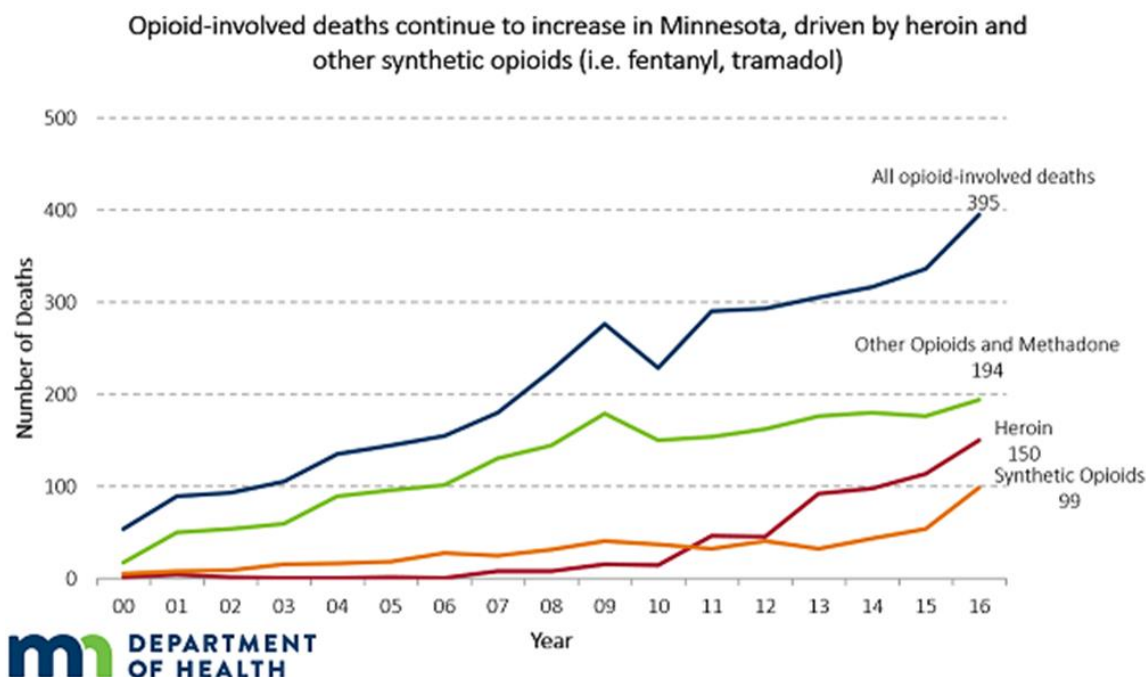


The Opioid Epidemic in Minnesota

Background and history

The destructiveness of substance use disorders are visible every day in Minnesota. Babies are born having been substance exposed, families are being separated and communities endure the problems associated with substance use including violence, absenteeism, injury and crime. The majority of substance use disorders in our state are related to excess alcohol usage with a rising second to methamphetamines. Although treatment admissions for opioids come in fourth behind marijuana, they certainly are the deadliest if left untreated. With approximately only 10 percent of our constituents meeting the criteria for substance use disorder seeking treatment that leaves a lot of lives at risk to the opioid epidemic.

The opioid epidemic was ignited with the overprescribing of prescriptions to treat pain that emerged in the 1990's and the inability to identify, engage and treat clients with evidence-based opioid addiction treatment. The full impact of these changes weren't fully recognized until the increase in deaths associated with opioid abuse emerged; from 1999 to 2015, the number of deaths involving opioid drugs quadrupled in the United States to over 30,000 in 2015. In 2016, 395 Minnesotans died from opioid overdose, more than six times higher than the opioid overdose deaths in 2000. Prescription opioids account for the greatest number of overdose deaths in Minnesota, but since 2010, heroin and fentanyl-involved deaths have increased in Minnesota. People addicted to prescription opiates all too frequently convert to heroin, because heroin in Minnesota is easily accessible, affordable and of very high quality.



Disparities in Opioid Overdose Deaths

There are stark disparities in prescription drug overdoses among racially and ethnically diverse populations in Minnesota. Opioids and other drugs have been especially harmful in tribal communities and communities of color in Minnesota. Opioid drug overdose and death rates provide us with a road map to understand which populations are most vulnerable in this epidemic. In 2015, American Indian Minnesotans were five times more likely to die from a drug overdose than white Minnesotans, and African American Minnesotans were two times more likely to die from a drug overdose than white Minnesotans. Overall in 2015, Minnesota ranked 45th among all states in the age-adjusted rate of death due to drug poisoning, without consideration of race (AAR: 10.6). While this “traditional” ranking indicates that Minnesota is ‘healthy’ compared to other states, it masks this important racial disparity.

The urgent need to reach American Indian and African American communities is supported though numerous data sources. It is notable that in 2015 Census data, although American Indians made up an estimated 1.1 percent of the state’s population, they made up 15.8 percent of those who entered the treatment for opioid abuse during the state fiscal year 2015. American Indian communities in Minnesota have drug overdose death rates nearly five times higher than white Minnesotans from 1999 to 2014 and are 8.7 times more likely to be diagnosed with maternal opiate dependency or abuse during pregnancy compared to non-Hispanic whites; infants are 7.4 times more likely to be born with neonatal abstinence syndrome (NAS) now referred to as Neonatal Opioid Withdrawal Syndrome.

African Americans made up an estimated 5.8 percent of Minnesota populations are African American (non-Hispanic) but make up 10.1 percent of the treatment population for opioid abuse in state fiscal year 2015. In addition the age-adjusted drug overdose mortality rate for African American/Blacks in Minnesota (AAR: 20.5) is the sixth highest in the U.S. (among the 38 states for which data are available). However, the age-adjusted disparity rate ratio of African Americans/Blacks relative to whites (DRR: 2.0) ranks first in the U.S., meaning death due to drug poisoning was two times greater among African Americans/Blacks relative to Whites.

Neonatal Opioid Withdrawal Syndrome

Chronic opiate exposure to the unborn baby during the mother’s pregnancy or upon abrupt discontinuation of opioid after birth can result in newborns showing signs of opiate withdrawal, termed Neonatal Abstinence Syndrome (NAS) or Neonatal Opiate Withdrawal Syndrome (NOWS). NOWS is characterized by a wide array of symptoms including increased irritability, hypertonia, tremors, feeding intolerance, watery stools, seizures and respiratory distress, etc.

From 2010 to 2014, rates of NOWS more than doubled in Minnesota. Babies that are born with NOWS are more likely to be born preterm, have low birth weight and have inadequate or no prenatal care. It is important to remember that not all mothers of babies born with NOWS are diagnosed before birth as being dependent on opiates, not all pregnant women dependent on opiates give birth to a NOWS baby. Therefore, opiate dependency in some percentage of pregnancies will remain unknown as there is no universal screening for substance use disorders in pregnancy.

Additionally concerning is the disparities that occur in NOWS. More than one in ten pregnancies among American Indian women have a diagnosis of opiate dependency or abuse during pregnancy. NAS occurs when newborns withdraw from opiates due to maternal opioid use during pregnancy. In Minnesota, there is an 8-fold higher rate of NAS among infants born to American Indians.

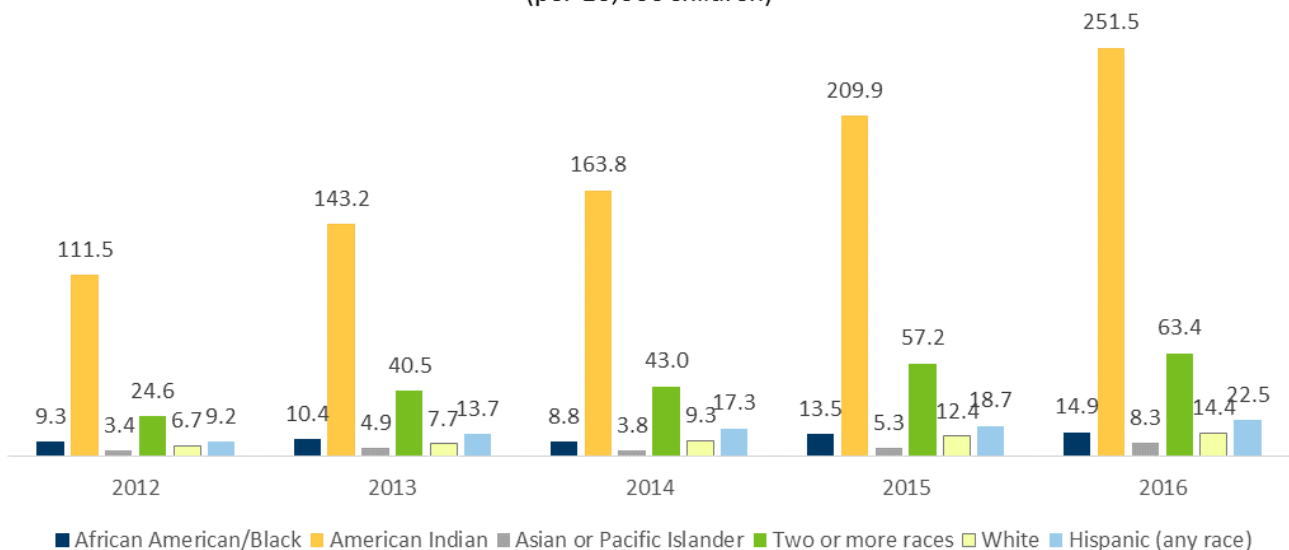
Children are being removed from their Parents

Removing children from their biological parents is a significant side effect of the opioid epidemic—when parents are unable to care for their children due to opioid use disorder, or when children born with neonatal abstinence syndrome need extra care, officials must step in to protect children. This type of significant adversity in childhood can lead to problems in later life, including substance abuse (contributing to cycles of substance abuse and related trauma over generations). Children are much more likely to need the intervention of government child protective services if their parents are chemically dependent or if they were exposed to opioids prenatally. In an analysis of 103,127 children age 0-3 enrolled in Medicaid during 2012, those who had a chemically dependent parent were 2.4 times more likely to be involved in child protection. This was the strongest risk factor. The second strongest risk factor was newborn opioid exposure: children who were exposed to opiates prenatally were 1.5 times more likely to be involved in child protection.

The number of children entering care (that is, children being removed from their homes for their protection) due to parental drug use has increased from about 1,200 in 2012 to about 2,800 in 2016, an increase of 128 percent. Though the data are for all types of drugs, other trends suggest that these increases are due primarily to opioids and methamphetamines.

This problem is particularly prevalent in communities of color and tribal communities in Minnesota. Children from these communities, particularly American Indian children, were disproportionately more likely to have parental drug abuse listed as at least one of the factors contributing to their removal. For example, in 2016, American Indian children were more than 17 times more likely than white children to be removed from their home as a result of parental drug abuse. The chart below shows these trends over the past five years.

Children entering care - drug use as a reason
(per 10,000 children)



Geographical Distinctions

Minnesota is vast state with high geographical areas of rural communities that are not connected to urban centers. Minnesota also recognizes that greater Minnesota and the Twin Cities metro area have different demographics related to opioid use and require different strategies to address service gaps. While the greatest number and rates of misuse and related deaths are in the seven-county metro area, multiple data sources point to high rates of misuse, treatment admissions, and deaths in a few northern Minnesota counties.

- Rural counties of Cass, Clearwater, and Mahnomen Counties have the highest rates of youth prescription drug misuse; school district level data show particularly high rates in the Cass Lake-Bena district, the Waubun-Ogema White Earth district, and the Red Lake district
- Mahnomen and Cass have the highest rates of drug poisoning deaths; Clearwater has the fifth highest rate
- Cass, Clearwater, and Mahnomen Counties are in the top ten highest counties for percentage of treatment admissions involving opioids as the primary substance of abuse
- Prescriptions filled per 100 population were higher in Cass (189), Clearwater (194) and Mahnomen (183) as compared to metro/urban Hennepin (140) or Ramsey: 138

Department of Human Services Response to the Opioid Epidemic

The State of Minnesota is a both a leader and a partner in addressing the opioid epidemic. We're using existing collaborative efforts, and we're forming new collaborations with partners inside and outside of government. Our actions to respond to this epidemic must be well integrated with the work of other organizations and levels of government. This section highlights current leadership and collaboration efforts.

In 2012, the state established a comprehensive, multi-agency plan to tackle substance abuse (including opioid abuse), focusing on prevention, treatment, and recovery services. The agencies that developed the statewide strategy guided their work with shared principles of collaboration, community responsiveness, and competency. An executive sponsors group meets quarterly. The group's membership includes the Commissioners of the Minnesota Department of Human Services (chair), Corrections, Education, Health, Public Safety, Labor and Industry, the Governor's policy advisor, Executive Director of Board of Pharmacy and the State Court Administrator.

In 2014, the National Governors Association selected Minnesota as one of six states to participate in a year-long prescription drug abuse academy. This led to the formation of the State Government Opioid Oversight Project (SOOP) with the Minnesota departments of Human Services, Corrections, Education, Health, Labor and Industry, and Public Safety, the State Judicial Branch, Board of Pharmacy, Board of Medical Practice, Board of Dentistry, Board of Nursing, Board of Podiatric Medicine and Veterinary Medicine. The group meets regularly to coordinate opioid-related activities across state government and reports to the executive sponsors group.

With the coordination and collaboration in place the Department of Human Services has been able to be the lead agency in the following initiatives:

- **Substance Use Disorder Reform:** Starting in 2012, the Department of Human Services has been working to streamline and modernize the substance use disorder treatment system in Minnesota. The system is moving away from a focus on responding to acute episodes to a person-centered model of care, with an emphasis on managing substance use disorder as a chronic disease. In 2017, Governor Dayton and the Minnesota Legislature enacted new reforms, removing barriers to access substance abuse treatment for people who use Medical Assistance. The reform package allows patients to more quickly access services, and it adds important services like withdrawal management, care coordination, and peer support.
- **State Targeted Response to the Opioid Crisis:** In spring 2017, divisions within the Department of Human Services and the Department of Health developed a proposal for a comprehensive response to the opioid epidemic, which would include increased prevention, emergency response, and treatment and recovery programs. This coordinated effort led to the selection of over 30 grantees, who will receive over \$10 million in federal funds over the next two years. The grantees meet to share progress and integrate efforts. This has allowed the state to invest in increasing access to naloxone, improvements to the withdrawal management services, recently released from incarceration, early adoption of enacting new substance use disorder reforms, increasing primary prevention efforts, creation of a opioid focused media campaign and the creation of a hub and spoke model for medication assisted treatment prescribers.
- **Medication-Assisted Treatment expansion grants:** In 2017, Governor Dayton and the Legislature provided \$825,000 for health care providers to purchase direct injectable drugs to treat opioid addiction. Additionally in the fall 2017, the state received \$6 million to expand medication-assisted treatment for the African American community and the American Indian community over three years, working in partnership with tribal governments and healthcare providers.
- **Opioid Prescribing Workgroup:** The Department of Human Services convenes an advisory group of experts through the Opioid Prescribing Improvement Program that have recommended a statewide opioid prescribing protocol, measures for providers, and quality improvement processes for acute, post-acute, and chronic pain. The workgroup consists of medical professionals, consumers, health care and mental health professionals, law enforcement, and representatives of managed care organizations.
- **Increasing integrated care for high-risk pregnancies:** In 2015, Governor Dayton and the Minnesota Legislature passed legislation to support five Minnesota tribes in providing prenatal care for women with opioid use disorder and services for infants, including community supports. In 2017, the state issued additional grants to support work by tribal governments and counties in Greater Minnesota and in the Twin Cities metropolitan area.

Federal Allocations Received for the Opioid Response

The Department of Human Services has been able to address the Opioid crisis in Minnesota with the federal funds from the congressional passage of the 2015 Protecting Our Infants Act, the 2016 Comprehensive Addiction and Recovery Act, The 21st Century Cures Act and through the Substance Abuse Prevention and Treatment Federal Block Grant.

The congressional passage of the 2015 Protecting Our Infants Act allowed Minnesota to begin addressing concerns brought forward by tribal entities with the disparities in the number of American Indian babies born dependent on opiates. Minnesota was able to have numerous community and planning meetings with tribal partners within State agencies identified and has begun addressing a number of specific needs, including: earlier identification of women using opiates during pregnancy; better alignment of systems to address this issue efficiently; access to treatment for these women; and a need for community consensus or agreement about what kinds of treatment are appropriate for this population as a result of the Protecting Our Infants Act.

The 2016 Comprehensive Addiction and Recovery Act (CARA) has allowed Minnesota to expand access to medication assisted treatment through the SAMHSA's Medication Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA). Minnesota received a \$2 million per year, three-year grant was awarded to expand Medication-Assisted Treatment. Minnesota has chosen a multi-prong effort that will be used to increase state capacity for providing medication assisted treatment for opioid use disorder by increasing the availability of office-based opioid treatment and the development of collaborative relationships between behavioral health and substance use disorder providers.

The 21st Century Cures Act funding through the State Targeted Response to the Opioid Crisis Grant funding awarded Minnesota \$16.6 million. Minnesota used the funding to award grants to more than 30 agencies across the state including tribal governments, counties and community organizations in an attempt to curb the runaway epidemic of opioid misuse throughout the state. The grants will supplement ongoing proven effective substance use disorder services across Minnesota, as well as offer new and innovative approaches. The grant activities include expanding medication-assisted treatment, making it easier and faster for people to receive a substance use disorder for treatment services, increasing opioid-specific peer recovery and care coordination, piloting the Parent Child Assistance Program, a peer support program for pre- and post-natal mothers, expanding access to naloxone, a drug that serves as an immediate life-saving antidote to opioid overdose, for opioid treatment programs and emergency medical service teams and launching "Fast-Tracker," a website showing real-time treatment bed availability.

The Substance Abuse Prevention and Treatment Block Grant (SABG), first authorized in 1992, is a vital source of funding for states that accounts for approximately 32 percent of total state substance abuse agency funding. For many people seeking to recover from opioid addiction, this public funding represents the only support for treatment. In addition, the block grant's recent change has resulted in a more flexible structure that enables states to use the funds to address pressing challenges within their communities, such as the opioid crisis.

Recommendations for Additional Federal Support

Minnesota often is ineligible for Federal Grant Allocations due to our rankings in the National Opioid Epidemic, however any life lost to the opioid epidemic is too many. With consideration for support of these recommendations for additional federal support we could prevent any unnecessary deaths:

- Relaxing the IMD restrictions for those with drug treatment in facilities with more than 16 beds Grant waiver approvals to quickly eliminate barriers to treatment resulting from the federal Institutes for Mental Diseases.
- Leveraging Medicaid policy and funding to ensure that substance use disorder providers are not denying access to treatment for individuals receiving medication assisted treatment.
- Increase funding to Indian Health Services to prevent rationing of care so American Indians can receive necessary surgery rather than just IHS having to prescribe for pain.
- Provide federal support to tribal entities that license, certify and regulate professionals and treatment programs on reservation lands to help ensure the development and sustainability of the American Indian workforce and treatment program capacity.
- Centers for Medicare and Medicaid should permit Medicaid reimbursement for traditional cultural supports when used for prevention, treatment and recovery of substance use disorder support. Traditional cultural support is essential to reduce disparities in treatment outcomes, including recognition of traditional healing provided by medicine men/women.
- Assistance in getting an adequate number of medication assisted treatment providers. Congressional action could consider providing stipends, reducing educational costs expanding medication assisted treatment providers. Minnesota encourages your committee's support of the purpose and substance of US HR 3692. US HR 3692 would amend the Controlled Substances Act to allow for additional flexibility with respect to MAT for opioid use disorders. US HR 3692 would revise the definition of qualifying other practitioner to include all APRN roles of certified nurse practitioner, clinical nurse specialist, registered nurse anesthetist, and nurse midwife, and would eliminate the time limitation for these providers to obtain the required waiver to provide MAT October 1, 2021.
- Promote universal substance use disorder screening as best practice for pregnant women.
- Restoration of some power to the Federal Drug Enforcement Agency to ensure enforcement of power over drug distributors and improve multisector data collection and sharing.
- Strengthening or improving mandatory reporting laws to assure that women can seek prenatal care, treatment of their substance use disorders without fear of losing custody of their children.
- Minnesota could utilize congressional action to ensure the costs of Medication Assisted Treatment medications and the costs of overdose prevention medications remain affordable.
- Funding and Resource allocation for culturally-specific programming. The impact, as with the broader opiate epidemic, disproportionately effects certain communities. American Indians and African Americans, in particular, are facing the greatest burdens in programming for the opioid epidemic.
- Require interoperability between electronic health records and state prescription drug monitoring programs.
- States should be given more prevention funding or allow more flexibility to choose prevention services in grant awards. For example, the SAMHSA Opioid State Targeted Response grant awards required that 80 percent of the grant had to be spent on treatment. Minnesota has chosen to spend the remaining 20 percent on prevention.