SUPPORT Act Section 1003:
Exploring Michigan's SUD Treatment Capacity and Access

FINAL PROJECT REPORT

October 2022

Project Leadership

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This work was supported by a grant from the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) through the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Section 1003. The contents do not necessarily represent the official views of, nor an endorsement by, CMS/HHS, or the U.S. Government.

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Overview

On October 24, 2018, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act became law. Under section 1003, the Centers for Medicare & Medicaid Services (CMS), in consultation with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality (AHRQ), was charged with conducting a demonstration project to increase the capacity of Medicaid providers to deliver treatment and recovery services. Michigan was selected as one of fourteen grantees to conduct a two-year statewide capacity assessment and recommend policy and funding changes to increase substance use disorder (SUD) treatment and recovery services capacity. The funding period was September 2019 to September 2022.

Led by the Michigan Department of Health and Human Services (MDHHS), and supported by partner organizations, the 1003 team sought to:

- Assess the capacity, qualifications, and willingness of providers to offer SUD treatment and recovery services to Medicaid beneficiaries in Michigan;
- Gather information from focus populations about access to SUD services; and
- Identify gaps and prioritize opportunities for improvement and strategies to increase SUD provider capacity, including those related to program policy, payment, delivery system structure, administrative issues, training and education, and initiatives for recruitment and retention.

The 1003 team employed a range of strategies to accomplish these goals, including analysis of Michigan Medicaid claims and administrative data; key informant interviews with current and former providers and administrators across a variety of practice settings; surveys, interviews, and focus groups with beneficiaries; policy review; and process mapping of intake and treatment initiation in the public SUD system. Subprojects focused on SUD provider capacity for special populations, including tribal nations, the justice system, and the foster care system.

Working with partners, the 1003 team also conducted a variety of activities to support and extend SUD provider capacity in Michigan. Capacitation activities included statewide continuing education training for social workers; training of SUD providers on the ASAM Continuum software; and enhanced SUD training and resources for perinatal providers. Information collected informed other departmental initiatives, including the Opioid Task Force, Social Determinants of Health strategy, Opioid Health Homes, and 1115 waiver activities; and 1003 team members have provided input on state policies related to SUD.

This Final Report presents high-level findings of 1003 project activities. The initial section describes trends in SUD treatment services over time for Michigan Medicaid beneficiaries. A series of At a Glance briefs outline capacity challenges and potential solutions, focusing on specific SUD settings and provider types, barriers to care, and special populations. A final section describes capacitation activities conducted as part of the 1003 project. Full reports for many project components can be found in the appendices.

Trends in SUD Treatment

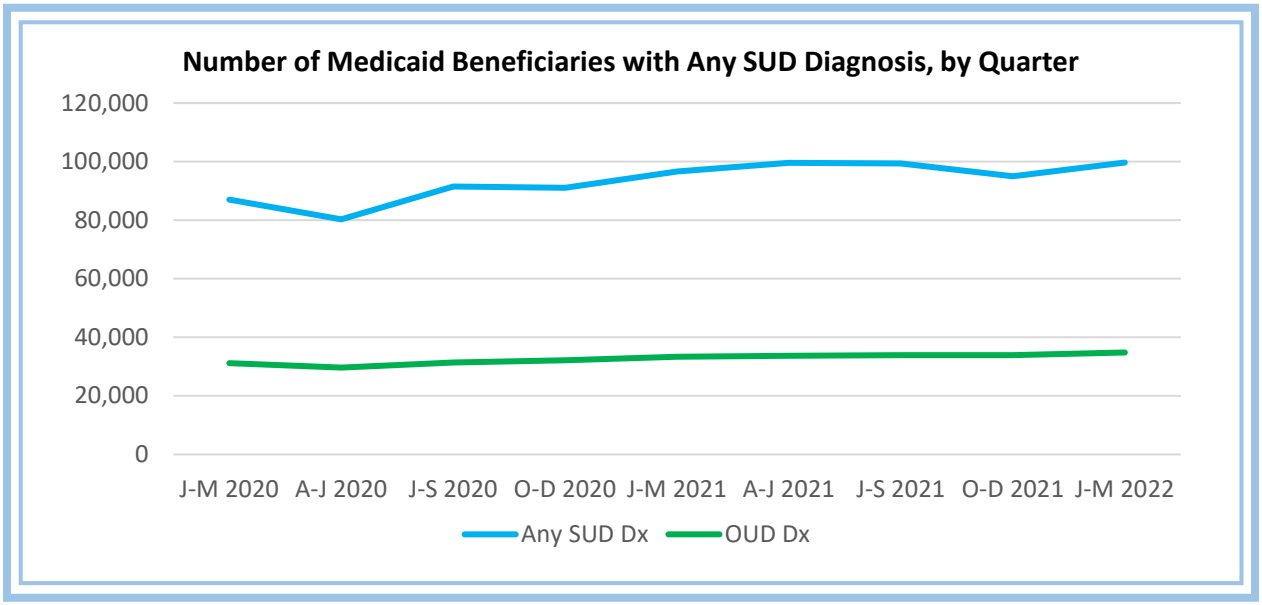
SUD-related metrics derived from Medicaid administrative data illustrate trends in SUD treatment among beneficiaries. The University of Michigan's Institute for Healthcare Policy and Innovation (IHPI) generated and reviewed annual measures that show broad trends over time, as well as quarterly data to provide a more granular view of changes in trends during the 1003 project period.

Contextual Factors. Several contextual factors are likely to influence trends. The COVID-19 pandemic had a dramatic effect on health care delivery. In-person health services delivery was constrained both to comply with recommended social distancing and due to staffing shortages when personnel were exposed to COVID or were off to care for family members. This situation created pressures on both capacity and finances for SUD providers. Notably, state officials used the additional funding to offer flexibility to PIHPs in order to maintain provider capacity.

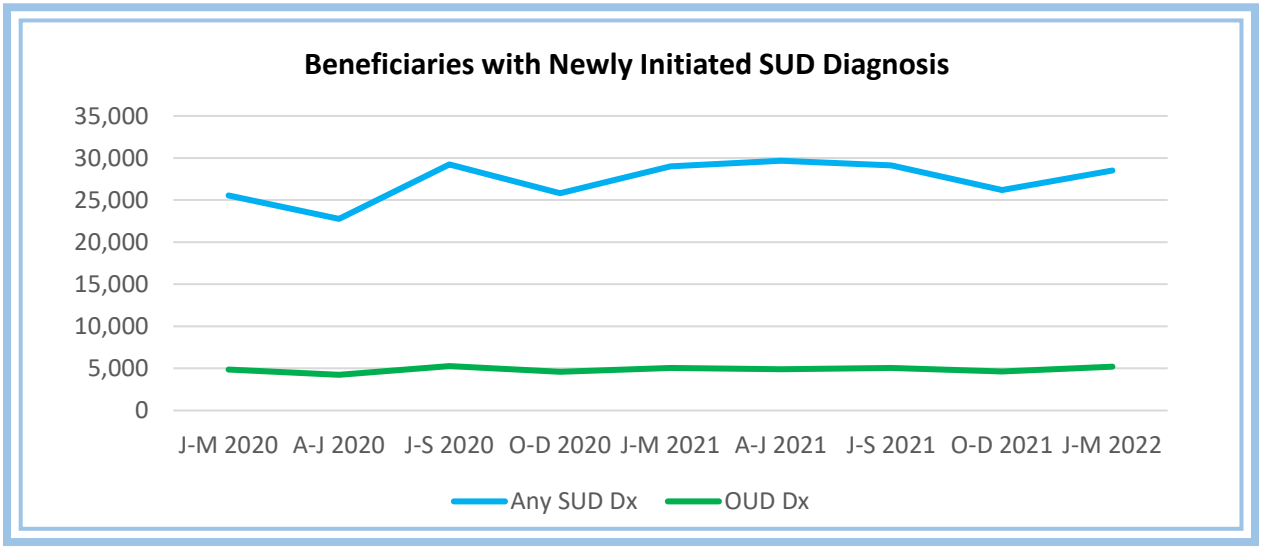
State Medicaid officials used the flexibility of the COVID public health emergency (PHE) to expand the list of services that could be delivered via telehealth, including initiation of medication assisted treatment (MAT). Michigan also allowed telephone-only (i.e., no video component) visits for most of the expanded services and allowed telehealth visits to be done from the beneficiary's home. These policy changes altered the provision of SUD treatment services, yet also created a burden on providers to adopt new technology and new billing and recordkeeping procedures.

In August 2021 Michigan expanded Medicaid reimbursement for office-based treatment for alcohol use disorder and opioid use disorder in the primary care setting under the beneficiary's medical benefit, without a requirement for contracting with the PIHP.

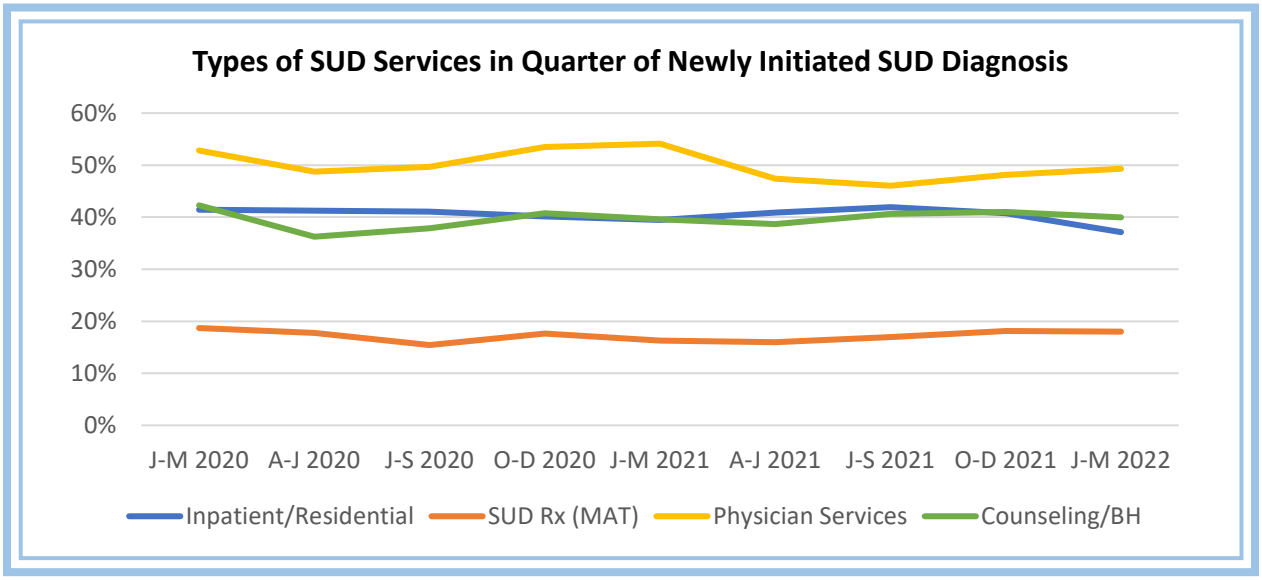
Broad Trends. During the 1003 project period, there was an increase in the number of Medicaid beneficiaries receiving at least one Medicaid-covered health service with an SUD diagnosis code; there was a slight increase in beneficiaries with an OUD diagnosis.



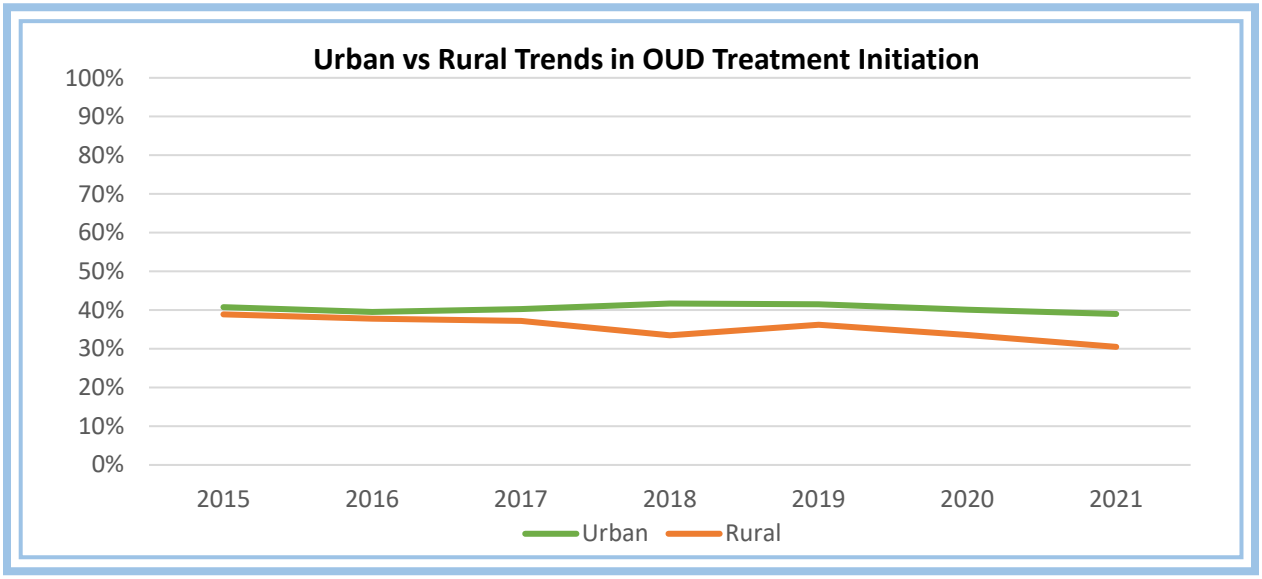
After an initial COVID-related dip, there was an increased number of Medicaid beneficiaries with a newly initiated SUD diagnosis among those with no SUD-related service in the prior quarter. Notably, the trend line for newly initiated OUD diagnosis was relatively flat, suggesting that increases were primarily due to other substances.



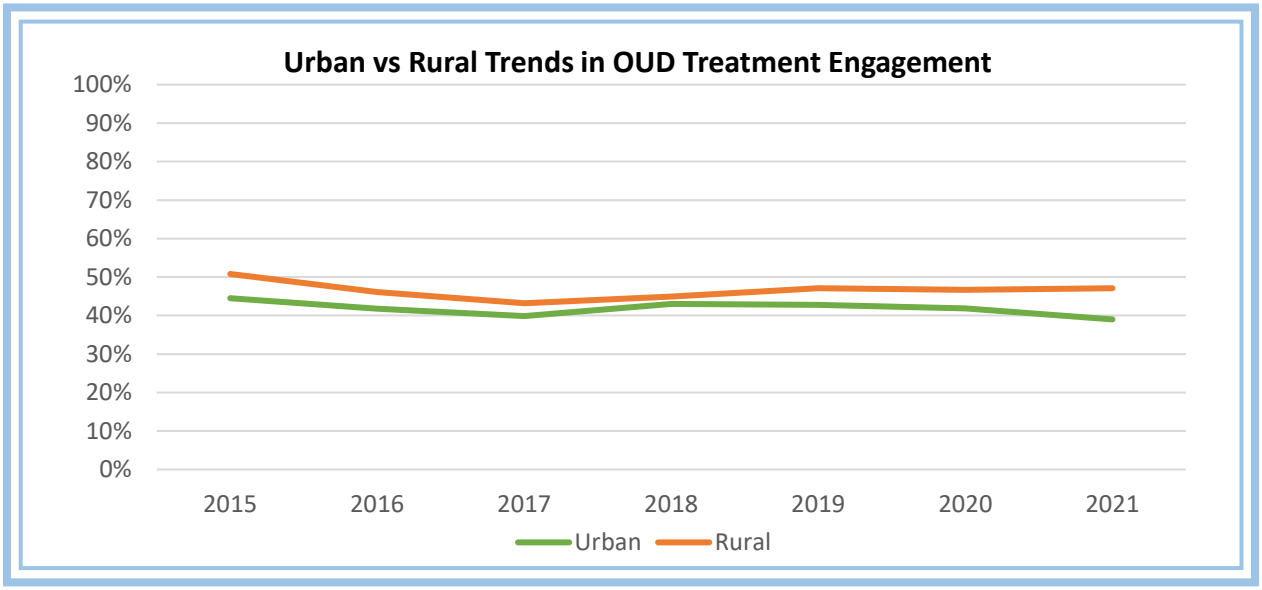
Beneficiaries received a relatively stable mix of SUD services during the quarter in which a new SUD treatment initiation was identified. Physician services were most common, but declined to less than 50% in the later quarters of the project period. Medication assisted treatment (MAT) was least common.



Focusing just on opioid use disorder (OUD) over a longer period, there has been little improvement since 2015 in the proportion of beneficiaries in urban areas who initiated OUD treatment within 14 days of a new diagnosis; for rural beneficiaries, OUD treatment initiation has declined. Only 4 in 10 Medicaid beneficiaries newly diagnosed with OUD initiate treatment.

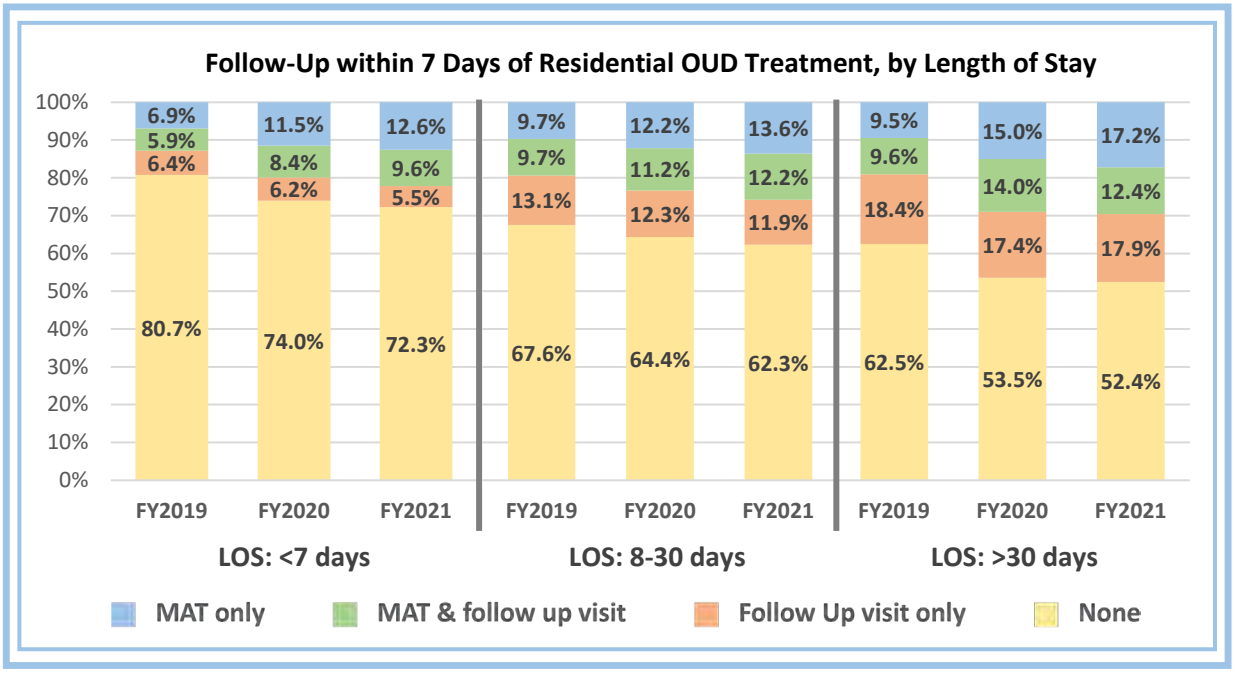


Engagement with OUD treatment within 30 days of the initiation visit is not substantially better. Rates of OUD treatment engagement for beneficiaries in urban areas have fallen below 40%; for rural beneficiaries, OUD treatment initiation rates have increased slightly to near 50%.



Engagement with treatment often requires coordination across levels of care. An important area to examine is receipt of follow-up within 7 days of discharge from residential OUD treatment. Timely follow-up supports treatment continuity and protects against overdose risk for individuals who have decreased their drug use during a residential stay.

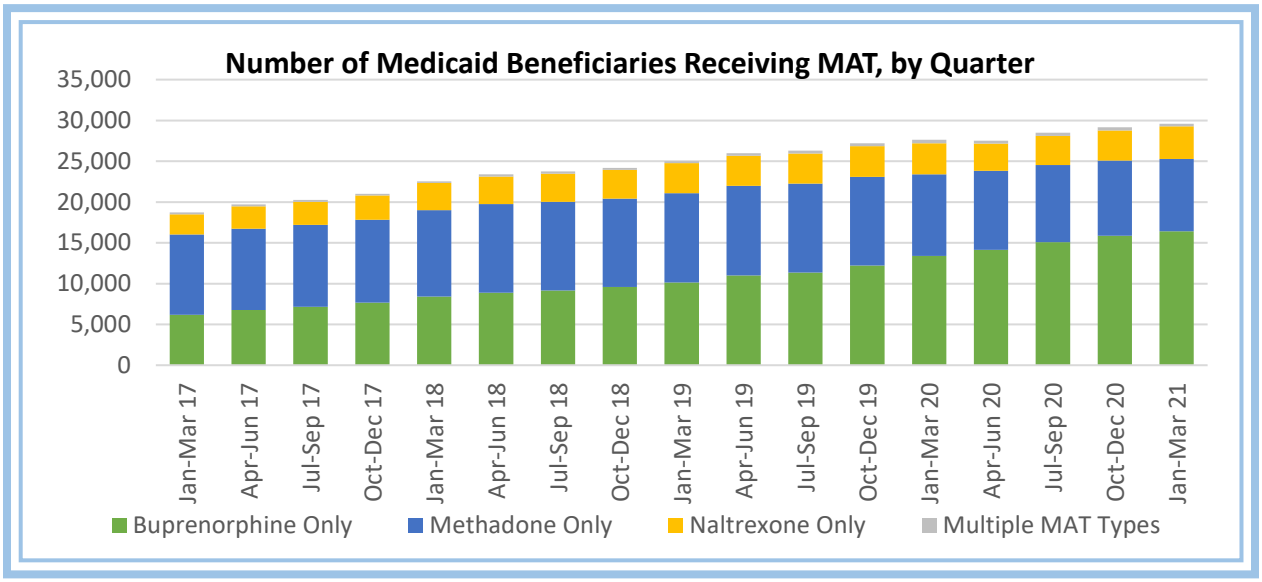
The graph below highlights several key findings. First, follow-up rates are consistently better with longer residential stays. Second, follow-up rates improved from 2019 to 2021 across all length-of-stay groups. Third, the proportion of follow-up that included MAT (or medication for OUD) increased from 2019 to 2021 across all length-of-stay groups. Finally, even in the group with the best performance, less than half of beneficiaries receiving residential OUD treatment had evidence of follow-up services within 7 days.



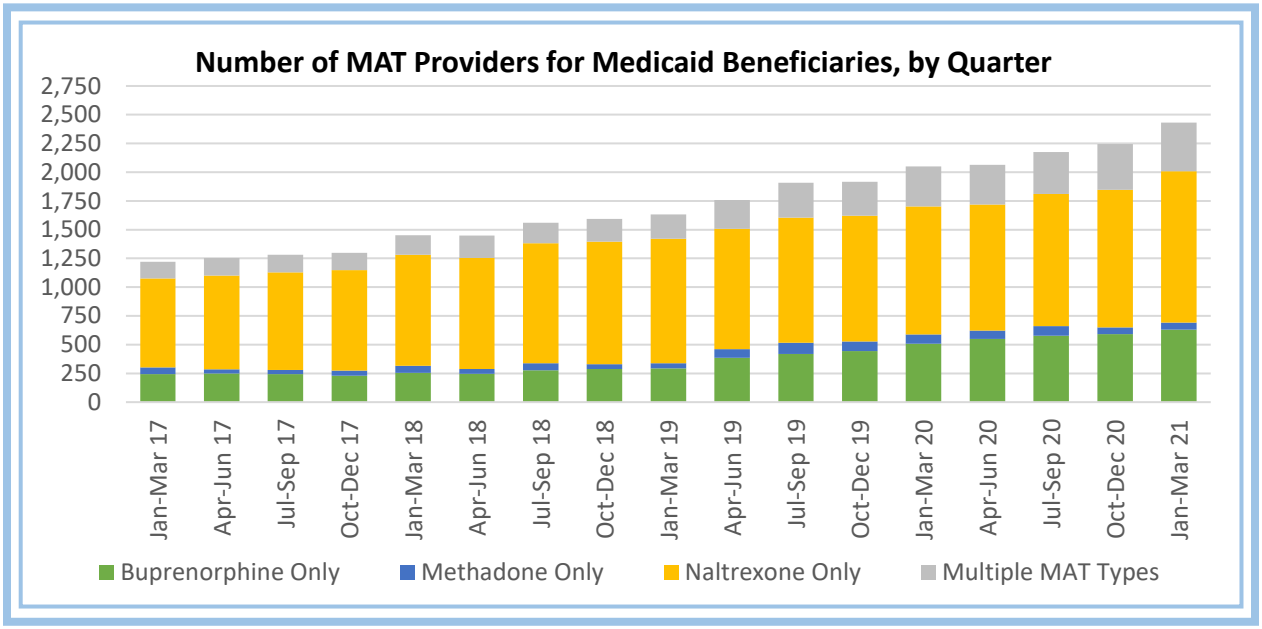
As shown in prior graphs, most beneficiaries do not initiate SUD treatment with residential treatment, and trends over time reinforce that the majority of beneficiaries have evidence of other (non-OUD) SUD. Thus, it is essential to examine treatment patterns for both beneficiaries with OUD and those with SUD.

Medication assisted treatment with methadone, buprenorphine, or naltrexone is a core component of substance use disorder treatment. The type of MAT should be chosen based on the needs and preferences of the individual. However, because MAT products are not available across all providers in all treatment settings, it is particularly important to examine trends in the types of MAT that beneficiaries receive *and* the types of MAT that providers offer.

The number of Medicaid beneficiaries who received at least one dose of any type of MAT in the quarter nearly doubled in four years, driven primarily by increased use of buprenorphine.



Over that same time period, the number of Medicaid providers who prescribed or administered at least one dose of MAT in the quarter also doubled. However, this increase was largely driven by increased administration of naltrexone, along with small increases in providers who prescribed buprenorphine or multiple MAT types.



Expanded use of MAT as a component of SUD treatment is a positive trend. However, these findings suggest that efforts will be needed to ensure that beneficiaries receive treatment that is best suited to their needs and preferences, rather than the convenience of their provider.

At a Glance Briefs

Effective treatment for substance use disorder (SUD) requires adequate provider capacity across the continuum of care. Assessment of SUD provider capacity asks if there is an adequate number of providers, clinicians, and provider organizations offering SUD services at the appropriate level of care, with the training and skills to deliver those services effectively and in locations and settings that allow people to access those services.

This analysis of SUD treatment trends over time indicates substantial need for improvement in the SUD provider capacity and deployment to meet the treatment and recovery needs of Michigan residents. The following series of brief reports, called **At a Glance: Exploring Michigan's SUD Treatment Capacity and Access**, present additional 1003 project findings focused on key structures and factors that influence SUD provider capacity and receipt of SUD treatment for Medicaid beneficiaries. Each brief report includes recommendations for policy and/or programmatic changes to facilitate improvement.

At a Glance: Exploring Michigan's SUD Treatment Capacity and Access

Maintaining Provider Capacity in the Public SUD System

BACKGROUND

Michigan's public system for substance use disorder (SUD) treatment and recovery services is administered by ten regional Prepaid Inpatient Health Plans (PIHPs), which are charged with maintaining a network of contracted SUD providers that meet minimum per capita ratios for specific levels of care. The University of Michigan's Institute for Healthcare Policy and Innovation conducted key informant interviews with PIHP officials, clinical and administrative staff from current and former SUD providers, and Medicaid beneficiaries, to understand challenges to maintaining provider capacity in the public SUD system.

KEY FINDINGS

Administrative and Financial Barriers to Maintaining Provider Capacity. The state's Department of Licensing and Regulatory Affairs (LARA) administers licensing and certification for SUD providers; PIHPs are responsible for ensuring that all contracted providers have met LARA criteria for their level of care. The regulatory and administrative requirements for SUD provider organizations in the public system are substantial. PIHPs opined that this administrative burden is a major deterrent to recruitment of new provider organizations.

SUD providers confirm that the compliance burden, including health IT requirements, is substantial. Providers with facilities in multiple PIHP regions describe having to do to separate parallel processes with each region; PIHPs indicate that they try to work with their peers in other regions but express some reluctance around accepting administrative audits of SUD providers that were conducted by another PIHP.

PIHPs typically reimburse network SUD providers on a fee-for-service basis. They understand that their reimbursement rates are low compared to other sectors; however, they say they are limited in their provider payment options by their state-established capitation rates for Medicaid and funding algorithms for other funding sources (e.g., block grant). PIHP officials describe SUD services as being chronically underfunded relative to other behavioral health services; moreover, the low rates are incorporated in the rate-setting process for future years, which causes the low reimbursement levels to be perpetuated in a vicious circle.

Provider Capacity vs Access to Services. PIHPs conduct network adequacy assessments at all levels of care. Generally, PIHPs believe they have adequate SUD provider capacity to meet the needs of adults. However, SUD provider capacity is not synonymous with availability at any given time; timely access to SUD treatment relies on availability of appointments, beds, and other services. Currently, many SUD provider organizations are operating at less than capacity, a situation that has been exacerbated by the COVID public health emergency. PIHP officials and representatives from SUD provider organizations agree that the key barrier is difficulty with staff recruitment and retention.

However, PIHPs do not necessarily accept all eligible providers in their networks. Nine of ten PIHPs either have a closed network or utilize Request for Proposals (RFPs) for specific needs (e.g., certain provider types, geographic areas). In addition to network adequacy ratios and geographic accessibility, PIHPs say they also consider the financial viability of current network providers in determining whether, when, and where to seek additional providers. However, SUD providers question this rationale, expressing frustration with their inability to expand their range or location of services in regions that have not opened their network in some time.

> A downside we run into is that PIHPs only have to open contracts so often. So we are in [x county] on a commercial basis, but are hearing from the community that there is a six-month waiting list for Medicaid. How do we get contracts to allow us to see them?

> People are dying because you do not have services, and I'm standing here saying I will take your low reimbursement and I will do this work, let me serve your population, and whoever was on the other end of that email was like, Our panel is full, we are not currently looking to expand our network.

The path to accessing SUD services starts with intake and initial eligibility screening, which includes verifying Medicaid enrollment and residency within the region. The next step is a more comprehensive assessment and determination of the appropriate level of care, which can occur within a few hours or up to two weeks later; initiation of treatment typically begins within 2 business days of the level of care determination.

Frontline staff identify several barriers to timely assessment and initiation of treatment. The lack of clinician availability delays scheduling of comprehensive assessments as well as individual and group counseling appointments. Treatment can also be delayed by client factors such as lack of transportation and competing personal demands. Staff also report that screening, assessments, treatment plans, billing, and reporting must be documented in multiple systems. Delays in receiving clinical data from other providers and the inability to share information collected during screenings and assessments with external providers add to the administrative burden and delay the initiation of SUD treatment.

Perspectives of Beneficiaries. Medicaid beneficiaries express confusion about many aspects of the public SUD system, in large part because it operates differently from their medical benefit. Beneficiaries are accustomed to working through their Medicaid Health Plan for provider referrals, but report not getting assistance for SUD services. They are frustrated when told they are "out of region" for SUD services, which has no parallel within their medical benefit. The confusion and delays impact their resolve to follow through with treatment.

> The whole district thing. I was in an inpatient program and because I was in District Four they would not approve it, but someone who lived in District Six or Seven can get approved.

> It took me two months to find a substance abuse counselor when required by the courts. I called the number on the card and the places they gave me were not helpful. One would refer me to the other that referred me to them.

Coordination Between Providers. It is expected that SUD treatment will include changes in the level of care; this requires coordination so that providers in different settings can share information and beneficiaries have access to services without delay.
SUD providers are concerned that current levels of coordination are inadequate – both within the PIHP network of SUD providers, and outside the PIHP network with providers in the medical setting who often manage MAT or other aspects of outpatient SUD treatment.

> People who are contracted to provide medical treatment for SUD should have at their disposal a MAT provider all the time. Detox and residential treatment facilities should have memorandums of understanding with outpatient substance use providers for rapid admission. I had a client who waited six months for a residential bed. That was six months of every single day where they could have died. There's no excuse for gaps in the continuity of care.

FUTURE DIRECTIONS

MDHHS may consider options to strengthen SUD provider capacity within and adjacent to the PIHP system.

- Revise actuarial models that inform funding algorithms for PIHPs to achieve equity with payment levels under medical and behavioral health systems.
- Streamline network participation requirements for SUD providers operating in multiple PIHP regions.
- Encourage collaboration between the PIHPs and Medicaid Health Plans to ensure that staff in either system can assist beneficiaries with transportation, care coordination, and other supports.
- Encourage PIHPs to open network contracting to address wait times and other access barriers.

At a Glance: Exploring Michigan's SUD Treatment Capacity and Access

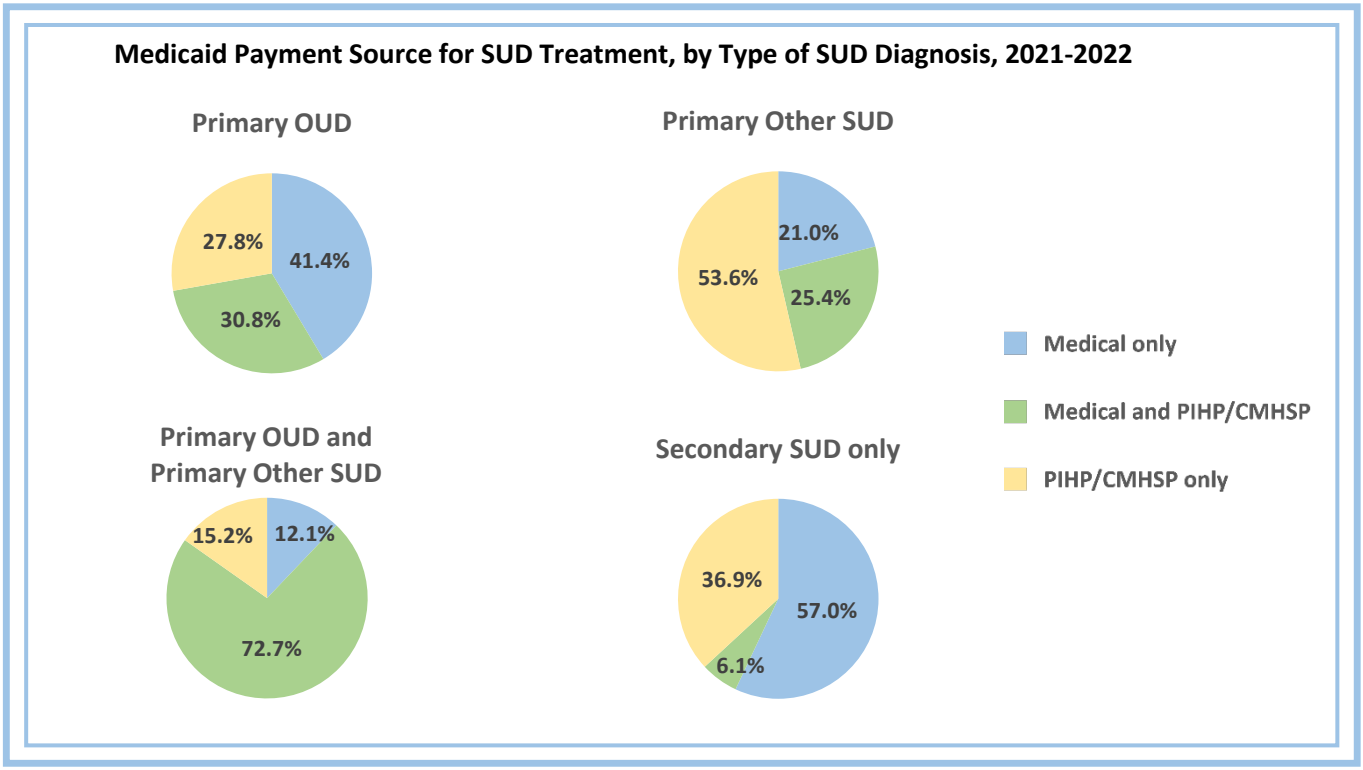
Supporting SUD Treatment in the Primary Care Setting

BACKGROUND

Michigan's health care system for Medicaid beneficiaries separates SUD care, which is managed by ten regional Prepaid Inpatient Health Plans (PIHPs) and their contracted network of SUD providers, from medical care, which is usually managed by Medicaid Health Plans and their contracted network of primary care providers. Some Medicaid beneficiaries seek SUD treatment outside the PIHP system due to distance, wait times for services, or personal preference. In other cases, primary care providers recognize SUD problems in their patients and build on their existing relationship to offer services and support.

KEY FINDINGS

Evidence from Medicaid Claims. The University of Michigan's Institute for Healthcare Policy and Innovation analyzed Medicaid administrative data for the period July 2021 to June 2022, documenting the type of SUD diagnosis and source of payment. Beneficiaries with primary OUD were more likely to receive SUD-related services only through their medical benefit, compared to those with non-OUD SUD or those with primary diagnoses for both OUD and another SUD. Among beneficiaries with AOD as a secondary diagnosis only, more than half receive SUD-related services only through their medical benefit.



The prevalence of SUD treatment through the medical benefit highlights the need for medical providers to have adequate knowledge, resources, and skills to provide appropriate care, and the understanding of when and how to connect higher-need patients with SUD specialists.

Perspectives of PIHPs. In key informant interviews, PIHP officials noted that in general they have few interactions with primary care practices in their region. They were uncertain if primary care providers have adequate knowledge about SUD treatment and recovery, or if primary care practices understand how to connect patients to SUD services in the PIHP system. Lack of interactions also impeded their ability to coordinate care for patients receiving services in both the SUD and medical systems.

Perspectives of Beneficiaries. Beneficiaries reported varying degrees of success with SUD treatment in the primary care setting. Some had access to comprehensive primary care sites that offer medication assisted treatment (MAT), counseling, transportation, and peer recovery services. Others described difficulties with provider unwillingness to offer SUD care, as well as punitive practices when they struggled with their addiction.

> After I got out of rehab, my primary doctor would not give me a prescription [for naltrexone]. She said she did not know enough about it.

> I was fired from my PCP. They said I dropped dirty for drugs.

Perspectives of Primary Care Providers. In key informant interviews, many primary care providers expressed reluctance to provide SUD treatment, due to lack of knowledge about SUD diagnosis and treatment standards, the administrative burden of becoming a MAT provider, concern about missed appointments and other problematic behaviors of patients with SUD, and fear of becoming known as an "SUD practice".

Supporting SUD Treatment in Primary Care. Opioid Health Home is an innovative program to support primary care practices in providing appropriate treatment for Medicaid beneficiaries with OUD and comorbid chronic conditions. Opioid Health Home sites must meet specific staff ratios and provide six core services (comprehensive care management, care coordination, health promotion, transitional care and follow-up, individual and family support, and referral to community and social services). In each region, the OHH network includes SUD and behavioral health providers. Network meetings allow primary care providers to connect with colleagues in other settings, which expands their understanding of SUD treatment practices and facilitates their ability to obtain advice and logistical help when a patient needs additional services.

> Initially…honestly I was a little concerned, like "Oh God we're going to have a whole different population of patients," but we're really not. Some of these people we're already seeing and we didn't know. Some of these people we were seeing and we did know, but they were going…to a place that they pay cash out of pocket. So if we can see them and bill their insurance and save them $250 a month, great… Dr. X was leading that charge and [other providers] were seeing "oh okay it's not that bad…"

> It is really a full spectrum of wellness that's automatically built in – and the fact that it is reimbursed and encouraged that we're looking at every level of services that they might need. I think [the OHH model] might be useful for other people as well.

FUTURE DIRECTIONS

MDHHS should expand efforts to support appropriate SUD treatment in the primary care setting.

- Expand Opioid Health Homes and other programs that provide additional funding, training, networking opportunities, and technical assistance to primary care sites seeking to improve SUD treatment.
- Offer and incentivize training on SUD recognition and treatment for primary care providers and staff so they are better prepared to understand patient needs.
- Establish SUD-related expectations for Medicaid Health Plans to facilitate beneficiary access to primary care SUD treatment, including MHP knowledge of which practices offer MAT, counseling, and peer support services.

At a Glance: Exploring Michigan's SUD Treatment Capacity and Access

Maintaining the SUD Clinician Workforce

BACKGROUND

Clinicians (e.g., licensed clinical social workers, addiction counselors) are the backbone of the SUD workforce, providing individual and group counseling to individuals working to overcome addiction. Many clinicians work for SUD provider organizations; others serve beneficiaries with SUD in other settings such as primary care and behavioral health providers. Interviews and analyses conducted by the University of Michigan's Institute for Healthcare Policy and Innovation identified challenges with maintaining the SUD clinician workforce.

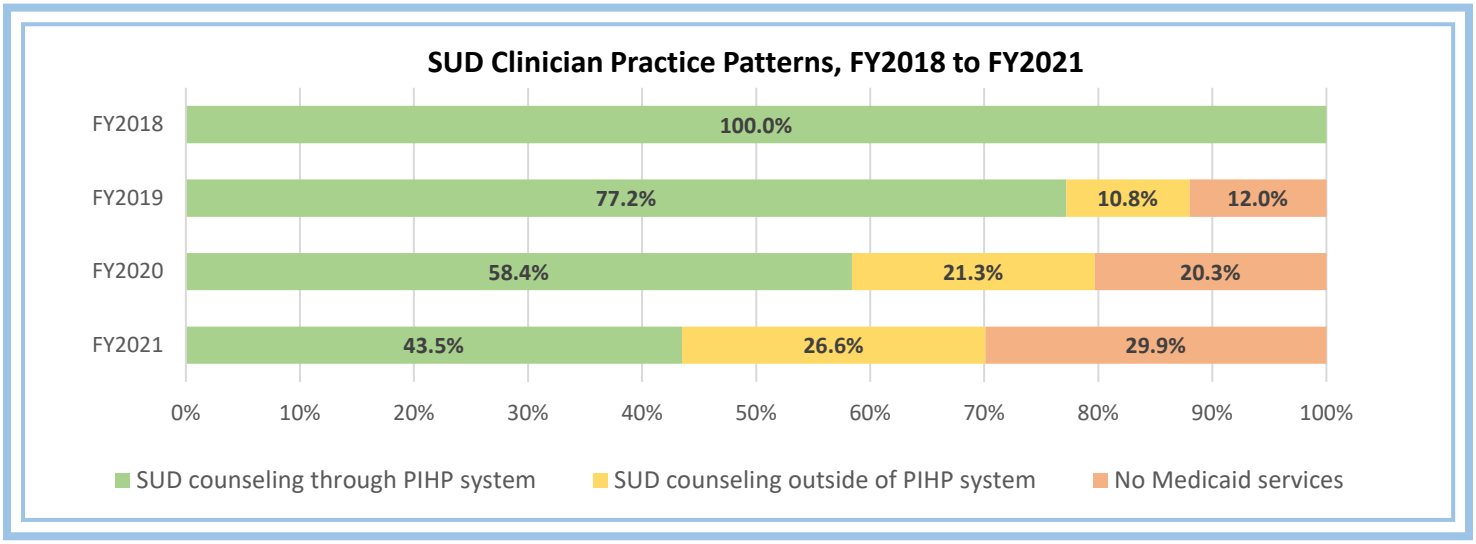
KEY FINDINGS

Perspectives of PIHP Officials and SUD Provider Organizations. In key informant interviews, both PIHP officials and SUD provider organizations described challenges hiring and retaining SUD clinicians, which impacts beneficiary access to services. A major issue is the low salary offered in the SUD setting compared with health systems or other behavioral health organizations. Retention also is impacted by clinician burnout due to the unique challenges of SUD work, as well as uneven availability of professional development opportunities across the state. Additionally, the cost and time burden of continuing education and supervision requirements impede clinician recruitment and retention in the SUD setting.

> We as a nonprofit are competing with hospital, psych hospital, CMH… I just interviewed someone almost fully licensed, has all the hours, is not taking the exam, was wanting to make $62,000. That's about 8-10 grand over probably what we could do, especially not being fully licensed. There's definitely a discrepancy there.

Evidence from Medicaid Claims. Evidence from Medicaid administrative data highlights the challenge of retaining clinicians in the SUD setting. The University of Michigan team analyzed Medicaid claims over a four-year period to identify patterns over time for clinicians who provided individual and/or group SUD counseling billed through the PIHP system.

Of 986 clinicians who provided SUD counseling through the PIHP system in FY2018, only 43.5% continued through FY2021, while 26.6% continued counseling to Medicaid beneficiaries outside of the PIHP system, such as through a CMHSP or in an integrated health system. Finally, 29.9% discontinued serving Medicaid beneficiaries by FY2021.



After clinician drop-out, beneficiaries had decreased counseling visits through the PIHP system: 50% of beneficiaries had no additional PIHP counseling visits, while the others had a median 84-day gap until they resumed counseling.

Perspectives of Beneficiaries. Beneficiaries view engagement with clinicians as a key element of their SUD treatment. In phone interviews with over 2,000 Medicaid beneficiaries:

- 15% said delays in getting counseling or other services was a major problem.
- 1 in 3 respondents were somewhat (23%) or not (8%) confident they would be able to see or talk with a provider if they were having a crisis.

> It took me two months to find a substance abuse counselor when required by the courts. I called the number on the card and the places they gave me were not helpful. One would refer me to the other that referred me to them. For people needing help it should not be so difficult.

> To be honest, after I've been there for 12 months, they're switching my therapist and I don't know why. It's seriously making me consider not going anymore. I've spent all that time with that one person and now I have to start with this new person and it's causing a lot of anxiety for me. And I understand it's not their fault, but still.

Perspectives of Former SUD Clinicians. In key informant interviews, SUD clinicians who have discontinued providing counseling for Medicaid beneficiaries provided their perspectives. They echoed concerns about salary, certification and supervision requirements, and burnout. Many also cited administrative burden.

> Pure and simple, I left [the public SUD system] because of money. I went from life being a struggle financially, to now money's not an issue. I think that's why a lot of people leave.

> I've finished one year in the tuition reimbursement or forgiveness program. The biggest problem I found with it, it was difficult to apply for...I had to get the paperwork, provide it to my employer, get it back to the program or portal, and then verify like three or four other things, and at the time I didn't have them... that's not hard, but when you're working full time, you're trying to get all this done, it felt like a lot.

> I left because my therapist told me that she was not going to release me because I had too much secondary PTSD.

> I have to have twice-monthly supervision, which isn't cheap... Do I really want to spend that amount of money on supervision when it would often be from somebody who maybe doesn't even have the experience or skill base as me?

> This field is hard. Substance use is a hard population to stick with long term... the pre-contemplation stage of change is brutal. There's just no motivation, so [the clinician must do] a lot of tapping into some external motivators like probation or parole. But that is really draining.

> One of the reasons why I left: at one point in time, with all the groups I was doing, I was probably managing care for 175 clients a month, and I was seeing them two or three times a week. It was awful. There was no way to catch up on paperwork.

FUTURE DIRECTIONS

MDHHS should prioritize actions to support clinician recruitment and retention in the SUD system.

- Review PIHP funding formulas and reimbursement levels to compare the SUD system to other settings.
- Expand salary bonus/retention and loan forgiveness programs for clinicians; ensure opportunities are equitable across regions.
- Allow continuing education credits in lieu of certification requirements.
- Reduce administrative burden on clinicians, such as enhancements to the electronic medical record, to avoid duplicate recordkeeping, as well as relaxed requirements for prior authorization.
- Offer programs on recognizing and dealing with trauma for SUD clinicians and supervisor.

Involving Peer Recovery Coaches in SUD Treatment and Recovery

BACKGROUND

Peer recovery coaches are individuals with personal experience with addiction and recovery who complete specialized training and provide non-clinical recovery support to individuals in or seeking recovery from SUD. Peer recovery coaches are often integrated into SUD provider organizations; increasingly, they are placed in other settings such as primary care practices, behavioral health organizations, hospital emergency departments, drug courts and other criminal justice settings.

KEY FINDINGS

Benefits of Peer Recovery Coaches. In key informant interviews, SUD providers and administrators note that through shared experiences, peer recovery coaches foster patient engagement and establish connections with patients who have been reluctant to engage with services. They often are available by cell or email after hours and in some cases will assist with transportation or visit patients at the hospital. Peer recovery coaches demonstrate their commitment by being available when others are not.

Peer recovery coaches offer unique input to an SUD treatment team, and many providers appreciate the opportunity to become more knowledgeable about recovery.

> [looking back] I feel like I needed to kind of change my approach to things and kind of meet the patient where they are. So utilizing the information that the peer coaches can give me from their experiences really helped me with the population.

> One of our peer recovery coaches has added resources like celebration into the mix … because not everybody is ready to be in recovery…we have to find some kind of value in that, and it might not be the same value as if they were in full blown recovery because it's a harm reduction approach. They're still not using or if they were using ten things, they're now only using a few so yay we're happy for you!

Deployment of Peer Recovery Coaches. In some settings, as providers gain comfort with peer recovery coaches, they expand their role to allow other team members to focus on core responsibilities. For example, some practices assign peer recovery coaches with the task of assisting with case management and social determinants of health (SDOH) needs, so that therapists can devote their efforts to providing therapy. Some SUD practices have peer recovery coaches take the lead on new enrollments, using that relationship to jump-start start the process of developing a care plan and freeing up nurses for other tasks.

However, in many situations, placement and deployment of peer recovery coaches continues to be challenging. Outpatient providers may not understand how to utilize peer recovery coaches and may not have sufficient volume of patients with SUD to sustain an onsite coach. PIHP efforts to deploy peer recovery coaches in hospitals and emergency departments have hit roadblocks due to liability concerns. Supervision is an issue across settings; some providers and administrators are uncertain about how to oversee an employee who works outside the clinic setting and hours. Many peer recovery coaches have a criminal background, which hinders placement in jails or prisons and other justice settings, as does stigma.

Financing of Peer Recovery Coaches. SUD providers and PIHP officials cite limited ability to recoup costs as a barrier to expanded use of peer recovery coaches. For example, Medicaid reimbursement is limited for some common peer support activities, such as telephone calls, and does not allow concurrent support from peer coaches in multiple provider locations. This becomes complicated when a patient sees a peer recovery coach in multiple settings, which is not uncommon. Even providers with enhanced funding, such as Opioid Health Homes, found that the increased reimbursement still does not fully cover the cost of a peer recovery coach.

Financial constraints can limit the consistency with which peer recovery coaches are available to patients, which impedes the establishment of standard protocols to incorporate them at specific points in the encounter. SUD providers in the emergency department express frustration when peer recovery coaches are unavailable to patients at a crucial time in the decision of whether to seek treatment.

Outside the PIHP system of care, other regulations limit what peer services can be billed and who can bill them.

> We would've very much welcomed the ability to do the peer recovery coaching, but we didn't have an easy pathway to that. As a CMHSP, we have to follow specific regulations for our Medicaid contract, we primarily operate out of a behavioral health carve out rate per member per month. So we have a specific set of codes we're allowed to bill under that per member per month and unless we were paneled as a SUD provider which came with all kinds of licensing hoops, we couldn't bill for the peer recovery coach. We could bill as a peer, but we weren't really reflecting what they were doing which was the recovery coach piece.

> This person sent me a resume yesterday, currently working at a local competitor. He's a behavioral health tech and a certified recovery coach. And that's great! He's had 40 hours of training; he's got the certificate to prove it. The issue is they won't allow us to bill for recovery coach services if they're not CCAR accredited. Now we're forced to look for people who get the less known, more obscure MDHHS training.

Perspective of Peer Recovery Coaches. Many peer recovery coaches love the work and thrive in settings where they are value. Yet there is little discussion of a long-term career path. Wages for peer recovery coaches are low and often do not include benefits. Current and former peer recovery coaches say that low wages and lack of benefits make it infeasible to view this role as a viable long-term job option.

> When it came to questions about clients and stuff, they'd ask me directly, What's going on? Can you help me understand what this guy is thinking? They'd never got to see it from the addict's side. They always saw it on the outside looking in, where I was the guy on the inside looking out and I could explain that to them and make them understand. I felt respected, valued, I felt very comfortable.

> I loved it. I wish it would have paid better and had some benefits, or I would have stayed with it longer. It's hard to support a family, at $13 an hour... I asked if we can turn this into a full-time position and [the manager] said no.

FUTURE DIRECTIONS

MDHHS may consider strategies to enhance the impact of peer recovery coaches:

- Expand policies for reimbursement for peer recovery coaches in the PIHP system and in the medical and behavioral health systems, and reflecting the broad array of settings where peer recovery coaches are deployed, including outpatient clinics, emergency departments, and recovery housing.
- Establish best practices for supervising and deploying peer recovery coaches and include in training and educational opportunities for SUD providers.
- Eliminate requirements that limit the ability to hire and deploy peer recovery coaches, including requirements to have numerous years free of a felony and recognition of only some certifications.
- Identify career paths, with realistic funding options, for peer recovery coaches beyond initial certification.

Trends in Medication Assisted Treatment for SUD By Race/Ethnicity

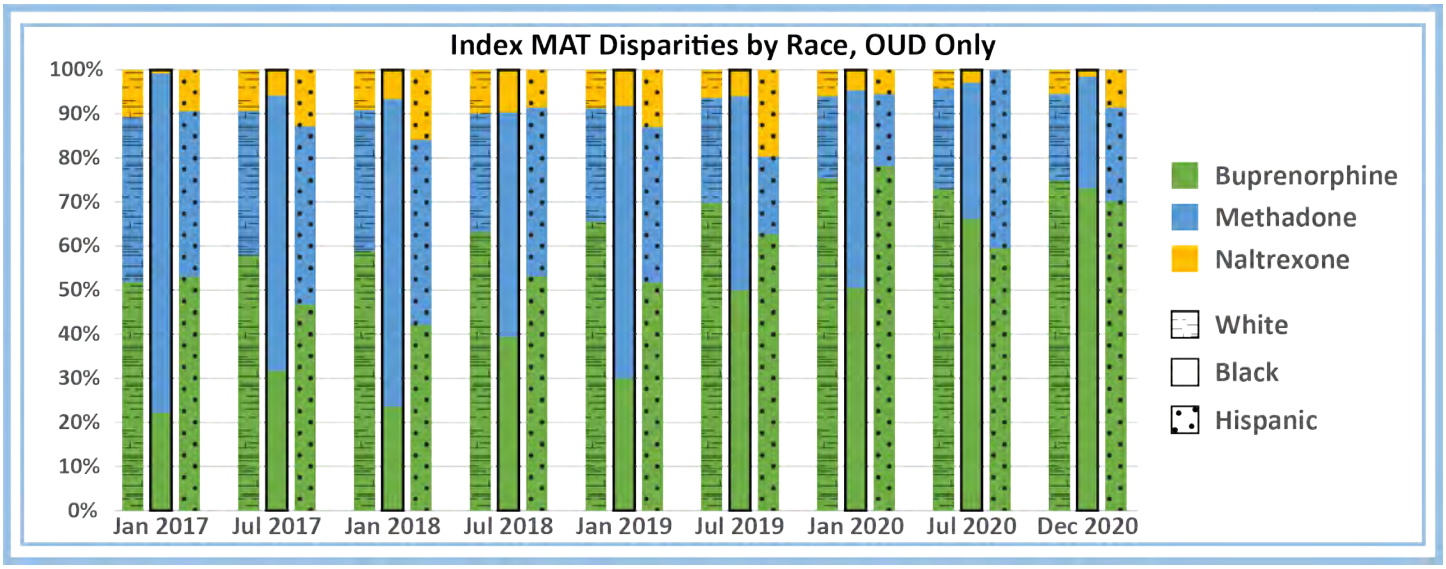
BACKGROUND

Medication assisted treatment (MAT) with methadone, buprenorphine, or naltrexone is a core component of substance use disorder (SUD) treatment. The type of MAT should be chosen based on the needs and preferences of the individual. Disproportionate use of MAT by race/ethnicity may signal inequitable access to care or provider patterns.

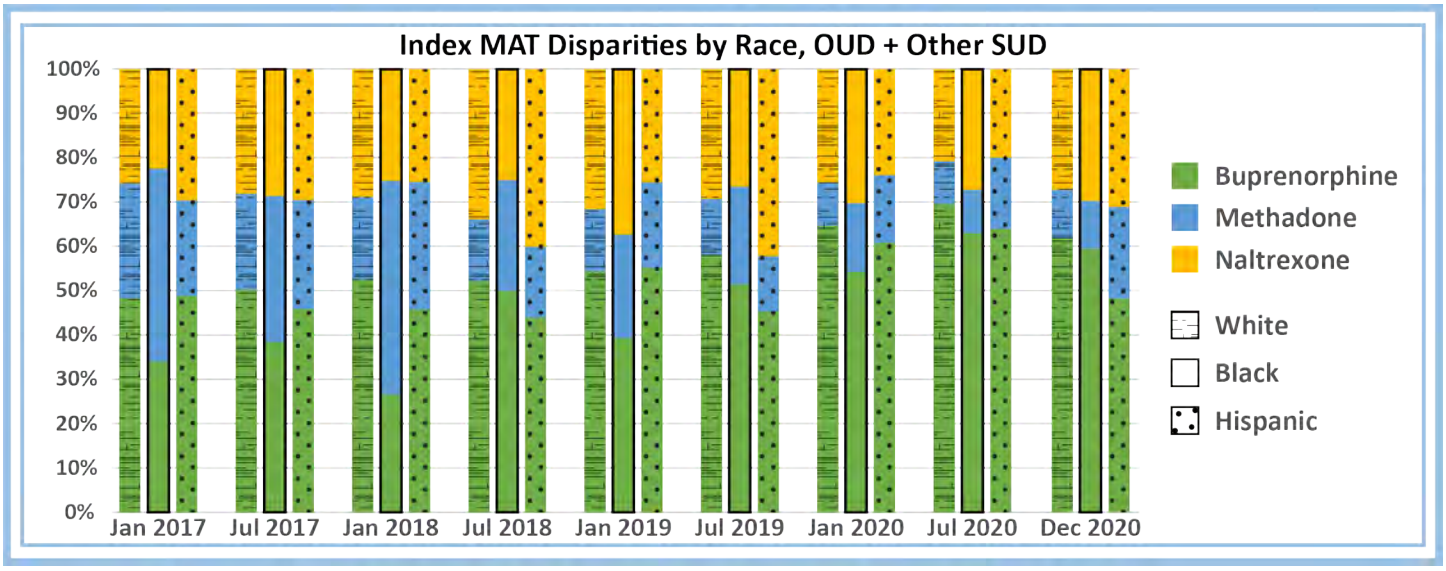
KEY FINDINGS

Race/Ethnicity Differences in Index MAT. The University of Michigan's Institute for Healthcare Policy and Innovation analyzed Medicaid claims data to "Index MAT" cases, defined as a beneficiary's first claim for MAT after ≥12 months with no other MAT claim. Each Index MAT was linked to type of MAT, the type of SUD, and the race/ethnicity of the beneficiary.

Among beneficiaries with OUD, throughout 2017-2019, non-Hispanic Blacks were more likely to receive methadone. Race/ethnicity differences narrowed during 2020.

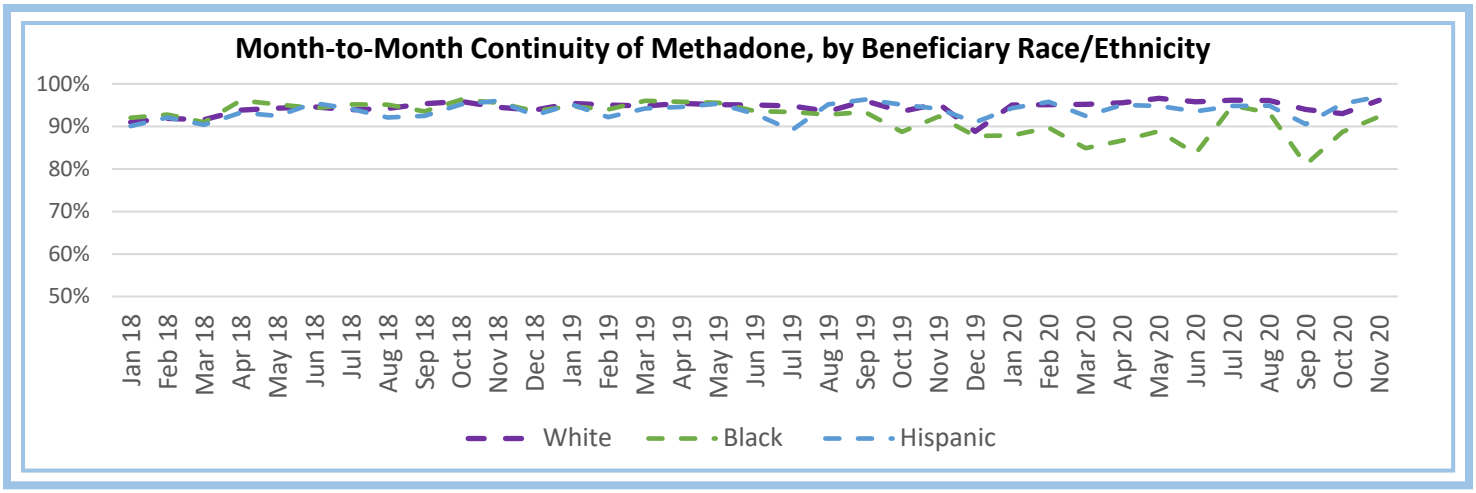


A similar pattern was seen among beneficiaries with OUD and another type of SUD, with non-Hispanic Blacks being more likely to receive methadone. Race/ethnicity differences narrowed during 2020.

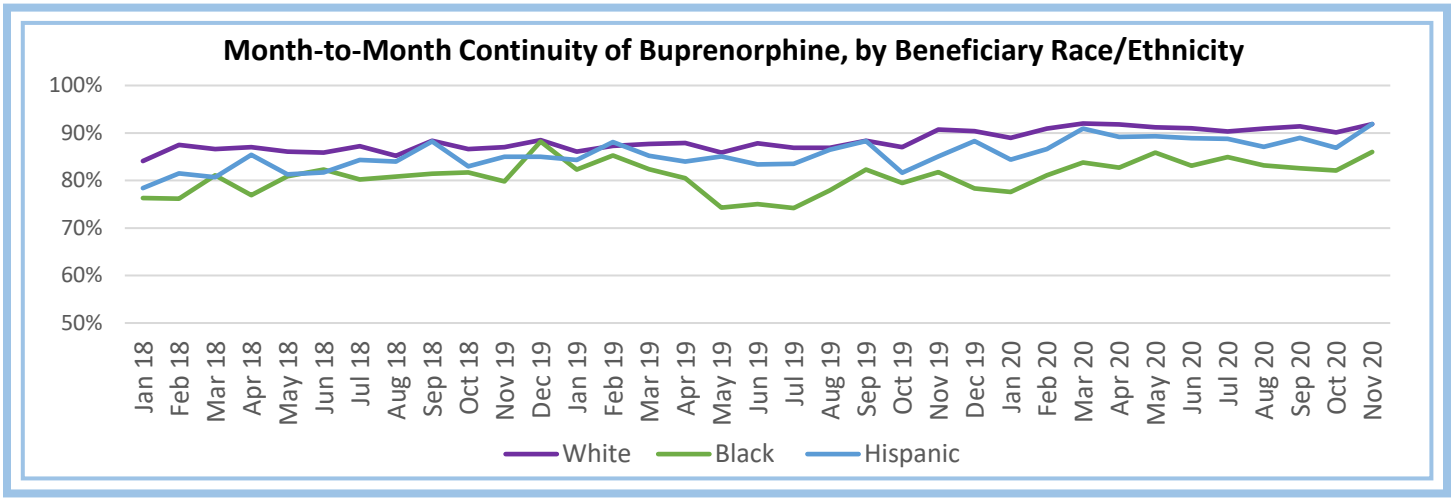


Race/Ethnicity Differences in Continuity of MAT. The University of Michigan documented month-to-month continuity of methadone and buprenorphine. Continuity was defined as the proportion of beneficiaries with at least one dose of methadone or buprenorphine in a given month, among those receiving that MAT type in the preceding month. Continuity was calculated by MAT type and by beneficiary race/ethnicity.

Among beneficiaries receiving methadone treatment, month-to-month continuity was high across all groups through 2018. In late 2019 and 2020, methadone continuity among Black beneficiaries decreased.



Among beneficiaries receiving buprenorphine treatment, month-to-month continuity was notably lower for Black beneficiaries and slightly lower for Hispanic beneficiaries compared to White beneficiaries.



FUTURE DIRECTIONS

MDHHS should monitor trends in MAT initiation and continuity by race/ethnicity:

- Consider policy and programmatic changes to ensure that beneficiaries have access to peer recovery coaches, transportation, and other services to facilitate engagement with treatment.
- Offer training to ensure providers have adequate knowledge of MAT options, and enact policy and programmatic changes to reduce financial or regulatory barriers to offering multiple types of MAT.

At a Glance: Exploring Michigan's SUD Treatment Capacity and Access

Impact of Transportation Difficulties on SUD Treatment Initiation and Continuity

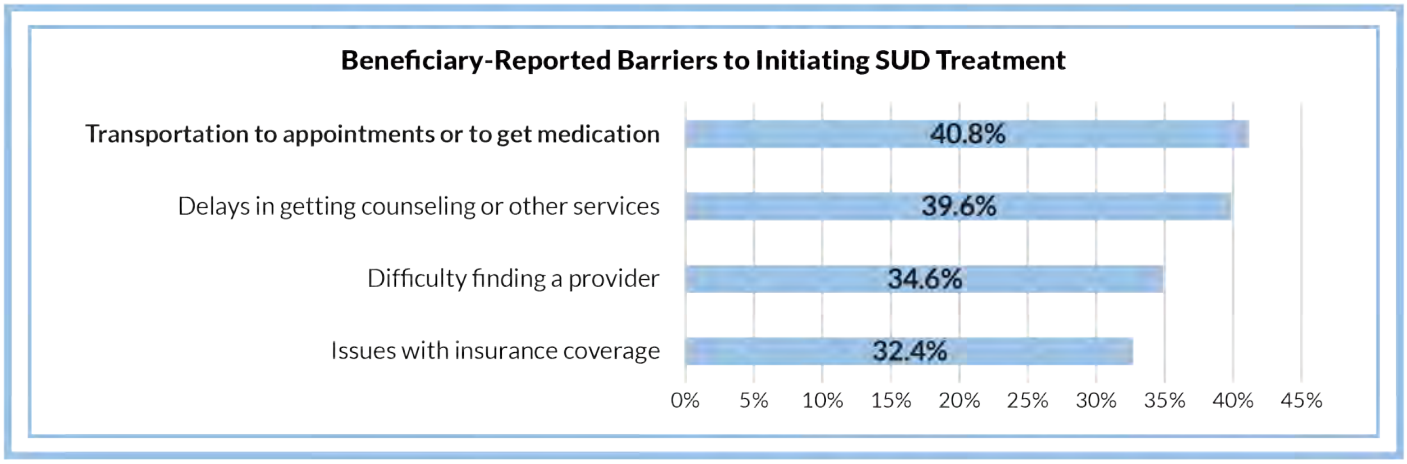
BACKGROUND

Consistent access to treatment is essential to helping people overcome substance use disorders and avoid overdose. Interviews and analyses conducted by the University of Michigan's Institute for Healthcare Policy and Innovation found that transportation is a significant impediment to accessing SUD treatment services.

KEY FINDINGS

Perspectives of Providers. SUD providers express frustration that transportation options for SUD treatment are unclear, inconsistent, and inequitable. Providers have trouble understanding the different systems for accessing transportation assistance. PIHPs use block grants or other flexible funds to cover transportation, but these funds may not be consistently available throughout the year. This creates a problem for clients, who experience changes in whether and how they can receive transportation assistance.

Perspectives of Beneficiaries. In phone interviews with over 2,000 Medicaid beneficiaries who had begun SUD treatment within the prior three months, transportation was the most common barrier to SUD treatment.



In follow-up phone interviews six months later, transportation also was the most frequently reported barrier to continuing SUD treatment. Interview participants were 12 times more likely to say transportation was a problem for SUD treatment than for primary care visits.

> I went to the first meeting which was to meet with a counselor. And then the second one was to meet with a doctor and because of transportation issues, I actually missed that appointment... I have yet to get back.

> I had a hard time getting there with transportation so I stopped [taking methadone] after about a month and a half.

> Transportation is a huge problem. I don't have a car. I'm stuck walking everywhere. I have weekly visits with the counselor but it's an hour to walk there and it's too hard.

> It was a toss up with [Health Plan]. Sometimes they'll give you transportation, sometimes not. But they will not transport you to the [OTP] clinic.

> I really wish [transportation] was made a little easier for my appointments. Everything else except substance abuse is covered with my insurance or through the clinic, so that would be nice if they had some sort of option for that.

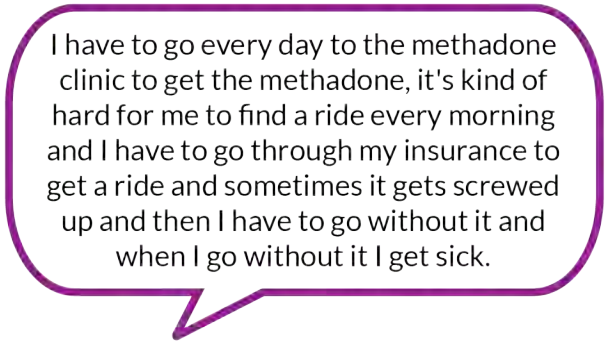
Evidence from Medicaid Claims. Administrative data supports the views of providers and beneficiaries. From July 2021 to June 2022, among beneficiaries with SUD:

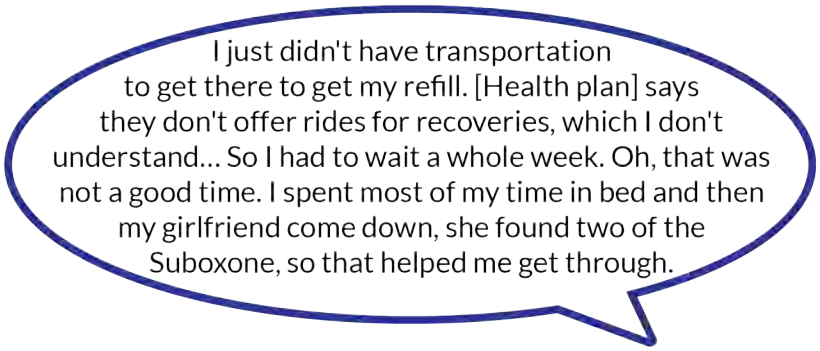
- 84.1% did not receive non-emergency medical transportation assistance
- 15.3% received transportation assistance through their medical benefit
- Less than 1% received transportation assistance through specialty behavioral health system

Emphasis on MAT. An essential element of successful medication assisted treatment for SUD is consistent dosing. Beneficiaries on MAT are at risk when their MAT provider is distant or difficult to visit and they have limited options to get transportation assistance, which can lead to missed doses and missed appointments.

1 in 6 beneficiaries reported missing at least one dose of medication assisted treatment in the prior six months because they couldn't get to the clinic or pharmacy to get their medication

Missing doses creates a no-win set of options: go without and experience withdrawal symptoms, try to obtain MAT doses diverted from another person in treatment, or obtain a substitute drug through other means.





Missed appointments can lead to beneficiaries being ineligible for an increased number of take-home doses, which in turn perpetuates the burden of frequent appointments, or even being suspended or discharged from a practice, which leaves them without access to medications, counseling, or other needed services.

FUTURE DIRECTIONS

MDHHS should prioritize policy and programmatic changes around transportation to SUD services.

- Include SUD treatment in the standard Medicaid transportation assistance benefit.
- Streamline processes so beneficiaries have a single process for medical and SUD care.
- Consider options to waive advance-notice policies for MAT appointments.
- Minimize the transportation burden for SUD treatment and recovery by enacting policies that allow mobile and satellite MAT units, MAT telehealth, MAT take-home doses, and drug testing requirements to the full extent allowed by federal law.

At a Glance: Exploring Michigan's SUD Treatment Capacity and Access

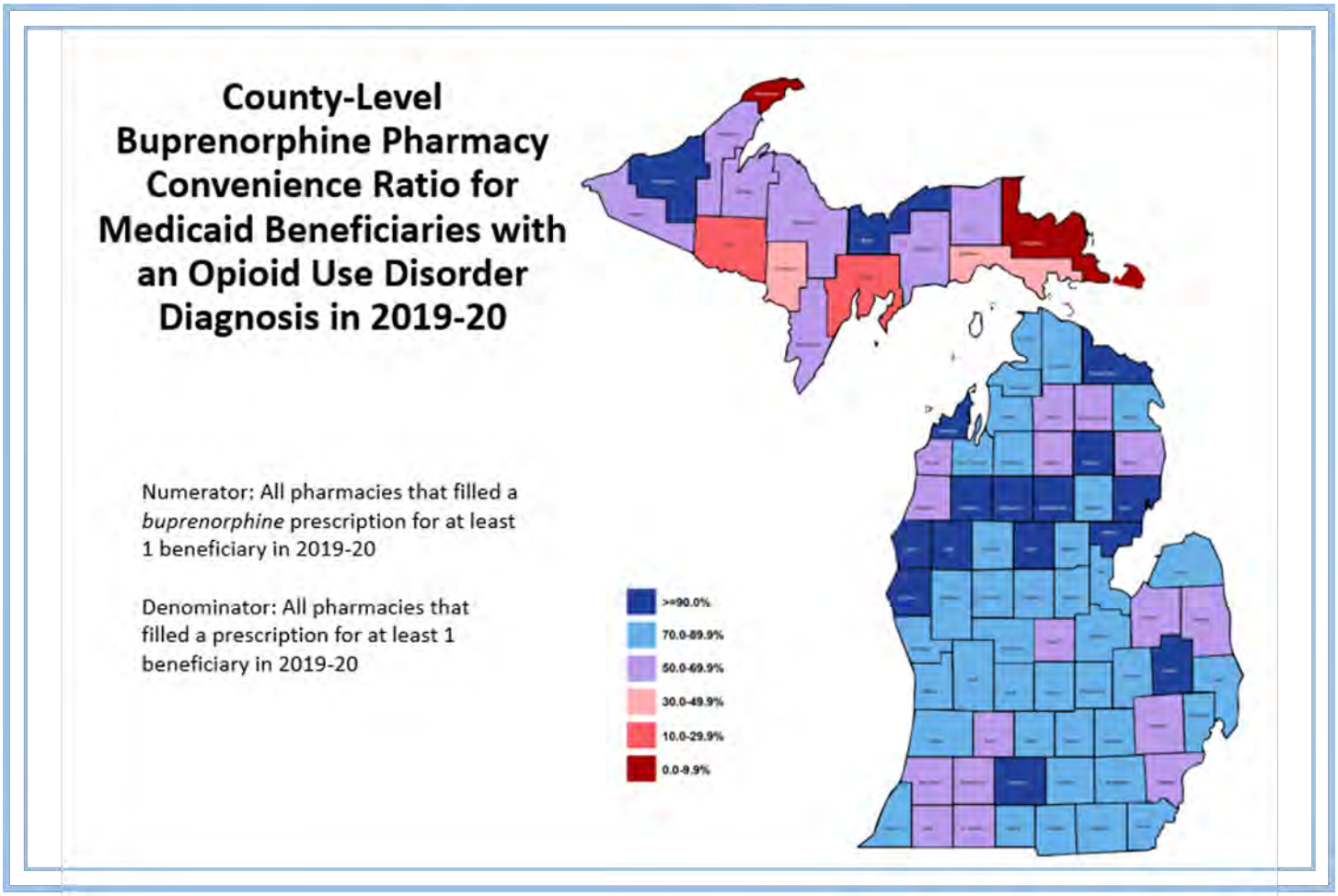
The Role of Pharmacies in SUD Treatment Engagement

BACKGROUND

Community pharmacies are a widespread and commonly used access point for Medicaid beneficiaries, often more so than traditional health care settings. For beneficiaries with SUD, pharmacists are well positioned to encourage compliance with medication assisted treatment, identify potential interactions with other prescribed medications, and recognize signs of disengagement with SUD treatment.

KEY FINDINGS

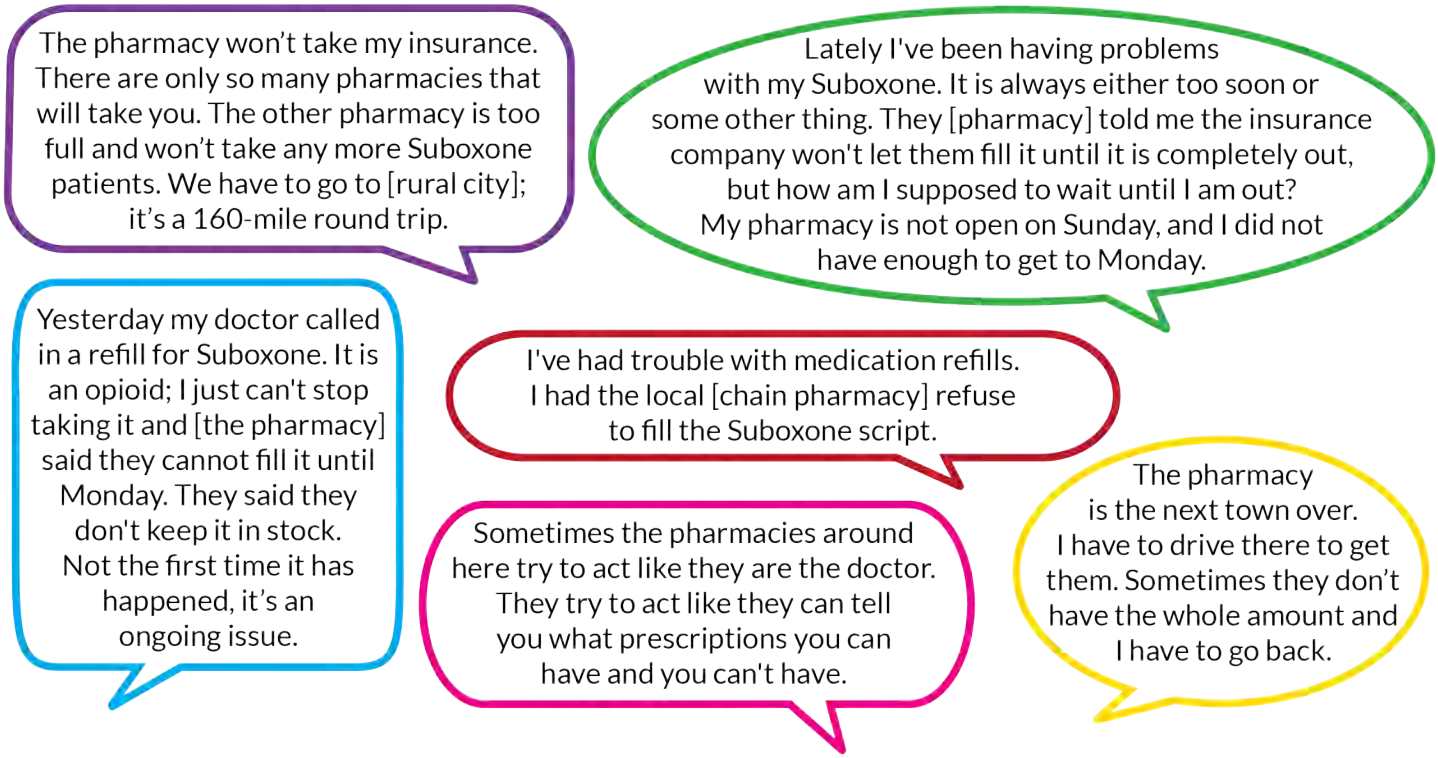
Evidence from Medicaid Claims. The University of Michigan's Institute for Healthcare Policy and Innovation analyzed Medicaid administrative data for a two-year period (2019-2020) to document county-level prescription fills for Medicaid beneficiaries compared to county-level buprenorphine prescription fills.



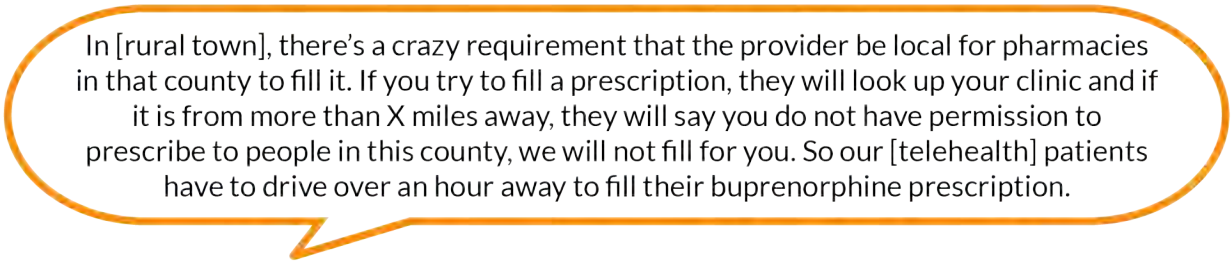
These data indicate that access to medication assisted treatment may be suboptimal in several counties:

- In six counties (all rural), among pharmacies that fill prescriptions for Medicaid beneficiaries, less than half had filled a buprenorphine prescription.
- In an additional 23 counties, including both rural and urban areas, less than 70% of Medicaid-serving pharmacies had filled a buprenorphine prescription.

Perspectives of Beneficiaries. Due to buprenorphine restrictions, beneficiaries cannot obtain refills in advance of their specific days' supply; in other words, there is a tight window in which they get the refill scrip from their provider and pick up the medication from the pharmacy. Beneficiaries report problems with pharmacies that do not keep buprenorphine in stock; it can take 3-4 days for the medication to arrive at the local pharmacy. In that time, beneficiaries may run out of medication and face challenges with cravings and/or withdrawal symptoms.



Perspectives of Providers. SUD providers confirm that their patients have difficulty with pharmacy service for buprenorphine. For example, buprenorphine management via telehealth was expanded during the COVID public health emergency, yet some pharmacies would not recognize that method.



FUTURE DIRECTIONS

MDHHS may consider strategies to enhance beneficiaries' access to MAT through pharmacies.

- Establish clear expectations that pharmacies provide MAT as prescribed. Partner with the state pharmacist association to educate pharmacists about the importance of timely refills for MAT.
- Consider pilot programs to expand the pharmacist role in supporting engagement in SUD treatment.
- Support the development of prompts in health information systems that notify providers and pharmacists when MAT refills are imminent.

SUD Treatment and the Justice System

BACKGROUND

Individuals with SUD may engage in behaviors or actions that result in contact with the justice system, including arrest or incarceration. Justice system involvement create barriers to assessment and treatment initiation, or disruption to continuity of MAT or other forms of SUD treatment. A team at the University of Michigan's Institute for Healthcare Policy and Innovation conducted key informant interviews with stakeholders about their experiences with SUD treatment and the justice system.

KEY FINDINGS

Perspectives of SUD Providers. SUD providers reported frustrations in their interactions with both the justice system and law enforcement agencies, including: the inability to consistently communicate with individuals while they are in jail, lack of cooperation from those working in justice-involved settings, and lack of understanding on the part of law enforcement officials on the needs of individuals requiring SUD treatment. These experiences varied widely and were described as being largely dependent on the inner workings and individual decisions made by those working in local justice system and law enforcement settings.

As a result, the ability of individuals to receive SUD screening, assessment and treatment was largely dependent on where they were jailed. For example, one PIHP region reported that some county jails allow individuals in the jail to contact them and initiate SUD treatment, while others provide very limited access to phone calls or required the PIHP to contact incarcerated individuals at very specific times. SUD providers also felt that their ability to meet individuals' SUD treatment needs is highly dependent on the specific officer or justice-related staff working in any given moment. SUD providers felt largely powerless to impact their interactions with justice system and law enforcement officials.

Several CMHSPs and PIHPs have a dedicated staff member working as a justice involved and law enforcement liaison, which they felt greatly improved their relationships with law enforcement and justice system officials, as well as their ability to serve individuals with SUD. Several PIHPs have attempted to place peer recovery coaches in jails and prisons, but commonly face restrictions on individuals with criminal backgrounds. Some PIHPs noted efforts to work with the court system to facilitate access to treatment, but stigma toward SUD clients and negative attitudes about medication assisted treatment can impede buy-in from justice personnel.

Perspectives of Beneficiaries. In interviews with 2000 beneficiaries, required SUD treatment was a common theme. Beneficiaries had a range of positive and negative experiences with court-ordered treatment.

> I am in a program for people who just got out of prison. They got housing, they got counseling, they have a doctor if you need to see a doctor. If you need to see a therapist it is right there. We do groups about all kinds of things. I can also sit down and talk with a peer specialist.

> [MDOC] gave recommendations, actually, but it was a place that you were going to have to pay for. They didn't waive anything... It's like they [MDOC] deal with certain people, I feel, and they send the people right to where they want to send them ... So it's like it ain't what you know, it's who you know.

> I got out of prison a few months ago. Heroin. Every week I have a Zoom group meeting. They have meetings there. It is a place for helping people get jobs and stay out of prison and get treatment. While I was in prison I did substance abuse programs; they had me do an interview and they tell you what places may be best for you.

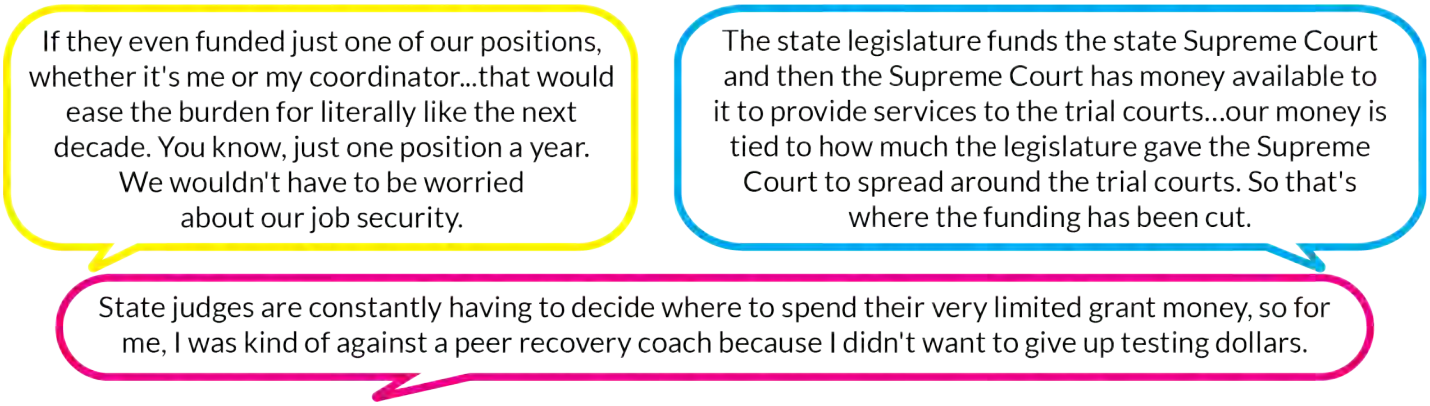
> It was drunk driving in 2018. I went to outpatient for 12 weeks. [District Court] referred me there. That was not a good program. I would like to see the court ordered treatment system improved drastically. The biggest thing is that they rely on incarceration more than rehabilitation so that it tends to make people lie. I was honest about struggling and wanting more treatment, so they put me in jail for 30 days rather than giving me more treatment.

Treatment Courts. In Michigan, treatment courts (sometimes called drug courts or problem-solving courts) are an optional program funded through the State Court Administrative Office. Judges agree to lead treatment court and receive no pay or caseload adjustment. Treatment courts vary in staffing, how participants are identified, and program contents. However, all focus on participants who are high need and high risk.

In key informant interviews with judges, coordinators, and other treatment court staff, common characteristics stand out:

- Treatment court judges and staff are knowledgeable about SUD; in most cases, they know and adhere to established best practices, and strive to learn more.
- Treatment court personnel recognize that participants will have a variable path toward recovery; they expect slip-ups and prioritize engagement. They view drug testing as a tool to identify need for greater intensity of treatment, not as a punishment. A positive drug test is not a cause for dismissal.
- Typically, peer recovery coaches are an essential part of the team and maintain close ties with participants to promote treatment engagement.
- Judges and staff work to establish positive relationships with local law enforcement, recognizing their need for ongoing education about SUD.

Treatment court participation is constrained by funding. Their primary costs are drug testing and staff to support close engagement with participants. Judges described their funding challenges:



In addition to funding, treatment court judges and staff identify other barriers, including lack of recovery housing, turnover among SUD providers and staff, Medicaid limits on residential treatment, and lack of SUD knowledge among law enforcement and government officials.

FUTURE DIRECTIONS

MDHHS and its state partners should support efforts to improve interactions between the justice system, beneficiaries with SUD, and their providers.

- Expand advocacy and financial support for enhanced collaborations between PIHPs and jails, prisons, and courts to facilitate access to SUD treatment services, including medication assisted treatment.
- Encourage and incentivize training to increase knowledge about SUD recognition and treatment in law enforcement organizations
- Identify and incentivize best practices for supporting SUD treatment initiation and continuity in jail and prison settings.
- Expand funding for existing treatment courts and identify funding for new treatment courts to allow equitable participation across the state.

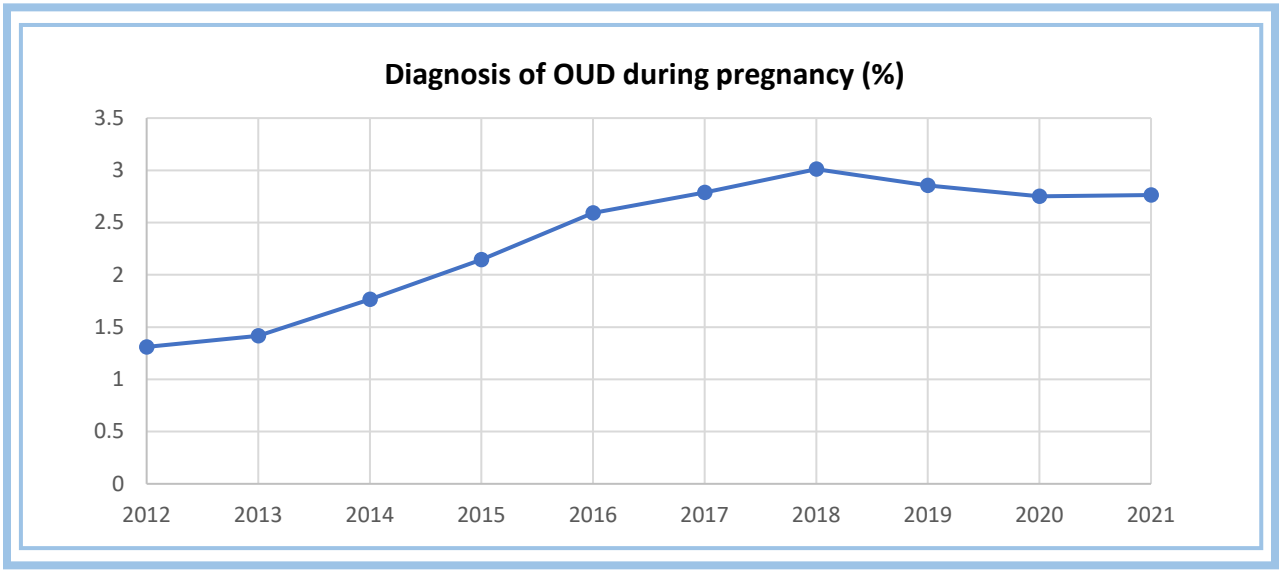
Recognizing and Treating Opioid Use Disorder (OUD) During Pregnancy

BACKGROUND

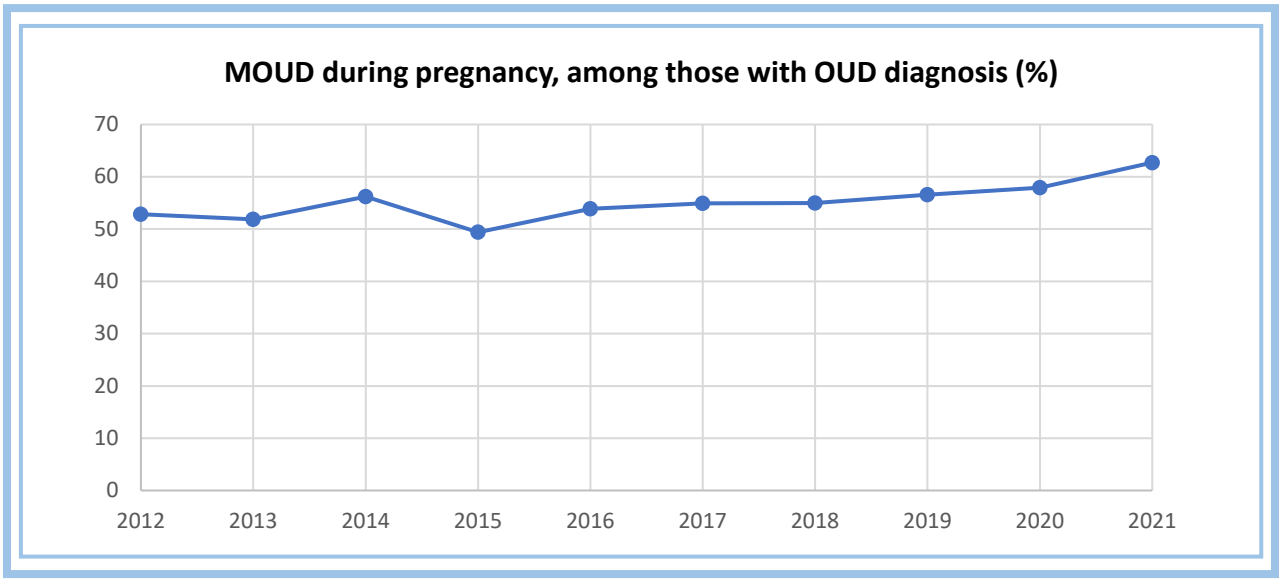
Identification and treatment of opioid use disorder (OUD) in pregnant women is important not only for the health of the mother but also for minimizing the negative impacts on the baby. A team from the University of Michigan analyzed Medicaid administrative claims data to illustrate trends in diagnosis of OUD during pregnancy, as well as trends in treatment among pregnant individuals with OUD.

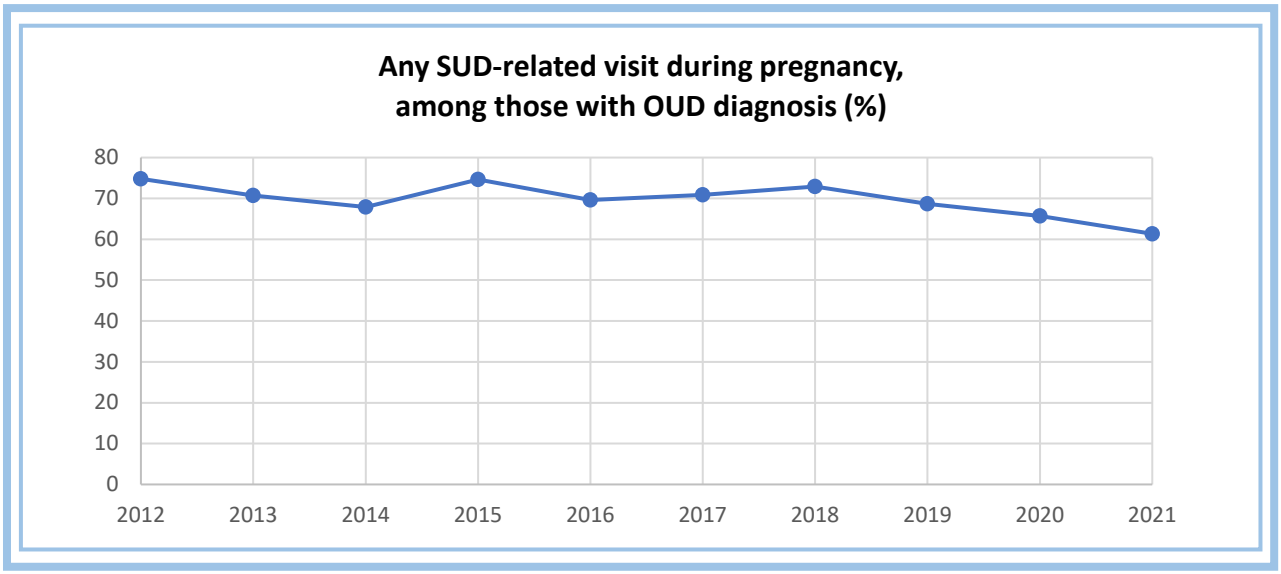
KEY FINDINGS

From FY2012 to FY2021, diagnosis of OUD during pregnancy doubled (from 1.3% to 2.8%).



Among beneficiaries with an OUD diagnosis during pregnancy, the proportion who received medications for opioid use disorder (MOUD) increased over time (52.8% to 62.7%) while the proportion with SUD visits decreased slightly over time (74.8% to 61.3%). However, roughly one-third of pregnant women with OUD have no evidence of SUD treatment during pregnancy.





Expediting SUD Treatment during Pregnancy
To ensure prompt access to treatment, PIHPs have established pregnant women as a priority population for expedited SUD assessment and initiation of treatment. Interviews with frontline intake staff, other SUD providers, and Medicaid beneficiaries confirm that pregnant women receive priority for services.

Efforts to enhance OUD recognition and treatment during pregnancy
Provider knowledge and practices are a likely barrier to improving OUD recognition and treatment during pregnancy. Many obstetricians do not have standard screening processes to recognize OUD and may not be familiar with recommended treatment.

To better support perinatal providers, a team at the University of Michigan has integrated efforts of two successful provider support programs: the Michigan Opioid Collaborative (MOC), which trains and supports primary care providers around recognition and treatment of SUD, and the MC3 (Michigan Child Collaborative Care) program, which provides psychiatry support to primary care providers in Michigan who are managing patients with behavioral health problems. With support from the 1003 project, MOC and MC3 staff created a dual enrollment path for perinatal providers, conducted training webinars addressing comorbid mood disorders and SUD/OUD, and revised perinatal psychopharmacology cards to include medication assisted treatment options for perinatal women with SUD.

FUTURE DIRECTIONS

MDHHS should continue to support efforts to train perinatal and SUD providers in recognizing and treating OUD and other SUDs during pregnancy.

Future work may include documenting rates of treatment by region and by demographic subgroups.

At a Glance: Exploring Michigan's SUD Treatment Capacity and Access

Perspectives on SUD Treatment for Youth in Foster Care

BACKGROUND

Youth in foster care are at significant risk for SUD given their history of stressful home circumstances and other trauma, while the complexities of the foster care system create unique challenges related to SUD treatment and prevention.

A team from Oakland University's William Beaumont School of Medicine conducted key informant interviews with foster care youth, parents, and workers to explore their perspectives and experiences on access to SUD treatment, recovery, and prevention services for youth in foster care.

KEY FINDINGS

Youth, families and workers in the foster care system identified barriers to recognizing and accessing appropriate treatment for SUD. Some common barriers across these three groups related to challenges inherent to the foster care population, limited access to SUD services, and a lack of youth-focused options for SUD prevention and treatment.

Perspectives of Youth in Foster Care

Youth in the foster care system described factors unique to their situation. These included:

- Frequent placement changes and inconsistency of foster care workers makes it difficult to recognize and get help for SUD problems
- Dismissive or judgmental interactions with adults reinforce the fear of acknowledging that need help
- Current system is adult focused and does not address SUD in a way that is helpful from a youth's perspective

> I've switched probably three times. And it got to the point where two weeks ago, my caseworker said that she would no longer have me as hers' and I literally had to step up and be like, no, I'm not going through this again.

> ... it was very difficult for me to reach out for help.

> ...lots of booklets, so many fricking booklets. Booklets don't help. Those are one of the least useful things.

Perspectives of Foster Care Parents

Foster care parents shared numerous barriers; among them:

- Youth are not taken seriously by adults and services are not youth/patient-centered
- There are long wait times to receive services, which impacts the burden on parents and motivation of youth to be engaged in SUD treatment
- Treatment seems to be "one size fits all" and medication focused

> ... you will be more successful if you incorporate the ideas and notions of the youth in whatever it is you intend for them to do.

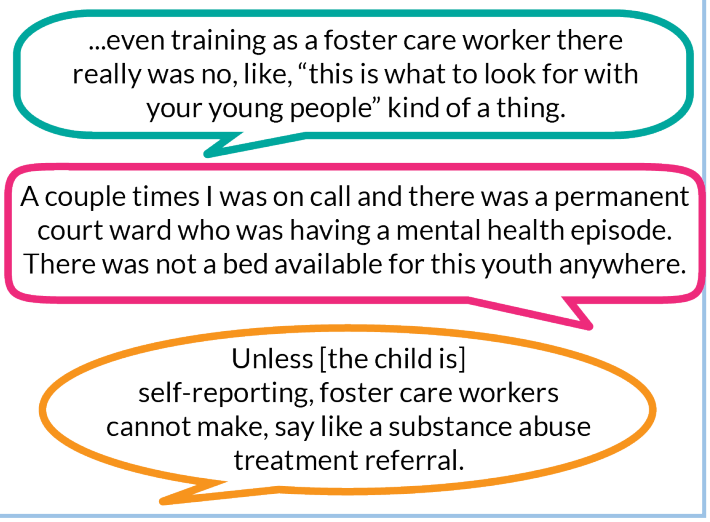
> ...you're talking about weeks to get your child to the proper place. Getting the proper relief or help.

> ...make sure that your child really needs that medication and be an advocate for that child. That if he feels the medication is wrong, then 9 times out of 10, the medication is wrong. He had a right to say and feel and get some results of how the medication is working for them.

Perspectives of Foster Care Workers

Workers in the foster care system described their challenges, which included:

- Foster care workers have limited experience with and inadequate training for dealing with SUD
- Access to SUD services is hindered by limited providers, long wait times, and lack of geographic diversity
- Youth may feel they can't reach out for help due to stigma or they don't recognize that their use is a problem, et foster care workers feel that they cannot initiate SUD care



FUTURE DIRECTIONS

MDHHS and its state partners should consider improvements to SUD identification and treatment for youth in foster care including:

- Develop and disseminate training and resources for foster care parents, workers, and other adults working in the system on identifying, referring, and caring for youth who misuse.
- Identify and develop ways to promote more youth-focused treatment and resources, including having access to youth peers in recovery, having a youth advocate within the system, and developing more youth-friendly health education options.
- Increase the geographic availability and number of providers who will treat youth, so that more youth will have access to local, community-based services.

At a Glance: Exploring Michigan's SUD Treatment Capacity and Access

Service System Facilitators and Barriers for Native Americans in Michigan

BACKGROUND

Within Michigan, there are 12 federally recognized and dependent sovereign Native nations. The state recognizes four additional Tribal bands and has a sizeable urban Indian population. Michigan Public Health Institute (MPHI) used a community-based participatory approach to work with Tribal behavioral health programs and the Inter-Tribal Council of Michigan (ITCM) to explore SUD treatment and recovery services and provider capacity for serving Native Americans.

KEY FINDINGS

Perspectives of Providers. Tribal behavioral health programs commonly offer screening, individual and group therapy, counseling, peer support, and spiritual and cultural services directly within their program, although the service array varies among Tribes. Cultural services include traditional healers, ceremonies, sweat lodges, smudging, pow wows, traditional art and crafts, cultural teachings, and Wellbriety. Other services are available through coordination with other Tribal agencies or referred care to non-Tribal agencies, such as detox, inpatient treatment, case management, transportation, and housing assistance. Medication assisted treatment (MAT) is offered by some Tribal programs and is typically limited to Vivitrol; clients are sent to external providers for all other medications.

Providers identify key barriers and facilitators to meeting the needs of patients:

- Inpatient services, such as detox and residential treatment, are not available locally, and generally are not culturally responsive or trauma informed for Native people.
- Cultural and traditional healing helps clients explore their Native spirituality and reconnect to their culture and community throughout their recovery journey. However, there is limited funding and lack of Medicaid coverage for cultural services, traditional healing, alternative medicine, and other "non-medical" services.
- Tribal programs operate with small provider teams burdened with large caseloads and staffing shortages. The ability to address immediate, concrete needs of clients enables them to focus on their recovery; this often depends on flexible funding for transportation, housing, food, and childcare.

> We struggle quite a bit with clients that only have Medicaid. Their options for inpatient care are very, very limited. We have just a couple Medicaid treatment centers that are available to our Medicaid only clients. They are typically a 14-day turnaround, and they are not as inclusive, especially when it comes to Native American care.

> It seems like every time I have to deal with a state facility, …they don't understand the timing and the family dynamics of Native American families on the reservations. So, some of their expectations are just not attainable for somebody born and raised and living on the reservation.

> We've had clients where we sometimes have to transport them for three hours and sometimes they have to use before they go to make sure they don't have any seizures or anything…That's always been a huge barrier here, the lack of detox in the area.

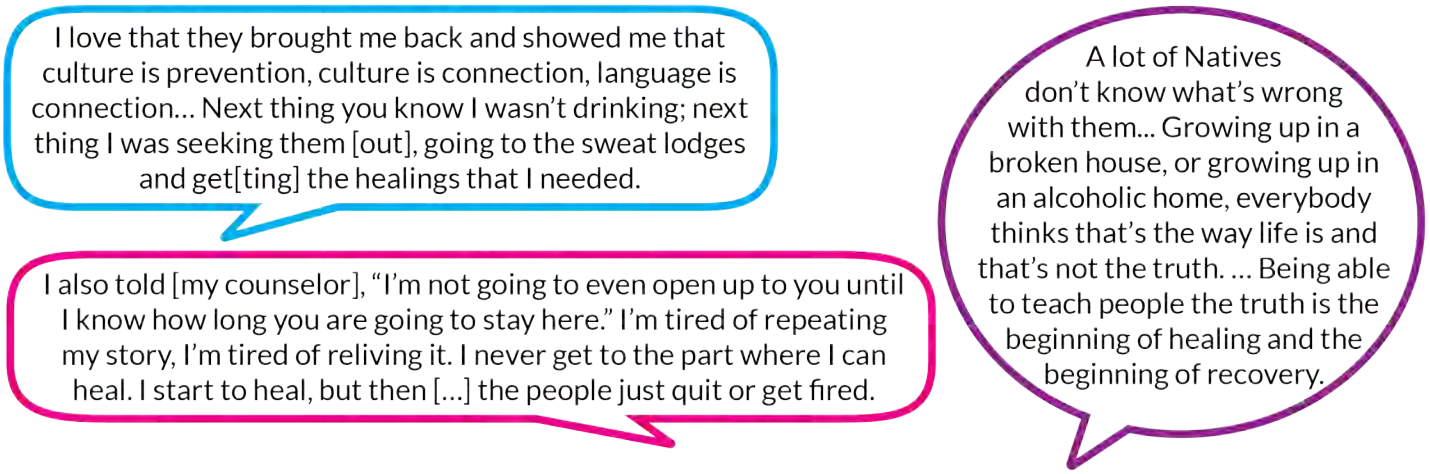
Evidence from Access to Recovery Data. Voucher utilization data from 2008 to 2017 support these perspectives: Among Access to Recovery program participants with SUD, spiritual and cultural services, social support services, and other support services were associated with more positive outcomes for Native clients. These services were particularly important for Native clients who did not receive inpatient detox and residential treatment. Clients had lower rates of illegal drug use at follow-up than clients who didn't receive spiritual and cultural services.

Perspectives of Clients. Clients describe the impacts of intergenerational trauma and the normalization of substance use among their family, friends, and community. Their experiences of loss and grief are interrelated with a profound feeling of disconnection to their Tribe, culture, and spirituality. They have numerous cycles of treatment and recovery services, and several periods of sobriety and relapse on their recovery journey.

Clients identify key facilitators to sustaining SUD treatment and recovery:

- Access to spiritual and cultural support services has a positive influence. Sweat lodges, Traditional Healers, cultural teachings, Wellbriety, prayer, smudging, and traditional medicines are beneficial.
- Long term care coordination and ongoing support from trusted service providers are especially valuable.
- They were motivated to stay sober by their involvement with services that allowed them to help other people.

Clients described key barriers as lack of local detox and residential treatment; long waitlists to access services; lack of culturally responsive services and supports in treatment facilities; provider turnover; and providers who are disengaged, distracted by other tasks, or do not have their 'hearts in the work' of caring for people with addictions.



FUTURE DIRECTIONS

MDHHS and its partners should collaborate to improve access to SUD treatment and recovery services for Native Americans including:

- Strengthen and expand formal mechanisms for Tribal Consultation and Tribal Self-Determination to inform how decisions are made to provide better access to culturally responsive SUD treatment and recovery services.
- Continue to explore options to expand the array of Medicaid-covered services and benefits to allow a more comprehensive suite of recovery supports (including cultural and traditional healing services) to better meet the unique needs of Native people.
- Create new and more flexible system innovation grants to allow Tribes to determine what workforce issues are most pressing and implement strategies that are most appropriate for increasing local capacity with minimal administrative reporting requirements.
- Incentivize behavioral health systems to provide more inpatient detox and residential treatment programs that include culturally responsive providers and services.

1003 Project-Supported Activities to Enhance Provider Capacity

Continuing Education for Social Workers

The Michigan Chapter of the National Association of Social Workers (NASW-Michigan) developed the *SUD Workforce Enhancement Training Series*, which provides SUD education and treatment strategies for social workers interested in increasing their knowledge in providing services to underserved populations:

- Aging / Dual Eligible (Medicaid & Medicare)
- Deaf and Hard of Hearing
- Housing Insecure
- African American, Latinx, Indigenous/Native American
- Adolescents & Young Adults
- Justice-Involved
- Pregnant & Parenting Women
- LGBTQIA+
- HIV

The training series was delivered via free micro-courses, hosted by subject matter experts using the ASAM criteria as the evidence-based tool to deliver the trainings. The 403 participants came from every part of Michigan, including rural and urban communities; 76% serve Medicaid clients. After completion of the training, 84% of participants reported that they better understand the needs and services of the populations they serve; and 83% felt confident they can apply their new knowledge and skills to their respective practice areas.

Enhancing SUD Providers' Toolkit for Working with Parents

Michigan Medicine's Zero to Thrive Strong Roots program offered training, resources, and curricula for professional development and delivery of group intervention to SUD providers and staff. The goal of the Strong Roots program is to develop workforce capacity to enhance parents with SUD/OUD resilience and parenting skills. This training was offered at no cost to clinicians, peer recovery coaches, and other staff providing direct client services at PIHPs, affiliated CMHs, or network SUD providers.

The Strong Roots Principles and Practices program included short, targeted training on trauma-informed parenting, kids with neurodevelopmental vulnerabilities, sensitive parenting, early relational health, and provider resilience (8-12 hours total); technical assistance to develop a targeted plan to implement Strong Roots Principles and Practices in day-to-day SUD service; and reflective coaching webinars to process and learn from implementation experiences.

Expanding SUD Resources and Technical Assistance to Perinatal Providers

Provider knowledge and practices are a likely barrier to improving OUD recognition and treatment during pregnancy. Many obstetricians do not have standard screening processes to recognize OUD and may not be familiar with recommended treatment. To better support perinatal providers, a team at the University of Michigan has integrated efforts of two successful provider support programs: the Michigan Opioid Collaborative (MOC), which trains and supports primary care providers around recognition and treatment of SUD, and the MC3 (Michigan Child Collaborative Care) program, which provides psychiatry support to primary care

providers in Michigan who are managing patients with behavioral health problems. With support from the 1003 project, MOC and MC3 staff created a dual enrollment path for perinatal providers, conducted training webinars addressing comorbid mood disorders and SUD/OUD, and revised perinatal psychopharmacology cards to include medication assisted treatment options for perinatal women with SUD.

Improving Provider Capacity around SUD Assessment

In conjunction with Michigan's 1115 behavioral health waiver demonstration project, MDHHS implemented statewide adoption of the ASAM Continuum as the standard SUD assessment tool for the PIHP system of care. To build capacity for providers new to this tool, the 1003 project funded training of SUD providers in use of the ASAM Continuum. The training included both live instruction and self-paced training material.

The 840 providers trained by September 2021 rated the ASAM Continuum as very useful (70%) or somewhat useful (27%) to their SUD assessment and treatment recommendations. Key concerns about implementation were time required to administer the tool (67%), individual's acceptance of Level of Care recommendations (22%), provider capacity at each Level of Care (19%), compatibility of the tool with EMR and other practice recordkeeping systems (17%), and accuracy of the Level of Care recommendations (10%). The feedback provided through the training evaluation allows state officials to be proactive in addressing provider concerns.

Understanding Processes for Accessing and Initiating Treatment in the PIHP System

Access to public-sector SUD treatment in Michigan is administered through the ten regional PIHPs. To inform MDHHS's efforts to improve access to SUD care via the 1003 planning grant and to support improvement efforts within each PIHP, a team from the University of Michigan conducted process mapping and evaluations with frontline staff that have a role in treatment access and initiation. The project involved virtual group and individual meetings with frontline staff to delineate the detailed steps carried out within each organization to get an individual seeking SUD treatment from the initial interaction with the PIHP to initiation of treatment. These steps were then graphically represented in a customized process map.

Four PIHP regions completed process mapping and evaluation activities, resulting in process maps for five entities (two centralized PIHPs; three CMHSPs located in decentralized PIHPs). Several commonalties in processes, challenges, and opportunities to improve delivery of care were identified. Challenges and suggestions for improvement centered around data sharing and interactions with the justice system.

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Appendix (separate file)

The Appendix presents a series of comprehensive reports generated as part of the 1003 project. These reports provide additional detail and context beyond that included in the main project findings. The reports include the following:

Assessment of the Substance Use Disorder Treatment and Recovery Service Systems for Native Americans in Michigan. Michigan Public Health Institute

Gaining Perspective on Substance Use Disorder (SUD) Treatment and Recovery Services for Foster Care Youth in Michigan. Oakland University William Beaumont School of Medicine

Assessing Content and Curriculum for Behavioral Health Providers: A Survey and Qualitative Analysis of Michigan Education and Training Programs. University of Michigan Behavioral Health Workforce Research Center

State-based Comparisons of Substance Use Disorder Scopes of Practice. University of Michigan Behavioral Health Workforce Research Center

Opportunities to Strengthen SUD Provider Capacity and Enhance SUD Treatment Services for Medicaid Beneficiaries in Michigan: Suggestions from Key Informant Interviews with PIHP Officials. University of Michigan Institute for Healthcare Policy & Innovation

Access to Substance Use Disorder Services During the Initial Months of COVID: Voices of Medicaid Beneficiaries. University of Michigan Institute for Healthcare Policy & Innovation

Initiation of Medication-Assisted Treatment for Substance Use Disorder: Voices of Medicaid Beneficiaries. University of Michigan Institute for Healthcare Policy & Innovation

Accessing and Initiating Treatment for Substance Use Disorder: Understanding the Process. University of Michigan Institute for Healthcare Policy & Innovation

Substance Use Disorder Social Work Workforce Enhancement Training Series. National Association of Social Workers (NASW)-Michigan Chapter

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MDHHS-Pub-1623 (10-22)