Prioritizing Barriers to Providing Medication for Opioid Use Disorder in Emergency Departments

Introduction

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

Key Findings

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

EXHIBIT 1. Barriers by Theme

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

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

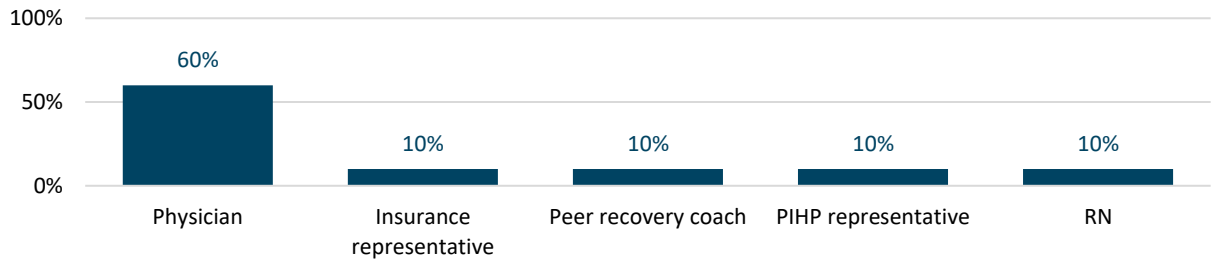
Survey

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

Survey Respondents

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

EXHIBIT 2. Percent of Respondents by Role



N = 10

Barrier Category Rankings

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

EXHIBIT 3. Barrier Category Ranking by Level of Impact

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

Subbarrier Significance

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

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

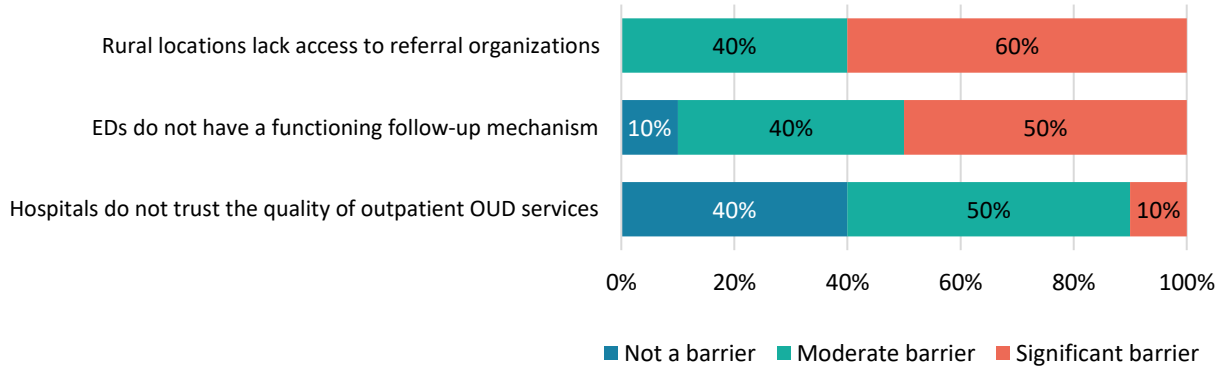


EXHIBIT 5. Barrier Significance Within Lack of Buy-in from Hospital Leadership

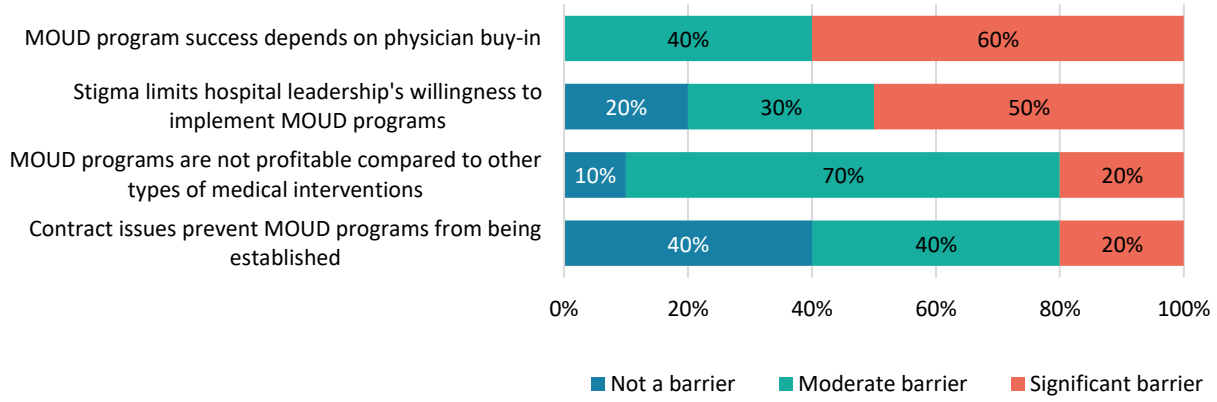


EXHIBIT 6. Barrier Significance Within Inadequate Integration and Reimbursement of Peer Recovery Coaches

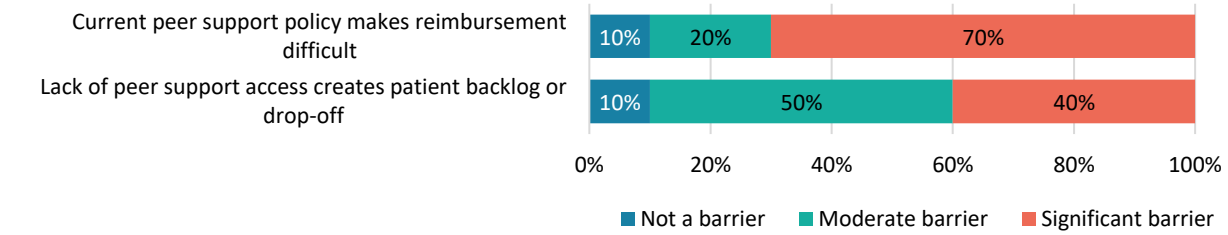


EXHIBIT 7. Barrier Significance Within Staff Resistance to Culture Change in EDs

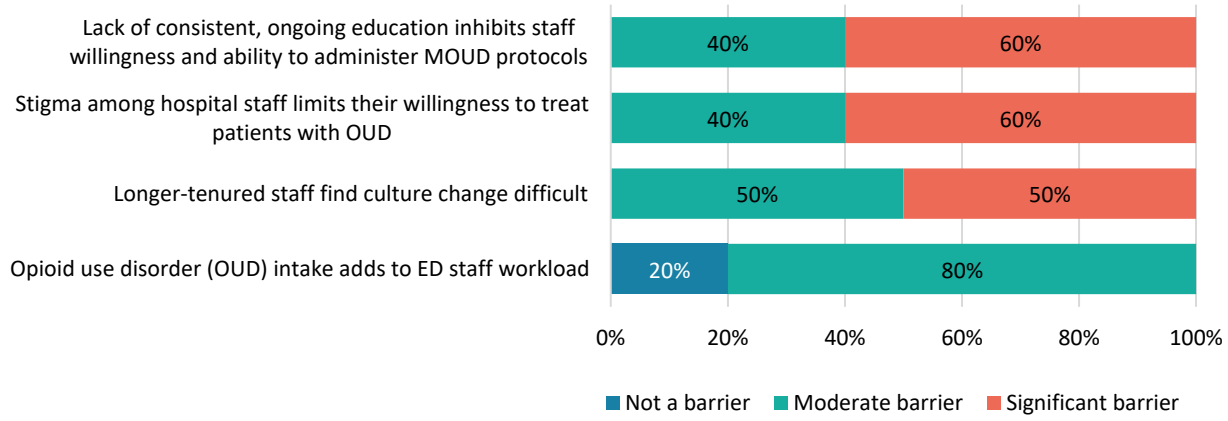


EXHIBIT 8. Barrier Significance Within Disjointed Patient Navigation

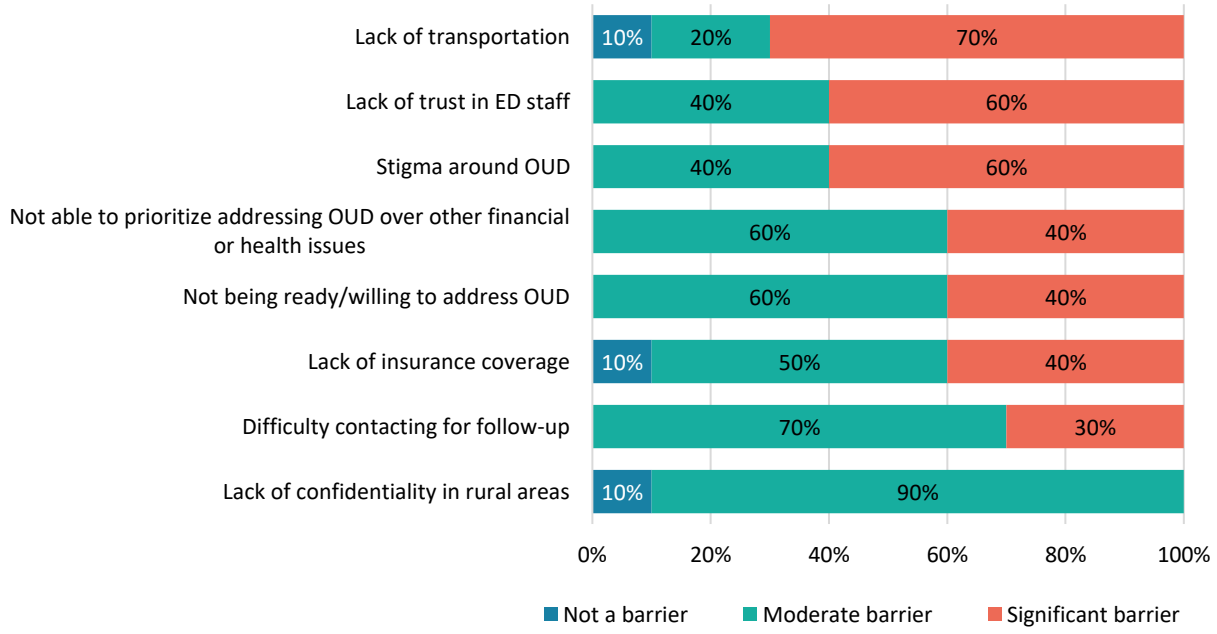


EXHIBIT 9. Barrier Significance Within Siloed and Varied MOUD Program Development

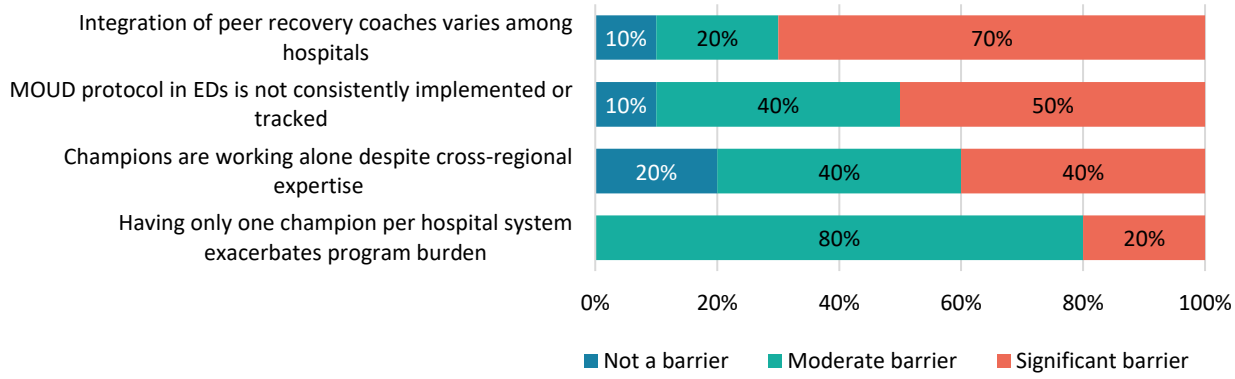
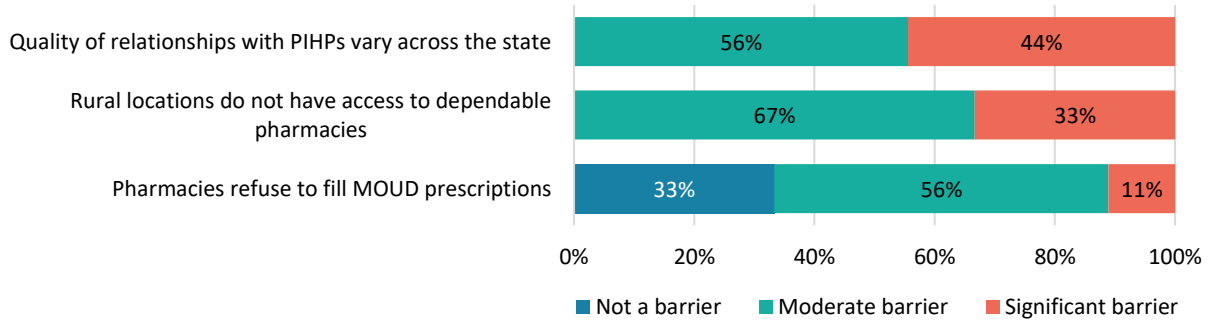


EXHIBIT 10. Barrier Significance Within Inadequate Relationship Building with PIHPs and Pharmacies



Facilitated Workgroup Session

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

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

Discussion and Prioritization

Barrier Category Ranking

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

EXHIBIT 11. Barrier Categories by Average Impact Ranking

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

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

Subbarrier Prioritization

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

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

EXHIBIT 12. Barrier Category/Subbarriers Significance and Workgroup Changes

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

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

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

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

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

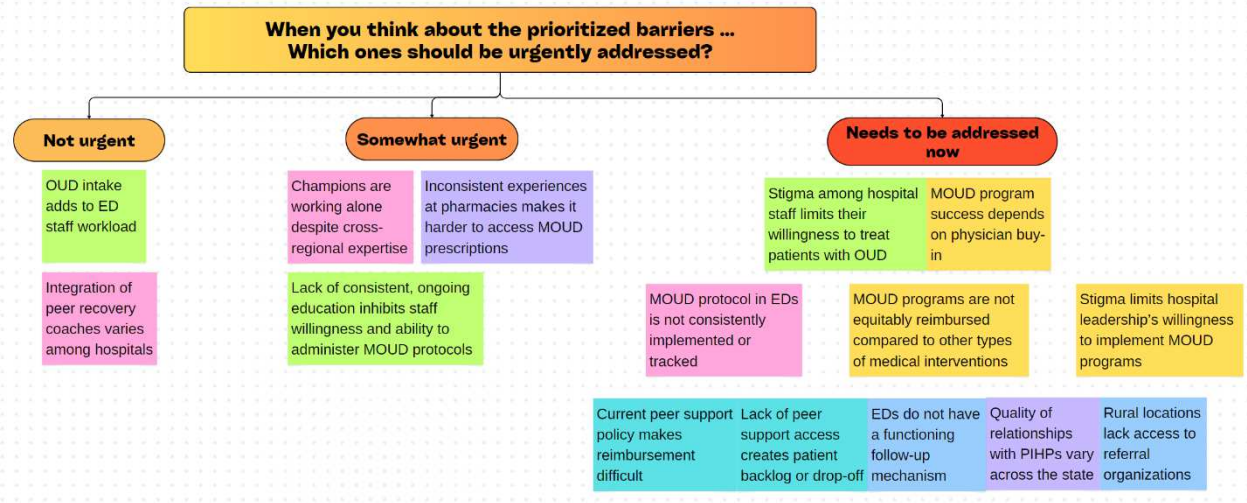
4. One of the barrier categories identified in the survey was "disjointed patient navigation." Although this barrier category includes significant barriers that patients experience that should be addressed, the subbarriers are systemic and will need to be solved at multiple implementation levels. As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

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

Barrier Urgency

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

EXHIBIT 13. Barrier Urgency Prioritization



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

EXHIBIT 14. Highly Urgent Barriers and Themes

Theme	Highly Urgent Barriers
Stigma	Stigma among hospital staff limits their willingness to treat patients with OUD
	MOUD program success depends on physician buy-in
Peer utilization	Current peer support policy makes reimbursement difficult
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	EDs do not have a functioning follow-up mechanism
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The group connected the top two barriers because both relate to MOUD program growth and success being inhibited by stigma. They said addressing stigma would solve both barriers. The next five barriers were grouped by their connection to peer utilization. The workgroup said peers play an essential role in hospital MOUD programs by connecting patients to referral organizations and providing dependable follow-up with patients after they leave the ED. They shared that removing barriers to peer utilization and

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

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