MILLE LACS BAND OF OJIBWE
Executive Branch of Tribal Government

OVERSIGHT HEARING ON EXAMINING THE TRUE COSTS OF ALCOHOL AND DRUG ABUSE IN NATIVE COMMUNITIES

SENATE COMMITTEE ON INDIAN AFFAIRS

STATEMENT BY CHIEF EXECUTIVE MELANIE BENJAMIN

NON-REMOVABLE MILLE LACS BAND OF OJIBWE INDIANS

JULY 29, 2015

Mr. Chairman and Members of the Committee, as Chief Executive of the MilleLacs Band of Ojibwe, I thank you for allowing me to testify today about the true cost of addiction in our community. The Mille Lacs Band of Ojibwe is located in east-central Minnesota, with 4,462 enrolled tribal members.

Like most tribes, our fight against alcohol addiction has been on-going for more than a century, as a by-product of colonization. In the 1960s, marijuana came into our communities. In the 1980's, crack and meth entered into the fray.

But I am here today to focus my remarks on a family of drugs that has just recently hit our tribal communities in Minnesota, and is claiming as its victims our youngest and most vulnerable band members: **Our babies.**

Minnesota now leads the Nation in babies being born addicted to opiates. It is with profound sadness and concern that I report that my community, the Mille Lacs Band of Ojibwe, is among the hardest hit in Minnesota. In my January 2015 State of the Band Address, I had the difficult task of informing our tribal members that babies born addicted to opiates is now the single greatest threat to the future of the Mille Lacs Band of Ojibwe.

The State of Minnesota Health Commissioner Lucinda Jesson reports that in Minnesota, treatment admissions for heroin addiction have doubled over the last five years, and this epidemic disproportionately impacts Native Americans in Minnesota. **Minnesota ranks first among all states in deaths due to drug poisoning among American Indians of all ages.** [i]

The focus of this hearing is the cost of addiction. The opiate crisis has exploded in Minnesota, Mr. Chairman, and is so new that there is a great deal of information we do not yet know. I want to clarify that when I refer to "opiates", I am referring to the prescription drugs Vicodin, Oxycontin, Percoset, Morphine and codeine. Each of these is a pathway to the street drug heroin, also an opiate.

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I will begin by sharing what little we do know:

- Nearly 100% of heroin addicts report that their addiction began with a legal prescription from a doctor for one of these drugs.
- Of babies born addicted to opiates in Minnesota, **more than 28% are Native American babies,** even though we only comprise about **2% of the state population.**
- Of these opiate-addicted Indian babies, **78% are born in rural Minnesota**, which means this is largely an out-state, reservation problem.
- American Indian women **are 8.7 times more likely than non-Indians** to be diagnosed with opiate dependency or abuse during pregnancy than non-Indians.
- **57% of these women have a legal opiate prescription given to them by a physician for pain, even throughout pregnancy!** [ii]

The Mille Lacs Band has commissioned a study with a national laboratory examining how our tribal members metabolize various substances. The first phase of this research has been completed, and preliminary results appear to show that the majority of Mille Lacs Band Members sampled are very rapid metabolizers of many addictive drugs. What this means is that when these drugs are prescribed for pain management, they may hit the system of a rapid metabolizer must more quickly, causing more intense and immediate physical sensations, but these drugs also run through the body much more quickly. This rapid metabolizing can result in the pain returning much sooner than it would for someone who is not a rapid metabolizer, thereby causing a person to need more of the drug more often in order to control the pain. This, Mr. Chairman, is how the seeds are planted for opiate addiction.

Methadone clinics, which are intended to treat opiate addiction, have also had a devastating impact on Native Americans in northern Minnesota. For several years, Minnesota tribal officials expressed alarm over practices of the Lake Superior Treatment Center, the only methadone clinic operating in northeastern Minnesota. This clinic was well known among opiate users to disperse methadone very liberally and with little patient oversight or follow-up care, largely driven by profits. Much of the methadone dispersed from this clinic was eventually sold illegally in tribal communities.

Finally, in response to alarms raised by tribal officials after methadone-related deaths of 11 American Indian patients and others, the Minnesota Department of Human Services launched an investigation and revoked the clinic's license in September 2012 after finding 50 violations during an inspection that summer. An additional 22 violations were found in 2014; yet this clinic continued to operate while appealing the decision. It is finally scheduled to close this summer. [iii]

While the National Institute of Health and the Centers for Disease Control both describe methadone as the most effective treatment for opiate addiction, we doubt that studies on drug efficacy included Native Americans and certainly did not include Mille Lacs Band Members. Again, our preliminary evidence from our own laboratory study indicates

that **methadone is s also metabolized very rapidly by Mille Lacs Band Members,** making it a drug with heightened risk for addiction for our community.

This Committee is particularly interested in costs, and we do know some of the short-term costs. When babies are born addicted to opiates and go through withdrawal, this is called "Neo-Natal Abstinence Syndrome", or "NAS". What these NAS babies go through is horrifying, including pain, seizures, rapid breathing, sweating, trembling, vomiting, diarrhea, slow weight gain and they are at high risk of pre-mature birth and sudden infant death syndrome.

On average, the medical cost of caring for one newborn going through withdrawal averaged $30,000 in 2013 for an average stay of 15 days in neonatal intensive care. Last year, there were approximately 260 Native American NAS babies born in Minnesota, costing approximately $7.8 million dollars in medical care immediately after birth, 77.6% of which was attributed to state Medicaid programs. [iv]

But the costs don't stop there when withdrawal is finally over. Most often, these babies must be placed in foster care until the mother is able to care for her child. But when the baby is removed, **all the other children in the home are removed as well.**

Mr. Chairman, every reservation in Minnesota is facing a crisis of out-of-home placement of Native children. We simply do not have enough Native foster families on or off reservation to take in these high numbers of children, nor do we have enough resources. It is hard for our staff to not wonder, *"What good is the Indian Child Welfare Act when we have no Indian homes left to place these kids in?"*

We also lack critical information about the long-term medical and educational costs for these babies through their lifetime. Anecdotally, we are hearing from providers and early childhood specialists that these children appear to have similar symptoms as children with Fetal Alcohol Syndrome, but their medical issues might be far more complex, including higher rates of cerebral palsy and other serious physical medical complications.

This committee has done many hearings on Fetal Alcohol Syndrome, and has documented that government spending can average $2 million over the lifetime of a child born with FAS. Until we get more data, we must assume that the cost of providing care to these children will be very similar to FAS babies.

Mr. Chairman, we need your help in addressing this crisis. I have some recommendations that I respectfully request you consider.

1. **We need research about this crisis.** We must know more about the long-term impacts of newborn opiate addiction, but we need help. The tribes in Minnesota have joined forces and our providers are working together to share data, but we are in urgent need of research. Either a federal agency needs to study this issue or a federal grant should be provided to a research entity to conduct the study. With our preliminary research I referenced earlier, it is critical that any research done must be specific to Native Americans

due to the strong possibility that many Native people beyond the Mille Lacs Band of Ojibwe might also metabolize these drugs differently than the majority population.

2. Tribes in Minnesota are in urgent need of support for a culturally-based in-patient treatment facility for expectant Native women. Over the years, this Committee has done an excellent job of documenting that traditional 12-step programs are ineffective for Native people without a very strong cultural component that is specific to American Indian spirituality and identity. Currently, the only program like this in Minnesota has just 21 beds, and is located in Brainerd, MN. At Mille Lacs alone, we had more than 21 babies born with NAS in 2014. The Band is currently in discussions with the State of Minnesota and considering purchasing this facility and expanding it to 56 beds. Even with the expansion, however, this will barely make a dent in the need at Mille Lacs alone; there are 10 other tribes in Minnesota which face the same crisis as we do.

3. Because there will never be enough beds, we also need support for a culturally-sensitive out-patient treatment program targeted toward expectant Native women. Project Child is an out-patient program operating in Hennepin County that has shown promising results, and has been discussed with regard to replicating it for Native American women with a Native American focus on culture, identity and spirituality. State officials estimate that offering a similar program targeted toward Native American women might cost $272,000 in the first two years, but they also predict it would generate "at least $1.3 million in savings in the ensuing two years by eliminating prolonged state-funded hospital stays for infants suffering from opiate exposure." [v] In the first nine months of 2013, Project Child served 124 women and "all but one or two gave birth "free of chemicals," found stable housing, completed long-term support programs, and maintained custody of their children", according to its program director, Tom Turner. The Mille Lacs Band Health and Human Services Department [vi]

4. We need the state and federal government to make and enforce severe consequences for those physicians over-prescribing opiates to Native Americans. In the late 1800's, Indian people and children were devastated by small pox after being given blankets infested with the disease. **Mr. Chairman, opiates are our 21st century version of smallpox blankets.** It is inexcusable and even criminal for any physician to prescribe drugs like Vicodin to teenagers with depression, but it happens every day. Opiates are extremely dangerous drugs, yet they are prescribed for such minor ailments as sore ankles and tooth-aches; conditions that could be effectively treated with ibuprofen or acetaminophen.

Mr. Chairman, we need the medical community and the pharmaceutical companies to step up and police themselves, and if they will not, then you must. Physicians also routinely prescribe more medication than is necessary to elderly people; these excess medications are guaranteed to end up in the hands of those with opiate addictions.

At the request of Governor Mark Dayton, the State of Minnesota has included in his 2015 legislative proposal the formation fo a community-based Opiod Prescribing

Workgroup (OPWG) to make recommendations regarding educational resources for providers. They are also charged with developing a system for notifying Minnesota Health Care Plan providers whose practices fall outside recommended quality controls, and dis-enrolling providers who practices are "so consistently extreme" that they warrant dis-enrollment. [vii] This will not address non-MHCP providers, however. We need federal standards to address over-prescription of medications to Native American patients and suggest the Indian Health Service be requested to begin working on these standards with tribal providers.

I would be remiss if I did not mention one more systemic issue that directly impacts opiate addiction and over-prescription to Native people in Minnesota. In 2014, the Minnesota Department of Health released a report entitled "Advancing Health Equity: A Report to the Legislature". This report directly identified of Minnesota structural racism as a key factor in health inequities by race in Minnesota, specifically referencing that American Indian babies have twice the mortality rate of white babies. The report states:

> **"Structural Racism -- the normalization of historical, cultural, institutional and interpersonal dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians — is rarely talked about. Revealing where structural racism is operating and where its effects are being felt is essential for figuring out where policies and programs can make the greatest improvements."** [viii]

Mr. Chairman, tackling structural racism as it is embedded throughout our state policies and systems is overwhelming to think about, because often it is invisible to everyone but those whom it impacts. Yet as Native people, we know structural racism exists and see it every day. In Minnesota, state agencies are being encouraged to examine their policies and try to identify where structural racism may exist in invisible ways, but impacting the health outcomes for Native people and communities of color. But that is a problem that will take decades to solve, and frankly, our children don't have the luxury of time to wait.

I want to close with a note about what tribes in Minnesota are doing together to combat the opiate crisis. Last summer, the Minnesota Indian Affairs Council (MIAC) under the leadership of our President Kevin Leecy (Bois Forte) held a statewide Summit on the crisis facing Native children. Our health and human service directors came together with elected tribal leaders to convey the magnitude of this crisis and work together toward solutions. Many county and state officials were also involved, and committed to partnering to face this crisis.

On May 28, the Mille Lacs Band hosted the MIAC's second state-wide summit, where several of the recommendations in my testimony today were developed. We will continue to meet and partner with the State where possible to combat this terrible epidemic.

I also want to note that we are also fighting this issue on the front lines in our communities and our families. I am including as an appendix a report from our

Commissioner Samuel Moose, of the Mille Lacs Band Health and Human Services Department, which was prepared as an internal roadmap for doing what we can do address this crisis as a tribe. [ix]

Finally, we are not just looking to government to solve these issues. We know that as community and family members, we must learn how to identify and prevent addiction in our loved ones and help them get the help they need. The Mille Lacs Band held our own two-day conference for Band Members on this topic on April 1, 2015. At this conference, we had community dialogue about strategies for confronting opiate use among our family members, and getting treatment and help for our loved ones whom we fear have become victims of opiate addiction.

The sooner a young woman gets help, the greater her chances are of delivering a healthy baby. We know this is not just a government responsibility, but a personal responsibility each of us has to our family members.

Mr. Chairman, in Anishinaabe culture, we always say that we look ahead seven generations. Right now, we are living in fear about the impact of this problem on the generation that is being born today. I am hoping that, with your help, we can do something about this crisis immediately, before we lose a generation.

Thank you for this opportunity to testify, and I look forward to answering any questions you might have.

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[i] 2016-17 Revised Biennial Budget, Human Services, March 2015. Appendix 1.
[ii] DHS Commissioner Lucinda Jesson letter to Secretary Burwell, April 23, 2015
[iii] http://www.twincities.com/localnews/ci_28416912/methadone-clinic-operating-without-license-close-duluth
[iv] https://www.minnpost.com/mental-health-addiction/2014/02/pregnant-and-addicted-awful-burden-carry
[v] http://www.startribune.com/minnesota-comes-to-the-aid-of-opioid-exposed-babies/295105051/
[vi] https://www.minnpost.com/mental-health-addiction/2014/02/pregnant-and-addicted-awful-burden-carry
[vii] DHS Commissioner Lucinda Jesson letter to Secretary Burwell, April 23, 2015
[viii] Advancing Health Equity in Minnesota: A Report to the Legislature, Feb 1, 2014.
http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf
[ix] Opiate Crisis: A Community Response for Health and Human Services, Commissioner Samuel Moose,

OPIATE CRISIS:

A Community Response from Health and Human Services

Abstract

The Mille Lacs Band is facing an epidemic of drug abuse that Chief Executive Melanie Benjamin has called "the single greatest threat to the future of the Mille Lacs Band of Ojibwe." This paper outlines a series of steps coordinated by the Mille Lacs Band of Ojibwe Department of Health and Human Services. The approach will address community needs from a variety of perspectives to address the impact of opiates.

Samuel Moose, Commissioner

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Executive Summary

The Mille Lacs Band is facing an epidemic of drug abuse that Chief Executive Melanie Benjamin has called "the single greatest threat to the future of the Mille Lacs Band of Ojibwe." This problem does not just affect the users; innocent newborns are also facing the effects. In recent months the Band has learned that American Indian babies are 8.7 times more likely than white babies to be born with Neonatal Abstinence Syndrome (NAS), and that 28 percent of Minnesota babies born with NAS are born to Indian mothers. The Mille Lacs Band is among the hardest hit communities in the state. The extent of the opiate problem at Mille Lacs is further evidenced by increased drug related arrests, increases in medical calls to tribal police, and increases in out-of-home placements due to opiate-related issues.

This paper outlines a series of steps coordinated by the Mille Lacs Band of Ojibwe Department of Health and Human Services. The approach will address community needs from a variety of perspectives to address the impact of opiates.

Background and History

The Mille Lacs Band has approximately 4,462 members. The Mille Lacs Reservation consists of three districts, the most populous of which is District I. More than 1,400 Band members live in District I. Districts II and IIA are near the cities of McGregor and Isle with a population of 359 members total. District III, near the city of Hinckley, has 555 members. Most of the remaining Band members live throughout Minnesota and the United States. The MLBO service area population is approximately 51% of the total 4,462 Mille Lacs Band membership.

Issues related to health and wellness are common themes for the Mille Lacs Band of Ojibwe communities. Unfortunately, this population leads just about every category of health disparities, including alcohol and drug abuse and addiction and resulting out-of-home placements. Child Welfare services and out=of-home placement have seen an increase in the past year. Many tribal members are raising grandchildren or their siblings' children, in order to keep their family together.

Over the course of several decades, the community has seen a recurring cycle of chemical use and abuse, beginning with alcohol and moving to cocaine, methamphetamines, and opiates. During recent years, Band members who have become addicted to prescription

opioid painkillers have turned to heroin because it is cheaper and more readily available. Tribal police data also show that methamphetamine abuse is still common in the area.

The blame for this cycle of addiction falls largely on historical trauma suffered by generations of Mille Lacs Band members who experienced violence, broken treaties, forced relocation, assimilation, racism and discrimination. This trauma has resulted in broken families and suffering individuals who have turned to alcohol and other drugs out of hopelessness and pain.

The Mille Lacs Band already operates behavioral health and maternal-child health programs that address drug and alcohol dependency and strive to increase healthy birth outcomes. The Behavioral Health department of HHS offers mental health and chemical dependency assessments and counseling, as well as prevention and support programs. The Public Health Department offers prenatal and postpartum visits, family planning, childbirth education, tobacco cessation and health promotion. Unfortunately, the prevalence of neonatal abstinence syndrome indicates that these programs have not been adequate to keep women and children safe. More needs to be done to ensure that pregnant women remain chemical free and that Mille Lacs Band children are given the healthiest possible start.

Six Initiatives

While many of the causes of drug and alcohol dependency are known, the solutions are much harder to pinpoint. What is clear, however, is that a multi-dimensional problem requires a multi-pronged solution. After consultation with elders, experts and other tribes, the Mille Lacs Band's Health and Human Services Department has arrived at a six-pronged strategy to address the problem and help the community move in a healthy direction.

The initiatives in the process of implementation are as follows:

- Creation of a Neonatal Drug Use Response Team
- Development of a recovery-oriented care system
- Strengthening of outpatient services
- Exploration of new residential treatment options
- Expansion of women's and children's programs
- Enhancement of existing prevention programs and collaborations

I. Neonatal Drug Use Response Team

A multidisciplinary team of professionals is needed to respond urgently when it is reported that a pregnant woman or newborn infant tests positive for opioids or other drugs. This team will provide a collaborative approach and wraparound services to stop the drug use, treat the symptoms, and prevent relapse through ongoing support.

The team consists of a public health nurse, a chemical dependency counselor, and a social worker to help provide support and intervention.

If the team is informed through county child protective services that a pregnant woman or newborn tests positive for drugs, the team will provide timely assessments for chemical dependency treatment and help mothers access treatment immediately. The team will also assess other types of support they may need to remain clean during pregnancy and afterwards. The team will coordinate prenatal care and follow the mother throughout pregnancy and beyond, providing support both to the mother and to the child. The team will be led by an Licensed Alcohol and Drug Counselor due to the focus being on accessing treatment and recovery based services. Each mother will have a case plan developed that addresses

The team will collaborate closely with our MLBO partners in housing, law enforcement, tribal courts, health services, law enforcement and other departments. Additionally the team will develop strong collaborative relationships with county partners who will coordinate needed services that the MBLO systems are unable to access currently.

II. Recovery-oriented care

People enter the care system from various points, so coordination of care is often lacking. A times, services lose track of those in need of care during transitional periods, like going to or returning home from inpatient treatment. It is critical that mothers and their families have access to a system that helps to keep them engaged as they move through the continuum of services.

A team of case managers is being developed to work with people from their initial assessment through all levels of care. Case managers will maintain contact with those who are going away to treatment and reestablish face-to-face contact when they get home.

A true recovery-oriented system engages peer supports. Until a system of peer support is developed, professionals or paraprofessionals will provide that support.

III. Strengthening outpatient services:

Holes in services need to be filled to strengthen existing programs. Individuals returning from treatment may face homelessness, unsafe environments, lack of peer and family support, and lack of financial resources to maintain sobriety.

Outpatient services in all three districts will be revised or created to provide flexibility and full integration of mental health and chemical health treatment services so care is coordinated and addresses all the individual's needs. Support services will also be individualized to treat each person's specific recovery needs.

IV. Residential treatment options

Residential treatment in Minnesota has been in the process of changing to meet the evolving demands of clients and the ever-changing climate of drug and alcohol use and abuse. Over the past several years Mille Lacs Band of Ojibwe officials, employees and members have discussed the need for an inpatient or residential treatment component that meets the direct needs of community members. Residential treatment options vary and decisions need to be made that identify key community needs for the Mille Lacs Band.

Based on community needs, HHS is pursuing a number of options to develop a facility that provides a residential treatment option for Mille Lacs Band members. The program will be rooted in Anishinaabe culture and utilize our spiritual heritage to provide a foundation for recovery for our community members.

The establishment of this program needs to be fiscally responsible and sustainable for it to be an effective tool for members to access for the long term.

V. A program for women and children

Historically, addiction treatment services have struggled to meet the needs of pregnant and parenting women. Treatment programs have often taken mothers out of the home and moved children to foster care in an attempt to stabilize the mother.

Over the past 10-15 years, a movement has developed to provide addiction treatment services that allow women to live with their children in a supportive residential environment while they begin their recovery journey. This kind of family-centered treatment resonates with the MLBO values of maintaining family relationships and support, and it strives to meet the needs of mothers and their children in treating addiction as a disease that impacts the entire family.

The Mille Lacs Band's Health and Human Services Department is developing a Family Healing Center project that enables women to have access to residential addiction and mental health services and continue to live with their children. The department is working to identify a site that can provide a housing option as well as accommodate the needs for mothers and children to access recovery support, child care services and the professional counseling and therapeutic care necessary to build a solid family-based recovery foundation.

VI. Prevention, harm reduction and community-based intervention efforts.

The Mille Lacs Band Health and Human Services will focus available and appropriate financial and staffing resources toward prevention of the spread of addiction problems and to community-based campaigns that address efforts to minimize the impact of drug use.

a. The MLBO will develop media and marketing campaigns that present messages designed to prevent youth from turning to experimentation, provide clear education about the dangers of drug use, educate women about the dangers of use during pregnancy and appropriate strengths-based messages designed to engage youth in positive activities, values and cultural connections.
b. The MLBO Health and Human Services Department will collaborate with other agencies to establish access to naloxone for families and law enforcement first responders to have ready access to intervene on overdose incidents
c. HHS will coordinate sharing of information with the Community Development department to ensure that drug issues within the housing department are communicated clearly to HHS departments that can help families.
d. HHS will propose a drink tax expansion to include Eddy's and other sites from Corporate Ventures as a source of revenue to support treatment, intervention and prevention services.
e. HHS will collaborate with Tribal Police to communicate and engage individuals in getting help and understanding services available.

Minnesota Department of **Human Services**

April 23, 2015

Sylvia M. Burwell
Secretary of Health and Human Services
Washington, D.C. 20201

Dear Secretary Burwell:

I am writing on behalf of Governor Mark Dayton. Thank you for the opportunity to inform your office of Minnesota's planning efforts to reduce the injury and mortality associated with prescription and illicit opioid use and overdose. The Minnesota Department of Human Services (DHS) in conjunction with the National Governors Association and the Minnesota State Substance Abuse Strategy, which includes the Departments of Health, Education, Public Safety, and Corrections as well as the state judicial branch and the Minnesota Board of Pharmacy, has developed a robust approach to reduce access to prescription opioids, increase access to naloxone and expand medication-assisted treatment.

In 2015, Minnesota is experiencing unique public health tragedies as a result of the over-prescribing of opioid pain relievers and the availability of heroin in our communities:

- Minnesota ranked first among all states in deaths due to drug poisoning among American Indians/Alaska Natives.
- Approximately 3,000 Minnesota Health Care Plan (MHCP) enrollees become chronic opioid users annually.
- Of the new chronic users, over 80 percent have a recent diagnosis of mental illness, substance abuse disorder, or both mental illness and substance abuse disorder, each of which make it more likely that a person will become opioid dependent.
- More than half of pregnant Minnesota women who are known to be opioid dependent are still prescribed opioids for pain during pregnancy.
- The number of fetuses exposed to illegal or prescription drugs disproportionately impacts American Indians in Minnesota. The rate of prescribed opioids for pain during pregnancy is twice as high among American Indians then among other Minnesotans.

Overprescribing Opioid Pain Relievers - In response to inappropriate opioid prescribing, the governor's 2015 legislative proposal recommends the following:

- Formation of a community-based Opioid Prescribing Work Group (OPWG) to recommend protocols that address all phases of the opioid prescribing cycle, such as prescribing for acute and chronic pain

and the period in between. The OPWG will make its recommendations to the commissioners of health and of human services.

- Developing educational resources and messages for providers about communicating with patients about pain and using opioids to treat pain.
- Providers not enrolled in MHCP may voluntarily use the OPWG's recommendations to improve their opioid providing practices.
- DHS will notify MHCP-enrolled providers whose practices fall outside recommended quality improvement thresholds. These providers will be required to submit plans in order to bring their practices into alignment with community-developed standards.
- DHS will dis-enroll MHCP providers whose practices are so consistently extreme that they meet OPWG recommended opioid disenrollment thresholds.

Results:

Within four years of implementing the recommendations, DHS anticipates that our state will see:

- Fewer deaths attributed to prescription opioid overuse.
- A decline in substance abuse disorder related to prescribed opioids.
- A decline in opioid overuse, particularly for treatment of chronic pain, and among populations with disparate rates of opioid overuse.
- A reduction in the incidence of fetuses exposed to prescription drugs.

The State Opioid Oversight Project - At the request of the Office of Governor Mark Dayton, the Chemical and Mental Health Services and Health Care Administrations of DHS along with the MDH, the DHS Office of the Inspector General, the Board of Pharmacy, and the Department of Public Safety are participating in the yearlong National Governors Association prescription drug abuse summit, are working together to provide a state opioid oversight project which will oversee seven multi-agency focus areas addressing the spectrum of challenges from prevention to treatment of opioid abuse. The State Opioid Oversight Project will report to the Minnesota State Substance Abuse Strategy Executive Sponsors to ensure that all parties are able to reduce the impact of opioid dependence among Minnesotans while appropriately managing pain.

The State Opioid Oversight Project is organized to best address the complex issues of opioid use and abuse. SOOP has developed these focus areas to tackle opioid use and abuse from every angle. This project will allow us to reduce the consequences associated with prescription drug abuse and increase the awareness of this important issue within our communities. The approach will address prescription drug abuse with a recovery oriented systems of care (ROSC) philosophy and will incorporate a person centered approach that builds on the strengths of community to improve the quality of life for the individual, family member and communities.

The State Opioid Oversight Project is focusing on seven targeted focus areas:

1) Neonatal Abstinence Syndrome
2) Medication Assisted Treatment
3) Opioid Prescribing
4) Prescription Monitoring Program
5) Increasing Access to Naloxone
6) Prevention/Awareness
7) Increasing Prescription Take Back Opportunities

Neonatal Exposure to Opioid Medications - In response to the burgeoning problem of opioid related neonatal exposure use disorder, the governor's 2015 legislative proposal recommends the following:

- Grant funds to support the provision of targeted integrated services for pregnant mothers who are at high risk of adverse birth outcomes due to either maternal opioid use or prematurity/low birth weight in geographically identified areas of high need.
- Support for planning, system development and integration of medical, substance use disorder and social services for women within target areas.
- Integration of community-based paraprofessionals such as doulas and community health workers, as a routinely available service component.
- Systematized screening, collaborative care planning, referral, and follow up for behavioral and social risks known to be associated with poor birth outcomes.

In addition to the governor's legislative recommendations, the Department of Human Services established the neonatal abstinence policy academy workgroup to address the impact of opioid addiction on Native American women of child-bearing age. The three priorities of the workgroup are to develop education materials for provider and community members on neonatal abstinence syndrome, develop a culturally-based treatment model across the spectrum of prevention, treatment and recovery, and to encourage substance use screening for all pregnant women and subsequent referral for treatment services, if necessary.

The Alcohol and Drug Abuse Division in the Department of Human Services supports specialized women's treatment services with grant funding. These grants provide treatment support and recovery services for pregnant and parenting women who have substance use disorders. With enhanced services, families can access additional recovery supports, meet their basic needs of daily living, address mental and physical health needs and obtain parenting support to increase family stability.

Increasing Access to Naloxone – In 2014, the Minnesota legislature passed a bill that is referred to as "Steve's Law," which increases the availability of naloxone and provides some Good Samaritan protections. The intent is to increase both the availability of overdose reversal medications as well as decrease the fear of contacting law enforcement/first responders in an overdose situation by granting limited immunity to the caller. Wider distribution of emergency use naloxone will reduce mortality among individuals using illicit opioids.

The State Opioid Oversight Project will target its efforts to increase the availability of naloxone for needle-exchange clinics, law enforcement, and emergency responders and for prescribing it with opiate prescriptions until it is available over the counter. The project recognizes that the price of naloxone has continued to double since last year which can cause a financial burden to states trying to expand the availability. The project also recognizes there is much work to be done within law enforcement to reduce the resistance from law enforcement to carry naloxone.

Expanding Medication Assisted Treatment – The State Opioid Oversight Project recognizes that individuals need treatment, but access to treatment has not kept up with the demand. The increase in individuals using and abusing prescription drugs has led to increased need for addiction treatment and recovery resources. Traditionally, the Minnesota model of addiction treatment excludes medication assisted therapies. Nearly 90% of Minnesota treatment programs still use a 12-step, abstinence-based treatment, which is ineffective for some patients with opioid dependence. The availability of medication-assisted treatments is scarce in relation to the demand particularly in rural Minnesota, as

troubled methadone-clinics are in danger of closing and the primary care community has not yet engaged to meet the need with offering buprenorphine-based treatments.

As we develop strategies to add medication assisted treatments to specialty addiction programs and in primary care settings, we will also integrate this evidence-based treatment into a comprehensive, modernized model of care. We believe that treatment can be offered in a variety of clinical settings and the opportunity to recover is enhanced with peer support, care coordination and long-term care.

The Minnesota Department of Human Services will continue to support the strategies deployed through your office and welcomes the opportunity to collaborate in order to stop the unnecessary death and suffering associated with opioid use.

Thank you for considering these comments.

Sincerely,

Lucinda E. Jesson
Commissioner

Change Item: Opioid Prescribing Improvement and Monitoring Program

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	54	(21)	(21)	(21)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	54	(21)	(21)	(21)
FTEs	1.5	1.5	1.5	1.5

Request:

Effective July 1, 2015, the Governor recommends the implementation of a community-based, collaborative approach to reduce inappropriate opioid analgesia prescribing within the Medical Assistance (MA) program. This proposal has a general fund cost of $33,000 in the FY2016-17 biennium and a savings of $42,000 in the 2018-19 biennium.

Rationale/Background:

At any given time, there are approximately 19,000 chronic opioid users in Minnesota's public programs. Based on 2011 data, approximately 3,000 MHCP enrollees become new chronic opioid users each year. Of the new chronic users, over 80% have mental illness; current or a history of substance abuse; or both substance use and mental illness.

Within the data is a marked racial disparity. Preliminary data show a doubling of the rate of neonatal abstinence syndrome over the past five years. The crisis disproportionately impacts newborns from the American Indian nations located in Minnesota. In 2010, Minnesota ranked first among all states when measuring the age-adjusted disparity rate ratio (DRR) of deaths due to drug poisoning among American Indians/Alaska Natives relative to Whites (out of 13 states for which data are available) and of Blacks relative to Whites (out of 36 states for which data are available). The age-adjusted rate of death due to drug poisoning was more than four times greater among American Indians/Alaska Natives relative to Whites and nearly two times greater among African Americans/Blacks relative to Whites.

In 2012 DHS' Health Services Advisory Council (HSAC) formed an ad hoc Emergency Department (ED) utilization work group (ED work group) charged with recommending one or more approaches for improving ED care while also reducing costs. The ED work group chose to focus its efforts on improving opioid-related prescribing practices within the ED. The ED work group comprised representatives

- HSAC
- health plans
- hospitals and health systems
- emergency medical professionals (both rural and metro-based)
- emergency medical responders
- MN Community Measurement
- Institute for Clinical Systems Improvement (ICSI).

The work group developed collaborative recommendations that built on the best of their respective, individual efforts to curtail inappropriate prescribing within EDs. The group's recommended protocols would form the basis for the emergency department setting-specific protocols described in this proposal.

Proposal:

This proposal calls for the following:

1. Endorsement and development of prescribing protocols that address all phases of the opioid prescribing cycle (prescribing for acute pain, prescribing in the time after the immediate acute event, and prescribing for chronic pain). Protocols will be developed in collaboration with the community and under contract with an organization identified through a Request for Proposal process. The protocols will differentiate between opioids prescribed in emergency settings and those prescribed in other outpatient settings.

2. Development of sentinel measures of the quality of opioid prescribing (such the duration and type of opioids prescribed for non-malignant acute or chronic pain for patients).
3. Development of consistent messages and other educational resources for prescribing providers about communicating with patients about pain management and use of opioids to treat pain.
4. Development of a data feedback system to providers that will
    a. annually collect and report to providers their sentinel measures compared to their anonymized peers
    b. attribute individual providers to one or more provider groups with which they are affiliated or employed. DHS will develop mechanisms for attribution in consultation with the provider community.
5. Outlier providers will be identified based on criteria developed by the provider community. Individual, outlier prescribers will be notified, as will any practice group with which the provider is affiliated or employed. Any identifiable information about a provider or practice group will be considered protected for peer-review, quality improvement purposes, unless the provider or practice group's enrollment in MHCP is temporarily or permanently restricted or the provider or practice group is disenrolled.
6. Practice groups together with their outlier provider(s) will submit plans for quality improvement for review and approval by the Commissioner, with the objective of bringing their providing practices into alignment with the community-developed standards described in paragraph 1.
7. If any individual or groups remain outliers for two or more years, whether or not consecutive, the Commissioner may take any or all of the following steps:
    a. Monitoring performance more frequently than annually and/or monitoring more aspects of prescribing practices than the sentinel community measures
    b. Requiring additional quality improvement efforts, including but not limited to mandatory use of the Minnesota Prescription Monitoring Program
    c. Temporarily or permanently restricting the individual provider's enrollment in MHCP.
    d. Temporarily or permanently restricting the provider group's enrollment in MHCP
    e. Disenrollment of the individual provider
    f. Disenrollment of the practice group and of individual providers affiliated with or employed by the practice group

Within one year expected outcomes include better data and understanding of opioid prescribing and use within MHCP and a more coherent set of expectations for improved prescribing practices among providers who provide care to MHCP recipients.

Within four years DHS anticipates

1. Fewer deaths attributed to prescription opioid overuse;
2. A decline in opioid use overall, particularly for treatment of chronic pain and particularly among populations with disparately high rates; and
3. Reduced incidence of neonatal abstinence syndrome, particularly in populations with disparately high rates.

One-time contracting costs total $250,000.The program will also require 1 FTE with significant policy expertise in opioid prescribing and the treatment of pain. It will also require 0.5 FTE for a research scientist to provide data and analytics support.

This proposal will result in cost offsets that will include savings due to reduced spending on prescription opioids, reduced conversion of acute pain patients to chronic opioid users, reduced rates of conversion of prescription opioid use to dependence on prescribed opioids or heroin, and prevention of other medical complications of opioid dependence, including HIV and Hepatitis C.

Results:

This proposal will result in a decrease in the percentage of MHCP recipients receiving opioid prescriptions and a decrease in the overall volume of opioids prescribed as measured by total days supply.

Statutory Change(s):

M.S section 152.126 – Prescription Monitoring Program

Advancing Health Equity in Minnesota

Report to the Legislature

MINNESOTA MDH DEPARTMENT OF HEALTH
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February 2014

Advancing Health Equity in Minnesota: Report to the Legislature

February 1, 2014

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As requested by Minnesota Statute 3.197: This report cost approximately $18,859 to prepare, including staff time, printing and mailing expenses.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

February 1, 2014

Dear Legislators:

It is a great privilege to present this report on Advancing Health Equity in Minnesota. The growing economic inequities and the persistence of health disparities in our great state are a matter of life and death for many. Communities across the state are being devastated by high rates of infant mortality, diabetes, suicide, and more. Multiple efforts have been made to try to close the significant gaps in health outcomes across populations, but essentially we have been running in place.

This report reveals that:

- Even where health outcomes have improved overall, as in infant mortality rates, the disparities in these outcomes remain unchanged: American Indian and African American babies are still dying at twice the rate of white babies.
- Inequities in social and economic factors are the key contributors to health disparities and ultimately are what need to change if health equity is to be advanced.
- Structural racism — the normalization of historical, cultural, institutional and interpersonal dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians — is rarely talked about. Revealing where structural racism is operating and where its effects are being felt is essential for figuring out where policies and programs can make the greatest improvements.
- Improving the health of those experiencing the greatest inequities will result in improved health for all.

In the process leading to the release of this report, hundreds of critical conversations took place. Relationships were strengthened, new leaders emerged and important tensions, challenges and resistance were uncovered. Individuals and organizations from both the community and the health department made invaluable contributions to this report, sharing evidence of the devastating effects of health inequities throughout the state as well as examples of what can be done to improve health for all. Although we were not able to include every example of the heath inequities or effective strategies shared with us, the passion of many for addressing health disparities and advancing health equity was evident in the process of compiling this work.

It is our hope that this report will provide a much-needed foundation for building on the work to eliminate health disparities and ultimately achieve health equity for all people in Minnesota.

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