Community Foundation FOR SOUTHEAST MICHIGAN

Michigan Opioid Partnership

MHA Keystone Center
A Certified Patient Safety Organization

Addressing Michigan's Opioid Crisis

The Case for Medication for Opioid Use Disorder in the Emergency Department

Acknowledgments

The Emergency Department Medication for Opioid Use Disorder Initiative was funded by State Opioid Response (SOR) Grants from the Michigan Department of Health and Human Services (MDHHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Additional funding was provided by the Michigan Opioid Partnership (MOP).

We would like to acknowledge the members of the MOP for their support in moving this work forward:

- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of Michigan Foundation
- Community Foundation for Southeast Michigan
- Ethel and James Flinn Foundation
- The Jewish Fund
- Michigan Department of Health and Human Services
- Michigan Health Endowment Fund
- Superior Health Foundation
- Vital Strategies

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About Us

The **Community Foundation for Southeast Michigan** is a full-service philanthropic organization leading the way to positive change in our region. As a permanent community endowment built by gifts from thousands of individuals and organizations, the foundation supports a wide variety of activities benefiting education, arts and culture, health, human services, community development, and civic affairs. Since its inception, the foundation has distributed more than $1.4 billion through more than 85,000 grants to nonprofit organizations throughout Wayne, Oakland, Macomb, Monroe, Washtenaw, St. Clair, and Livingston counties.

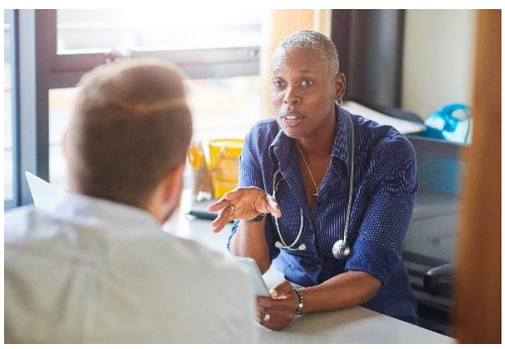
The Community Foundation for Southeast Michigan is the home to the **Michigan Opioid Partnership**, a public-private collaborative including the State of Michigan and key philanthropic organizations. The Michigan Opioid Partnership's mission is to decrease Michigan opioid overdoses and deaths through prevention, treatment, harm reduction and sustained recovery.

Our Background

In 2017, five health-focused, Michigan-based funders came together to create an initiative to help address the opioid epidemic through prevention, harm reduction, and treatment provision. The project, "Taking Action on Opioid and Prescription Drug Abuse in Michigan by Supporting Community Responses," funded community coalitions with action plans to combat the effect of opioid and prescription drug misuse in their communities. In 2018, the Michigan Department of Health and Human Services and additional funders joined the initiative, and the project became known as the Michigan Opioid Partnership. In 2019, several MOP funders pooled resources and announced a multi-million-dollar effort to respond to the overdose crisis.

To date, the MOP has granted over $7 million. Funding has supported hospitals, county jails, community foundations, and non-profits to increase harm reduction, post overdose rapid response, and treatment services. A primary focus has been on increasing access to medication for opioid use disorder and transforming the patient experience in emergency departments - a critical care access point.

Problem



In 2019, Governor Gretchen Whitmer called the opioid epidemic **"the greatest health crisis of our lifetimes,"** and the State of Michigan set a goal to cut opioid overdose deaths by half in five years.

1

Mortality

From 1999 to 2017, opioid overdose deaths in Michigan increased 17-fold. In 2018, **more Michigan residents died from drug overdose than by firearm-related and motor vehicle-related incidents.** In 2021 alone, Michigan experienced over 3,000 overdose deaths.

2

Racial Disparities

In 2018, the overall overdose death rate decreased slightly across the state (3.2%) while the **overdose fatality rate among Black residents increased by nearly 20%.** Black residents comprise 14% of Michigan's population, yet they account for 21% of opioid overdose deaths.

3

Cost

Each year in the United States, opioid use disorder accounts for approximately **$35 billion in healthcare costs**, $14.8 billion in criminal justice costs, and $92 billion in lost productivity. Opioid overdoses alone are estimated to cost U.S. hospitals approximately **$11 billion annually** and account for 1% of total annual hospital expenditures.

4

Stigma

Opioid use disorder is a chronic illness, but people often **incorrectly perceive it as a moral failing**. Institutionalized stigma and misinformation frequently prevent individuals with substance use disorder from accessing evidence-based, person- centered care and treatment.

5

Treatment Gap

Medication for Opioid Use Disorder (MOUD) is the gold-standard treatment for opioid use disorder and significantly reduces mortality in patients experiencing nonfatal overdose. Still, **MOUD remains vastly underutilized and misunderstood** even in critical access points to care, like the emergency department.

Solution

MOUD is Gold-Standard Treatment

Medication for opioid use disorder (MOUD) is an evidence-based approach to treat opioid use disorder, prevent overdose, and sustain recovery. Studies show that **one in two patients using high-dose buprenorphine have retention in treatment**. MOUD is recommended by trusted agencies and practice groups, including the **American College of Emergency Physicians (ACEP)**, **Substance Abuse and Mental Health Services Administration (SAMHSA)**, **National Institute on Drug Abuse (NIDA)**, **Surgeon General**, and **National Academy of Sciences (NAS).**

MOUD is Cost-Effective

Opioid use disorder (OUD) patients tend to have more admissions, readmissions, outpatient visits, and longer lengths of stay than the general population. **MOUD is cost-effective, reduces the utilization of emergency departments, and decreases length of stay**. Improving access to evidence-based treatments for OUD has been associated with **savings of $25,000 to $105,000 per person** in lifetime costs.

MOUD is Best Practice for Hospitals

Hospitals are a critical intervention point to reach and treat those with OUD, increase access to MOUD, and provide equitable care. The **emergency department is often the only contact individuals with OUD have with the healthcare system**, and its 24-hour, 365-day accessibility positions it well to help close the treatment gap. Patients need to be greeted by providers who understand opioid use disorder as a disease and offer evidence-based treatment.

Medication, such as methadone, buprenorphine, and naltrexone, improve treatment outcomes and reduce the utilization of emergency departments and hospital care **by decreasing**:

- Cravings
- Illicit opioid use
- Poor birth outcomes
- Withdrawal symptoms
- Infectious disease transmission
- Mortality
- Overdose

Framework

The **Emergency Department Medication for Opioid Use Disorder (ED MOUD) Initiative** was a federally funded project led by the Michigan Opioid Partnership of the Community Foundation for Southeast Michigan in collaboration with the **Michigan Health & Hospital Association (MHA) Keystone Center**. The initiative aimed to increase access to MOUD in emergency departments across Michigan and support the patient transition to community-based care. Participating hospitals worked toward setting up an ED MOUD program with three key components.

Step 01

Identify Patients with OUD

Patients enter an open and accepting environment. Non-stigmatizing signage encourages them to disclose their opioid use disorder and to ask for help. Clinicians are trained to screen patients, spot the signs and symptoms of opioid use disorder, and to approach patients compassionately.

Step 02

Start MOUD during the ED Encounter

A healthcare provider assesses the patient for withdrawal and administers or prescribes medication to begin treatment. If the patient is experiencing opioid withdrawal, the initial dose helps reduce the painful symptoms and allows for better a tolerated discussion about harm reduction, treatment, and recovery.

Step 03

Connect to Community-based Care

Trained staff, such as a peer recovery coach, social worker, or case manager, support the patient as they make their way to an outpatient provider. They provide the patient with a warm hand-off to community-based care and assist them in scheduling their first appointment. This is essential to the success of long-term treatment and recovery.

"If we're going to tackle the opioid crisis and get Michigan families on track to recovery, we need to build strong partnerships between state government, philanthropy, and the medical community." ~ Governor Gretchen Whitmer

Growth

Since 2019, participation in the ED MOUD initiative has grown from six to 75 hospitals — representing approximately half of Michigan's emergency departments and all ten prepaid inpatient health plan regions. The expertise of key stakeholders and leaders in the healthcare ecosystem has been leveraged to inform development, increase equity, and overcome barriers.

2017

Five funders created the project: 'Taking Action on Opioid and Prescription Drug abuse in Michigan by Supporting Community Responses.

2018

Additional funders, including MDHHS, joined. Rebranded as the Michigan Opioid Partnership.

2019

State Opioid Response grant funding awarded to Community Foundation for Southeast Michigan. First hospital-based MOUD grant made.

2020

Supported 6 hospitals. Partnership with Vital Strategies and Johns Hopkins Bloomberg School of Public Health established to focus on evaluation and equity.

2021

Supported over 20 hospitals. Partnership with Michigan Health & Hospital Association (MHA) Keystone Center established to increase hospital engagement. Partnership with New Detroit established to address racial biases.

2022

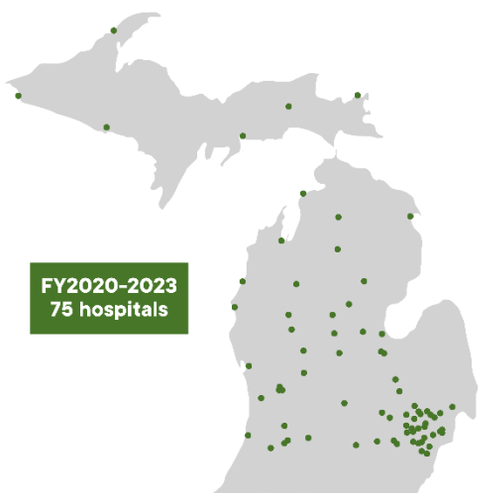
Supported over 40 hospitals. Clinical consultant team created to provide free technical assistance.

2023

Supported over 40 hospitals - bringing the total number of hospitals to 75.

Impact

The Community Foundation's ED MOUD Initiative established Michigan as a leader in this space, and early data indicates that it increased access to medication for opioid use disorder.



50%

Of Emergency Departments Statewide

Between 2019 and 2023, the ED MOUD initiative successfully engaged half of Michigan's emergency departments. Participation occurred statewide and represented **all ten prepaid inpatient health plan regions**.

Hospitals received grant funding and technical assistance from local subject matter experts. The funding was primarily used for staff time to set up protocols, train providers, and make technology updates.

Evaluation Results

The **Johns Hopkins Bloomberg School of Public Health conducted an evaluation of participating hospitals** between October 2020 and September 2021. Overall, participating hospitals saw greater provision of buprenorphine inductions and prescriptions, improved OUD screening processes during patient intake, expanded networks of community-based providers to facilitate warm-handoffs, and broadened ability to monitor patients after leaving the ED to ensure care continuity.

All participating hospitals

- increased use of buprenorphine.
- connected more than 500 patients to follow-up behavioral healthcare.

Nearly fifty percent of participating hospitals

- administered medication to 450 individuals in the ED to treat opioid use disorder.
- provided 250 prescriptions for continued supply of medications after leaving the hospital setting.

Words From Leadership:
Michigan Health & Hospital Association Keystone Center

MHA Keystone Center
A Certified Patient Safety Organization | Leading Healthcare

Michigan Hospitals are Committed to Evidence-Based, Person-Centered OUD Care

Hospitals are anchor institutions in their communities and are often integral players in addressing key issues impacting the patients they serve. As cases of opioid use disorder (OUD) rise, Michigan hospitals and health systems are determined to ensure emergency departments are a safe space for patients to not only receive immediate intervention, but also the necessary resources for sustained recovery.

The Michigan Health & Hospital Association Keystone Center is proud to partner with the Community Foundation of Southeast Michigan to support the implementation of effective Emergency Department Medication for Opioid Use Disorder (ED MOUD) programs in Michigan emergency departments. **So far, 75 hospitals have participated in the initiative to equip Michigan emergency department teams with the education and tools needed to provide both person-centered and evidence-based care to those with OUD.**

Initial research has already demonstrated the benefits of the ED MOUD program. We have not only seen an increase in the use of buprenorphine, a prescription treatment used to treat OUD, but also an increase in the number of patients connected to follow-up behavioral, community-based and outpatient care.

The care OUD patients receive in emergency departments can set the tone for an individual's recovery process – and Michigan hospitals have put measures in place via the ED MOUD initiative to make sure patients are properly supported in their recovery.

Emergency departments are one of the first places an individual will go to seek treatment for OUD, but hospitals are only one of the many access points available to them in the state. As strong patient advocates, Michigan hospitals will continue establishing and fostering partnerships with organizations and institutions working to support individuals with OUD.

Addressing the opioid epidemic with a collaborative approach is vital – the ED MOUD initiative is an impressive reminder of the power in partnership.

Sincerely,

Sarah Scranton, MPA, MPP | Vice President, Safety & Quality
Michigan Health & Hospital Association (MHA)
Executive Director, MHA Keystone Center

Words From Leadership: Michigan Opioid Partnership

Michigan Opioid Partnership | An Initiative of the Community Foundation For Southeast Michigan

The Michigan Opioid Partnership is thankful for the commitment Michigan hospitals have made to increasing access to quality care for people with opioid use disorder.

Established in 2018, the Michigan Opioid Partnership lives at the Community Foundation for Southeast Michigan and is a collaboration of public and private funders who support organizations at the forefront of addressing this epidemic. The Michigan Opioid Partnership has prioritized increasing access to evidence-based treatment, supporting harm reduction programs, launching post-overdose response efforts, and our largest commitment to date, initiating and coordinating a statewide emergency department medication for opioid use disorder project.

Through this project, the Community Foundation for Southeast Michigan, Michigan Health & Hospital Association Keystone Center, Michigan Opioid Partnership, and clinical consultants have spent the last four years working closely with hospitals and health systems to stand up programs in their emergency departments that offer medication for opioid use disorder. Faced with multiple barriers such as stigma of those who use drugs, COVID-19, and a workforce shortage crisis, hospitals have had a great deal of challenges in the last few years. But even with these challenges, hospitals continued to push forward, especially because the clinical champions within each hospital did not give up. We recognize that these champions have their own reasons why they keep this work moving and many have shared personal and professional stories about why addiction medicine and working with people who use drugs is so important to them.

We applaud and thank these incredible champions, and all the people who have been working to ensure that everyone in Michigan has access to evidence-based, caring, and quality care for opioid use disorder and people who use drugs. We know that we have a long way to go, and we are committed to doing everything we can to ensure that the emergency department medication for opioid use disorder program continues.

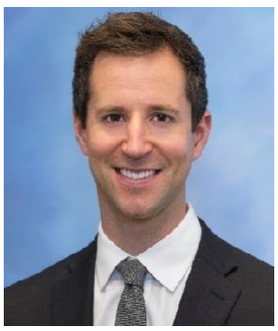
Thank you again for being on the forefront of treatment solutions and sacrificing so much as you dedicate yourselves to this work. To learn more about the Michigan Opioid Partnership, including stories from the field, information on medication for opioid use disorder, and to sign up for our newsletter, please visit **cfsem.org/opioid**.

Sincerely,

Michigan Opioid Partnership

Blue Cross Blue Shield of Michigan
Blue Cross Blue Shield of Michigan Foundation
Community Foundation for Southeast Michigan
Ethel and James Flinn Foundation
The Jewish Fund
Michigan Department of Health and Human Services
Michigan Health Endowment Fund
Superior Health Foundation
Vital Strategies

Provider Voices: Fact or Fiction? The Truth About Medication for Opioid Use Disorder


Dr. Nick Rademacher


Dr. Andrew King

The Centers for Disease Control, World Health Organization, and National Institute on Drug Abuse are among the agencies that confirm medication for opioid use disorder (MOUD) combined with behavioral therapies is the gold standard for resolving opioid use disorder. Despite the evidence supporting the efficacy of this treatment approach, false and conflicting messages about MOUD persist.

As a result, health providers and people seeking assistance for themselves or a family member can find it challenging to make clear decisions. Understanding how opioids affect brain chemistry and the benefits of MOUD can help separate fact from fiction. This article explores common myths held by healthcare providers and patients, demystifying them to reveal the truth about opioid use disorder and the medications available to treat it.

Myth: Using medications to treat opioid use disorder (OUD) is trading one addiction for another.

Fact: Medications used to treat OUD are longer-acting, safer drugs that allow individuals to wean themselves off short-acting, dangerous substances such as heroin and fentanyl.

It is true that methadone and buprenorphine, the drugs most used to treat OUD, are opioid-based, class three medications that result in physical dependence. Dr. Nick Rademacher, an emergency room doctor at Mercy Health St. Mary's Hospital in Grand Rapids and advisor on the Michigan Opioid Partnership, says, "Healthcare providers are concerned that they're prescribing something that patients are just going to abuse or sell like they've traditionally done with other opioids."

He points out that MOUD is fundamentally different from heroin and prescription painkillers, however, in that they do not create overwhelming feelings of euphoria that contribute to uncontrollable cravings.

"Buprenorphine is the primary medication for opiate use disorder. It is a long-acting treatment that doesn't activate the brain receptor in the same way as drugs that lead to the harmful effects of addiction." MOUD lessens patients' desire for other drugs' immediate and short-term impact, enabling them to participate in behavioral interventions that lead to recovery and improved health.

Dr. Andrew King, an emergency room physician at Detroit Medical Center who also advises on the Michigan Opioid Partnership, affirms addiction trading as a common myth of MOUD. He reminds healthcare providers and patients that buprenorphine and methadone are proven addiction treatments and asks them to focus less on the dependency factor.

"Use of drugs like prescription painkillers, heroin, and other highly addictive substances puts people at risk for infectious diseases such as HIV and hepatitis, erodes their interpersonal relationships, and gets in the way of their ability to fulfill major life and family obligations. MOUD helps to end the use cycle, allowing patients to focus on other human being-oriented activities that really we're here on this earth to do."

Myth: If a person cannot stop using independently, they are weak, and medications will not help them.

Fact: Genetics and environment are determinants of addiction that are difficult to control.

Opioid use disorder is when a person continues to take addictive substances despite adverse consequences or the desire to stop. People suffering from this malady, their families, and communities often view their inability to quit as a moral failing or lack of willpower. In truth, it is much more complicated. Since 1987, the **American Medical Association** (AMA) has defined addiction to drugs as a disease that impacts the brain's reward system, which releases dopamine during pleasurable experiences. Over time, it causes lasting changes to the brain chemistry, and drugs become necessary to feel normal. Genetics make some people more likely to develop OUD than others, and ideally,

these individuals should never be exposed to drugs or alcohol. Those genetically predisposed may not necessarily know that they are, however, and find themselves in an environment that triggers the disease.

"People who use drugs regularly experience significant biochemical incentives that make it hard for them to stop," says Dr. Rademacher. "When they try, they have uncontrollable cravings or painful withdrawal. It's not a series of high-level decisions that make them continue using—it's their brain telling them to do so."

Dr. King points to a related myth, which promotes OUD as being intractable. "OUD is like asthma, hypertension, or any other chronic medical condition controllable with medication, and we have to start treating it like that. The stigma associated with drug use prevents us from seeing it that way." He uses the term "therapeutic nihilism" when referring to healthcare providers' belief that OUD is not treatable, and people cannot get better. "To prevent a heart attack or stroke among hypertensive patients, you'd have to treat about 100 people. After treating just two OUD patients with buprenorphine, you'll start seeing people enter the recovery phase. It's hard to overlook those types of outcomes."

Myth: MOUD is a short-term treatment approach and can be terminated after a few weeks.

Fact: OUD is a chronic disease like diabetes and high blood pressure that may require long-term use of medication.

Even those who do not subscribe to other myths about buprenorphine, methadone, or OUD think they or their family members will only need the medications long enough to stop using opioids and feel fewer cravings. This is not the case. OUD is a chronic medical condition similar to hypertension and diabetes and, like those diseases, requires ongoing use of prescribed medications to yield the highest success rates. Additionally, to-date, no evidence exists to support stopping the use of the medications. Dr. Rademacher says one of the risks of short-term use is returning to patterns of opioid abuse. "We know that once a person has stopped using and then returns, they are six times more likely to overdose. It can be very dangerous to discontinue MOUD, and we have to think of this as a

Dangers of Myths

Using medication to treat opioid use disorder is an ongoing conversation riddled with misinformation and misconceptions. Now that some of the predominant myths have been explored, the focus can shift to the danger these fallacies pose to those delivering and seeking treatment.

Dr. Rademacher and Dr. King agree that patients are at greater risk of opioid overdose and death when they, their families, and healthcare providers choose a treatment plan that excludes medication.

“Perpetuating the message that people with OUD are weak or insufficient wears on them, causing them to stop taking their medication and putting them at risk of overdosing. We don’t do that to those with diabetes or high blood pressure,” says Dr. King.

The doctors also highlight the danger associated with physicians’ hesitancy to prescribe medication, thereby depriving patients of MOUD’s survival benefits. Dr. Rademacher cites statistics published in 2020 by the **Society for the Study of Addiction**. Based on their findings, he says, “We know using MOUD decreases OUD sufferers’ chance of death by 82 percent. I think that far outweighs any risks associated with taking the medications.”

Combating Myths

Extolling the virtues of the science-based evidence behind MOUD, education and outreach are among the tools used to dispel misinformation and build the community of patients and healthcare providers knowledgeable about the benefits of medication in the treatment of substance abuse.

“Having calm but challenging discussions with people about their flawed concepts and putting a human face on OUD are essential,” says Dr. King. “We have to avoid stigmatizing and using punitive language that inspires shame and hopelessness—definitely among patients, but also among healthcare providers, many of whom often feel powerless to treat this pervasive illness. We all have things we struggle with, and we need to be more sensitive to one another.”

Drs. King and Rademacher collaborate on an educational initiative for healthcare professionals interested in prescribing buprenorphine. The three-hour session addresses myths while helping participants understand the drug’s benefits.

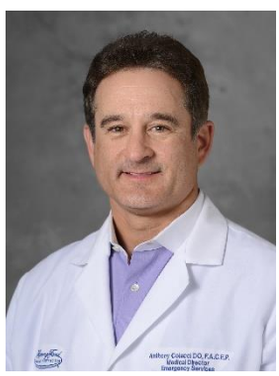
“Some physicians don’t understand the full scope of use as it relates to buprenorphine, and it can be intimidating. I emphasize the importance of working collaboratively with other healthcare professionals and specialists in their departments to help broaden their thinking about the various ways it can be implemented to improve the patient’s life,” Dr. Rademacher says.

The doctors admit the culture shifts necessary to bring their colleagues fully onboard are slow.

“We need to cultivate empathy and sympathy for people dealing with opioid use disorder,” says Dr. King. “It’s often a very complex set of issues that landed them where they are. Taking the time to understand the patients’ needs and make sure healthcare staff are empowered to help them are critical to success.”

Provider Voices: Healthcare Providers Shifting Perceptions Impact Quality of Care


Dr. Jacob Manteuffel


Dr. Anthony Colucci

Attitudes toward people with opioid use disorder (OUD) and the medications to treat the disease have significantly changed over the last 20 years. In this dialogue, Dr. Jacob Manteuffel, Emergency Medicine Physician and Addiction Specialist, Director of Public Health at the Department of Emergency Medicine, Henry Ford Health Detroit Campus, and Dr. Anthony Colucci, Emergency Medicine Physician at the hospital's Macomb Campus, reflect upon how their perceptions shifted throughout their work with OUD patients and the impact on the quality of care. Recognizing the emergency department's (ED) role in providing equitable treatment for this population, Henry Ford Health was among the Community Foundation for Southeast Michigan's first **Michigan Opioid Partnership** (MOP) grantees. The hospital used the funds to strengthen the medication for opioid use disorder (MOUD) services offered through the ED. Dr. Manteuffel is also a MOP **Clinical Consultant**.

Early Perceptions and Practices

Dr. Manteuffel

When I was in medical school and then starting residency, we used opioid medications for pain without a deep understanding of the source of pain or whether opioid medication was appropriate in each case. Even ten years ago, to be honest with you, when patients would come into the ED in opioid withdrawal, we wouldn't have great options for them, and I would say "Opioid withdrawal is not going to kill you. Here's a number to call for help and maybe some **clonidine** or zofran. Have a great day. You're discharged."

And then, there started to be some momentum in the emergency space for buprenorphine, and I was unsure of the role of emergency medicine in the treatment of opioid use disorder. I was vice president of **MCEP** (Michigan College of Emergency Physicians) in 2015 or '16, and I was going to the national meetings every year. Physicians from New Mexico and California were talking about needing to give this (medication) to patients in the ED. I listened, but also thought, "You guys are crazy! We're just going to attract all the addicts. Nobody wants that!"

Dr. Colucci

When I started practicing 34 years ago when people with substance abuse issues came into the department, you'd think, "How do I get rid of this person?" No one thought maybe they had some genetic predisposition. They made this choice, and shame on them.

Part of my addressing people who would come and request Dilaudid, Demerol, or Norco, you know, the typical thing we saw day-to-day, was to use **MAPS** (Michigan Automated Prescription System) to show the patient their prescription history. It's like they got caught with their hand in a cookie jar because I knew what they were doing. I also used MAPS to have intelligent conversations about why it was malpractice for me to give them opiates because they'd developed a dependency. Another thing I did throughout my practice was I never prescribed more than 15 tablets. Colleagues said to give 30 with a couple of refills. I said patients don't need it that long. I guess I was right because here we are today, limiting the amount of narcotics prescribed.

Evolving into Champions

Dr. Manteuffel

Over the last decade, my whole perspective has completely changed when it comes to opioid use disorder. I started hearing some of the stats about the mortality numbers of these patients, especially in the fentanyl era. If somebody who comes into your ED overdosed, there's anywhere between a 5 and 15 percent chance that they'll die within a year. That's right up there with trauma, sepsis, and **STEMIs** (ST-elevation myocardial infarction, a type of heart attack).

I got interested in MOUD, and I feel like it is in emergency medicine's space because we want to help people—period. We want to save lives. That's why we became ER docs. And so, it really is our space, and this is our acute opportunity to intervene because these are generally not people engaged with the healthcare system. And so that's kind of how I try to sell it to my colleagues. This is a high mortality condition. We're at Henry Ford! Sepsis is a high-mortality condition; we're all over it. We should be all over this as well.

Dr. Colucci

FAN (Families Against Narcotics) made me aware of how bad it was in the community. We share the blame as physicians on the frontline. That was the start of my thinking, "Wow! There's a big problem, and I'm glad I did what I did at the beginning of my practice." It was the beginning of changing the landscape and culture of the ED in terms of limiting the number of tablets prescribed.

I remember giving a talk at one of the FAN meetings. Somebody asked me what I thought of **Suboxone** and the opiate issue. I said I would caution against trading one addiction for another. FAN's founder was so offended! She took me aside; that was the first lecture I got about how Suboxone was helping people function. I still didn't grab onto it until I started learning about MOUD, buprenorphine, and the **X-waiver**.

I became interested in the X-waiver because I wanted an alternative. You know how many times you work a weekend or holiday, and that tends to be when people with OUD show up in the department, and your hands are tied. The methadone clinic is closed. What do I do to help these patients?

A light bulb went off in my head during that education (for the X-waiver). Shame on me for what I was thinking! These patients, they're screaming for help. And I think this (MOUD) is a good way to allow them to curb the dependency they've developed and let them function in society without being ostracized like we used to make them feel.

Dr. Manteuffel

I was listening to an emergency medicine doctor in New Mexico talk about becoming board certified in addiction medicine and starting a clinic in the community because there weren't any other resources. At the time, I thought his ideas were out there and not a path I would want to follow. Sure enough though, in 2022, I became board certified in addiction medicine. It's low-hanging fruit to help these patients. You can potentially change the course of someone's life, and that's rewarding.

People with OUD are so used to being stigmatized by themselves and the healthcare industry. And they are legitimately caught off guard when someone talks to them about their use and aims to help them in any way possible. Even if you just say, "I understand you're not ready to change, and that's okay. We're always here. We can help you because I don't want you to die."

Dr. Colucci

And first, do no harm. We've taken an oath to help these patients. And it doesn't help when we have preconditioned or predetermined opinions about them when they come in. If you go into a room with a preconceived idea and attitude, you just did that person a disservice. I've tried over the years just to step back and give them the same fresh clean slate I'd give anybody else. So, it's been an education, a metamorphosis. That's my story of the transition and how I became a butterfly.

Continuing the Journey

Dr. Colucci

I like where I'm at right now with my thinking. This (MOUD) is the right thing to do. Moving forward, we need to make the community and healthcare field aware that there's a major opioid problem, then you can educate them. Trying to educate somebody about something they're unaware of, we can't move the needle. After that, you get engagement. I think that's when you really move the needle, change the culture, change attitudes, and hopefully, change the whole epidemic by reducing the number of people who become fatal statistics.

Dr. Manteuffel

It's interesting to me how widespread this issue is. It crosses all socio-economic borders. I think those who have means have more ability to be engaged in treatment, whereas a lot of our patients might not have, and we are the only ones that can help them. I'm dedicated to helping spread MOUD across the whole Henry Ford system, not just the Detroit campus. I want everyone to have a streamlined process that works for the doctors and the patients.

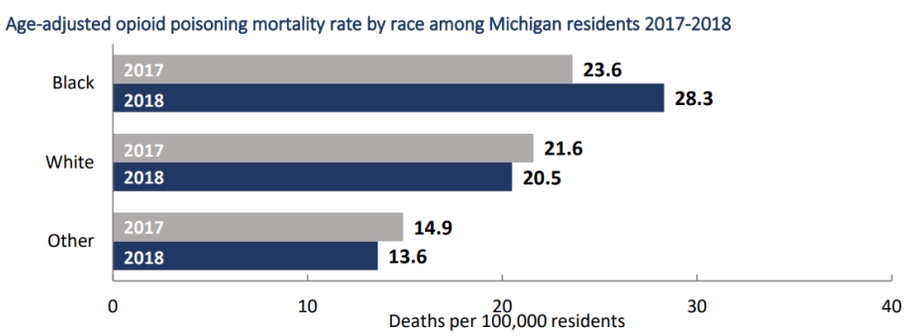
Provider Voices: Achieving Equity through Medication for Opioid Use Disorder

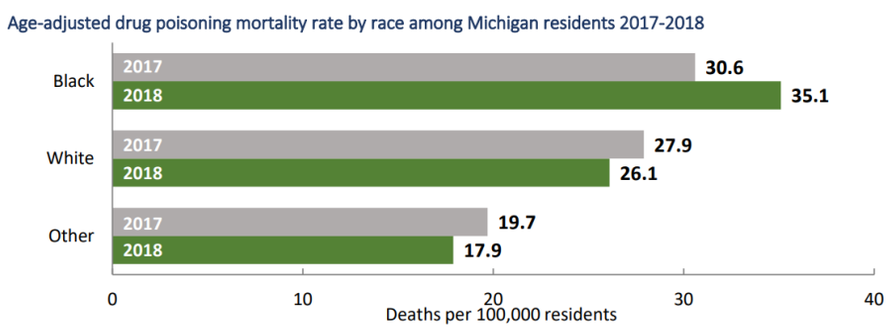
Improving Emergency Department Opioid Treatment for People of Color

Medication for Opioid Use Disorder Addresses Racial Disparities in Michigan's Hospitals

With more than 400,000 lives—and growing—claimed by opioid-related deaths, opioid use disorder is an ongoing public health crisis. Yet, attention to the opioid epidemic and its subsequent deaths have focused primarily on White suburban and rural communities even though people of color are bearing the brunt of its consequences. This is particularly true for members of the Black population. At 12.9 percent, they had the third highest opioid-related overdose death rate compared to other races/ethnicities in the country in 2017, according to data from the **Centers for Disease Control and Prevention** (CDC). The **Michigan Department of Health and Human Services** reports that between 2017 and 2018, opioid mortality rates among Black residents increased by 19.9 percent while White residents saw a 5.1 percent decrease.

A provisional study released by the **CDC** confirms conditions for residents continued to worsen throughout the COVID-19 pandemic, with a 13.9 percent increase in overdose deaths among Blacks from 2019 to 2020.





Data Resources: Michigan Department of Health and Human Services

Increasing access through partnership


Julie Rwan, MPH

Leveraging the priorities of the Michigan Opioid Partnership, Vital Strategies collaborated with the Community Foundation for Southeast Michigan to strengthen the capacity of hospitals and emergency departments, particularly in Wayne and Genesee counties, where overdose rates are among the highest in the state and where data shows the greatest racial disparities. **Vital Strategies**, a global public health organization, provided the foundation with the seed funds to work with emergency physicians in both counties to help them recognize their implicit bias and begin to address systemic racism in treating opioid use disorder (OUD).


Michael Rafferty, MA

Another impetus for the effort was the fact that even though medication for opioid use disorder (MOUD) combined with behavioral therapy is an evidence-based treatment yielding impressive outcomes for people with OUD, it is not provided equitably to people of color. **A Journal of American Medical Association Psychiatry** letter written by researchers at the University of Michigan and the VA (Veterans Affairs) Ann Arbor Healthcare System published in 2019 found that Black patients are 77 percent less likely to receive buprenorphine—one of the more effective medications for the disease—than Whites in an outpatient setting. Further, when the medication is administered, Blacks are more likely to receive inadequate doses, diminishing the drug's life changing results. According to Julie Rwan, Senior Technical Advisor at Vital Strategies, "The Black community in Wayne and Genesee counties is disproportionately impacted by overdoses. Our work is to assist practitioners in emergency departments with identifying people who could benefit from medication for opioid use disorder."

Given the limited access to MOUD and the impact addiction is having on Black people, Amanda Reed, Analyst with the Health Initiative Team at the Community Foundation for Southeast Michigan, emphasizes the importance of "addressing the racial disparity issues that exist within our community." The foundation is working closely with New Detroit to design a training program for hospitals and emergency departments that will help health care providers engage more Black people in medication for opioid use disorder. **New Detroit**, a local racial justice organization, is a great partner for this work as they were already piloting a curriculum called Just Care, a general anti-bias training geared toward the health care sector.

New Detroit recognized that social determinants are not the only contributing factors to disproportionate health outcomes. Just Care specifically addresses racism, implicit biases, and stigma among health care practitioners as root causes of disparities related to treatment of people with OUD. Michael Rafferty, President and CEO of New Detroit, says the training program will result in emergency departments having more positive interactions and outcomes with Black patients seeking help with addiction. "How can we do everything that we can to make folks aware of their own bias? Everybody needs to participate in dismantling bias in health care."

Treatment disparities anchored in history

Overcoming health care provider bias is only one of the issues hindering access to quality care for OUD sufferers of color. Negative media portrayal of opioid use is another contributing factor. While the conversation about drug dependency is shifting from one of moral failure to chronic disease, coverage still often portrays White people with OUD as victims whose promise and potential have been co-opted by profit-driven drug companies. Conversely, Black people are depicted as remorseless criminals, lacking humanity.

Amanda Reed, MPA, MPH

Sara Lawson, a Black Family Development Clinical Therapist, who counsels emergency department patients seeking assistance with mental health and substance abuse treatment and advises on the Just Care curriculum, is often dismayed by the lack of sympathy and empathy health care providers show toward Black people. "I often tell my coworkers they can't judge a book by its cover," Lawson says. "It's not their place to criticize people who repeatedly come to the emergency room with the same problem. They don't know how deep that person's trauma is. Patients deserve respect."

Sara Lawson, Clinical Therapist

Punitive drug laws must also be curbed to close treatment gaps. According to Lawson, fear of incarceration is a primary reason why Black people do not seek treatment for addiction. She recalled a scenario involving a White woman under the influence of an opiate and caught by the police while driving with her children sitting on top of the car. "She got probation," Lawson exclaims. "Had that mother been Black, she likely would have gotten jail time and lost custody of her kids."

Research seems to support Lawson's prediction. According to ***The Changing Racial Dynamics of the War on Drugs***, published by the Sentencing Project in 2009, two-thirds of people incarcerated for drug offenses were Black or Latinx despite representing less than one-third of the population and using drugs at a rate similar to Whites.

These practices and outcomes have been cultivated over the last 50 years through U.S. drug policy. While the federal government battled illicit drugs throughout the 20th century, modern attitudes regarding drug addiction have been shaped by The War on Drugs first declared by President Richard Nixon in 1971 and re-established by President Ronald Reagan in 1982. The Anti-Drug Abuse Act of 1986, enacted during Reagan's second term, resulted in mandatory and severe sentencing for low-level, nonviolent drug offenses, particularly related to cocaine, for a disproportionately high number of people of color. Federal laws held the same penalty for one gram of crack cocaine as 100 grams of the substance's powder form. As crack was more common in Black communities, those caught using the drug received much harsher sentences than their White counterparts choosing cocaine.

The War on Drugs played to Americans' worst fears about illegal drugs and was sold as a balm to what was ailing urban centers plagued by drug-related crime. It was later revealed that Nixon's true motive for the initiative was to discredit both the Civil Rights and Anti-Vietnam movements of the late 1960s and early 1970s in an authoritarian attempt to quiet voices of dissent and distract the public from the issues these movements raised. The underlying racism became entrenched in the medical field with

the crack epidemic of the 1980s, solidifying racist attitudes of hospital staff regarding who used drugs and where, permeating approaches to treatment in emergency departments across the country.

Teaching health care providers about this episode in United States history is important, says Reed. “A lot of the physicians in emergency departments are younger and may not understand the implications that these policies have had on people’s health outcomes and how they’ve shaped perceptions about Blacks,” she says.

Pathways to equity

The deleterious legacy of The War on Drugs must be dismantled to reverse the opioid epidemic’s trends. Fortunately, public health professionals at the community and institutional levels are beginning to work with health care providers on strategies that could enhance access to and engagement in MOUD among Black people.

Examine and deconstruct racial bias in emergency departments and hospitals.

Health care providers exhibit the same levels of implicit bias as the broader population. The primary difference, however, is that their negative evaluations of a person based on irrelevant characteristics like race can impact that individual’s health. Training them to recognize and confront the role identity, privilege, and perception play in how they treat people of color with OUD is a critical step toward equity and why programs like Just Care are so important.

Invest in a workforce that is qualified to respond to the clinical aspects of MOUD and the cultural needs of diverse populations.

Mounting evidence supports one of the best ways to address health care disparities is to develop a workforce that represents the client population. This is considered one of the main practices of cultural competency and enables institutions to function effectively with diverse communities. Compatibility between cultural backgrounds of staff and clients is thought to improve retention in treatment programs, helping OUD sufferers achieve full recovery.

Foster partnerships with grassroots organizations working close to the impacted population.

To improve the quality of care Black people with OUD receive, it is essential that stakeholders understand their needs. Before this can happen, health care professionals have to breakthrough long-held feelings of fear and mistrust, resulting from decades of discrimination and abuse. Community-based leaders can help overcome these issues and work to engage a broad cross-section of individuals, including policy makers, health care providers and administrators, patients, and advocates who are committed to making systemic change.

Implement a multi-layered approach to address opioid use disorder in traumatized communities.

Poverty, oppression, and violence have plagued Black people for centuries. Drugs became a way to escape the sense of hopelessness many of them faced. Employing a holistic methodology to address

OUD that includes wrap-around services to meet patients' most primal needs like food, housing, education, and employment is essential to resolving the crisis.

Improving access to culturally responsive and evidence-based treatments like MOUD is the only way to reduce the opioid epidemic's impact on Black people. That requires collaboration and a commitment to equitable policies and services that cater to their needs.

"Racial equity work can't be done in a silo. It is broad and requires intersectionality," says New Detroit's Rafferty. "Industry, philanthropy, and community all have to work together to create a vision of what racial justice in health care looks like and understand the biases that prevent us from achieving that vision."

NEW DETROIT
A RACIAL JUSTICE ORGANIZATION

JUST INSTITUTE
by NEW DETROIT

Provider Voices: Patient Success and Cultural Change Give Providers Hope


Becky Gomez, RN


Tiffany Morelli, RN

Passion is at the core of many health systems' drive to develop medication for opioid use disorder (MOUD) programs in their emergency departments (ED). With the number of opiate-related deaths continuing to rise, numerous providers and their families have been touched by the epidemic, resulting in a strong desire to normalize quality care. Tiffany Morelli, Emergency Center Registered Nurse and Opioid Use Disorder Program Manager at **Corewell Health Beaumont Troy Hospital**, is familiar with this reality.

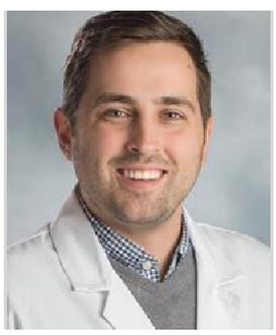
"I worked with a patient in 2017 who presented to the emergency room that had overdosed on heroin," Morelli recalls. "I connected with her and provided her with the resources to begin her journey in recovery." The young woman called Morelli the following day, launching a long-term relationship with the nurse acting as her support system and champion. "My husband and I welcomed the patient's two children into our home while she worked on her recovery. It's hard for a parent to focus on their recovery when they don't have resources to help with their children," says Morelli. "Here we are years later, and she is still in recovery doing well with her kids back home. I'm so happy for her and proud of her." Morelli's motivation to work with this growing patient population was solidified when, a year later, she lost her brother to an overdose after he became addicted to narcotics following surgery.

Morelli's interactions with those suffering from opioid use disorder (OUD) proved prophetic. She started what she describes as a "grassroots" initiative within the ED to connect patients in overdose or withdrawal to continued care. **Corewell Health** (formerly Beaumont) received a grant from the Community Foundation for Southeast Michigan's Michigan Opioid Partnership (MOP) for an initiative within the ED that provides guidance, education, and resources to OUD patients. The program began at the **Royal Oak campus** and expanded to the Troy campus a year later, enabling Morelli to formalize her work. "With support and guidance from the emergency center nursing director and the chief nursing and medical officer, I created a program for Troy's emergency center in partnership with Royal Oak," Morelli explains.

ED Staff Reinforce Ongoing Care

As an early adopter of MOUD and one of the first MOP grantee partners, the Royal Oak ED had an established practice of treating OUD patients with medication. Becky Gomez, a registered nurse specializing in addiction, shares, "The grant dollars allowed us to enhance the continued care protocols. We have a team composed of the nursing director and care coordinators."

Another essential team member is Dr. Michael Gratson, an emergency physician and medical director for the Royal Oak MOUD initiative. “Dr. Gratson is a mentor and champion who was instrumental in developing the program,” says Gomez. He is also leading MOUD efforts at Corewell sites throughout southeast Michigan.

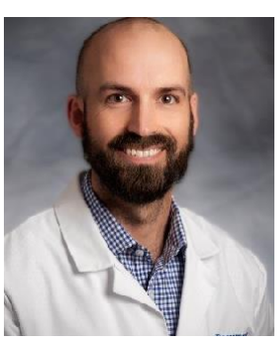


Dr. Michael Gratson

Gomez shares Morelli’s passion for OUD patients. “Everyone has a right to get better,” she declares. “I often cry when I see how these patients are stigmatized. I don’t understand treating people with such disdain.”

Given the proximity of the Troy and Royal Oak campuses, the respective EDs often see the same patients. Morelli and Gomez collaborated to design a warm handoff process that both hospitals could institute. Dr. Trevor Eckenswiller, an emergency physician, joined them as the medical director for the MOUD program in Troy.

“Beaumont has been on the frontline of intervening with medications for people who suffer from addiction and substance use disorder,” he observes. “I don’t know that we’ve done a great job identifying and getting the social and outpatient help for them, and that needs to become mainstream in providing medical attention to all patients.”



Dr. Trevor Eckenswiller

Having relatives with OUD, Eckenswiller’s compassion for the effect on people close to the patient drew him to the work. “Witnessing this disease’s impact on families who come through the emergency department can be devastating.”

Another program goal is to ensure patients treated by the multidisciplinary team do not experience withdrawal symptoms and receive proper resources to bridge care to an outpatient setting. “We spend time with them in the hospital and release them with referrals to community partners who can help manage their addiction. We also follow up to support them,” according to Morelli.

Beyond ongoing treatment, several of these partners offer transportation, job placement, and other services essential to patients’ needs. **Families Against Narcotics (FAN)**, **Dynamic Healthcare**, **Gammons Medical**, **Judson Center**, **Bicycle Health**, **AccessPoint**, and **Beaumont Troy Family Medicine & Substance Use Disorder Clinic** are among the local resources included in both hospitals’ referral networks.

Overcoming Barriers to Deliver Patient Success

The collaborative nature of the relationship has helped each hospital acknowledge its unique cultural dynamics and bypass roadblocks.

“We are slowly changing the narrative, but bias and stigma persist,” says Gomez. “We need to reinforce education about OUD being a disease.”

Dr. Eckenswiller noted that additional MOUD training is needed. “Prescribing or administering buprenorphine isn’t familiar to a lot of providers, and unfamiliar drugs and treatments create barriers,” he says. He pointed to the necessity of an X-waiver to prescribe buprenorphine as another significant obstacle. He was highly supportive of President Biden’s December 29, 2022 decision to sign a multi- part end-of-year appropriations bill that included the bipartisan Mainstreaming Addiction Treatment (MAT) Act. The MAT Act removes the X-waiver requirement, making it possible for all practitioners with a current DEA registration that includes Schedule III authority to prescribe buprenorphine if permitted by state law. “Getting people X-waivered has been a huge challenge. Hopefully, now we can expand the number of providers prescribing medication for overuse disorder.”

In addition to education, communicating about patient success is another effective tool for building buy-in and changing minds. Both hospitals see a broad spectrum of patients and define victories relative to where they are on the continuum. Gomez considers all her patients successful because it is all about seed planting. “The length of a person’s sobriety isn’t always the best measure of success,” she says. “If a patient leaves the hospital knowing they have somebody they can call who won’t judge them and help them in any way possible, that’s a win.”

Dr. Eckenswiller echoes Gomez’s thoughts, recognizing that some people might not be ready to abstain but at least accept they have a problem. The program also benefits the hospital, according to Morelli.

“Not only can we provide the care these patients deserve, but we are reducing repeat visits and shortening lengths of stay,” she says. “Also, we are here for those not yet ready to enter recovery. We provide support, education, harm reduction resources, supplies, and follow-up,” Morelli explains.

While the partners at the Royal Oak and Troy sites acknowledge their work is relentless and demanding, their enthusiasm is undeniable. “What motivates me is meeting a patient who’s decided they want help and knowing that we can get them the help they need,” says Dr. Eckenswiller. He is also inspired by being a sounding board for patients’ families and witnessing his colleagues alter their mindsets and accept OUD as a disease worthy of treatment.

People are also at the center of Gomez and Morelli’s passion for their work. Gomez fondly describes her relationship with an OUD patient she helped get into treatment. “One of my patients calls just to say hi, and I love him. He’s been in recovery since last April, and it’s awesome. His story is awesome!”

Beyond linking people with OUD to quality care, Morelli wants to spare families the pain she experienced after losing her brother to an overdose. “We have changed the lives of so many people and their families,” she exclaims. “I’m blessed to be part of this mission.”

Provider Voices: One Hospital's Approach to Building MOUD Sustainability

Dr. Nathan Menke

Deaths from opioid overdoses **increased** by 30 percent in Washtenaw County from 2020 to 2021. This parallels national trends, with the **Centers for Disease Control and Prevention** reporting 15 percent growth for the same period. These devastating statistics compelled **University of Michigan Health**, part of Michigan Medicine, to step up its efforts to improve care for people suffering from opioid use disorder (OUD). "Once you see these numbers, it validates the need to immediately institute specialized care using evidence-based medicine for these patients," says Dr. Nathan Menke, Medical Director of the Inpatient Addiction Medicine Consult Team.

Emily Smith, Social Worker

"Figuring out the best way to serve this population has been a work in progress for quite a while," says Emily Smith, Addiction Consult Team (ACT) Social Worker. "Thanks to funding, we were able to get programming off the ground, and we've continued to expand exponentially." Smith referred to a grant Michigan Medicine received from the Community Foundation for Southeast Michigan's Michigan Opioid Partnership to support establishing a medication for opioid use disorder (MOUD) program.

"The funding is specifically to treat OUD patients coming through the emergency department (ED), but our team supports the inpatient medical units," Smith explains.

Providing a Comprehensive MOUD Program

ACT began when Michigan Medicine hired Smith in February 2021 to help start the MOUD program. "We did a soft launch with our ED in April and hired a peer recovery coach in May," she recalls. The team worked with ED physicians to ensure practitioners had a protocol for starting OUD patients on buprenorphine or SuboxoneTM and connecting them to ongoing care upon discharge. An ACT member sees patients if they come in during business hours or follows up the next business day if they come in after hours. "Our goal is to ensure a warm handoff to the next level of care and that these patients don't just fall through the cracks when they're coming through the ED," says Smith.

Due to complications such as cellulitis, endocarditis, or other infections related to injection drug use, the hospital often admits patients who use substances. Michigan Medicine acknowledged the need for a comprehensive approach that integrated ED and inpatient treatment. In June 2021, it rolled out the MOUD program across University of Medicine Health after hiring Dr. Menke. As an addiction specialist, he assists with pain management strategies that do not exacerbate OUD patients' disease. Arranging warm handoffs is also an essential part of care for this patient group.

"Inpatients come from all over the state and country, and we work hard to ensure that wherever they're coming from, they get plugged back into care in their local community," according to Smith.

Michigan Medicine can offer such a comprehensive program because they have a group of professionals bringing the necessary skill set to provide quality care. ACT consists of a peer recovery coach, nurse care manager, pain pharmacist, social workers, and physician. The team has worked to develop strong community partnerships, including with **Packard Health**, a federally qualified health clinic that offers services for people with OUD.

Overcoming Stigma

Despite Michigan Medicine's commitment to institutionalize care for OUD sufferers, stigma remains a significant barrier. "Healthcare has historically done a poor job of taking care of people who use substances," Smith says. "We're making progress regarding how patients are treated, but many providers don't think they deserve care." Dr. Menke says providers' unwillingness to get MOUD training is another challenge. "They don't understand substance use disorder and feel very uncomfortable prescribing buprenorphine, so some patients are not getting evidence-based treatment."

Smith and Dr. Menke agree that education is vital to reducing stigma and making providers more comfortable prescribing MOUD. "We've been invited to speak to various departments throughout the system about our work," says Smith. Residents from family medicine, internal medicine, psychiatry, and other departments spend time learning how to treat patients with OUD. "Our arms are open to anyone who wants to know about this work. We enjoy teaching almost as much as the clinical care," she exclaims.

Their efforts resulted in greater collaboration and sensitivity among providers treating people with OUD. Patients routinely thank ACT members for effectively managing their withdrawal and pain. They also tell others with the disease and in need of care that the staff at Michigan Medicine is understanding and compassionate.

"Seeing the difference we've made for patients is really rewarding. It's a tribute to how far we've come," says Smith.

Sustaining and Expanding

According to Smith and Dr. Menke, champions and administrative support are the most critical elements for creating a sustainable program. Smith acknowledged a small group of providers familiar with MOUD's benefits laid a foundation for sustainability by creating buy-in before she and Dr. Menke joined Michigan Medicine. The team built on these efforts by securing a commitment to support vital positions as a step toward sustaining the program. "The MOP grant initially funded Emily. We've since convinced leadership to include her role in the operating budget at the hospital," Dr. Menke says.

Witnessing the impact of ACT's work has deepened the hospital's commitment. "Colleagues and the executive leadership team agree that we're adding value and have provided additional funding and staff," according to Dr. Menke.

Michigan Medicine expanded clinical support for ACT by hiring its first-ever peer recovery coach and adding another social worker. The team is considering an addiction medicine fellowship and building support for extended physician coverage, allowing them to serve patients outside regular business hours. “Anyone on my team will tell you I dream of taking over the world and normalizing this care, so I will always advocate for expansion,” Smith effuses. “I hope to make this more readily available for folks.”

If asked to advise other health systems on sustaining their programs in the absence of solid administrative support or champions, Smith would remind them to focus on delivering patient-centered care that inspires change. Positive health outcomes can lead to buy-in and help stabilize MOUD initiatives. “I tell my patients how happy I am to see them. They talk to me about their drug use because they know I want to help them,” she says. “Never underestimate the value of compassion.”

Gaps & Needs

Despite the evidence and growing support for MOUD, service gaps remain. Most emergency departments face a similar set of initial challenges when implementing MOUD as standard of care. Similarly, most have a handful of needs that they must address to overcome those barriers.

Stigma and bias persist among society, providers, and patients.

Opioid use disorder is one of the most stigmatized health conditions, and that stigma poses a significant barrier to treatment and recovery. It results in systems that are unnecessarily complex and difficult to navigate, providers that determine care with implicit bias - not evidence or patient interest, and patients that avoid seeking treatment and lifesaving care. Stigma intersects with and is compounded by marginalization linked to race, gender, ethnicity, socioeconomic status, sexual orientation, and age. **Education, person-first language, policy reform, and expanded access to MOUD are a few tools required to combat stigma**.

Emergency departments have competing priorities and limited support.

While many emergency departments in Michigan have started doing this work, over half have not yet established MOUD as standard of care. **Ultimately, evidence-based OUD protocols and outcomes should be embedded in policy, practice, tools, and quality metrics**. However, hospitals often cite lack of provider and leadership buy-in, competing system-wide priorities, and misinformation as reasons for slowed or stalled progress.

Emergency departments have unmet needs.

When asked what they would need to establish an ED MOUD program, emergency departments overwhelming called out **'time.'** Securing buy-in, training staff, embedding protocols, and changing culture takes time. Emergency departments need sufficient time and longer grant periods to move logistical pieces into place and create sustainability plans. Second to time, **flexible grant funding, in-person trainings, and culture change** were also cited by most emergency departments as gaps.

Get Started

Check out these resources to learn more about medication for opioid use disorder and how to implement it in an emergency department or hospital setting.

Michigan Opioid Partnership

Increasing access to MOUD in Michigan's emergency departments through technical assistance and collaboration with the Michigan Health & Hospital Association.

National Bridge Network & CA Bridge

Leading an inclusive network of leaders in implementation and quality improvement of ED-based addiction treatment and harm reduction.

American College of Emergency Physicians

Empowering emergency physicians to take on the opioid epidemic through initiatives and resources.

MI Cares

Guiding and supporting providers through the Practice Pathway program for the Addiction Medicine sub-specialty.

UM Opioid Research Institute

Taking action to save lives by addressing the opioid epidemic in Michigan and across the U.S. through collaboration and evidence-based strategies.

Thank You

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