Eastern Upper Peninsula  
Opioid Response Consortium  
Newberry, MI

<table>
<thead>
<tr>
<th>Grantee Organization</th>
<th>LMAS District Health Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant Number</td>
<td>G25RH32967</td>
</tr>
<tr>
<td>Address</td>
<td>14150 Hamilton Lake Road, Newberry, MI 49868</td>
</tr>
<tr>
<td>Service Area</td>
<td>Targeted counties include Alger, Chippewa, Luce, Mackinac, and Schoolcraft</td>
</tr>
<tr>
<td>Project Director</td>
<td>Name: Josh Mickelson</td>
</tr>
<tr>
<td></td>
<td>Title: Health Education Coordinator</td>
</tr>
<tr>
<td></td>
<td>Phone number: 906-341-6951 ext. 120</td>
</tr>
<tr>
<td></td>
<td>Email address: <a href="mailto:jmickelson@lmasdhd.org">jmickelson@lmasdhd.org</a></td>
</tr>
<tr>
<td>Contributing Consortium Members and Stakeholders</td>
<td>See Attachment 1</td>
</tr>
</tbody>
</table>
In recent years, the opioid epidemic has quickly become one of the nation’s most disturbing and daunting challenges. It is a complicated, devastating problem that does not discriminate based upon income, gender, or community standing. It crosses all socio-economic segments and leaves a trail of destruction in its path. Every day in the United States, 130 people die from an opioid overdose. In Michigan alone, the number of people diagnosed with an addiction to opioids between 2010 and 2016 increased by a staggering 493 percent. More people now die of drug overdoses than car crashes in the state of Michigan. While medication-based treatment for substance use disorders combined with behavioral health and peer recovery support is effective, substantial barriers exist to accessing this comprehensive care. In Michigan, less than one-third (32%) of treatment facilities offer medication-based treatment for opiate addiction, this is at least in part due to the lack of the necessary wrap-around services that make for effective comprehensive treatment. If Michigan is to see a dramatic reduction in substance use related harm, ensuring access to comprehensive, accessible treatment options is critical.

Figure 1
The Luce, Mackinac, Alger, and Schoolcraft District Health Department (LMASDHD) was awarded a $200,000 Rural Communities Opioid Response Program (RCORP) planning grant by the Health Resources & Services Administration (HRSA) to focus on Opioid Use Disorder (OUD) in 5 “at-risk” counties in the eastern portion of the Upper Peninsula. LMASDHD has been assisted in facilitating this work by the Michigan Center for Rural Health (MCRH), Mary Kushion Consulting, and other experts across the UP and lower Michigan.

The Eastern Upper Peninsula Opioid Response Consortium (EUPORC) was formed with the goal to address Substance Use Disorder and its related deaths, hospitalizations, medical and social issues in 5 counties in the eastern portion of the Upper Peninsula: Alger, Chippewa, Luce, Schoolcraft, and Mackinac. This work follows the work of the Northern Michigan Opioid Response Consortium (NMORC) which began in 2018. Eastern Upper Peninsula Consortium members are working with and learning from NMORC members, while also addressing unique needs and challenges in the EUP region.

The EUP RCORP Board of Directors is committed to pursuing and leveraging additional resources to maintain and grow the work that has begun during this planning year. The Board has approved applying for the Rural Communities Opioid Response Program - Implementation grant from the Health Resources and Services Administration when it is released in January 2020. Also in January, the EUP RCORP will begin the process of attaining 501c3 status which will open up additional funding streams for the work to reduce substance use disorder in the five county region.

Despite the natural beauty of the picturesque Upper Peninsula, the local population is dealing with the worst economic and health conditions in the State of Michigan. Many tourists flock to “up-north” for peaceful vacations at family cottages or to explore the wonders of Tahquamenon Falls but life is much different for year-round residents. This portion of the Upper Peninsula lacks economic prospects, has generational poverty, healthcare access issues, and high rates of chronic disease and substance abuse. The 5 counties were prioritized for demonstrating a great need for a coordinated approach to combating the opioid epidemic as the epidemic is incredibly complex.

The 5-counties stood out for a variety of reasons, but the short explanation is that they have the greatest need for a coordinated approach to combating the opioid epidemic. The counties reflect the incredible complexity of the opioid epidemic. The epidemic was not created by one factor, and a holistic, multi-faceted approach is needed when examining the health status and socioeconomic factors at the root of the epidemic. The needs reflected in the targeted counties are vast in both broad categories.

The counties consistently rank as those at high risk in the State due to economic factors, health conditions, social and behavioral barriers, lack of access to care, prescribing patterns, and prescription drug abuse.
All 5 designated counties are rural and are designated as Primary Care Health Professional Shortage Areas (HPSAs) and Mental Health HPSAs; and all 5 counties are identified by the Centers for Disease Control and Prevention as being at risk for HIV and Hepatitis C infections due to injection drug use.

The Needs Assessment’s purpose is to help us better understand the current environment of our 5-county rural service area. This data guides the work of the strategic plan to reduce the number of persons with Substance Use Disorder in the Eastern Upper Peninsula, increase access and delivery of SUD treatment services in the five EUP counties and expand the local recovery community model (individual support, family support, peer recovery coaches, and housing) for persons with SUD in EUP focused on the availability and access to long-term recovery support services.

### Background Information

The counties of Chippewa, Luce, Mackinac, Alger, and Schoolcraft are contiguous with one another and make up the entire eastern end of Michigan’s Upper Peninsula. The Eastern Upper Peninsula provides the ideal vacation destination for tourists, while residents struggle with some of the worst economic and health conditions in the State of Michigan. The Eastern Upper Peninsula is surrounded by three of Michigan’s great lakes; Superior, Huron, and Michigan, and have striking inland lakes, islands, and waterfalls that are a haven for all season recreational activities. Residents of the region have few economic prospects, multi-generational poverty and trauma, healthcare access issues, and high rates of chronic disease and substance abuse. The 5 counties were prioritized for a variety of reasons, including the great need for a coordinated and comprehensive approach to combating the opioid epidemic.

Three of the 5 counties fall in the bottom 35th percentile for Michigan Health Outcomes, according to 2018 County Health Rankings Data. The Health Outcomes ranking aggregates two data elements – length of life and quality of life. Both data elements provide a more nuanced look at life in the counties. Two of the 5 counties fall in the bottom 35th percentile for length of life which is determined by premature death rates (years of potential life lost before age 75). Three of the 5 counties fall in the bottom 10th percentile for the Quality of Life ranking, with Luce County ranking at 78, Mackinac County ranking at 76, and Schoolcraft County ranking at 75 (out of 83...
counties). The Quality of Life metric is an aggregate of four data elements – poor or fair health, poor physical health days, poor mental health days and low birthweight. According to 2018 County Health Rankings Data, four of the 5 counties fall in the bottom 35th percentile for Health Factors. All five of the 5 counties fall in the bottom 37th percentile for social and economic factors (children in poverty, income inequality, violent crime, high school graduation, some college, unemployment, children in single-parent households, injury and social associations). Many jobs are tied to the seasonal tourism industry, causing large swings in unemployment across the area.

Table 1: Demographic Information related to Targeted Counties

<table>
<thead>
<tr>
<th>County</th>
<th>Percent of without Health Insurance Coverage</th>
<th>Percent on Medicaid</th>
<th>Percent living below the FPL</th>
<th>Percent of Children living below the poverty level</th>
<th>Percent unemployed - avg 2018</th>
<th>Percent Unemployed - February 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alger</td>
<td>9</td>
<td>19.4</td>
<td>14.8</td>
<td>20</td>
<td>8.3</td>
<td>11.4</td>
</tr>
<tr>
<td>Chippewa</td>
<td>10</td>
<td>16.6</td>
<td>17.7</td>
<td>21</td>
<td>7.2</td>
<td>10.5</td>
</tr>
<tr>
<td>Luce</td>
<td>10</td>
<td>23.3</td>
<td>18.6</td>
<td>29</td>
<td>6.5</td>
<td>8.3</td>
</tr>
<tr>
<td>Mackinac</td>
<td>12</td>
<td>16.0</td>
<td>15.3</td>
<td>24</td>
<td>11.0</td>
<td>24.1</td>
</tr>
<tr>
<td>Schoolcraft</td>
<td>10</td>
<td>26.3</td>
<td>20.7</td>
<td>25</td>
<td>7.9</td>
<td>11.3</td>
</tr>
</tbody>
</table>

Nationally, 11.3% of Americans are considered uninsured. In Michigan, this number drops to 7%. This is due to the expansion of Medicaid through the Healthy Michigan Plan. The 5 counties have some of the highest uninsured rates in the State with all 5 counties having a higher percentage of uninsured residents than the state average; ranging from 9% to 12% of residents uninsured. Medicaid coverage is prevalent in the targeted counties ranging from 16% to 26% of the population on Medicaid. All insurance payers have barriers to providing comprehensive treatment to those with SUD and specifically OUD, and there are more barriers that are specific to the Medicaid population. These include barriers to payment and coverage barriers for

Table 2: Percent Age, Race/Ethnicity Demographics related to Targeted Counties

<table>
<thead>
<tr>
<th>County</th>
<th>White</th>
<th>Black or African American</th>
<th>American Indian and Alaska Native</th>
<th>Asian</th>
<th>Two or more races</th>
<th>Hispanic or Latino</th>
<th>Persons under 18 years</th>
<th>Persons 65 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alger</td>
<td>83.5</td>
<td>7.2</td>
<td>4.4</td>
<td>0.5</td>
<td>0.1</td>
<td>1.5</td>
<td>15.1</td>
<td>25</td>
</tr>
<tr>
<td>Chippewa</td>
<td>70</td>
<td>6.7</td>
<td>15.9</td>
<td>1.0</td>
<td>0.1</td>
<td>1.7</td>
<td>18.6</td>
<td>17</td>
</tr>
<tr>
<td>Luce</td>
<td>78.7</td>
<td>11.2</td>
<td>5.3</td>
<td>0.3</td>
<td>0.1</td>
<td>1.5</td>
<td>16.8</td>
<td>20.5</td>
</tr>
<tr>
<td>Mackinac</td>
<td>73.7</td>
<td>2.5</td>
<td>16.7</td>
<td>0.7</td>
<td>0.0</td>
<td>1.6</td>
<td>16.1</td>
<td>27.5</td>
</tr>
<tr>
<td>Schoolcraft</td>
<td>86</td>
<td>0.3</td>
<td>9.2</td>
<td>0.2</td>
<td>0.0</td>
<td>0.9</td>
<td>17</td>
<td>25.9</td>
</tr>
</tbody>
</table>

https://www.countyhealthrankings.org/
comprehensive treatment. An example includes a Medicaid requirement for a Certified Advanced Alcohol and Drug Counselor (CAADC) certification to bill for services.

The 5 counties are battling, and have been battling, generational poverty. According to the U.S. Census Bureau, 14.0% of Americans are living in poverty. This number rises to 14.9% when looking at the State of Michigan. All 5 counties are above the national average, and 4 of the 5 counties are above the state average, with three counties rising to near 20%. In the U.S. the Median Household Income is $57,617; in Michigan it is $52,436. All five Consortium counties fall well below the national and state median for income. Schoolcraft is the lowest at $37,428, followed by Luce $41,221, Mackinac $42,559, Alger $42,647, and Chippewa $44,030. The low incomes are multi-generational in many families, and this chronic poverty has a profound effect on the growing opioid epidemic.

Poverty and unemployment go hand-in-hand, and the unemployment statistics for the targeted 5 counties reiterate that. According to the Bureau of Labor Statistics, the average unemployment in the Consortium counties in 2018 ranged from 6.5% in Luce County to 11% in Mackinac. Seasonal unemployment shows a significant lack of stable employment. In February 2018, unemployment rates ranged from a low of 8.3% in Luce County to a high of 24.1% in Mackinac.

When looking to future generations, the depressing statistics of the adult and total population in the 5 counties do not get any brighter. Nationally, 19% of American children are living in poverty; in Michigan this number rises to 21%. Four of the 5 counties have a higher percentage of children living in poverty than the state average; ranging from 20% to 29%. Unfortunately, economic conditions are not the only area where youth are struggling. Michigan ranked poorly on data elements focusing on education, and family & community. According to the 2018 Kids Count Data by the Annie E. Casey Foundation, Michigan ranks 33 (out of 50) for overall child-well-being. When comparing Michigan to its Midwestern counterparts, Michigan finished last: Minnesota (4th), Wisconsin (12th), Illinois (22nd), Ohio (25th) and Indiana (28th). Adverse Childhood Experiences (ACES) related to trauma of domestic violence, poverty, and exposure to substance abuse have profound effects well into adulthood and are a foundational issue in the fight against substance use and opioid use disorders.

The prevention efforts in the 5 counties are good beginnings but must be part of a connected effort between all partners in the region. Prevention efforts surrounding prescribing best practices are discussed further in the narrative. Prevention efforts at the community level, including community education on diversion and the negative effects of opioids has happened in silos within each organization. Most organizations have provided some sort of community outreach but understanding the true impact of community awareness is hard to ascertain. There is no coordinated approach to educating the community on prescription drug misuse.

There are an incredible number of factors that can impact a person’s recovery journey. Recovery is disconnected from the healthcare system in the 5 counties. There is a lack of
treatment beds, lack of recovery housing, and unsupportive communities, creating a massive challenge for the SUD population. Treatment beds may be integrated into the healthcare system, but after that point in care the support is typically provided by social mission agencies, or faith-based agencies. It is disconnected from the healthcare continuum leading to a wide gap in coordination and communication.

There are 2 residential facilities in the 5 counties, a men’s and women’s operated by Great Lakes Recovery Centers is in Sault Ste. Marie, MI which is over a two hour drive for some residents of the 5 counties (see Fig. 10). Other aspects of recovery include reducing stigma in communities, working with employers to provide a supportive employment space, and building recovery friendly communities. All of these will require intense collaboration with several stakeholders.

A connected and compassionate model of care must be developed to truly address the opioid epidemic, including the delivery of services, harm reduction efforts, creating an easy path for people seeking care, and a coordination of recovery that includes care coordination and support. Stigma is rarely based on facts but rather on assumptions, preconceptions, and generalizations; therefore, its negative impact can be prevented or lessened through education.

Harm reduction strategies are often met with barriers and lack of understanding, even though empirical evidence shows the benefits. Reduction strategies such as needle exchanges have not been widely adopted in Michigan, with four in lower Michigan and two recently started in the Upper Peninsula (Chippewa and Marquette counties). Strategies around education to the community and provider population will be a focus of the strategic planning process.

Supportive recovery works. It is not only a benefit to the individual but the community. Research from the Bureau of Labor Statistics shows that nationally around 24.9% of the population volunteers in their community. Over 83% of individuals in recovery volunteer. It is an important part of the recovery process. Understanding how to leverage volunteering opportunities to better support those in recovery will be vital to improving recovery outcomes. Ideas to be explored include, but are not limited to, enhancing the role of recovery coaches, incorporating recovery coaches into the healthcare system, and the role between recovery coaches and community health workers.

The above statistics in Table 2 are related to the socioeconomic conditions of the 5 counties. We know that economic conditions surrounding poverty, correlate with higher opioid use and a population with a higher number of opioid use disorder diagnoses. The counties are also identified by the CDC as at risk for HIV and Hepatitis C infections due to injection drug use.
Three of the 5 counties fall in, or above, the range of 52.14 – 83.63 Chronic HCV Rate per 100,000 Persons according to MDHHS, and as depicted by the image to the right.

15,629 Michiganders are living with HIV. Access issues for this population are prevalent. Also, prevention of HIV among injection drug users has promise if access was not an issue. Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of becoming infected to prevent HIV infection by taking a pill every day. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%. There are no PrEP providers in the 5 counties. The closest provider is over 4 hours away for some residents of the region.

The increased use of opioids can be seen via statistics, but it is also important to put it into real-life context for providers and patients battling the epidemic. In 2017, all six local public health departments across the Upper Peninsula planned and distributed a Community Health Needs Assessment to 24,000 UP households. Survey data showed that the highest percentage of those reporting to have “ever injected or snorted to get high” at 10.1% in Schoolcraft followed closely by 9.9% in Mackinac county. The highest percentage of those reporting “ever used prescription drugs to get high” was 6.8% in Mackinac and 5% in Chippewa. For synthetic (such as bath salts) or over the counter drug use, 5.8% in Mackinac and 3.6% in Chippewa report ever using these drugs to get high.

Due to the complexity of the opioid epidemic, looking at one “cause” for the crisis is not appropriate. We need to understand each of the factors leading to the increased number of rural Michiganders abusing opioids. One factor is the number of prescription drugs being prescribed in certain counties and understanding the variance in prescriptions per county. Healthcare providers, and their prescribing patterns, play an important role in offering safer and more effective pain treatment. It is also important to note that Michigan has some of the highest prescribing rates as depicted in the image above. A visual representation of prescribing patterns in Michigan can also be found.
above. This image from the 2016 CDC Vital Signs report, *Opioid Prescribing – Where you Live Matters* breaks down the counties into the following ranges for morphine milligram equivalents, (MME) per 100 population. MMEs is a way to calculate the total amount of opioids, accounting for differences in opioid drug type and strength. As one can see there is great overlap in the counties that are targeted in this proposed consortium response. This information is depicted in a table format below.

In addition, the MDHHS, analyzed data to determine the neediest counties for an Opioid Health Home Model initiative. One component of that data is looking at Opiate Prescriptions per 10,000 people. All the targeted 5 counties have higher opiate prescriptions than total population ranging from 10,490 per 10,000 to 14,236 per 10,000. Schoolcraft County has a total population of 8,001 but prescribes 14,236 opioids per 10,000 residents. Figure 6

One issue is that providers do not consistently follow the CDC guidelines regarding opioid prescribing for a multitude of reasons including, lack of enterprise standardization, patients who have been “inherited” well beyond the guidelines, the burden of tapering, and the general lack of awareness. In addition, providers are not consistently using evidence-based tools that help predict and monitor patient response to opioid medications and risk for OUD (i.e. SOAPP), nor are using evidence based functional assessment tools (i.e. SF-8/PEG).

*Table 3: MME in EUP Consortium Counties and US Averages*

<table>
<thead>
<tr>
<th>EUP Consortium Counties and US Averages</th>
<th>MME (Morphine Milligram Equivalents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Average – 1999</td>
<td>180</td>
</tr>
<tr>
<td>US Average – 2015</td>
<td>640</td>
</tr>
<tr>
<td>Alger County – 2015</td>
<td>823.6</td>
</tr>
<tr>
<td>Chippewa County – 2015</td>
<td>751.2</td>
</tr>
<tr>
<td>Luce County – 2015</td>
<td>1841.2</td>
</tr>
<tr>
<td>Mackinac County – 2015</td>
<td>951.3</td>
</tr>
<tr>
<td>Schoolcraft County – 2015</td>
<td>932.1</td>
</tr>
</tbody>
</table>
Michiganders are dying in greater numbers due to drug overdoses than car accidents. In 2016, 2,356 people died of drug overdoses. Of this, there were 1,762 opioid-related overdose deaths in Michigan—a rate of 18.5 deaths per 100,000 persons compared to the national rate of 13.3 deaths per 100,000. More than half of deaths, totaling 921 in 2016, were attributed to synthetic opioids and 727 were related to heroin. From 1999 to 2016, the total number of overdose deaths involving any type of opioid increased more than 17 times in Michigan, from 99 to 1,699. In the targeted 5 counties there were 8 drug related deaths related to opioids alone in 2016. These numbers are striking as is, but unfortunately are likely not telling the complete story. A recent study published in Public Health Reports found that states may be underestimating the effect of opioid-related overdose deaths because of incomplete cause-of-death reporting. This is especially relevant for Michigan due to the Medical Examiner (ME) structure. County level medical examiners have different processes and protocols for completion of the death certificates, lacking standardization among records. Michigan is one of only two states in the nation that has a county ME system. In 2016, 13.2% of the states overdose deaths were listed as unspecified. Likely Michigan is underreporting deaths related to opioids.

The data we do have tells us that Michiganders are dying due to opioid related overdoses at a much larger percentage than most of the nation and are being overprescribed. Michigan ranks number 11 when comparing the worst states for opioid related overdose deaths in 2016. As depicted by the image to the right, from the National Institute on Drug Abuse, Michigan is in the same scenario as states that the national press has highlighted such as West Virginia and Ohio. While Michigan rarely makes national headlines, the problem is just as dire. This problem is highlighted, by county, in the data table below.

Table 4: Substance Use Disorder - Admission into treatment
**Vision:**
Working collaboratively, the EUP will implement the prevention, treatment and recovery services necessary to reduce harm and heal the persons, families and communities impacted by substance use disorders.

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**Mission:**
The mission of the EUP Rural Community Opioid Response Consortium is to eliminate substance use disorder in the EUP

**Planning Values:**
Build on Consortium members strengths while addressing the most pressing needs of the 5 counties.

### Substance Use Disorder - Admission into treatment October 1, 2016 through September 30, 2018
**Michigan Upper Peninsula Counties: Chippewa, Luce, Mackinac, Alger, Schoolcraft**

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Opioid/Heroin admissions vs total admission for SUD*</th>
<th>Percent admissions into detox, outpatient, or short-term residential only*</th>
<th>Percent admissions unemployed*</th>
<th>Percent repeat admissions into treatment*</th>
<th>Number of opioid prescriptions written per every 10 residents (2017)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alger</td>
<td>9,601</td>
<td>46/90</td>
<td>97%</td>
<td>71%</td>
<td>32%</td>
<td>11.3</td>
</tr>
<tr>
<td>Chippewa</td>
<td>38,520</td>
<td>200/444</td>
<td>96%</td>
<td>64%</td>
<td>38%</td>
<td>9.8</td>
</tr>
<tr>
<td>Luce</td>
<td>6,631</td>
<td>23/63</td>
<td>94%</td>
<td>59%</td>
<td>41%</td>
<td>10.6</td>
</tr>
<tr>
<td>Mackinac</td>
<td>11,113</td>
<td>35/93</td>
<td>100%</td>
<td>54%</td>
<td>27%</td>
<td>12.5</td>
</tr>
<tr>
<td>Schoolcraft</td>
<td>8,485</td>
<td>24/45</td>
<td>93%</td>
<td>64%</td>
<td>15%</td>
<td>13.1</td>
</tr>
<tr>
<td>Total or avg</td>
<td>74,350</td>
<td>328/735</td>
<td>96%</td>
<td>62%</td>
<td>31%</td>
<td>11.5</td>
</tr>
</tbody>
</table>

*Data Source: NorthCare Prevention Network  **Data Source: MDHHS Media Office
**Needs Assessment Methodologies**

**Quantitative**: A total of 100 participants provided input regarding regional needs and priorities through the completion of the regional need’s assessment online survey. (see figure 7)

**Qualitative**: 52 providers participated in workforce focus groups, and 14 individuals participated in Recovery Community focus groups. Recovery groups were facilitated by representatives from LMAS DHD and held in Chippewa and Schoolcraft counties. The workforce focus groups were held at the 5 hospitals representing the region: Helen Newberry Joy Hospital (Luce County), Mackinac Straits Hospital (Mackinac) and providers from the Sault Tribe Health Center, Munising Memorial Hospital (Alger County), Schoolcraft Memorial Hospital, and War Memorial Hospital (Chippewa County) and were facilitated by the Strategic Planning Consultant.

![Figure 7](image)

**Overview of Findings**

The Eastern Upper Peninsula Opioid Response Consortium (EUPORC) was formed in June 2019, supported by the Rural Community Opioid Response Program – Planning funds to coordinate efforts to identify areas of best practice for replication and expansion, identify gaps in care for the target population, develop solutions in identified gaps in care, leverage state resources to address system and policy issues, and reduce the duplication of efforts. The EUPORC has representatives from the prevention, treatment, and recovery community that will each be
represented in the strategic plan. The Consortium will be governed by a Board of Directors and will have provider and patient (recovery advocate) representation. The Consortium has stakeholders include: five rural hospitals; two local health departments; and a behavioral health provider agency. A detailed listing of Consortium members is provided in Attachment 1.

**Overview of Existing SUD/OUD Programs and Services, and gaps in services, in the EUP:**

Providers are currently screening patients with alcohol, opioid, or other substance overuse/misuse, or at risk for overuse/misuse using the RAAPS, AUDIT-C, SOAP, DAST-10 screening tools. In some cases, those who are identified as at-risk, based on the screening are referred to inpatient care, out-patient services, therapy, or peer support services if any of these are available.

There are currently no detox beds in the 5 counties. There is a total of 35 detox facilities in the state of Michigan, including inpatient recovery solutions, however most of these are clustered in the metro areas of Detroit, Grand Rapids and Kalamazoo. Bed availability surrounding psychiatric care is a problem in Michigan. Many times, when an individual has a mental health crisis or is brought to the hospital by law enforcement, there are not enough psychiatric beds available to place the individual. Not having enough beds, nor providers, for Michigan’s mental health needs, directly affects the SUD population due to the large percentage of patients with co-occurring diagnoses.

Education to the public regarding prevention strategies for SUD/OUD and prevention campaigns that create awareness of the risks of alcohol and other legal or illegal substances are tools beginning to be utilized for prevention in the 5-county region. Additionally, outreach and education services that contact individuals who use substances, to encourage safer behavior are being implemented.

Chippewa County has implemented a needle distribution/recovery program that distributes sterile needles and other harm reduction supplies. The LMASDHD will also be starting a harm reduction program in 2020, with the goals of reducing disease associated with shared drug use supplies, improve proper disposal of materials, and support those with SUD in finding and utilizing SUD recovery programs if any are accessible to them.

Additionally providers are encouraging Naloxone distribution and co-prescribing naloxone, when prescribing opioids, for high-risk individuals.

According to the Michigan Department of Licensing and Regulatory Affairs, Bureaus of Community and Health Services, there are eight licensed Substance Use Disorder Programs in the 5 counties. Most of these SUD programs, who provide OUD services, are Consortium members. Only two comprehensive SUD programs providing prevention, treatment, and recovery are available in the five county region, both are in Chippewa County. The geographic distance for the other four counties makes accessing these SUD services very difficult for those seeking treatment and recovery. The range of one-way distance traveled to Chippewa from Alger, Luce, Mackinac and Schoolcraft counties is 50 miles to 121 miles. The 121 miles is
equivalent to someone in lower Michigan traveling from Grand Rapids to Ann Arbor or Kalamazoo to Flint to receive treatment. The miles in the UP don’t include the amenities of lower Michigan such as rest areas and other services.

In addition to the distance, rural travel poses difficulties of its own. The winter season brings an average of 206 inches of snow, with the counties of Alger, Luce, and Chippewa receiving 300 inches or more. The winter season begins early and ends late, resulting in frequent inclement weather, an abundance of snow and ice on the roads along with multiple closures of the two main highways. Many areas also lack cellular service in large sections across the UP.

Medication Assisted Treatment (MAT) is an evidence-based practice that combines pharmacological interventions with substance abuse counseling and other specialized services. MAT reduces the effects of opioid withdrawal and reducing cravings. MAT leads to (SAMSHA, 2015) reduced opioid use, reduced incidence of HIV and Hepatitis C, increased survival, increased retention in treatment, increased employment, and improved birth outcomes for pregnant consumers. Unfortunately, these treatment options are scarce in the Upper Peninsula, especially in the 5 counties. Understanding that there are no other FDA-approved medications, expanding the access to these treatments is critical in battling the epidemic. Methadone, one type of MAT, can only be dispensed for addiction treatment through an opioid treatment program (OTP) certified by SAMHSA. There are no OTP providers in the 5 counties.

Buprenorphine is another option for MAT. The approved use of buprenorphine products for opioid dependency has increased steadily across the nation, but unfortunately this is still not a readily available option for residents in the targeted 5 counties. According to SAMHSA, there are three providers in the targeted counties identified as a buprenorphine treatment practitioner. There are over 800 in the State of Michigan, but that number decreases significantly when analyzing the number in rural areas and decreases even more when looking at the rural Upper Peninsula. While an analysis has not been conducted, there are prescribers who have received the waiver, but many do not prescribe at all, or do not come close to the treatment panel allowable under their waiver. Providers may be hesitant to go through the waiver training and provide MAT services. Some of the reasons include reimbursement issues, the complexity of the patients which take more time, having lack of professional support to provide wrap-around care and support, the stigma associated with the patients, and fear of medication diversion.

Telehealth is emerging as a tool for recovery. Pathways Community Mental Health and Great Lakes Recovery Centers utilize Telehealth services. Helen Newberry Joy Hospital provides Behavioral Health services although not specialized to OUD/SUD. Bay Mills Health Center is identifying the individuals personal pathway and finding alternatives for pain management such as acupuncture and massage therapy. Additional recovery services include food assistance, transportation, providing linkage to the recovery community, sober living events, and recovery coach counseling. However, as noted below, only there are only a combined 11 Behavioral Health Specialists and Licensed Practice Counselors in the 5-county region.
1 of the 5 counties does not have a psychologist or a psychiatrist and 3 of the 5 counties do not have a psychiatrist.

OUD Workforce and Gaps in the Consortium Counties:
The statistics on page 10 highlight the opioid problem relative to prescribing patterns and overdose deaths in the 5 counties. The need is critical in the 5-county region, especially when the lack of available services are factored into the equation. In general, these counties struggle much more than areas where healthcare access is not in such short supply. All 5 counties are designated as Primary Care Health Professional Shortage Areas (HPSAs) and Mental Health HPSAs. The Primary Care HPSA designation reflects the access issues related to basic healthcare services. Scores range from 13 to 21 in the targeted counties. When looking at specialty services, such as Mental Health, the scores increase considerably as highlighted in the map below.

Recruitment in this extremely rural area is an ongoing challenge for any medical and behavioral health specialist.

As mentioned before, Medication for Assisted Treatment (MAT) as the name implies, is one aspect to a comprehensive treatment program. Patients should also participate in counseling and social support. Expanding the number of providers prescribing buprenorphine will not solve the problem. Integrating MSWs, and other mental health and social support providers, into primary care practices, developing solutions in building this workforce, and providing incentives for mental health providers to live and work in the 5 counties will be part of a comprehensive solution.
The table below highlights the number of providers, by county, using data from the Michigan Shortage Designation Management System. The data does include duplicates for providers with multiple locations.

*Table 5: Providers in 5-County Region by Type*

<table>
<thead>
<tr>
<th>County</th>
<th>Psychiatrists</th>
<th>MD/NP/PA Mental Health Specialist*</th>
<th>Clinical Psychologist</th>
<th>Clinical Social Worker*</th>
<th>Licensed Practical Counselor*</th>
<th>Primary Care Providers DO, MD, NP, PA*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alger</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Chippewa</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>14</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Luce</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Mackinac</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Schoolcraft</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>12</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>36</td>
<td>6</td>
<td>44</td>
</tr>
</tbody>
</table>

*Some providers are limited in practice to schools or other specific population groups.*

Peer coaching is a key aspect to recovery care. Currently there are 2 coaches with Bay Mills Behavioral Health and 2 with Great Lakes Recovery Center. All four are in Chippewa County. Figure 10 shows the distance for residents in Luce, Mackinac, Alger, and Schoolcraft counties to reach comprehensive treatment and recovery services in Chippewa. Difficulty lies in the current barriers to recovery coach training such as requiring having previously been on state assistance along with 18-24 month sobriety requirement.

Two harm reduction programs will be leveraged as part of the EUP RCORP work. Chippewa County Health Department started a mobile van harm reduction program in the Spring of 2018, and LMAS District Health Department will be starting a mobile program as well, in early 2020. Both programs employ a nurse and peer recovery coach. Leveraging this local best practice and deploying strategies around education to the community and provider population will be a component of the prevention work plan. These programs are funded though Northcare Network, one of Michigan’s ten Prepaid Inpatient Health Plans (PIHPs) responsible for the management of the Medicaid Managed Specialty Supports and Services, and also the Michigan Department of Health and Human Services. Additional services that will be leveraged through Northcare Network funding in the EUP include substance use disorder and behavioral health services.

![Figure 10](image-url)
Families against Narcotics (FAN) is a community-based program for those seeking recovery, those in recovery, family members affected by addiction and community supporters. FAN seeks to change the face of addiction, dispel the stigma of addiction, and educate the community as well as those affected by addiction. Through Community Health Improvement Planning (CHIP) there are goals set to expand FAN to other counties, leveraging the knowledge from FAN of Chippewa County.

UP Home Visiting Networking is working in substance use disorder prevention efforts involve the facilitation of a UP Perinatal Collaborative Care Coordination project. Funding for this work is from the Upper Peninsula Health Care Solutions (UPHCS). UPHCS is the non-profit, 501 (c) (3) hospital network serving the Upper Peninsula. UPHCS’ mission is to create opportunities of viability for health care providers in the Upper Peninsula of Michigan, and to improve access to quality health services for residents within their communities.

The EUP RCORP Board of Directors is committed to leveraging all current resources and pursuing additional resources to maintain and grow the work that has begun during the planning year. The Board has approved applying for the Rural Communities Opioid Response Program - Implementation grant from the Health Resources and Services Administration when it is released in January 2020. Also in January, the EUP RCORP will begin the process of attaining 501c3 status which will open up additional funding streams for the work to reduce substance use disorder in the five county region.

The Consortium conducted a comprehensive needs assessment from September 2019 to identify areas of best practice for replication and expansion, and pinpoint gaps in care for the region. The responses were gathered from the 5-county region and include a wide range of organizations and professions.

Quantitative: A survey was conducted that received 100 responses. Survey questions were developed by utilizing the Northern Michigan Opioid Response Consortium’s Needs Assessment Survey. Responses were requested from community members within the reach of Consortium members and key people in their organizations. Through survey response it was indicated that there are distinct barriers to prevention, treatment, medication assisted treatment and recovery. The top three barriers identified for each category are listed below.

As you consider the opioid epidemic, what do you believe are the greatest barriers in our region in preventing opioid use disorder?
Table 6

As you consider the opioid epidemic, what do you believe are the greatest barriers in our region to treating opioid use disorder?

Table 7
As you consider the opioid epidemic, what do you believe is the greatest barrier in our region to medication-assisted treatment?

Table 8

As you consider the opioid epidemic, what do you believe are the greatest barriers in our region to recovering from opioid use disorder?

Table 9

Additionally, the graph below highlights what the respondents found to be the most important initiative that should be included in the RCORP strategic Plan (complete Needs Assessment Survey report is attached)
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Very important; high priority</th>
<th>Important; should be addresses in the first three years of plan</th>
<th>Somewhat important; a more long-term priority</th>
<th>Not important; already being addressed</th>
<th>Not sure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure funding to expand programs and services in our region</td>
<td>71.43%</td>
<td>27.27%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.30%</td>
<td>77</td>
</tr>
<tr>
<td>Design a comprehensive, regional treatment model that provides multiple entry points for patients</td>
<td>58.44%</td>
<td>33.77%</td>
<td>3.90%</td>
<td>0.00%</td>
<td>3.90%</td>
<td>77</td>
</tr>
<tr>
<td>Develop a strategy to increase the number and location of treatment providers in our region</td>
<td>58.44%</td>
<td>32.47%</td>
<td>6.49%</td>
<td>0.00%</td>
<td>2.60%</td>
<td>77</td>
</tr>
<tr>
<td>Educate and prepare primary care and other medical providers to diagnose, treat and refer patients with opioid use disorders</td>
<td>54.55%</td>
<td>35.06%</td>
<td>5.19%</td>
<td>3.90%</td>
<td>1.30%</td>
<td>77</td>
</tr>
<tr>
<td>Develop an easy and seamless referral process between law enforcement, providers, and multiple agencies</td>
<td>52.63%</td>
<td>28.95%</td>
<td>13.16%</td>
<td>5.26%</td>
<td>0.00%</td>
<td>76</td>
</tr>
<tr>
<td>Provide screening tools and approaches to diagnose substance abuse disorders earlier in the cycle</td>
<td>48.05%</td>
<td>35.06%</td>
<td>11.69%</td>
<td>2.60%</td>
<td>2.60%</td>
<td>77</td>
</tr>
<tr>
<td>Educate the general public about preventing opioid use disorders</td>
<td>45.00%</td>
<td>31.25%</td>
<td>21.25%</td>
<td>2.50%</td>
<td>0.00%</td>
<td>80</td>
</tr>
<tr>
<td>Develop transition housing / sober living options for patients in recovery</td>
<td>42.86%</td>
<td>38.96%</td>
<td>16.88%</td>
<td>1.30%</td>
<td>0.00%</td>
<td>77</td>
</tr>
<tr>
<td>Educate the general public about treatment options</td>
<td>42.86%</td>
<td>23.38%</td>
<td>23.38%</td>
<td>10.39%</td>
<td>0.00%</td>
<td>77</td>
</tr>
<tr>
<td>Educate law enforcement about identifying and managing people with addiction problems</td>
<td>41.56%</td>
<td>31.17%</td>
<td>20.78%</td>
<td>5.19%</td>
<td>1.30%</td>
<td>77</td>
</tr>
</tbody>
</table>
Serve as advocates to influence legislation and statewide changes | 41.56% | 32 | 28.57% | 22 | 22.08% | 17 | 2.60% | 2 | 5.19% | 4 | 77
Reduce the stigma attached to opioid addiction | 38.96% | 30 | 32.47% | 25 | 20.78% | 16 | 6.49% | 5 | 1.30% | 1 | 77
Educate the general public about identifying opioid use disorders | 36.25% | 29 | 32.50% | 26 | 26.25% | 21 | 5.00% | 4 | 0.00% | 0 | 80
Work with employers in understanding how to address opioid use disorders in the workforce | 11.84% | 9 | 52.63% | 40 | 32.89% | 25 | 0.00% | 0 | 2.63% | 2 | 76
Other: | 66.67% | 2 | 33.33% | 1 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 | 3

Table 10

**Qualitative:** Through survey response and recovery and workforce focus groups, it was indicated that there exists a lack of access to care and treatment options available that address pain/pain management, lack of providers who are comfortable providing Medication for Assisted Treatment, and a lack of recovery support options.

**Provider Focus Groups:**
Five provider focus groups were held in August 2019. Participants were selected by hospital administration and medical directors from hospital systems in the targeted counties from Helen Newberry Joy Hospital, Mackinac Straits Hospital, Munising Memorial Hospital, Schoolcraft Memorial Hospital, and War Memorial Hospital. Of the participants, representation included but was not limited to physicians, nurse practitioners, clinic managers, pharmacists, and nurse anesthetists.

In regards to preventing Substance Use Disorder, measures included limiting the number of opioids prescribed, informing patients the practice does not prescribe opioids, education with patients, the “Start Talking” form, referrals to pain management specialists and to other forms of pain management treatment (physical therapy, yoga, acupuncture), and use of MAPS to track prescriptions. Many providers also have a pain management contract with their patients. Pill counts at every visit and random drug screens were also mentioned. Barriers to offering recovery and treatment services cited included a 60-day waiting period for in-patient treatment, lack of treatment options and mental health providers as well as reduced number of pain clinics, lack of transportation, insurance doesn’t cover other modalities for treatment, lack of childcare, lack of treatment options for pregnant women, state legalization of recreational marijuana.

The consensus from the provider focus groups was that not many, if any at all, in the community are prescribing suboxone, but many are providing naloxone (Narcan). To prescribe Suboxone, a waiver is needed and only 3 have the waiver. Also, mental health counseling is
mandatory with suboxone and mental health counselors are limited with only 5 in the EUP. There is at least one cash only provider who does prescribe suboxone. Providers indicated that not feeling comfortable managing MAT, not agreeing with its ability to treat those with SUD, and a lack of wrap-around care coordination as reasons for not pursuing or using a MAT waiver.

The participants indicated they were familiar with the laws and the impact they have on licensure. In general, they believe the current and new laws in place are good for checks and balances in the system. A few of the groups indicated the current prescribing laws makes it more difficult for their elderly patients and the ER physicians indicated it has increased the number of people presenting in the ER for opioids. Recommendation to have a person’s driver license number as the identifier for MAPS rather than a person’s name.

When asked about the role of primary care providers, most of the responses were focused on being supportive and intervening when requested by the patient. Responses included the need for education for patients and the community, continued use of patient contracts and seeking out rehab options as appropriate. In regards to what should be included in the implementation plan, the responses were wide-spread and included the need for recovery centers for all ages, improved transportation for treatment, use of suboxone with pregnant patients, provider education, offering pain injections rather than opioids, drug disposal resources, more detox centers so people can go into rehab (patient has to be “clean” prior to going into rehab), physical therapy and other modalities as forms of treatment. Additional social workers trained in cognitive behavior therapy and education for patients on personal responsibility were also recommended.

**Recovery Focus Groups:**
In Chippewa County, where there is some access to comprehensive services, participants were invited through Great Lakes Recovery. In Schoolcraft County, where there is no access to comprehensive services, participants were invited through the Drug and Mental Health Court. Both groups were asked to share their perceptions on accessing health care. The participants indicated that while in the ER, there was a stigma and their perception from staff was that they were only there for drugs and believed they were addicts, but one participant did express that they had a good experience and the nurse was helpful. The participants admitted having difficulty finding and maintaining a relationship with a primary care provider and did not have good relationships with them. One participant indicated the physicians need to look more carefully at patient history. Lack of compassion was a prevailing theme. OB care was mixed as well with some expressing, they received good care and others had a lack of empathy.

When asked about their experiences with law enforcement, some of the participants stated that they were helpful and get them into rehab. The group appeared to appreciate the concept of drug court, but more work needs to be done. Overall, the group believed that law enforcement needs to understand that addiction is more of a mental health issue than a criminal one. One stated stop focusing on “where I’m getting it” and start focusing on “why I’m getting it”. The participants stated that while they have been prescribed vivitrol, they would not recommend it without additional supports. They stated that persons on MAT are “shunned” by the recovery community that advocates for abstinence. The participants believe there needs to
be an end goal with step-down programs. More than once they indicated the need for emotional, spiritual, physical and mental health programs to assist with their addiction.

The focus group participants in Chippewa County indicated that many more options have become available. They stressed the need for recovery coaches who meet people where they are at; they emphasized that recovery coaches are more important and more needed than MAT. Only four coaches are currently available in the 5-county region (Figure 10). They also expressed a need to build and maintain “safe spaces” for people to go after they leave in-patient treatment such as a drop-in center with childcare provided. Reducing the stigma that comes from the community regarding their past addictive behavior was also mentioned. They want to be good parents, but believe they are judged for their history. The group indicated that Narcan is very accessible now and all have used it on others. They also expressed that most do not go to the hospital after needing Narcan. The recovery focus group in Schoolcraft County talked about a lack of services, mentioning that they can’t go to treatment or counseling everyday in another county when they also have to parent their children or go to a job.

Discussion/Conclusion

The 5 counties that are served by this plan consistently rank with the highest needs in the State due to economic factors, health conditions, social and behavioral barriers, prescribing patterns, and prescription drug abuse. Residents are facing shorter lifespans, low quality of life, children in poverty, violent crime, low graduation rates and high unemployment rates. Simultaneously, several of these targeted counties have higher opiate prescription rates than the total population. These counties demonstrate a great need for a coordinated approach to combating the opioid epidemic.

The Eastern Upper Peninsula Opioid Response Consortium (EUPORC) was established to engage the Eastern Upper Peninsula of Michigan in a coordinated response to reduce substance use disorders. Working collaboratively, the EUP will implement the prevention, treatment and recovery services necessary to reduce harm and heal the persons, families and communities impacted by substance use disorders.

Through the work of the Eastern UP-Opioid Response Consortium, both quantitative and qualitative data was gathered to gain a full scope of the perceived needs of the 5-county region. 100 participants provided input in an online Regional Needs Assessment survey. 52 individuals participated in giving provider-specific feedback through provider focus groups. 10 individuals provided insight from the recovery standpoint, allowing for a deeper understanding of the challenges faced by these communities.
A lack of service systems exist in the 5-county region as there are no detox facilities, no MAT providers prescribing in Medicaid, only 8 Substance Use Disorder Programs, and few providers who have completed the DATA 2000 waiver (most of whom do not prescribe at all or come close to the treatment panel allowable under their waiver) and PC HPSA scores within the 5-county region range from 13-21.

Surveys, focus groups, and feedback give a good picture of what the highest level of importance tasks are. These will be taken into consideration when developing the strategic plan to ensure meeting the needs indicated as most prevalent.

In summary, the choice of this 5-county rural region as a focus for federal opioid response funds is justified by its high need relative to the rest of Michigan, the rest of the Great Lakes/Upper Midwest and nationally. The EUP Rural Community Opioid Response Consortium will build on Consortium members strengths while addressing the most pressing needs of the 5 counties with the goal to eliminate substance use disorder in the Eastern Upper Peninsula.

Next Steps

Oct-Nov  Dec-Jan  Feb-April  May-Sept

- Needs Assessment
- Strategic Plan
- Workforce Strategic Plan
- Sustainability Plan

Attachment 1

Eastern-Upper Peninsula Opioid Response Consortium-Contributing Consortium Members and Stakeholders:
• Alcona Health Center
• Alger County EMS
• Bay Haven Crisis and Integrated Care
• Bay Mills Health Center
• Chippewa County Health Department
• Chippewa, Luce, Mackinac - Community Action Agency
• Delta-Schoolcraft ISD
• EUP ISD
• FAN of Chippewa County
• Great Lakes Recovery
• Helen Newberry Joy Hospital
• Hiawatha Behavioral Health
• Luce County Ambulance Service
• Luce Mackinac Alger Schoolcraft District Health Department
• Lutheran Church Missouri Synod
• Mackinac Straits Health System
• Marquette County Health Department
• Michigan EMS
• Munising Memorial Hospital
• NorthCare
• Opioid Data Specialist (Dr. Kevin Piggott - Marquette County, Michigan)
• Sault Ste. Marie Chippewa Tribal Court
• Sault Tribe Health
• Schoolcraft Memorial Hospital
• UP Health Care Solutions
• UP-Pathways
• Upper Peninsula Health Care Solutions
• Upper Peninsula Health Plan
• War Memorial Hospital