing MOUD that MOC cannot or can only indirectly address. MOC directly addresses clinician concerns about addiction knowledge and provides expertise. Although the BHCs provide referrals to addiction experts and counseling, addiction physicians and treatment centers remain scarce in many areas in Michigan. MOC can indirectly address barriers of stigma via community engagement, and reimbursement and regulation via advocacy. This approach also requires community and clinician involvement, education, and collaboration and these networks and connections take time to build and develop.

MOC's processes and programs are transferable to other states and communities seeking to increase access to evidence-based care through education and outreach.

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