MICHIGAN OPIOID PARTNERSHIP GRANTMAKING GUIDELINES

Supporting Hospital and Outpatient Partnerships to Treat Patients with Opioid Use Disorder

Deadline: March 22, 2019

A public-private collaborative including the State of Michigan and key nonprofit funders, the Michigan Opioid Partnership's mission is to decrease opioid overdoses and deaths in the state through prevention, treatment, harm reduction and sustained recovery.

The purpose of this initiative is to develop continuous care for those suffering from opioid use disorder, from hospital entry to treatment maintenance in the community. This is designed to decrease opioid overdoses and deaths in the state through prevention, treatment, harm reduction and sustained recovery by providing continuous care for persons with opioid use disorders from hospital entry to treatment and recovery in the community.

Issue

The United States' overuse of opioid drugs and its consequences has been declared a public health emergency. Deaths related to opioid use disorder have quadrupled in the last fifteen years and are among the highest in the nation. In 2017, drug overdoses killed nearly 2,700 people in Michigan, with 1,901 of those deaths attributed to opioids (MDHHS). According to the Centers for Disease Control, overall drug overdose deaths in Michigan exceeded traffic and gun deaths combined in 2017.

The annual cost of the opioid epidemic in the US increased from $29.1 billion in 2001 to an estimated $115 billion in 2017. These include the costs of healthcare services to treat opioid misuse and substance use disorders, criminal justice costs and premature mortality. These costs have been growing at an increasing rate and the trend is projected to continue. A recent report estimates costs to exceed $500 billion over the next 3 years if current use and mortality rates persist.

Nationally, Michigan ranks 10th among states for prescribing opioids and ranks 18th for opioid deaths. Data from the Michigan Automated Prescription System (MAPS) reported 11.4 million prescriptions for painkillers were written in 2015, or about 115 opioid prescriptions per 100 people.

A multifaceted sustained campaign involving prevention, harm reduction, treatment and recovery is needed to combat this crisis. This initiative focuses on access to effective treatment in hospital settings through medication assisted treatment and transition to long-term office-based treatment upon release.

Working Toward a Solution – Medication Assisted Treatment (MAT)

Increasing access to MAT has been proven to be effective strategy in addressing the opioid crisis. MAT has been proven to save lives, improve quality of life and lower medical costs, however it remains inaccessible to most of the people it could help. Data indicates that only one-third of people with opioid use disorder are receiving treatment.

MAT programs combine medication administration with behavioral therapy and support, which together have shown to improve outcomes and reduce costs for patients with opioid use disorder. FDA-approved drugs used to treat opioid use disorder include methadone, buprenorphine and naltrexone. While these medicines have

been shown to reduce cravings and withdrawal symptoms and prevent overdose, they are not available to patients without receiving treatment through licensed providers. Increasing access to these medicines by initiating MAT in hospitals has been piloted with success in California, Massachusetts and Iowa, including starting MAT in emergency rooms and then connecting patients directly to managed treatment for continued care.

The Substance Abuse and Mental Health Services Administration states that the goal of MAT is full recovery, including the ability to live a self-directed life. The MAT approach has been shown to:

- Improve patient survival
- Increase retention in treatment
- Decrease illicit opioid use and other criminal activity among people with substance use disorders
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among pregnant women with substance use disorders

When patients begin MAT during a hospital inpatient admission or emergency department visit, facilitated transitions and warm handoffs to outpatient care are more likely to lead to healthier patient outcomes. In addition, expanding patient access to MAT helps avoid potential treatment gaps and eases entry into appropriate outpatient care.[1]

Initiative Information

The purpose of this initiative is to develop continuous care for those suffering from opioid use disorder, from hospital entry to treatment maintenance in the community. Through this program, participating hospitals will identify patients with opioid use disorder (OUD) and begin medication assisted treatment (MAT) in a hospital inpatient and/or emergency department setting, then ensure the patient is able to start and maintain quality administration of MAT services in the community through a hospital outpatient clinic or a community health care provider. The program also seeks to empower hospital staff with information and tools to more quickly identify addiction and respond quickly with confidence in continuity of care post hospital. In addition, this effort will work to remove both the barriers that deter primary care providers from prescribing MAT and barriers that dissuade patients from entering outpatient therapy. The collaboration between the hospital and the MAT provider must reflect a formal partnership requiring sharing of health information and follow up care. Similar models have been implemented in California and Massachusetts (see references below).

REFERENCES

The California Health Foundation is leading two major projects in California to help hospitals provide MAT in their emergency departments (and in many cases, inpatient departments as well). One effort is Project SHOUT, which provides coaching for hospitals to start such programs and the other is a pilot program with eight hospitals that integrated MAT into their emergency departments along with close follow-up in an out-patient setting. Now out of the pilot phase, the project, ED-Bridge, is working to expand the number of hospitals using the piloted model: https://www.chcf.org/

Massachusetts General Hospital initiated a targeted substance use disorders effort five years ago that continues to grow. Through a framework of strong connections between inpatient, outpatient and community-based services, they provide improved access to treatment and smooth transitions between care levels, standardized

[1] Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department, Duber, Herbert C. et al., Annals of Emergency Medicine, Volume 72, Issue 4 , 420 – 431.

medical treatment for SUDs (including withdrawal management and buprenorphine and methadone initiation), enhanced treatment plan on discharge, and recovery coaches who bridge inpatient and outpatient care. https://www.massgeneral.org/substance-use-disorders-initiative.aspx?display=overview

Project Implementation

In order to implement this project, it is expected that the following components will be integrated into the hospital's program for addressing opioid use disorder - as comprehensively and seamlessly as possible:

1. Appoint a champion to direct the project and take responsibility for the development, implementation and evaluation
2. Identifying and screening for Opioid Use Disorder (OUD) including identifying evidence-based screening tools, securing screening platforms as needed, and modifying electronic health records
3. Implement Management of Opioid Withdrawal/Related issues
    a. Establish protocols for patients presenting post-opioid overdose or with OUD related issues
4. Commit to the provision of medications appropriate to treat opioid use disorder
    a. Provide training and consultation as necessary to medical providers to begin appropriate medications (including MAT) post overdose/when indicated
5. Transition patients from the hospital or ED
    a. Develop/support a real-time local treatment finder for referrals and warm handoffs
    b. Develop capacity and systems for peer support and identify and link patients to comprehensive harm reduction services
    c. Connect patients to the appropriate SDOH interventions where applicable

REFERENCES

The information below is from a technical brief by the Agency for Healthcare Research and Quality.
https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioid-use-disorder_technical-brief.pdf

Emergency Department Initiation of Office-Based Opioid Treatment

This system-based model focuses on the emergency department (ED) identification of OUD, with buprenorphine/naloxone induction initiated in the ED. Patients are connected to ongoing OBOT, then transferred to ongoing, office-based maintenance treatment or detoxification. Brief "medical management" counseling is performed by physicians; other psychosocial services vary. Medications, ED visits, and OBOT are funded through patient Medicaid and other insurance plans. An advantage of this model is that it identifies patients who might benefit from MAT and may not have access to primary care, or only sporadic access. Initiation of buprenorphine/naloxone in the ED also appears to increase retention in care rates versus a simple referral. A potential disadvantage of this model is added congestion in the ED as a means to access treatment. In the randomized trial that evaluated this model, ongoing management in primary care settings was provided through the OBOT model, which may not be the model available in all settings. However, the ED initiation model could be used to "feed" into various office-based models of care, depending on what is available in the community.

Inpatient Initiation of Medication-Assisted Treatment

This system-based model involves the identification of OUD in the hospital, with initiation of MAT (methadone, buprenorphine/naloxone, or naltrexone) during the hospitalization by a multidisciplinary addiction consult service. Patients are connected with primary care or specialty addictions care (patients initiated on methadone must be followed in an OTP), where treatment continues following hospital discharge. In some programs, when relevant, there is a buprenorphine "bridge" clinic for stabilization prior to transitioning to primary care. Ongoing psychosocial services are provided at primary care sites. A variation of this model involves identification of OUD in the hospital and brief counseling, with facilitated referral to a community-based clinic for induction of MAT and ongoing care following hospital discharge. Another variation uses a program nurse to identify inpatients

with OUD, a bridge clinic for initiation of methadone following discharge with provision of psychosocial services (case management, group health education, counseling), and transition to another OTP for long-term management; such a program could be adapted for office-based prescribing of buprenorphine/naloxone. This model requires hospital support for initial development of inpatient consult services. Like the model involving ED initiation, an important advantage of inpatient screening and initiation is that it identifies patients with complex morbidity and high risk of mortality who otherwise may have had limited or no access to MAT. Likewise, inpatient initiation appears to enhance retention in care rates versus simple referral for outpatient initiation of MAT after hospitalization. Like the ED initiation model, this model of care focuses on the inpatient aspect, but could be linked to one of the office-based models of care described above for ongoing management. Patients initiated on methadone would not be eligible for referral to office-based care.

Eligibility, Infrastructure and Organizational Capacity

Applicants must be a nonprofit hospital with a memorandum of understanding (MOU) or planned MOU with at least one MAT outpatient provider. The expectation is that the hospital will initiate MAT while the patient is in their care and then ensure that the patient is able to maintain quality administration of MAT services in the community. Community provision of MAT might be provided through a hospital outpatient clinic or a community health care provider, including an Opioid Treatment Program or an Office Based Opioid Treatment setting. The partnership between the hospital and the MAT provider must reflect a formal partnership requiring sharing of health information and follow up care. Applicants may subcontract a portion of grant funds to support the full range outpatient MAT services.

Applicants must be located in one of the following areas listed below. These areas were selected based on a statewide needs assessment that included analysis of high overdose death rates, large gaps in treatment, and high need for intervention. Eligible counties include:

- Southeast Michigan (including Macomb, Wayne, Livingston, Genesee, Oakland, St. Clair, and Washtenaw)
- Upper Peninsula (all counties)
- Northern Lower Peninsula (Emmet, Cheboygan, Presque Isle, Antrim, Charlevoix, Ostego, Montmorency, Alpena, Grand Traverse, Kalkaska, Crawford, Oscoda, Alcona)

In addition, applicants must meet these additional criteria and submit documentation with the application:

- Serve all patients regardless of income or insurance.
- Be recognized by the Internal Revenue Service as a nonprofit organization
- Be in good standing on all previous awards from the funding partners
- Possess a current Certificate of Need

For-profit hospitals and hospitals not located in Michigan are not eligible to receive grants for this program.

Applicants must describe their organizational capacity to carry out the activities, strategies, performance measures, and evaluation requirements for this program. The Michigan Opioid Partnership anticipates that over the two-year project period, all grantees will demonstrate their capacity to carry out the following activities:

- Demonstrate commitment from the hospital's key leadership (CEO, CMO, etc.)
- Ensure the hospital maintains appropriate staffing to support the program
- Identify a qualified staff person or equivalent responsible for managing the planning, implementation, monitoring, and reporting of the program, with management experience in population-based interventions relevant to the selected strategies

- Collect and report data for evaluation of individual programs and the program entirely. An evaluation template will be provided for grantees to collect and analyze data. The proposal should discuss the general evaluation approach. Grantees will also be required to report expenditures for all activities conducted by the grantee or sub-recipients.
- Establish and maintain other qualified staff, contractors, and consultants, as needed, sufficient in number and expertise to ensure project success and who have demonstrated skills and experience in partnership development, community engagement, substance use disorder, health equity, addressing the social determinants of health and other competencies related to the strategies supported by the RFP over the course of the project period
- Provide evidence of participation in community-based initiatives related to opioid prevention, harm reduction, treatment and recovery
- Ensure that appropriate medications are available
- Ensure there is a connection with an outpatient facility that can receive patients from the ED or hospital
- Train staff to identify opioid use disorder and dose appropriate medications
- Describe plan to transition patients to outpatient treatment

Reporting

Grantees will be expected to report in six-month intervals. Year two funding is contingent on satisfactory progress at year one. (Format will be determined later). Requirements will be outlined in the terms of agreement for each grantee. GPRA assessments will also be required for patients (see below for more information).

1. Provide documentation regarding the capacity to deliver key Program Components which include, but are not limited to, the following:
    a. Submit a detailed work plan including a budget that identifies the total cost and cost of each project component, including an evaluation
    b. Develop policies and procedures for every component of the project
    c. Develop or identify appropriate screening tools for each component
    d. The integration of all aspects of inpatient management into ED workflows
    e. The integration of transfer management of patients to outpatient settings (if referred to in-system provider)
    f. The integration of transfer and linkage activities into inpatient or ED workflows for external setting referrals
    g. Develop systems for each of the three components above to flow seamlessly between each other in the inpatient department or ED workflow
    h. Upgrade electronic health records to update work flows and order sets
    i. Educate and train staff members (physicians, APNs, pharmacists, Nurses, and Case Workers)
    j. Hire adequate staffing to ensure the project deliverables are met including, but not limited to a project manager to oversee the workflow
2. Comply with all applicable federal and state regulations, rules, statutes and guidelines regarding the expenditure of funds and program requirements. GPRA (Government Performance and Result Act) reporting is required. GPRA is a SAMHSA 32 question tool, collected on each patient and requires follow up at three and six months.
3. Submit invoices on a regular basis with documentation of the completion of each deliverable.
4. Grantees must follow and meet their terms of agreement. Grantees understand that their present allocation and/or future allocations will be determined based on the grantees' success in fully meeting their terms of agreement.

Awards

This program will award up to $2,600,000 over two years to Michigan-based nonprofit hospitals that partner with MAT outpatient providers and serve uninsured, underinsured, low-income and vulnerable residents. The average grant will be in the $200,000 to $400,000 range for the first year and may be continued in the second

year with demonstrated progress.

Timeline

February 13, 2019: Application opens

February 28, 2019: Application webinar

March 22, 2019: Application closes

Mid-April: Grant award and decline letters will be mailed to all applicants

Late April/Early May: Grants will be publicly announced

May 2019: Project period/year one begins

April 2020: Year one concludes. Interim report due, with second year funding conditional upon the progress made.

April 2021: Project period/year two ends. Final report due.

Proposal Contents

Submissions must include:

- Completed application
- Demonstrated readiness level
- Description of the proposed program and key elements and goals (separate or additional document)
- Estimated project budget
- Current board list
- Organization's operating budget
- MOU(s) with partner(s) applicable for this project

Review Criteria

The MOP review committee will select applicants who present the most complete and responsive applications demonstrating the most favorable mix of credentials, capacity, potential, and cost. The following criteria will be used to evaluate the applications by an internal evaluation team:

- Technical Capacity
- Past Experience
- Supportive Environment
- Cost Reasonableness
- Regional Opioid Response

At MOP's discretion, the above evaluation criteria are subject to change to best meet programmatic needs and funder requirements, as applicable.

Overview of the Michigan Opioid Partnership

A public-private collaborative including the State of Michigan and key nonprofit funders, the Michigan Opioid Partnership's (Partnership) mission is to decrease opioid overdoses and deaths in the state through prevention, treatment, harm reduction and sustained recovery.

The partnership's first initiative was the 2017 grant program, "Taking Action on Opioid and Prescription Drug Abuse in Michigan by Supporting Community Responses." Over $570,000 was awarded to community coalitions to address opioid use disorder in nine communities.

In 2018, the partnership expanded and made a commitment to increase Michigan's capacity to provide evidence-based treatment for opioid use disorder. This new effort provides grants to increase access to effective opioid use disorder treatment by partnering with hospitals and outpatient programs to provide a continuum of care that includes Medication Assisted Treatment. The intent of the grants is to help Michigan medical and behavioral health providers develop and initiate, enhance or expand comprehensive MAT programs that will be sustained after the grant period ends. The partnership expects that funded projects will share the results from this initiative with other providers and programs for possible consultation and replication.

The partnership is made up of Michigan Department of Health and Human Services, Michigan Health Endowment Fund, Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of Michigan Foundation, Ethel and James Flinn Foundation, Superior Health Foundation, The Jewish Fund and Community Foundation for Southeast Michigan.

**We would like to thank and give credit to the California Health Care Foundation and the Bridge Program at the Public Health Institute in Oakland, California for sharing their materials with us as we developed this request for proposal document.*

REFERENCES

Corwin N. Rhyan, The Potential Societal Benefit of Eliminating Opioid Overdoses, Deaths, and Substance Use Disorders Exceeds $95 Billion Per Year. Altarum Institute Center for Value in Health Care Research Brief. November 16, 2017. (https://altarum.org/sites/default/files/uploaded-publication-files/Research-Brief_Opioid-Epidemic-Economic-Burden.pdf)

Michigan Department of Health and Human Services. Prescription Drugs and Opioids in Michigan. (MDHHS: https://www.michigan.gov/stopoverdoses)

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Chris Regal. SCAN Health Plan Uses Holistic Pain Management to Reduce Opioid Use Among Seniors. AHIP Blog. April 26, 2018. (https://www.ahip.org/scan-health-plan-uses-holistic-pain-management-to-reduce-opioid-use-among-seniors/)

Robert King. Doctor shortage making it harder to fight opioid abuse, study finds. Washington Examiner, Feb 21, 2018. (https://www.washingtonexaminer.com/doctor-shortage-making-it-harder-to-fight-opioid-abuse-study-finds/article/2649647)

More information

For questions about the Michigan Opioid Partnership, visit CFSEM.org/Opioid. You can also contact Sarah Wedepohl, Senior Program Officer at the Community Foundation for Southeast Michigan, at swedepohl@cfsem.org or 313.961.6675.

Application Webinar

An informational webinar will be held on February 28, 2019. To register for the webinar, visit CFSEM.org/Opioid. The webinar will not be recorded, but slides will be available following the webinar.

Michigan Opioid Partnership Fund

To begin the submission of an application, start by clicking here to log in to our application portal. If you are a new applicant, you will first need to setup an account. Once inside that portal, you will be asked to submit the following items.

Note that you may begin a draft application in the portal, return to that draft as often as needed, and wait to submit the application to the Foundation until it is completed to your satisfaction:

1. COVER LETTER OUTLINING:

a. Legal name of the hospital
b. Dollar amount requested
c. Purpose of the proposed project
d. Description of the population being served
e. Length of time for which Community Foundation support is requested

The CEO/CMO of the hospital should sign the cover letter and the application should include some evidence of approval of the request by the hospital's board of trustees.

2. ORGANIZATIONAL INFORMATION

- ❑ Name, address and telephone number of the applicant organization and main contact person for the proposal
- ❑ Mission and brief background of the applicant organization
- ❑ Information about current programming of the organization and number of people served

3. PROJECT NARRATIVE

- ❑ Definition of the issue the proposal is addressing
- ❑ Description of the need for the scope of proposed project or target population
- ❑ Evidence of participation in community-based initiatives related to opioid prevention, harm reduction, treatment and recovery.
- ❑ Indication as to whether the proposed activity is new, expanded or an ongoing part of the organization's programming
- ❑ Basic objectives of the proposed project
- ❑ Detailed work plan and the time frame for accomplishing the project's objectives
- ❑ Evaluation approach and the ability to collect and report data for evaluation of individual programs and the program entirely.
- ❑ Relevant qualifications and experience of the project's principal staff. If a new position is included in the proposal, please include a job description that will be used to hire that staff
- ❑ An outline of the geographies (i.e. neighborhoods, cities, or counties) that will be served by the proposed project
- ❑ Description of a partnership with an outpatient facility that is occurring as a part of the proposed project, including an outline of the roles and responsibilities of each partner. Include a Memorandum of Understanding, with each partner signing off on what/how they will contribute to the project
- ❑ Demonstrated ability to train staff to identify opioid use disorder and dose appropriate medications
- ❑ Description of plan to transition patients to outside treatment
- ❑ Demonstrated presence in one of the identified counties in Michigan

4. REQUIRED FINANCIAL INFORMATION

- ❑ Copy of the most recent certified financial audit
- ❑ Dollar amount of grant support requested and the proposed time period for use of these funds
- ❑ Detailed budget for the project, using the template provided, including the proposed use of Community Foundation grant funds and any additional support anticipated or secured from other sources. Click here for our budget worksheet.
- ❑ Provisions for future project funding beyond the Community Foundation's grant period
- ❑ Organization's operating budget for the current fiscal year

5. SUPPORTING MATERIALS

- ❑ Copy of the most recent Internal Revenue Service 501(c)(3) federal tax-exemption letter
- ❑ List of current board of directors, trustees or governing board, with individuals' affiliations
- ❑ Letters of support or memoranda of understanding from project partners
- ❑ Resumes of principal staff for proposed project
- ❑ Information on the organization's commitment to its own diversity with regard to staff, board, and constituents
- ❑ Copy of the most recent annual report, if available
- ❑ Documentation of ability to serve all patients regardless of income or insurance

If you have any questions, please feel free to contact us at 313.961.6675.

February 2019