DEPARTMENT OF HUMAN SERVICES

Minnesota State Targeted Response to the Opioid Crisis

Project Narrative

April 2017

Contents

Abstract:

The Minnesota Department of Human Services, Alcohol and Drug Abuse Division (Single State Authority) proposes a comprehensive Minnesota State Targeted Response to the Opioid Crisis ("MN Opioid STR"). This proposal reflects collaborative planning efforts between The Minnesota Department of Human Services Alcohol and Drug Abuse Division, Health Care Administration and Office of Indian Policy along with the Minnesota Department of Health (MDH). The proposed MN Opioid STR expedites opioid treatment and recovery resources (Minnesota's Model of Care approach) and supports integration of services at each point in the continuum (e.g. behavioral treatment and Office Based Opioid Treatment (OBOT)/(MAT) Medication Assisted Treatment). In 2015, 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 16 states for which data are available) and Blacks relative to Whites (out of 38 states for which data are available). The MN Opioid STR is a comprehensive effort that recognizes urgent need to provide immediate response for the following target populations: American Indian; African American; Women/Pregnant Mothers and infants with Neonatal Abstinence Syndrome. 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. For prevention efforts, Minnesota draws upon the Strategic Prevention Framework (SPF) to guide planning and implementation of activities. Proposed activities include: Increasing access to "Rule 25" assessments and expediting access to treatment for Minnesotans experiencing opioid use disorder; increasing opioid-specific peer recovery and care coordination specialists; piloting of Parent Child Assistance Program (PCAP) peer mentoring for pre- and post-natal support of mothers experiencing opioid use disorder and infants with Neonatal Abstinence Syndrome (NAS); expanding Office Based Opioid Treatment/Medication Assisted Treatment (OBOT/MAT) in both the number of providers and their geographic reach, supported by launch of an Opioid-focused Minnesota Project ECHO (Extension for Community Healthcare Outcomes); Expanded access to naloxone for Opioid Treatment Programs and Emergency Medical Service (EMS) teams; Implementation of a statewide media campaign that expedites access to treatment resources through web-based tools such as an opioid-treatment "Fast-Tracker" and an Opioid Prescribing Improvement Program: Prescriber Education Campaign. Minnesota expects to serve 109,852 individuals in the State of Minnesota through the proposed MN Opioid STR. Measurable outcomes include reducing the number of opioid related deaths overall and reducing disparities for identified target populations, increasing retention in care, reducing opioid misuse for all age groups, increasing opioid-specific treatment and recovery services options and geographic locations throughout the State of Minnesota.

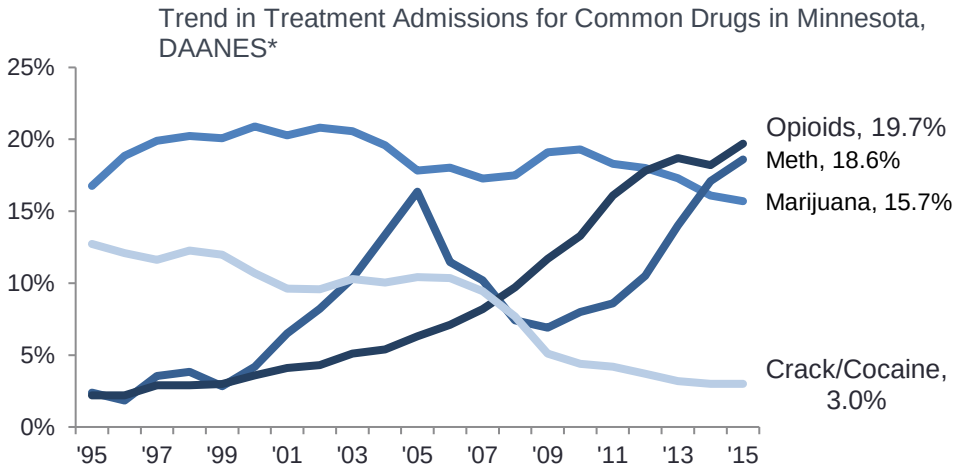
Section A: Population of Focus and Statement of Need

A.1 Communities of Focus at Highest Risk of Opioid Use Disorder

The opioid epidemic our country is experiencing is killing Minnesotans at an alarming and increasing rate. In 2008, less than ten Minnesotans died from heroin overdose, but by 2015 that number grew to 115. When added to the additional 216 overdose deaths that year attributed to prescription opioids, the Minnesota Department of Health cited 572 deaths by drug overdose for 2015. Overall, men are trending more drug overdose deaths than women with 964 vs. 651 from in 2013-2015. (MN death certificate data). And while no area of the state has gone unaffected, in the metro area middle-age adults (45-54) have the highest rates of death by drug overdose, whereas in greater Minnesota, adults ages 35-44 and 45-54 share this distinction. (Drug overdose deaths among Minnesota residents, 2000-2015, Minnesota Department of Health, 2015) In addition, discussed under disparities, American Indians, African Americans, women, pregnant mothers and infants with Neonatal Abstinence Syndrome (NAS) are experiencing OUD at alarming rates. The need for the support provided by the MN Opioid STR grant is urgent. Not yet published data from the Minnesota Department of Health tell us that the total number of drug overdose deaths for the first half of 2016 was 327. That is 15% higher than the first half of 2015, which was 285. Men continue to have a higher number of drug overdose deaths, and individuals 25-34 years old had the greatest number of drug overdose deaths for the first half of 2016, which, if this continues, will be a change as 45-54 year olds have had the highest number of drug overdose deaths. Heroin and fentanyl involved deaths are also higher for the first half of 2016 than 2015, although opioid pain relievers are still the drug most often involved in drug overdose deaths.

In addition to increased deaths, Minnesota has seen a significant increase in the number of treatment admissions for opioid use disorder, and recently opioids surpassed marijuana as the second most frequently cited primary substance of abuse by individuals admitted to treatment in the state, second only to alcohol.

Table I- Trends in Treatment Admissions for Common Drugs in Minnesota



Source: Minnesota's Drug and Alcohol Abuse Normative Evaluation System (DAANES) * *Approximately 48% of total admission episodes indicate alcohol as the primary substance. Other drugs shown are a portion of the overall total, which includes alcohol.*

Environmental and Co-Occurring Experiences of Minnesotans with Opioid Use Disorder:

To turn the tide of this opioid epidemic from high rates of usage, overdose and death to health, wellness and recovery, Minnesota recognizes that we must take into consideration the complex interplay of co-occurring experiences among opioid use disorder (OUD) populations to inform our comprehensive response. Effective approaches to recovery require that we see the whole person when we design treatment options and that we consider not only physical, but also psychological pain that may underlay a person's experience of opioid addiction. In many cases, multiple forms of substance use interplay in the lives of individual with OUD. To address opioid usage through a comprehensive approach requires providing treatment options for co-occurring forms of substance use disorder and providing bio-psycho-social wellness and recovery support. Minnesota has population-based data that supports a comprehensive approach that includes expediting access to peer support, care coordination and nicotine cessation treatment services, along with expedited access to broader substance use disorder and medication-assisted treatment.

Minnesota utilizes web-based Drug and Alcohol Abuse Normative Evaluation System (DAANES) to collect client surveillance information from both detoxification and substance use disorder treatment providers. DAANES collects data specific to "referral source" in both detoxification and SUD treatment. Focusing on 'referral source' seems to indicate that OUD detox clients vary significantly from the overall treatment population in the following ways:

- 38.0% of SUD treatment admissions list the primary referral as "criminal justice", while only 17.5% of OUD Detox clients list law enforcement as the primary referral source.
- 24.0% of SUD treatment admissions list the primary referral as "County social service agency" while only 4.6% of OUD detox clients list this as a referral source.
- The primary referral source most often cited (36.8%) by OUD clients was "self".

While an in-depth analysis has not been completed, it could be interpreted that people with Opioid Use Disorder (OUD) entering detox programs tend to have far less 'personal support' than the overall Substance Use Disorder treatment populations. It could be interpreted that the alignment and collaboration of law enforcement/criminal justice and social service agency assistance and guidance positively contributed to treatment admission. In addition, of people admitted for substance use disorder treatment during Minnesota State fiscal years 2014-2016, where opioid was the primary substance for admission, 83% identified as having co-occurring nicotine usage (of 29,018 total admissions for opioid use, 24,163 identified as smokers).

Table II- Current Smoking Activity for Heroin & Other Opioid SUD Admissions by State Fiscal Year

Table II	**SFY2014**	**SFY2014**	**SFY2015**	**SFY2015**	**SFY2016**	**SFY 2016**	**Total**	**Total**
Heroin & other opioids	Count	%	Count	%	Count	%	Count	%
Smoker	7,406	82.6	8,057	82.8	8,700	84.3	24,163	83.3
Non-smoker	1,558	17.4	1,675	17.2	1,625	15.7	4,855	16.7
Total	8,964	100.0	9,732	100.0	10,325	100.0	29,018	100.0

Source: Minnesota Department of Human Services, ADAD, DAANES (1/31/2017)

Minnesota Disparities: Opioid drug overdose and death rates provide us with a road map to understand which populations are most vulnerable in this epidemic. In 2015, 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 16 states for which data are available) and Blacks relative to Whites (out of 38 states for which data are available). The age-adjusted rate (AAR) of death due to drug poisoning was more than four times greater among American Indians/Alaska Natives relative to Whites (DRR: 4.6; AAR: 47.3) and two times greater among African Americans/Blacks relative to Whites (DRR: 2.0; AAR: 20.5). In the same year, 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 an important racial disparity. Addressing these extreme disparities is a priority for Minnesota's Opioid STR.

American Indian Communities

The urgent need to reach American Indian communities is supported though numerous data sources. It is notable that in 2015 Census data, although American Indians made up an estimated 1.1% of the state's population, they made up 15.8% 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 (CDC)
- 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) (2009-2012 MN Health Care Programs)
- Have the highest rates of adult prescription drug misuse and the second highest rates of youth prescription drug abuse (2015 MN Survey of Adult Substance Use-MNSASU)

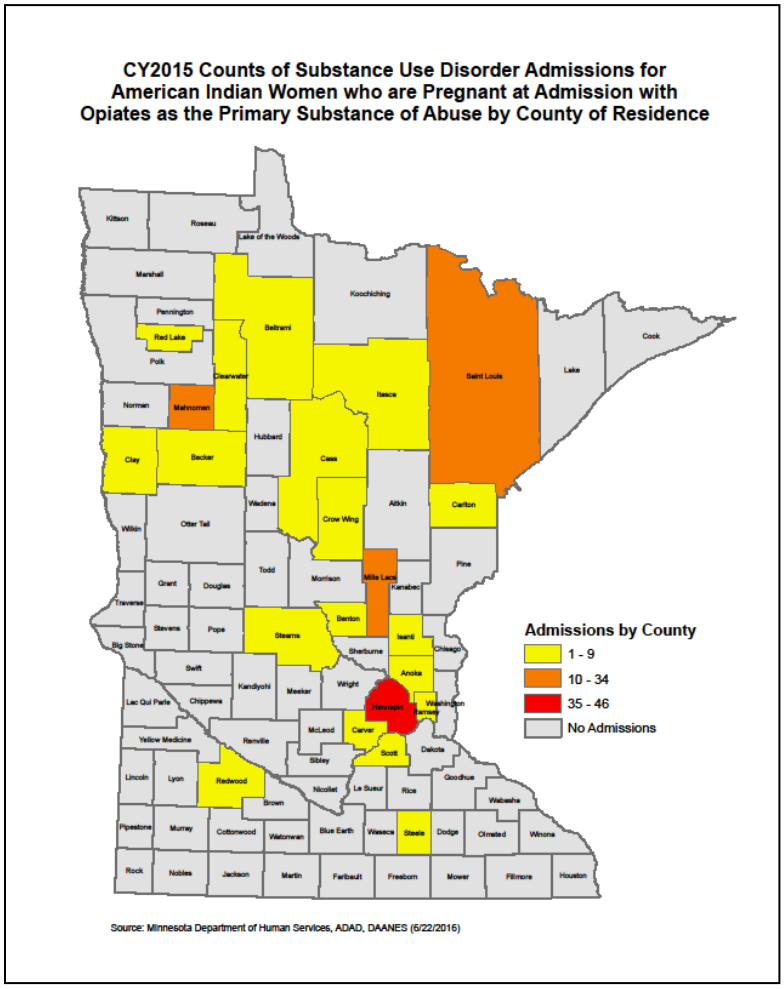
- Are most likely to identify opioids as the primary substance of abuse when admitted to treatment, as compared to other races/ethnicities (2015 DAANES)
- Among both youth and adults are least likely to perceive great or moderate risk of harm from prescription drug misuse (2016 MN Student Survey-MSS and 2015 MNSASU)

African American Communities

While 2015 Census data estimated that 5.8% of Minnesota populations are African American (non-Hispanic), African Americans made up 10.1% 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.
- African American Minnesotans are the second largest incarcerated population (34.6%) compared to whites (53%) and American Indians (8.8%). (2013 Minnesota Department of Corrections Adult Inmate Profile).

Women, Pregnant Mothers and Neonatal Abstinence Syndrome



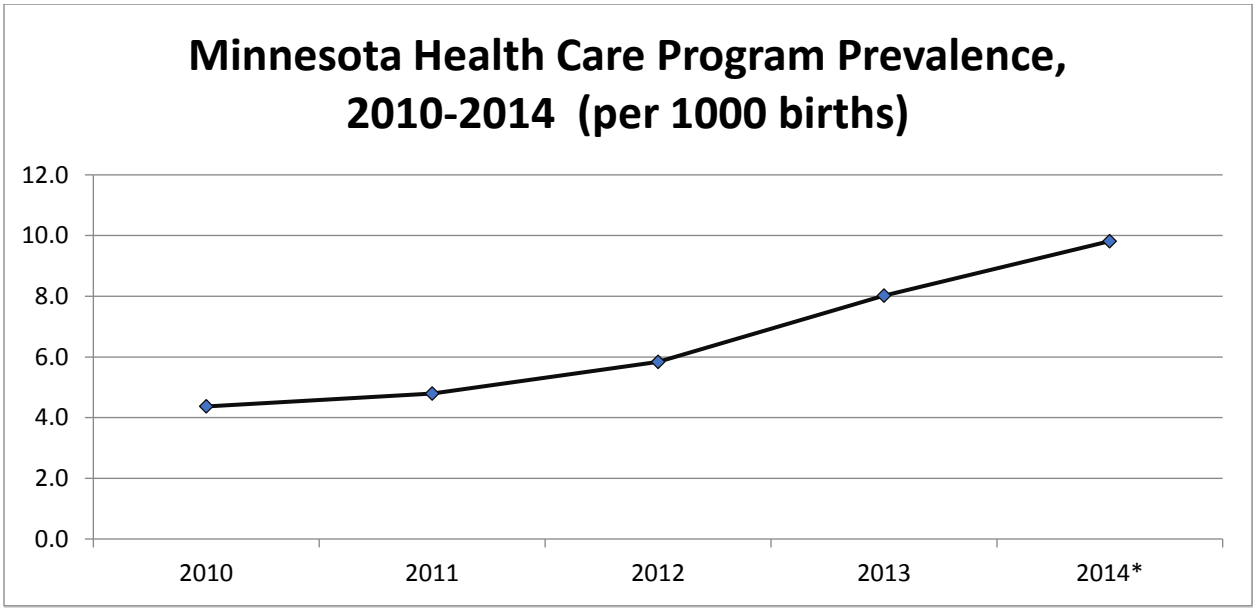
According to the 2013 and 2014 National Surveys on Drug Use and Health (NSDUH), Minnesota adults ages 18-25 were among the most likely to report past year non-medical use of pain relievers.

- Female adolescents are slightly more likely than males to report past month prescription drug misuse: 5.0% vs. 4.5% (2016 MSS)
- Women are more likely to be admitted to treatment for opioids as their primary substance of abuse: 21.7% vs. 13.0%; Native American women even more so: 44.7% (2015 DAANES)
- The prematurity rate among NAS newborns with NAS was 26%, compared to 11% of newborns without NAS. In addition, 25% of mothers of newborns with NAS previously had 3 or more viable pregnancies; this compares to 17% of mothers without children with NAS who had this many previous viable pregnancies

Further, data on maternal opiate dependency and Neonatal Abstinence Syndrome (NAS) point to concerning social and economic costs. According to data from the CDC, some 48,000 women died of prescription pain reliever overdoses between 1999 and 2010. Minnesota Medicaid claims data on maternal opiate dependency and infant NAS diagnosis show that these doubled from 2009 to 2012. As well, from Minnesota Medicaid data, it is known that five areas, on or adjacent to American Indian Reservations in the northern part of the state, show very high rates of prenatal maternal opiate use

(White Earth, Red Lake, Leech Lake, Mille Lacs, and Fond du Lac). These areas have shown an average rate of prenatal maternal opiate use of 9.8%, compared to the statewide average of 1.5% for all Medicaid-covered births. (Note: Minnesota tribal data uses "prenatal maternal opiate use" as the indicator. Prenatal maternal opiate use consists of births where *either* the newborn had NAS *or* the mother had a prenatal diagnosis of OUD. Not all NAS newborns had a mother diagnosed prenatally with OUD, and not all pregnant women with OUD give birth to newborns with NAS. It yields a higher rate than NAS alone, and better reflects the true picture of opiate exposure in pregnancy.)

Table III- Prevalence of Infants with NAS Minnesota Health Care Program 2010-2014 (Medicaid Statewide Data, Reported February 12, 2015)



Calendar Year	# of MHCP Infants with a dx of NAS in CY	Estimated number of MHCP Financed Births	# of Infants with dx of NAS per 1,000 live births
2010	131	29,991	4.4
2011	142	29,623	4.8
2012	175	30,004	5.8
2013	240	29,933	8.0
2014*	264	26,896	9.8

Note:
- Rates are estimates.
- *Data from CY 2014 are preliminary.
- Managed Care Encounter data is considered 95% complete 5 months after service date.

Geographic-Specific Approaches

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 (2016 MSS)
- Mahnomen and Cass have the highest rates of drug poisoning deaths; Clearwater has the fifth highest rate (2014 NVSS, CDC)
- 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 (2015 DAANES)
- 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 (2015 MN PMP)

A.2 Access, Service Use, and Outcomes for Focus Populations

In January 2017, Minnesota's governor's budget proposed a comprehensive reform of the substance use treatment delivery systems that is currently being considered with the MN Legislature. Through a process that was launched in 2012, this reform is the result of years of work and community, participant and provider input. The package of reforms, referred to as "Minnesota's Model of Care," is expected to be approved in this legislative session and would be fully implemented by late 2018, early 2019. For people experiencing opioid use disorder, this MN Opioid STR grant will make opioid-specific Minnesota Model of Care treatment and recovery services immediately available to opioid users in 2017, two years prior to full implementation of the model for all Minnesotan's experiencing substance use disorder. Within the framework of Minnesota's Model of Care, through the State Targeted Response to the Opioid Crisis Minnesota would expedite opioid-specific direct access to treatment, peer support, care coordination, and access to Medication Assisted Treatment (MAT). Several recent reforms in Minnesota will also provide a comprehensive recovery approach for the proposed opioid-specific Model of Care. In 2014 Minnesota enacted "Steve's Law," a Good Samaritan law that equips first responders with naloxone to reverse overdoses and also provides immunity for people who call 911, even if they may be users themselves. In addition, as Minnesota implements system-wide substance use treatment reform, in 2015 Minnesota implemented a positive supports rule requiring all providers to use positive supports (strength-bases strategies) in place of restrictive interventions or punitive practices.

The sum total of these reforms and laws promise to improve treatment and recovery supports for all Minnesotans experiencing substance use disorder. However, the full scope of implementation of these services remains a gap until these services are passed into law and then approved for Medicaid billing and are not currently available for response to immediate needs of Minnesotans impacted by opioid epidemic.

Expedited Access to Treatment, Comprehensive Assessment, Care Coordination and Peer Support:

In January 2017, the Governor's biennial budget proposal was introduced to the state's legislature. The proposal includes a comprehensive reform of the state's substance use disorder treatment delivery system, including adding new services to the state's Medicaid benefit set and establishing a streamlined person-centered process for directly and quickly accessing treatment services.

Following a multi-year implementation process, the reformed model of care for SUD in the state is projected to be fully operational on July 1, 2019, although most new services are expected to be Medicaid reimbursable by July 1, 2018. Funds available from this MN Opioid STR grant offer Minnesota the opportunity for early implementation of many functions of the model of care through state award of grant funds to providers who are postured to immediately provide the new services for individuals with opioid use disorder. The grants to programs would be able to sustain these services until the projected Medicaid approval is obtained in July 2018. Within the framework of Minnesota's Model of Care, through the MN Opioid STR grant, individuals would be offered expedited and direct access to Medicaid covered treatment for opioid use disorder, (Opiate Treatment Program-OTP, OBOT and behavioral support treatment services), and ongoing recovery support through grant-funded peer support and care coordination services (which are presently not in the Medicaid benefit set for substance use disorder).

The sum total of these reforms and laws promises to improve the quality and effectiveness of treatment and recovery supports for all Minnesotans experiencing substance use disorder. Unfortunately, until the enhanced access process and new services are passed into law and approved for Medicaid reimbursement, they are not available for an immediate response to the urgent needs of Minnesotans absorbing the impact of the opioid epidemic. However, early implementation of some components of the model of care is possible within an opioid-specific strategy supported by the MN Opioid STR grant. The proposed early implementation, targeted to individuals with OUD, would support an expedited process to access treatment, and permit the state to reimburse programs positioned to provide care coordination and peer recovery support services to individuals with opioid use disorder, both immediately and throughout the interim until Minnesota obtains approval from the Centers for Medicare and Medicaid for statewide implementation of the access process and new services.

Access to Treatment and Comprehensive Assessment

The current process for accessing publically funded SUD treatment requires an individual to first go to their county, tribal authority or managed care organization for a "Rule 25 assessment." This Rule 25 assessment is not part of an individual's treatment, rather, it is a prescribed tool whose only functions are the determinations of what type and intensity level of treatment service is authorized and which particular treatment program the individual is approved to attend. The process allows 30 days from an individual's request for an assessment until approval of services must be made. Once approved, depending on program capacity, the wait for admission could be even longer. In addition to the delays permitted in the current access process, it is of critical note that for individuals with OUD who access detox services, maximum length stays in detox often create a gap in time where a person has completed withdrawal services, but has not yet accessed a Rule 25 assessment or been approved for treatment services. There is a clear and urgent need for expedited access to treatment services in these circumstances, and a pressing need for safe harbor arrangements when treatment admission cannot occur immediately.

Peer Support and Care Coordination

As well, peer-support and care coordination for substance use disorder are not yet Medicaid reimbursable services in Minnesota. Minnesota proposes to leverage the opportunity presented by the MN Opioid STR grant to address these service gaps for people with OUD as part of the immediate, comprehensive response to the opioid epidemic, while continuing its ongoing effort toward full implementation of Minnesota's Model of Care reforms so that these treatment services will be sustainable at the end of the MN Opioid STR grant.

Expedited implementation of opioid-specific peer support and care coordination will allow for access to these services and expansion of Minnesota's workforce toward opioid-specific recovery services. Through MN Opioid STR funds, opioid-specific peer support and care coordination will be available to people experiencing OUD, whether or not they choose to enter a formal treatment environment. These services will be funded to be provided by Recovery Community Organizations and SUD treatment and detoxification programs. Peer support and care coordination services will be available for people with OUD in detox settings and before, during and after participation in a treatment program. In making these opioid-specific services available in 2017, Minnesota will be providing a bridge between detox or crisis settings (such as medical interventions for overdose) and long term treatment options in substance use disorder and medication assisted treatment settings. For people with OUD who choose not to enter treatment, opioid-specific peer support and care coordination will be available and will be reviewed for utilization to consider how grant dollars are focused on year two of the grant.

Through a Request for Proposal (RFP) process Minnesota Department of Human Services will select treatment providers and American Indian tribal entities who have the ability to effectively and efficiently provide assessment, care coordination and peer recovery services in regions of Minnesota where opioid misuse and related harms are most prevalent. In addition, to reduce the incidence of opioid overdose, detoxification sites located in regions of OUD high-need will be selected by the RFP process to provide transition services of care coordination and peer supports to bridge the gap in service from detox to treatment initiation, and in some cases, room and board to provide safe harbor in the interim.

The DAANES client surveillance system collects data for both licensed treatment and licensed detoxification programs. For the identified sub-grantee detoxification program, the state will analyze client detox admission and discharge data and corresponding SUD treatment admission and treatment data to gauge the effectiveness of the services delivered.

Office-Based Opioid Treatment/Medication Assisted Treatment Services

Minnesota has multiple prevention strategies, including an opioid prescribing improvement program. The bulk of Minnesota's medical treatment programs are Opioid Treatment Programs (OTPs), which employ primarily methadone and which are insufficiently distributed geographically. There are relatively few buprenorphine-waivered prescribers in Minnesota who are taking patients. Building workforce capacity and knowledge is needed to support clinics as they launch their medication-assisted treatment practices to treat OUD, dramatically extending the reach of Minnesota's few addiction medicine specialists.

Additionally, in 2015 Minnesota had over 10,000 treatment admissions for heroin (6485) and other opiates (3,777). Of these, 34.4% were admitted into OTPs and 65.6% were admitted into abstinence-based treatment programs (State Fiscal Year 2015, Minnesota Department of Human Services, ADAD,

DAANES). While OTP models may be adequate for individuals with co-occurring conditions or with more complex factors, we do not have a viable model for the provision of Medication Assisted Treatment (MAT) in primary care/office based settings. As Office Based Opioid Treatment (OBOT) is being developed, we must also develop an effective triage and treatment mechanism to assure individuals with OUD are connected with appropriate MAT and behavioral health resources.

Related to this, Minnesota's need for improving access to telehealth to address OUD stems from multiple factors:

- Thirteen of our 87 counties, including ten outside of the urban core, have opioid admission rates of over 7/1000 residents.
- Of the 10,000 opioid treatment admissions, 1,704 are for members of our American Indian community who live primarily in rural areas.
- Minnesota has 25 physicians certified by the American Board of Addiction Medicine, and Minnesota ASAM membership is 61, however some are fellows and may not be practicing. At present Minnesota sees lack of addiction treatment physicians as a critical gap to respond to the current opioid epidemic.
- Minnesota has 150 Buprenorphine waivered physicians on the SAMHSA locator site. Unfortunately, the majority of the waivered physicians in the state choose not to publicly report their participation via the SAMHSA web site.
- While Minnesota has a robust system of behavioral health providers of substance use disorder (SUD) treatment, cross training and communication between SUD treatment providers and OBOT providers is a growth area in the state. A barrier to collaboration between SUD treatment and OBOT providers is that some behavioral support programs are philosophically opposed to MAT as they consider themselves abstinence-based programs, and they do not view MAT as consistent with an abstinence approach. Other programs cite concerns created when an individual on MAT participates in behavioral support services, such as when an individual's dosage might not be properly titrated and safety issues are created, or symptoms of this are visible to other program participants. To get a snapshot of the extent of this barrier, the Minnesota Department of Human Services is mid-process gathering information with the "Barriers to Treatment Survey," which asks substance use disorder and mental health providers for information related to hard to serve populations. While the survey is not yet completed, 50% of 453 respondents replied that they do not serve people "…currently on medication assisted treatment for substance use disorder."

Minnesota is well positioned for expansion of medication-assisted treatment options for people experiencing OUD. Minnesota's 2013 National Survey of Substance Abuse Treatment Services (N-SSATS) indicated 35% utilization of "pharmacotherapies" in treatment programs and Minnesota's DANNES shows increased medication-therapies provided. Despite interest among providers and physicians, Minnesota is a large state with geographic and workforce barriers to high quality, evidence based, culturally sensitive MAT based treatment. A telehealth-supported infrastructure is an important part of the solution. Through Minnesota's proposed strategy to expand OBOT settings and create a Minnesota ECHO (Extension for Community Healthcare Outcomes) infrastructure we hope to increase connections, collaborations and integration of primary care & SUD treatment sites. This collaborative effort promises to support Minnesotans experiencing OUD in accessing immediate, integrated and holistic care in keeping with SAMHSA's guidance that "when treating SUDs, a combination of medication and behavioral therapies is the most effective." (SAMHSA July 11, 2014 Informational Bulletin)

Pre- and Post-Natal Treatment and Recovery Support

Women in Minnesota covered by Medicaid who give birth to newborns with Neo-natal Abstinence Syndrome (NAS) are much more likely to have not received any prenatal care—6.3% vs 0.5% of all other pregnancies (approximately 80% of all NAS-related pregnancies are covered by Medicaid). In addition, another 27.5% of such mothers of infants with NAS received inadequate prenatal care, compared to 13.5% of pregnancies not affected by NAS. For American Indian Medicaid pregnancies resulting in newborns with NAS, 11.5% received no prenatal care, and additionally 39.5% received inadequate care. In only 30% of Medicaid-covered pregnancies resulting in NAS did the mother receive Medication Assisted Treatment—either methadone or buprenorphine. However, 55% of pregnant women with a prenatal diagnosis of OUD also received prescribed opiate analgesics, compared to 15% of pregnant women without this diagnosis.

The large disparity in opiate-exposed pregnancies is manifest in the American Indian community, where rates of NAS and maternal opiate use are 7 to 8 times greater than in the white population. In addition, large disparities exist in Minnesota regarding foster care placements. American Indian children are 10 times more likely and African Americans are 4 times more likely to be put in out-of-home placement than whites. Most of these placements involve identified parental substance use.

In Minnesota, there is a lack of public health care program policy and financing infrastructure to recognize and support the role of highly specialized paraprofessionals such as peer specialists for pregnant mothers experiencing opioid use disorder who are cross-trained in pre- and post-natal support. The use of peer support for pregnant women and new mothers is a strategy Minnesota hopes to implement to reduce these health disparities. According to the Agency for Health Care Research and Quality, best practices around disparity reduction efforts should focus on reducing fragmentation in health care systems, improving awareness on the part of health care providers of these problems, strengthening culturally competent approaches to the delivery of health care, and increasing the diversity of the health care workforce. A core component in recommendations to address healthcare disparities is the involvement of the community: specifically, the involvement of paraprofessionals within collaborating service delivery systems.

Naloxone Distribution

Minnesota's gap in naloxone distribution is a result of a multitude of issues some of them stemming from a lack of education, training capacity in rural versus urban Minnesota, and availability. In Minnesota there remains some stigma attached to distribution of naloxone with some misinformation that the availability of naloxone gives the false security to overdosing that keeps individuals from seeking treatment or will perpetuate the issues addiction behaviors bring to the community. Funds allocated for education outreach and awareness are essential to begin providing widespread education that naloxone is like any other life-saving drug that requires follow-up and ongoing care and should be coupled with warm referrals to additional care.

Minnesota is vast state with high geographical areas of rural communities that are not connected to urban centers. Because of the compensation of our state urban training and distribution of naloxone is easily available. However, as you move farther away from the urban centers of our state, naloxone distribution and training is sparse. Our grant funded non-profits have struggled to provide training resources to rural Minnesota, either because of lack of their local training resources to travel to provide the training or rural family members not having the knowledge of whom to reach out to for naloxone

kits and training. With the grant funds our grantees will be able to locate to increase their capacity by partnering with additional trainers located outside of the urban area.

The Minnesota Medicaid program covers naloxone, however it is not unusual for an individual or family member to attempt to fill a prescription at their pharmacy to find out the product is not carried. At the same time we know that "quickly responding to an opioid overdose with the lifesaving reversal drug naloxone is critical. Expanding access to naloxone for first responders and individuals likely to witness an overdose and training health care providers to prescribe naloxone to at-risk patients are essential actions to reverse the epidemic" (*Opioid Epidemic: By the Numbers*, HHS, June 2016)**.** With the rising cost coupled with the shelf-life of naloxone pharmacies are not stocking naloxone. These grant funds will help immediately address these barriers in rural Minnesota as we look for sustainable options to continue efforts beyond the grant period through our strategic planning process.

The limited grant funding by the Minnesota Department of Health to Emergency Medical System has allowed for the training and distribution of naloxone to the first responders in Minnesota, which has predominately ensured rural access to this lifesaving drug. These funds have been essential in getting Minnesota's 200 full time widely distributed Violent Crime (drug and gang) Enforcement Investigators trained in the administration of naloxone and carrying a kit of naloxone when on duty. This has been essential not only in ensuring officer safety as they are processing a scene with the uptick in opioid synthetics but when they enter a scene to investigate and find an individual in an overdose or the individual swallows their supply, the officers are all trained to immediately provide naloxone. With additional funds we would continue to fund this important partnership that has also served as a turning point for officers to accept naloxone as just a tool in their toolkit.

Recently Incarcerated People

Through a statewide "Barrier to Treatment" survey currently being conducted by Minnesota Department of Human Services, 188 out of 453 respondents (44%) replied that they do not serve people who typically experience barriers to accessing chemical dependency of mental health due to history of felonies, level 1-3 sexual offenses or other predatory offenses. Minnesota plans to provide opioid-specific treatment and recovery support for people recently release from incarceration, with particular attention to people who have committed these categories of offenses.

Reaching High-Risk Communities through Prevention

Currently the Minnesota Strategic Prevention Framework Prescription Drug Project has funding from SAMHSA to work with one community under the SPF Rx grant. Minnesota proposes to fund a second or third community using funds made available through SAMHA's "State Targeted Response to the Opioid Crisis" Grant program. The selection of the second or third community in this process will require review of available data specific to prescription opioid misuse rates and heroin use and abuse in Minnesota. The approach to addressing the problem will be the application of the Strategic Prevention Framework (SPF).

In addition, in September 2016, the Centers for Disease Control (CDC) concurred with the Minnesota Department of Heath that Minnesota is at risk for increase in viral hepatitis or HIV infections due to injection drug use. Therefore, one aspect of Minnesota's prevention strategy includes needle exchange.

A3. Nature of the OUD problem, including currently available resources and service gaps.

Yet to be published recent data from the Minnesota Department of Health indicates that Minnesota's opioid-related deaths continued to rise is 2016 with a 15% increase in than the first half of 2015 (n = 285). Opioid pain relievers are still the drug most often involved in drug overdose deaths in Minnesota; heroin and fentanyl involved deaths are also higher for the first half of 2016 than 2015. Men continued to have a higher number of drug overdose deaths. In addition, American Indians, African Americans, women, pregnant mothers and infants with Neonatal Abstinence Syndrome (NAS) are experiencing Opioid Use Disorder (OUD) at alarming rates. Risk factors for opioid related deaths identified by the World Health Organization (WHO), inform Minnesota's strategy and response to the opioid crisis. These risk factors include: "People with opioid dependence, in particular following reduced tolerance (following detoxification, release from incarceration, cessation of treatment); people who inject opioids; people who use prescription opioids, in particular those taking higher doses; people who use opioids in combination with other sedating substances; people who use opioids and have medical conditions such as HIV, liver or lung disease or suffer from depression; household members of people in possession of opioids (including prescription opioids)." (November, 2014, World Health Organization Information Sheet on Opioid Overdose, Opioid Overdose Information Sheet Website link)

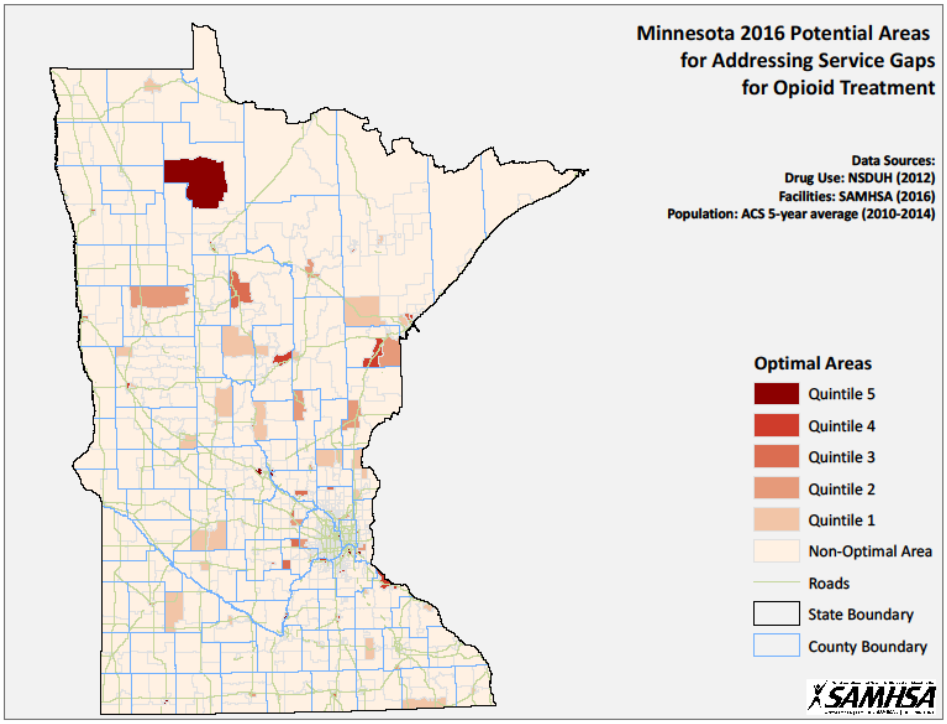
In addition, reviewing SAMHSA's "Minnesota 2016 Potential Areas for Addressing Service Gaps for Opioid Treatment, provided by as an additive point of reference to inform Minnesota's MN Opioid STR strategy, confirmed several geographic and population specific gap areas outlined in sections A1 and A2. This highlights in particular the vulnerability of Minnesota's American Indian Tribes. (See Table IV. Comparison of SAMHSA Map and Minnesota Reservation Locations).

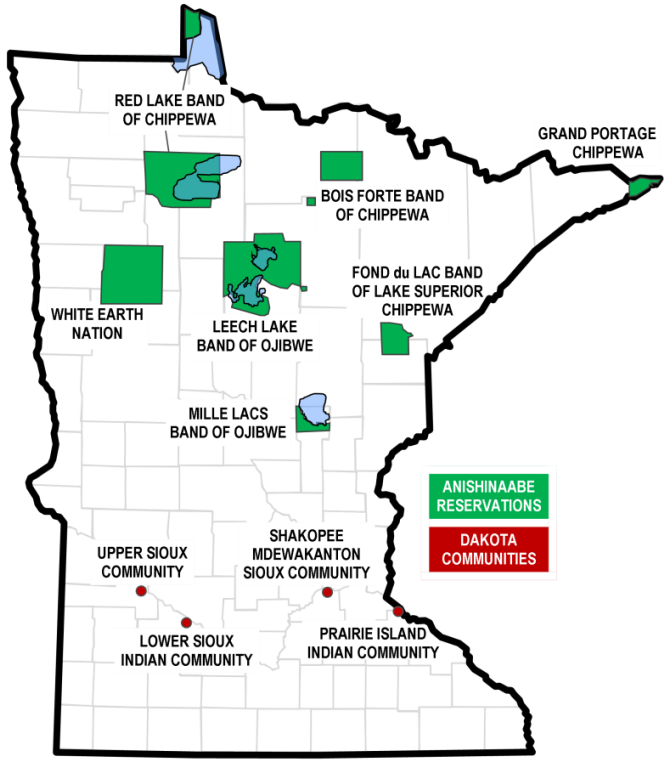
Section B. Proposed Implementation Approach

B1. Purpose of the proposed project, including its goals and measureable objectives.

Minnesota recognizes that the opioid epidemic requires a coordinated response between medical, public health, and Substance Use Disorder (SUD) treatment systems. The opioid epidemic requires "not only addressing how we manage pain, but also how we support communities and people in addressing the root causes of substance abuse, which go far beyond the individual person, specific substance or distinct community" (Drug Overdose Deaths Among Minnesota).

Table IV- Service Gaps for Opioid Treatment & Minnesota Reservation Lands





Residents, 2000-2015. *Department of Health,* 4). Solutions require ongoing response from multiple stakeholders including: federal and tribal governments, local public health, opioid prescribers, medical, mental health, and substance abuse treatment systems, and patients, families and communities. This proposal for MN Opioid STR funds builds on ongoing coordination between Minnesota Department of Human Services Alcohol and Drug Abuse Division and the Health Care Administration and the Minnesota Department of Health. The proposed project represents a continuum of strategies that incorporates primary prevention activities and blends medical interventions, public health and substance use treatment approaches to reach vulnerable Minnesotans quickly and to promote recovery.

The purpose of Minnesota's proposed MN Opioid STR strategy is to reach people experiencing opioid use disorder with life-saving treatment resources quickly to reduce use of opioids and deaths from opioid overdose and to prevent opioid use disorder in Minnesota's most vulnerable communities. To accomplish this goal, Minnesota's proposal facilitates improved collaborative integrated care between opioid treatment programs (OTPs), office based opioid treatment (OBOT), Emergency Departments (EDs), pain clinics, Behavioral Health Homes (BHH), Certified Community Behavioral Health Clinics (CCBHCs), community detoxification sites and specialty substance use disorder treatment, care coordinators and recovery community organizations (RCOs).

Current Minnesota Department of Human Services Identified Priorities

1. Overdose prevention via providing naloxone.
2. Provide expedited access to treatment assessments, care coordination and peer support.
3. Increasing state capacity for providing medication assisted treatment for opioid use disorder. Including increasing availability of office based opioid treatment and supporting the development of an infrastructure in the state for collaborative relationships between behavioral health and Substance Use Disorder (SUD) treatment.
4. Primary prevention efforts
5. Statewide media campaign for primary prevention and by expanding our Know the Dangers website to include opioids.

Needs Assessment: Data for this needs assessment is drawn from a variety of credible sources that concentrate on indicators related to opioid use/misuse. Launched in 2006 and funded through the Minnesota Department of Human Services, Alcohol and Drug Abuse Division (ADAD), the Minnesota State Epidemiological Outcomes Workgroup (SEOW) provides content expertise and guidance for Minnesota's current opioid-related needs assessment. SEOW is collaborative effort whose mission is to examine and synthesize available data related to Alcohol, Tobacco and Other Drug (ATOD) use, consequences, risk and protective factors. Various state agencies and community partners share data resources that provide an epidemiologic profile of communities. Data indicators focus on the youth and adult past 30-day use; consequences of misuse; adult and youth perceptions of harm; consequences of misuse; treatment admission; and overdose deaths.

Strategic Planning: This "State Targeted Response to the Opioid Crisis" (Opioid STR) grant gives Minnesota an opportunity to weave and expand current opioid crisis planning efforts together into a working whole. Especially important will be efforts to weave together both the continuum of treatment resources (our model of care approach) and the integration of services at each point in the continuum (e.g. behavioral treatment and OBOT). Minnesota is currently utilizing the Strategic Prevention Framework to guide planning and implementation of activities to prevent prescription drug misuse and opioid over-dose early among 12-17 year-old youth and 18-25 year-old young adults. Elements of this process may be used for the larger planning process to incorporate opioid treatment and recovery

services implementation. The MN Opioid STR grant will also allow us to address sustainability in a more integrated and comprehensive manner. Strategic planning efforts currently include the Minnesota Department of Human Services' (DHS) Alcohol and Drug Abuse Division, Health Care Administration and Office of Indian Policy along with the Minnesota Department of Health (MDH). Additional partner agencies and stakeholders may include Office of Inspector General, other state agencies and divisions, along with key community organizations/vendors engaged through this grant and input from participants, family members and others with lived experience of opioid use disorder. The planning process will include methods to integrate services, strategies to attain sustainable funding and sustainable management of services expanded through this grant funding. This process will be coordinated by the grant Project Manager. Key questions to be addressed in the MN Opioid STR project strategic planning include: How will Minnesota maintain integrated services across health and human services divisions and state agencies? How do we coordinate funding to continue services and resources beyond the life of this grant? How do we coordinate to avoid duplication across state agencies? How can we continue to engage service participants to inform planning? How can we monitor and report outcomes of efforts?

In addition, Minnesota recognizes that care for Minnesotans with opioid use disorder is fragmented. Perhaps the largest gulf is between the licensed addiction treatment community (which has historically provided the bulk of behavioral health and methadone-based MAT) and the medical community. The Minnesota Department of Human Services' internal organization reflects those silos and fosters fragmented care. To mobilize a rapid response to this opioid crisis and address underlying barriers to treatment that currently exist, Minnesota proposed to add a Cross-Administration Treatment Planning Coordinator. This staff member will work to ensure that DHS' systems and interfaces with providers and other community partners support integrated care. Integration will encompass primary care, OTP, and behavioral health platforms to assure seamless triage, appropriate transfer to higher/lower levels of care, and treatment coordination. The staff member will develop an implementation strategy, policies, and improved internal processes to support optimal treatment of people with OUD.

Table V- Opioid STR Goals and Measurable Outcomes

Strategy/Treatment Intervention	**Measurable Outcomes**	**Opioid STR RFP Goals**
Expedite Minnesota Model of Care Resources	▪ Increased number of opioid-specific peer recovery specialists trained ▪ Increased number of recoverees from opioid misuse/abuse referred for services ▪ Implement opioid-specific care coordination, peers support and bridge services for people	▪ Improve retention in care ▪ Increase access to treatment ▪ Reduce unmet treatment need ▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic

Strategy/Treatment Intervention	Measurable Outcomes	Opioid STR RFP Goals
	moving from detox to treatment services	
Medication Assisted Office Based Opioid Treatment Expansion	▪ Increase the number of participating clinics ▪ Increase patient volume for patients treated with opioid use disorder ▪ Reduced number of opioid-related overdoses	▪ Increase access to treatment ▪ Reduce unmet treatment need ▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic
Opioid Treatment Programs	▪ Increase number of naloxone kits distributed ▪ Increase number of people linked to treatment and recovery services ▪ Increase number of people receiving tobacco cessation treatment and recovery support.	▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic
Project ECHO and statewide implementation strategic planning	▪ Increase in geographic access to MAT ▪ Decrease in unmet need for addiction treatment by substance ▪ Increase in the number of Medicaid enrollees receiving MAT with a diagnoses of substance use disorder ▪ Reduced disparities between populations in access to MAT (such as Native Americans) ▪ Number of clinics and clinicians participating in Project ECHO	▪ Improve retention in care ▪ Increase access to treatment ▪ Reduce unmet treatment need ▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic ▪ Aligns and coordinates with CDC's state opioid program

Strategy/Treatment Intervention	Measurable Outcomes	Opioid STR RFP Goals
	▪ Increase in the number of buprenorphine-waivered physicians ▪ Increase in the number of buprenorphine-waivered physicians who actually prescribe ▪ Increased self-efficacy of clinic-based providers for addiction treatment	
Parent Child Assistance Program (PCAP)	▪ Successful development of curricula and certification standards for high risk maternity paraprofessionals ▪ Successful certification and program placement of trained paraprofessionals ▪ Program processes and outcomes would include client risk screening ▪ Referral and follow up rates ▪ Toxicology test results at delivery ▪ Annual relapse rates postpartum	▪ Improve retention in care ▪ Increase access to treatment ▪ Reduce unmet treatment need ▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic ▪ Aligns and coordinates with CDC's state opioid program
Naloxone Distribution via EMS and OTPs	▪ Number of kits distributed ▪ Number of kits utilized to administer naloxone ▪ Number of successful overdose reversals per kits used	▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic ▪ Aligns and coordinates with CDC's state opioid program
MN SPF Rx Project	▪ Reduced of students reporting past 12-month pain reliever misuse	▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic

Strategy/Treatment Intervention	Measurable Outcomes	Opioid STR RFP Goals
	▪ Reduced % of adults reporting past 12 month misuse of opioids ▪ Increased number of prescribers registered in the PMP ▪ Reduced rate of opioid and benzodiazepine prescriptions filled by population ▪ Reduced rate overdose deaths due to opioid misuse	
Opioid Prescribing Improvement Program: Prescriber Education Campaign	Monitoring impact of educational marketing campaign will be dependent on media used (e.g. social media, print advertising, website visits)	▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic.
Know the Dangers Media Campaign	▪ Extent of traffic and engagement with the opioid content ▪ Change in knowledge and awareness in the following: perceived barriers to contacting EMS, safe storage/disposal, and consequences of misuse and abuse. ▪ Number of printed resources and toolkits distributed statewide and in targeted communities ▪ Reduce the real or perceived barriers to contacting emergency medical services (EMS) ▪ Educate consumers on safe storage and disposal	▪ Increase access to treatment ▪ Reduce unmet treatment need ▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic

Strategy/Treatment Intervention	Measurable Outcomes	Opioid STR RFP Goals
	of prescription medications and potential consequences of misuse or abuse of prescription opioids.	

B2. Strategy for MN Opioid STR funds related to state, CDC, locally funded efforts

The Minnesota Department of Health (MDH) was an awardee of the CDC's Data-Driven Prevention Initiative (DDPI). Minnesota will receive $294,000 in funds for each year from 9/1/2016-8/21/2019. This grant will increase data collection analysis between MDH and the Minnesota Board of Pharmacy's prescription monitoring program with the expected outcome of creating a mechanism to better evaluate opioid misuse, abuse and prevent overdoses. The Minnesota Department of Health has just recently hired agency policy specialist to begin working on the grant and are in the process of hiring an epidemiologist that will be dedicated to analysis of the data. The Departments of Human Services and Health are collaborating to meet the three goals of the project; (1) improve the use and function of the our prescription monitoring program; (2) implement community and insurer/health system interventions to prevent prescription drug overdose, heroin overdose and abuse, across the population beginning with Minnesota's Medicaid population, which ensures cross-collaboration between agencies and the services we are proposing in the application; (3) evaluate state-level practices and policies. As we move forward on this grant, DHS will rely on our collaboration with MDH's CDC funded Injury and Violence Prevention Unit (IVPU), which is funded by the National Center for Injury Prevention and Control (NCIPC) since 1989. One of the focuses of the IVPU is preventing poisoning, which includes the subset of prescription drug overdose.

The State of Minnesota has current grant agreements through its Commissioner of the Department of Health with Minnesota's eight regional emergency medical services (EMS) programs to purchase opiate antagonists and educate and train emergency medical services persons, which includes an individual employed as a licensed peace officer, to administer the opiate antagonist to those whose lives are in peril. One time funding was appropriated from state general funds for the biennium (July 1, 2015 through June 30, 2017) for grants to the eight regional emergency medical services programs to purchase the opioid antagonist and to educate and train emergency medical services persons. EMS Grantees must share opiate antagonists purchased with State funds among themselves as dictated by need. As of December 30, 2016, the statewide remaining balance is $58,931 with several outstanding invoices and two regions at zero balance. State funding for the Opioid Prescribing Improvement Program: Prescriber Education Campaign ends June 2017.

Minnesota is proposing to incorporate smoking cessation evidence based practices in opioid treatment programs. This proposed activity is aligned with the CDC 6-18 initiative which covers implementation of 18 evidence-based interventions that target 6 high-burden conditions one of which is reducing tobacco use. The CDC Community Preventive Services Task Force recommends policies and programs to reduce tobacco users' out-of-pocket costs for evidence-based cessation treatments based on strong evidence of effectiveness in increasing the number of tobacco users who quit.

B3. Minnesota Opioid STR Timeline

Table VI- Phase I: May 2017 - Implementation immediately upon receipt of federal funds

Intervention/ Strategy	Treatment/ Prevention	Method	Responsible Staff	Start Date/End Date
Statewide Media campaign: *Know the Dangers* Media Campaign	Treatment and Prevention	Expand contract with Russel Herder	Helen Ghebre	05/2017 – 09/2018
Opioid Prescribing Improvement Program: Prescriber Education Campaign	Treatment and Prevention	Expansion of contract with vendor identified via RFP competitive process in January 2017	Sarah Rinn	05/2017 – 09/2018
Pre- and Post-Natal Peer Support	Treatment	Amendments to existing Integrated Care for High Risk Pregnancies (ICHiRP) American Indian tribal entities contracts	Fritz Ohnsorg	05/2017 – 09/2018
Pre- and Post-Natal Peer Support	Treatment	Amendments to existing Women's Services contracts	Ruthie Dallas	05/2017 – 09/2018
Pre- and Post-Natal Peer Support	Treatment	Contract with Northwest Indian Community Development Center (Bemidji) and Summit Academy (Metro Area) as PCAP Trainers, and Minnesota Community Health Worker Alliance as curriculum developer.	Fritz Ohnsorg	05/2017 – 09/2018
Naloxone Distribution, Tobacco Cessation, and Linkage to Treatment Services	Prevention And Treatment	Contract for naloxone distribution ▪ Steve Rummler Foundation ▪ Rural AIDS Action Network (RAAN)	Rick Moldenhauer Collin Frazier	05/2017 – 09/2018

Intervention/ Strategy	Treatment/ Prevention	Method	Responsible Staff	Start Date/End Date
Needle Exchange through RAAN				
Naloxone Distribution, Tobacco Cessation, and Linkage to Treatment Services Needle Exchange through RAAN	Prevention And Treatment	Contract for treatment service linkage, tobacco cessation and naloxone distribution: ▪ Meridian companies: Alliance Clinic LLC, Valhalla Place Woodbury, Valhalla Place Brooklyn Park, Pinnacle Recovery Services PSC. ▪ Emergency Medical Services via Minnesota Department of Health	Rick Moldenhauer Collin Frazier	05/2017 – 09/2018
Fast Tracker for OUD treatment services	Treatment	Partner with the Minnesota Mental Health Community Foundation for Fast-Tracker implementation	Cindy Swan-Henderlite	05/2017 – 09/2018
Project ECHO	Treatment	Contract with HCMC to launch Minnesota's first Project ECHO hub and technical assistance for additional ECHO hub locations identified via RFP	Ellie Garrett	05/2017 – 09/2018

Table VII- Phase II: July 2017 - Implementation through State-wide Request for Proposals (RFP) and Competitive Statewide Contracts

Intervention/ Strategy	**Treatment/ Prevention**	**Method**	**Responsible Staff**	**Start Date/End Date**
MN Strategic Prevention Framework Rx Project	Prevention	Grant for additional communities beyond current SPF Rx funding	Project Manager: Dave Rompa	RFP 3/2017 Contracts 6/2017-9/2018
Expedited Model of Care Treatment and Recovery Services	Treatment	Grants for opioid-specific: ▪ peer recovery services, ▪ care coordination, ▪ expedited access to comprehensive assessments/direct treatment	Project Manager: Dave Rompa	RFP 3/2017 Contracts 6/2017-9/2018
People Formerly Incarcerated	Treatment	Grant for opioid-specific: ▪ peer recovery services, ▪ care coordination, ▪ expedited access to treatment and recovery services	Project Manager: Dave Rompa	RFP 3/2017 Contracts 6/2017-9/2018
OBOT/MAT Expansion	Treatment	Up to 20 planning grants max. $25,000 each, will be provided to clinics	Project Manager: Dave Rompa	RFP 3/2017 Contracts 6/2017-9/2018
Opioid Treatment Programs	Treatment	Naloxone distribution and treatment services linkage through additional OTP programs identified through competitive RFP	Project Manager: Dave Rompa	RFP 3/2017 Contracts 6/2017-9/2018

Table VIII- Phase III: August 2017 – Listening Session and Project ECHO Hub Expansion

Intervention/ Strategy	Treatment/Prevention	Method	Responsible Staff	Start Date/End Date
Listening Sessions	Strategic Planning and Needs Assessment	Listening sessions with participants, family and community members in four Minnesota regions.	Dave Rompa	Sept 1-November 30, 2017
Quarterly Meetings with MN Opioid STR Grantees	Strategic Planning	Quarterly meetings with MN Opioid STR grantees to provide avenues for exchange of ideas, grantee support, EBP adherence and technical assistance.	Dave Rompa	
Project ECHO	Treatment	RFP that would elicit applications from multidisciplinary specialty teams to launch additional Minnesota ECHO hub locations	Ellie Garrett	October 2017

November 2017: Updated Needs Assessment and Strategic Plan for Sustainability

B4. Administrative Structure

Minnesota has identified the following staff positions within the Minnesota Department of Human Services Alcohol and Drug Abuse Division and the Health Care Administration to support administration, implementation and reporting for this grant. The following staff roles for this grant has been identified: Project Manager, Report Coordinator, fiscal and contract management, program implementation time from designated Statewide Opioid Authority staff person, program implementation through staff in Health Care for implementation of PCAP, OBOT/MAT and Project ECHO pilot. Each staff person identified is a current state employee. The split of their time is in Section C and bios for each staff identified are available as attachments.

The Project Manager will monitor grant compliance, report/data deadlines, and spearhead the strategic planning process. The fiscal and contract management positions will support contract execution with sub-grantees and set up sub-grantee payment system, while providing technical assistance to sub-grantees. A staff person from the Communications team will prepare all Grant required reports. The PCAP, OBOT, MAT, and ECHO staff will support innovative projects addressing cross-agency administration between ADAD and the Health Care Administration (Medicaid). The FTE grants specialist position will develop data collection systems, monitor compliance, report to SAMHSA in accordance with Grant requirements, and provide technical assistance to sub-grantees.

In addition, Minnesota will add a new evaluation staff person (1FTE), within the Alcohol and Drug Abuse Division, to support internal quality management of services offered under this grant through continuous monitoring of population outcomes, provider activities and outputs, and providing technical assistance to contracted vendors along with using a continuous quality improvement framework to guide implementation.

B5. Prevention Activities

MN Strategic Prevention Framework (SPF) Rx Project

Minnesota will apply the Strategic Prevention Framework (SPF) process to identify and prioritize communities with high opioid usage rates that would not be reached due to limitations in current SPT Rx funding. SPF requires assessment of local conditions to determine the specific strategies and activities for implementation. It incorporates a Collaborative Impact approach to evaluating outcomes and its overall effectiveness. The Minnesota organizational infrastructure includes the existing SPF Advisory Council, the MN State Epidemiology Outcomes Workgroup (SEOW), the Board of Pharmacy/Prescription Monitoring Program, and the Indian Health Services in Minnesota.
It is anticipated that Minnesota will be able to fund one community under our current SPF Rx grant. Minnesota proposes to fund a second or third community using funds made available through SAMHA's "State Targeted Response to the Opioid Crisis" Grant program. The selection of the second or third community in this process will require review of available data specific to prescription opioid misuse rates and heroin use and abuse in Minnesota.

State-wide Media Campaign: Know the Dangers

Minnesota proposes to develop a statewide media campaign to increase awareness and education of prescription opioid misuse and abuse. Minnesota will expand an existing online and social media awareness campaign to develop and disseminate information about the risk of opioid prescription misuse and abuse, as well as the risk for overdose deaths caused by prescription opioids. KnowtheDangers.com, along with the social media presence on Facebook, Twitter and YouTube is a highly successful public awareness initiative that was originally launched to increase understanding by educators, parents and young adults about synthetic drugs. More than 100,000 target market individuals have visited the website, thousands more have been reached through public service advertising and outreach, and major news outlets such as CNN have referenced the educational value of the campaign information. In addition, the campaign has won several prestigious national awards including "Best Cause Awareness Campaign" from *PR Daily.* Utilizing this highly successful, well-established platform to educate Minnesotans about the rising issue of opioid use is recommended as a cost-efficient and effective means of building upon this success. By enhancing the existing campaign, awareness efforts will leverage the resources already invested to increase understanding. The momentum of the existing campaign will provide more rapid access and engagement with the target markets.

The prevention goals of this campaign will be to:

- deepen the scope of the issue within key demographic sectors;
- drive awareness of opioid abuse with the greatest resonance; and
- offer general public information

- offer culturally responsive awareness and prevention messaging to focus groups experiencing higher rates of prescription drug misuse and greater risk factors for related negative consequences for harm and overdose death and/or addiction.

The resulting outcomes will include a more informed public, medical community and thought leadership; as well increased access to the resources necessary to identify and treat the issue. Also, while this program will be Minnesota-based, there is high potential that other states could benefit from the resulting campaign dimensions including lessons learned through interagency collaboration, field research insights, outreach methodologies and creative executions.

This campaign will seek to reach those within the public who are, or who may be prone to, use opioids, as well as those able to influence preventative action and treatment. The campaign will seek to strategically reach those who are experiencing higher rates of prescription drug misuse.

To effectively reach a broad spectrum of individuals as well as focus on high-priority populations, a multi-faceted focus is recommended. Strategic recommendations include gaining insights through focus groups, and collaborative engagement of subject matter experts within the designated sectors above, regarding current knowledge of the dangers of opiate misuse, optimal methodology for outreach to each focus groups, and definition of tactics with the greatest likelihood for successful behavior change. Campaign messaging and draft program materials will be developed and tested through subsequent qualitative research to optimize all elements of the campaign. It is anticipated that the following, measurable dimensions of public education and awareness building will be prioritized, pending results of the research: expanding content about opioid misuse on the existing *Know the Dangers* website; undertaking an aggressive social media campaign to build issue awareness and engagement; online and offline advertising to 1) draw qualified traffic to KnowTheDangers.com educational material; and 2) reach key audiences with messaging that will most resonate and lead to behavior change; an educational toolkit consisting of presentation and reproducible awareness materials for educators, public safety and state and grant-funded community-based prevention networks across Minnesota; support materials for providers, pharmacists and health systems to address educational needs of patients; educational videos; and awareness-building public relations that will be developed and launched in collaboration with appropriate DHS communications team members. Outcomes of the campaign will be measured against goal through analytics that will encompass target market reach and engagement within each of the focused areas, media coverage, public service advertising return on investment, growth in subject matter awareness and, long-term, an improvement in behavior change and population health. These programmatic analytics will be essential to most effectively fine-tune strategies and obtain a long term return on investment.

Expand Naloxone Availability

The goal of this portion of STR-Opioid is the increased distribution of naloxone for the purpose of opioid overdose reduction. By partnering with existing agencies, the State will increase the number of overdose reversal kits (along with training on their use) through the portions of the State showing the greatest usage of opioids and associated mortality. The State will develop a standardized tracking tool for the three organizations to collect data on each kit dispensed including both individual recipient demographics and geographic area. The State will also work across departments to compare and blend reported data on areas and populations where kits are dispensed as a function of reported OD reversals, but both individual demographic and geographic area. The grant monies will be specifically allocated to

purchase and distribute naloxone and train people who do not have access to naloxone through other publically funded programs.

The Steve Rummler Hope Foundation will dispense and train those people seeking naloxone who are not clients of an OTP and do not have access through State funded pharmacy benefits, primarily focusing on the seven county metro area. The Rural AIDS Action Network (RAAN) will distribute across the northern portion of the State, including the three federally recognized Tribal Nations (Red Lake, Leech Lake and White Earth) who have declared States of emergency specially related to the use and mortality associated with opioid use and overdose on their respective lands. RAAN will also distribute syringes to address state concerns related to viral hepatitis or HIV infections due to injection drug use. Steve Rummler Hope Foundation and Rural AIDS Action Network have been recipients of grant dollars and annual plans in the past for naloxone training and distribution and are currently under an annual plan with Minnesota for state fiscal year 2017 for this purpose.

B6. Describe Treatment and Recovery Services

Upon receipt of award funding, Minnesota proposes to immediately utilize "State Targeted Response to the Opioid Crisis" dollars to improve statewide access to treatment and reduce unmet treatment needs in a variety of settings. Minnesota is proposing an integrated and comprehensive response to the opioid epidemic among Minnesota populations. Services will be implemented to expand access to treatment and recovery support for hard-to-serve populations (i.e. pregnant and parenting women, culturally-specific populations, individuals re-entering communities from the criminal justice system). Strategic goals include expansion of treatment services and population-specific approaches to reach isolated and vulnerable communities. Minnesota proposes to:

- Expedite person-centered assessment, care coordination and peer recovery services pre-, during and post-opioid use disorder treatment to improve transitions from detox to treatment and treatment to community
- Implement a 'fast-tracker' system to include real-time information on statewide OUD treatment openings/availability.
- Pilot the Parent Child Assistance Program (PCAP) through amendments with thirteen current pregnant/parenting women's grantees and Integrated Care for High Risk Pregnancies (ICHiRP).
- Expand availability of Medication Assisted Treatment (MAT) by expanding the number of OBOT providers serving targeted hard-to-serve individuals with OUD and high acuity levels in terms of mental health and medical comorbidities.
- Increase the number of waivered prescribers in primary care so individuals with OUD who enter any of our 400+ state licensed SUD treatment programs has access to MAT with behavioral therapies

Expedited Access to Treatment, Comprehensive Assessment, Care Coordination and Peer Support

In January 2017, the Governor's biennial budget proposal was introduced to the state's legislature. The proposal includes a comprehensive reform of the state's substance use disorder treatment delivery system, including adding new services to the state's Medicaid benefit set and establishing a streamlined person-centered process for directly and quickly accessing treatment services.

Following a multi-year implementation process, the reformed model of care for SUD in the state is projected to be fully operational on July 1, 2019, although most new services are expected to be Medicaid reimbursable by July 1, 2018. Funds available from this MN Opioid STR grant offer Minnesota the opportunity for early implementation of many functions of the model of care through state award of grant funds to providers who are postured to immediately provide the new services for individuals with opioid use disorder. The grants to programs would be able to sustain these services until the projected Medicaid approval is obtained in July 2018. Within the framework of Minnesota's Model of Care, through the MN Opioid STR grant, individuals would be offered expedited and direct access to Medicaid covered treatment for opioid use disorder, (OTP, OBOT and behavioral support treatment services), and ongoing recovery support through grant-funded peer support and care coordination services (which are presently not in the Medicaid benefit set for substance use disorder).

The sum total of these reforms and laws promises to improve the quality and effectiveness of treatment and recovery supports for all Minnesotans experiencing substance use disorder. Unfortunately, until the enhanced access process and new services are passed into law and approved for Medicaid reimbursement, they are not available for an immediate response to the urgent needs of Minnesotans absorbing the impact of the opioid epidemic. However, early implementation of some components of the model of care is possible within an opioid-specific strategy supported by the MN Opioid STR grant. The proposed early implementation, targeted to individuals with OUD, would support an expedited process to access treatment, and permit the state to reimburse programs positioned to provide care coordination and peer recovery support services to individuals with opioid use disorder, both immediately and throughout the interim until Minnesota obtains approval from the Centers for Medicare and Medicaid for statewide implementation of the access process and new services.

Access to Treatment and Comprehensive Assessment

The current process for accessing publically funded SUD treatment requires an individuals to first go to their county, tribal authority or managed care organization for a "Rule 25 assessment." This Rule 25 assessment is not part of an individual's treatment, rather, it is a prescribed tool whose only functions are the determinations of what type and intensity level of treatment service is authorized and which particular treatment program the individual is approved to attend. The process allows 30 days from an individual's request for an assessment until approval of services must be made. Once approved, depending on program capacity, the wait for admission could be even longer. In addition to the delays permitted in the current access process, it is of critical note that for individuals with OUD who access detox services, maximum length stays in detox often create a gap in time where a person has completed withdrawal services, but has not yet accessed a Rule 25 assessment or been approved for treatment services. Clearly there is an urgent need for expedited access to treatment services in these circumstances, and a pressing need for safe harbor arrangements when treatment admission cannot occur immediately.

Peer Support and Care Coordination

As well, peer-support and care coordination for substance use disorder are not yet Medicaid reimbursable services in Minnesota. Minnesota proposes to leverage the opportunity presented by the MN Opioid STR grant to address these service gaps for people with OUD as part of the immediate, comprehensive response to the opioid epidemic, while continuing its ongoing effort toward full implementation of Minnesota's Model of Care reforms so that these treatment services will be sustainable at the end of the MN Opioid STR grant.

Expedited implementation of peer support and care coordination will allow for access to these services and expansion of Minnesota's workforce toward opioid-specific recovery services. Through MN Opioid STR funds, opioid-specific peer support and care coordination will be available to people experiencing OUD, whether or not they choose to enter a formal treatment environment. These services will funded when provided by Recovery Community Organizations and SUD treatment and detoxification programs. Peer support and care coordination services will be available for people with OUD in detox settings and before, during and after participation in a treatment program. In making these opioid-specific services available in 2017, Minnesota will be providing a bridge between detox or crisis settings (such as medical interventions for overdose) and long term treatment options in substance use disorder and medication assisted treatment settings. For people with OUD who choose not to enter treatment, opioid-specific peer support and care coordination will be available and will be reviewed for utilization to consider how grant dollars are focused on year two of the grant.

Through a Request for Proposal (RFP) process Minnesota Department of Human Services will select treatment providers and American Indian tribal entities who have the ability to effectively and efficiently provide assessment, care coordination and peer recovery services in regions of Minnesota where opioid misuse and related harms are most prevalent. In addition, to reduce the incidence of opioid overdose, detoxification sites located in regions of OUD high-need will be selected by the RFP process to provide transition services of care coordination and peer supports to bridge the gap in service from detox to treatment initiation, and in some cases, room and board to provide safe harbor in the interim.

The DAANES client surveillance system collects data for both licensed treatment and licensed detoxification programs. For the identified sub-grantee detoxification program, the state will analyze client detox admission and discharge data and corresponding SUD treatment admission and treatment data to gauge the effectiveness of the services delivered.

Expedited Cross-Administration Treatment Implementation

Minnesota recognizes that care for Minnesotans with opioid use disorder is fragmented. Perhaps the largest gulf is between the licensed addiction treatment community (which has historically provided the bulk of behavioral health and methadone-based MAT) and the medical community. The Minnesota Department of Human Services' internal organization reflects those silos and fosters fragmented care. To mobilize a rapid response to this opioid crisis and address underlying barriers to treatment that currently exist, Minnesota proposes to add a Cross-Administration Treatment Planning Coordinator. This staff member will work to ensure that DHS' systems and interfaces with providers and other community partners support integrated care. Integration will encompass primary care, OTP, and behavioral health platforms to assure seamless triage, appropriate transfer to higher/lower levels of care, and treatment coordination. The staff member will develop an implementation strategy, policies, and improved internal processes to support optimal treatment of people with OUD.

Implementing Fast Tracker for Opioid Use Disorder Treatment

The Minnesota Department of Human Services, Alcohol and Drug Abuse division will partner with the already established mental health 'fast-tracker' to include real-time information on OUD treatment openings. Fast-Tracker is Minnesota's searchable online tool to assist individuals, family members, health care providers find available mental health providers. We propose to develop a customized add-on search tool to this site so that individuals with opiate use disorder, family members, clinicians at

various access points can find treatment openings statewide so that individuals in need can access the right services Fast-Tracker website

Pilot the Parent Child Assistance Program (PCAP)

Several evidence-based models now exist which employ community-based paraprofessionals in an integrated, supportive role to assist women in accessing services, addressing multiple psychosocial risks (homelessness, partner abuse, mental illness, Adverse Childhood Experiences), and to provide recovery support for those who have concomitant substance use disorder (SUD), including opiate use disorder (OUD). In Minnesota we have Women's Recovery Services Initiatives and ICHiRP grants (focused on American Indian communities). Through MN Opioid STR funds we propose to expand these services in support of recovery for moms experiencing opioid use disorder and newborns experiencing NAS. Working with three pre-identified vendors, Minnesota will develop a specialize training based on the Parent Child Assistance Program (PCAP), the Baltimore Healthy Start model, the Pathways Community Hub Model, the Maternal Infant Health Outreach Worker (MIHOW) Program, Family Spirit home visiting model, and the Healthy Families America home-visiting model. The latter two models use paraprofessional home visitors supervised by public health nurses.

The models are targeted at women during pregnancy and early parenting. All of these models have developed training and supervision methods focused on utilizing community based paraprofessionals to help women with high psychosocial risks navigate service systems, assimilate knowledge and learn skills related to pregnancy self-care and effective parenting, and obtain confidence and competence in life skills needed for self-sufficiency as a parent. The PCAP program, targeted exclusively at women with SUD, has developed an additional focus in providing peer-based recovery support.

The proposed project, through the use of paraprofessional maternal outreach workers cross-trained in recovery support, is anticipated to improve rates of adequate prenatal care, rates of prenatal OUD treatment engagement, and reduce rates of prescribed opiate analgesic use. The care model being used, the Parent Child Assistance Program (PCAP), is also expected to affect rates of prematurity, and rates of subsequent unintended pregnancies. The PCAP model is informed by research on effective paraprofessional home visiting interventions. The PCAP intervention uses these general lessons and applies them specifically to women who abuse alcohol and drugs during pregnancy. PCAP's goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs. PCAP's primary aims are to assist substance-abusing pregnant and parenting mothers in obtaining SUD treatment, staying in recovery, and resolving myriad complex problems related to their substance abuse; to link mothers to community resources that will help them build and maintain healthy, independent family lives, and; to prevent the future births of alcohol and drug-affected children.

Expand Women's Recovery Services Initiative

For nontribal Medicaid eligible service providers, grant funds will support a pilot project involving existing grantees of the Minnesota Department of Human Services, Alcohol and Drug Abuse Division's Women's Recovery Services Initiative. These grantees are part of Minnesota's federal block grant set aside dollars for women services. Amendments will be made to the current grantee contracts to provide funding to strengthen and or enhance peer recovery support services being provided by paraprofessionals called Peer Recovery Support Specialists or Recovery Coaches. This will involve assistance with the hiring, training, and standardizing of the services being provided by these paraprofessionals. Additionally, single source contracts will be procured with Summit Academy and the

Minnesota Community Health Worker Alliance to support development of a standardized curriculum and certification standards for each of the two core sets of services Community Health Worker (CHW) Curriculum focused on maternal child health case management and DHS-ADAD Recovery Community Organization (RCO) Peer Recovery Specialist Training Curricula. Supplemental training will also be provided specifically on "Women In Recovery". Peer recovery support service standards will align with standards supported by the Minnesota Department of Human Services Alcohol and Drug Abuse Division.

Paraprofessionals trained and certified to provide the core service of maternal case management would be cross-trained to provide peer support services. Client eligibility for services would be defined by high psychosocial risk level, and concomitant SUD. For the pilot, there will be an emphasis on serving a majority of clients with OUD.

The proposed pilot activities work in synergy with existing projects already directed in whole or part in support of pregnant and parenting women with OUD. DHS' ADAD Women's Recovery Services Initiative is a grant program involving 13 sites. These sites provide treatment support and recovery services for pregnant and parenting women who have substance use disorders and their families. Through this initiative, grantees provide comprehensive, gender-specific, family-centered and trauma-informed services for the clients in their care. Over a 4-year period, June 2012 – February 2016, a total of 2,955 clients and 6,051 children were served by these programs.-The ICHiRP Initiative is a grant program involving five tribes, focused on providing multidisciplinary, collaborative supports and services for pregnant and parenting American Indian women with OUD.

Expand Integrated Care for High Risk Pregnancies (ICHiRP)

For services provided by tribal entities, grant funds will support a pilot project involving existing grantees of DHS' Integrated Care for High Risk Pregnancies Initiative. Grantees' contracts will be amended to provide funding for hiring, training, and provision of services by paraprofessionals. In addition, a single source contract will be procured with the Northwestern Indian Community Development Center, to support development of a standardized curriculum and certification standards for each of the two core sets of services. Peer support recovery service standards will align with standards supported by ADAD.

PCAP training for Enhanced Women's and ICHiRP Services

Training curricula and certification standards will be developed as part of the proposed project in ICHiRP and Women's Services Programs. Training and standards will be evidence-based, deriving and synthesizing materials and methods from recognized models. The PCAP program has been cited by the Association of Maternal and Child Health Programs as a Best Practice. Baltimore Healthy Start was reviewed by the Agency for Healthcare Research and Quality (AHRQ), which cited enhanced service access, high client satisfaction, improved perinatal outcomes, and associated cost savings in its evidence review. The MIHOW Program is a partnership between Vanderbilt University Center for Community Health Solutions and community-based organizations, and has published its program evaluation results in peer-reviewed journals. The Pathways Community Hub model has been endorsed by AHRQ, the CDC, CMS Innovation Center, Institute for Healthcare Improvement, National Institute of Health, National Science Foundation, Ohio Department of Health and Ohio Department of Medicaid. Family Spirit and the Healthy Families America home visiting models are both recognized by HRSA as evidence-based, to qualify for Medicaid reimbursement.

Office Based Opioid Treatment (OBOT)/ Medication Assisted Treatment (MAT)

Implement Minnesota Project ECHO (Extension for Community Healthcare Outcomes)

Minnesota is one of three states participating in a National Governors Association-sponsored Learning Laboratory to employ Project ECHO as a means to increase access and quality of clinic-based OUD treatment. Project ECHO is a lifelong learning and guided practice model that exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model™ is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities. The Learning Laboratory will produce a Minnesota's strategic plan for its Project ECHO initiative. We anticipate that the plan will encompass up to four, regional multidisciplinary hubs to support an expanding number of clinic-spokes employing medication assisted treatments for their patients with OUD.

Once implemented, Project ECHO long- and short-term outcome measures include:

- Increase in geographic access to MAT
- Decrease in unmet need for addiction treatment by substance
- Increase in the number of Medicaid enrollees receiving MAT with a diagnoses of substance use disorder
- Reduced disparities between populations in access to MAT (such as Native Americans)
- Number of clinics and clinicians participating in Project ECHO
- Increase in the number of buprenorphine-waivered physicians
- Increase in the number of buprenorphine-waivered physicians who actually prescribe
- Increased self-efficacy of clinic-based providers for addiction treatment

To expedite implementation of the first Minnesota Project ECHO hub, Minnesota plans to work with Hennepin County Medical Center (HCMC). HCMC is well-positioned to serve as a teleconsultative educational hub for substance use disorders and associated comorbidities. HCMC has a mission to educate, a history of partnership with underserved communities, and the largest collection of academic addiction specialists in the state including physicians with expertise in internal medicine, psychiatry, pediatrics, emergency medicine, and toxicology. The experience of the Primary Care Behavioral Health team will inform local community outreach efforts, and providers' relationships with the Minnesota Society of Addiction Medicine – as well as other statewide organizations and initiatives – will facilitate the clinic's efforts to reach rural and other urban underserved areas. Minnesota plans to partner with HCMC to: form a Project ECHO hub that HCMC's current partners could link to as spokes sooner rather than later, and also accept other spokes from around the state as those spokes become identified. Minnesota intends that this first Project ECHO hub will also serve as a resource for other hubs to be formed after competitive bidding via a request for proposals to be published in the fall of 2017. HCMC would thereby provide technical assistance to hubs located in geographically diverse areas of the state. HCMC would also provide buprenorphine certification training so that there is an in-person training option for providers interested in becoming buprenorphine certified. HCMC has already been identified as being willing and able to implement within the short timeframe of the grant, and that HCMC is Minnesota's sole public health care system, and it is also the sole health care system that houses an outpatient OTP program.

Office-Based Treatment – Medication Assisted Treatment

Up to twenty planning grants, maximum $25,000 each, will be provided to clinics throughout Minnesota. Patterned on Minnesota's highly successful health care home grants, the funds will help clinics and their communities develop the relationships and systems of care needed to integrate high quality medical care with behavioral and other social supports for patients suffering opioid use disorder. Providers participating in these grants will be supported by the development of an ECHO model that will support them with multidisciplinary, addiction specialty consultation and learning through telemedicine. Actual treatment services will be reimbursed with Medicaid claims; grant funds can be used for care coordination. The goals for this initiative are to (1) support access to high quality, well-coordinated medical clinic based MAT that results in improved health for Minnesota's public health care program recipients who suffer from OUD and (2) minimize diversion of drugs prescribed for MAT.

Grantees will be primary care clinics, general psychiatric clinics or health systems encompassing such clinics, with priority given to programs positioned to address health disparities, geographic access barriers and concentrations of greatest need. In Minnesota, the worst OUD-related health disparities are suffered by Americans Indians, so clinics serving large American Indian populations will be prioritized. Applicants will need to show support from their community's behavioral health and addiction treatment partners. As noted above, grantees will also need to join Project ECHO as spoke-participants or otherwise demonstrate that they have access to multidisciplinary specialty support. Planning for these grants will be accelerated and run in parallel to the strategic planning for Project ECHO.

Grants will be issued to clinics or clinic systems, with primary care or general psychiatric practices in the lead. Funds will be used to support internal planning regarding patient flow and coordination and formation of external partnerships. The plans must encompass processes for assessment and referral, induction and stabilization, initiation of medication-assisted treatment, integration with behavioral health care, ongoing medical management, patient progress reviews and recovery maintenance. Each grantee will submit a report outlining patient care processes and clinic system processes (e.g. scheduled case reviews with all relevant staff) to support patient care, with attention to each of the following components discussed in greater length below:

(1) Assessment and Referral
(2) Induction and Stabilization
(3) Behavioral Health Integration
(4) Ongoing Medical Management
(5) Review of Patient Progress
(6) Recovery Maintenance
(7) Mutually Planned Withdrawal from Medication
(8) MAT in Special Circumstances
(9) System Coordination internally and with external partners

The proposed expansion of office based opioid treatment (OBOT)/Medication Assisted Treatment (MAT) is designed to raise the bar in terms of both access and quality to MAT throughout the state. Minnesota's DHS has already consulted its Health Services Advisory Council (HSAC), an external clinical advisory body that informs the agency's evidence-based decision-making. After reviewing the evidence on medication assisted treatment (including in particular evidence-based programs in Vermont and Michigan), HSAC identified the following components necessary to high quality MAT:

Assessment and Referral

- Patients diagnosed with OUD should be assessed carefully at intake, and patients should be triaged to an appropriate level of care.

- Patients with severe OUD should be detoxified and stabilized prior to initiating MAT.
- Buprenorphine or naltrexone, together with intensive outpatient behavioral therapy, should be made available to patients with mild to moderate OUD.
- Severity of illness should guide treatment choices around site and medications. Patients with severe OUD should be considered for inpatient therapy and may be considered for buprenorphine or methadone as appropriate with outpatient follow-up.
- Directly observed therapy, administered via an OTP based on severity of OUD, may be preferred based on comorbidities and social risk factors
- Geographic access may be factored into triage decisions.

Induction and Stabilization

- Induction onto a medication should be performed by or in consultation with clinicians with demonstrated training and experience. Clinicians who are not yet experienced with managing medication induction of OUD patients should have access—either in person or via telemedicine—to consultation with an experienced specialist. (Patients requiring methadone must be referred to an OTP, in conformance with federal regulations.)
- Pharmacologically stabilized patients should be encouraged to commence behavioral health therapy as soon as possible.

Behavioral Health Integration

- Patients receiving MAT need high quality, well-coordinated, evidence based, culturally integrated behavioral health care. Follow up by the MAT provider should be part of the continuing coordination plan to assure that behavioral health services are initiated and maintained.

Ongoing Medical Management

- Ongoing management of MAT requires coordination of supports and services, such as behavioral and physical health care, life skills training, employment, self-help and family involvement.
- Access to consultation with an experienced specialist should be available to manage relapse, dosing and other issues. Telemedicine may support this consultation service between the specialist and the primary care provider/patient.
- Case management to assure integration of resources should be provided in a culturally appropriate context
- Prescribing guidance including adherence to evidence based dosing levels, oversight of other prescribed agents (benzodiazepines) and review of the prescription drug monitoring program.
- Random and ongoing drug screening must be enforced, but progressively balanced by rewarding patient successes with increased privileges such as take home doses. Protocols should be created and maintained to assure consistency across providers and over time.
- Consequences for diversion and concomitant substance use must be clearly articulated and consistently enforced. Protocols should be created and maintained to assure consistency across providers and over time.

Review of Progress

- Ongoing and periodic review of progress should be based on objective criteria.
- Standardized reporting should be required at all levels of care.

Recovery Maintenance

- OUD is a chronic condition requiring maintenance, including behavioral health supports, over time. MAT can play a role in maintaining recovery, though patients should be given the opportunity to taper and wean as they are ready. Recovery maintenance should be community-based, high quality, well-coordinated, evidence based, and culturally integrated.

Planned Withdrawal from Medication

- Patients who prematurely or too abruptly attempt medication discontinuation have a high risk of relapse. Patients should be assessed for readiness to taper at regular intervals and at least annually. The decision to taper should be voluntary, patient-centered and encouraged by the prescribing clinician. Tapering should be managed by clinicians with demonstrated training and experience. Clinicians managing tapering should have access to telemedicine consultation with an experienced specialist.
- Ongoing medical and behavioral support is especially important during the first 3 – 6 months after withdrawal.

MAT in Special Circumstances

- MAT is the preferred treatment for women who are identified as having OUD in pregnancy. Culturally appropriate care must be coordinated with obstetrical care and child welfare services to create an integrated, culturally appropriate approach for safe pregnancy, delivery and post-partum care.
- Special consideration should be given to treating individuals who have a history of OUD and are being released from settings in which opioids have not been available to them, such as jail or prison. Consideration should be given to continuous health care benefit access, behavioral health supports, and provision of naltrexone at change in status.

System Coordination

- Planning, collaborative effort and targeted capacity building are needed to support provider recruitment, training and certification of qualified prescribers within systems of primary care.
- Provider back-up needs should be considered and addressed within health care systems.
- Standardized means of obtaining consent for information sharing between the prescribing provider and behavioral health treatment provider should be developed and implemented. While patients cannot be required to consent to information sharing, providers must do all that they can to facilitate and encourage information sharing at the outset of treatment among members of the medical and behavioral health treatment team.
- System quality improvement should assess dosing, diversion risk, adherence to medical and behavioral health treatment protocols, coordination of social support services and other issues.

Opioid Treatment Programs, Naloxone and Linking to Treatment

The goal of this portion of STR-Opioid is the increased distribution of naloxone for the purpose of opioid overdose reduction. By partnering with existing agencies, the State will increase the number of overdose reversal kits (along with training on their use) through the portions of the State showing the greatest usage of opioids and associated mortality. The State will develop a standardized tracking tool for the three organizations to collect data on each kit dispensed including both individual recipient

demographics and geographic area. The State will also work across departments to compare and blend reported data on areas and populations where kits are dispensed as a function of reported OD reversals, but both individual demographic and geographic area. The grant monies will be specifically allocated to purchase, distribution and training of people who do not have access to naloxone through other publically funded programs.

Meridian Behavioral Health's four Opioid Treatment Programs (OTPs) - Valhalla Place Woodbury, Valhalla Place Brooklyn Center, Alliance Clinic and Pinnacle Recovery - collectively are half the OTP client enrollment for the State of Minnesota. Naloxone is an unscheduled drug of legend under Minnesota law. These dollars will fund the dispensing of naloxone kits to any client who does not have access to purchase one through the State formulary via a licensed pharmacy or practitioner. Immediate upon execution of the grant, grant monies will allow larger purchases of OD kit components and training to occur.

In addition, Minnesota has set a goal to educate opioid treatment staff to become competent in the treatment of individuals dependent on tobacco and encourage implementation of tobacco cessation treatment among Opioid Treatment Providers. DHS-ADAD will work with the four identified opioid treatment programs involved in the naloxone distribution efforts under this grant. Two staff from each of the participating programs will complete the week long Tobacco Treatment Specialist Training and become certified as Tobacco Treatment Specialists. Clients in the participating programs will complete a tobacco use and cessation readiness survey. Clients referred to receive tobacco dependence cessation/ treatment in combination with opioid or other drug treatment will receive treatment treatment/ cessation services. Tobacco cessation services will include access to text messages, email support, and a supply of nicotine patches, gum or lozenges. We anticipate serving 20% of the clients who go through the participating programs.

Emergency Medical Services (EMS)

The State of Minnesota has current grant agreements through its Commissioner of the Department of Health with Minnesota's eight regional emergency medical services (EMS) programs to purchase opiate antagonists and educate and train emergency medical services persons, which includes an individual employed as a licensed peace officer, to administer the opiate antagonist to those whose lives are in peril. These grants will be expanded to reach eight targeted EMS regions, allowing for access to naloxone in rural counties that have great need. Additionally, these funds have been utilized and we intend to continue to use them to disperse to Minnesota's 200 full time Violent Crime (drug and gang) Enforcement Investigators who have been trained in the administration of naloxone and carry naloxone when on duty. This has been essential not only in ensuring officer safety as they are processing a scene with the uptick in opioid synthetics but when they enter a scene to investigate and find an individual in an overdose or the individual swallows their supply, the officers are all trained to immediately provide naloxone. With the MN Opioid STR grant we would continue to fund this important partnership and look for opportunities to grow these relationships to ensure these investigators receive education and information on providing to treatment resources to those in need of those services.

People Formerly Incarcerated

As mentioned in the needs statement, Minnesota recognizes that people recently released from corrections environments are at high risk of drug overdose due to prolonged person of sobriety that leads to low tolerance and high risk of overdoes. This is supported through risk factors outlined by the

World Health Organization. As well, Minnesota has identified that people recently released from corrections who have a history of felonies, level 1-3 sexual offenses or other predatory offenses have barriers to gaining treatment and recovery services as they re-enter life in Minnesota communities. For these reasons, Minnesota will focus a section of its MN Opioid STR response to provide opioid-specific services that will begin at the point of discharge. As part of Minnesota's effort to expedite a continuum of care for people experiencing opioid use disorder, care coordinators and peer recovery specialist will help individuals in re-entry, providing direct support and linking to substance use treatment (when appropriate residential settings), and recovery support to reduce likelihood of relapse, overdose, and recidivism.

Statewide Media Campaign – Web-based Resources

Know the Dangers Campaign

In support of a comprehensive treatment response to the current opioid epidemic and given the urgency of reaching people with opioid-treatment and recovery resources, Minnesota will use the *knowthedangers.org* website as a centralized location for information on how to locate treatment related services, recruitment and referral for Minnesotans. The *Know the Dangers* website will also be expanded with treatment resources and will include support and reference to the the Opioid Prescribing Improvement Program: Prescriber Education Campaign (described below) and implementation of a Fast Tracker system for individuals experiencing opioid use disorder.

Opioid Prescribing Improvement Program: Prescriber Education Campaign

Minnesota proposes to use MN Opioid STR grant funds to support an extension of the Opioid Prescribing Improvement Program educational marketing campaign. DHS is currently seeking a vendor to develop and implement an educational marketing campaign directed to health care providers about communicating with patients about the use of opioids to treat pain and pain management. Funding for this project expires June 30, 2017. While a current RFP is in process, Minnesota will not be able to sustain efforts beyond June 30, 2017 without MN Opioid STR grant support.

The Opioid Prescribing Improvement Program (OPIP) is an initiative to reduce opioid dependency and substance use by Minnesotans enrolled in Minnesota Health Care Programs (MHCP)—dependency and substance abuse that are related to the prescribing of opioid analgesics by health care providers. The Commissioner of Human Services oversees the OPIP in collaboration with the Commissioner of Health. Its core components are grounded in community input via an expert work group: the Opioid Prescribing Work Group (OPWG). The OPWG convened in November 2015 for a two-year commitment to perform its legislatively set tasks:

- Recommending clinical protocols that address all phases of the opioid prescribing cycle
- Overseeing development of educational resources and messages for providers to use in communicating with patients about pain and the use of opioids to treat pain (the purpose of this RFP)
- Recommending quality-improvement measures to assess variation and support improvement in clinical practice
- Recommending two thresholds directed at MHCP-enrolled providers with persistently concerning prescribing practices, one threshold that will trigger quality improvement and the other termination from MHCP

The clinical protocols or recommendations developed by the OPWG apply to all Minnesota health care providers. Although DHS does not have authority to enforce the recommendations outside those providers who are enrolled in the MHCP, the intent of the clinical recommendations is to set the standard of care for opioid prescribing across the state. The clinical recommendations address the three pain phases: acute pain (0 – 4 days following an acute injury or surgery); post-acute pain (4-45 days following an acute event); and the chronic pain phase (greater than 45 days following an acute event).

Effective communication between patients and providers about pain management and opioid medications is necessary to improve health outcomes, and to avoid the harm and risks associated with opioid therapy. Evidence suggests that effective communication can be challenging, and a source of frustration and conflict. A recent study showed that 73% of providers described working with chronic pain patients to be a "major source of frustration."[1] Providers may find it difficult to communicate effectively with these patients for at least three key reasons. First, high rates of opioid diversion and misuse lead providers to be skeptical of patients requesting opioids.[2] Second, providers may feel disillusioned working with patients whose chronic pain they are unable to adequately treat. Finally, discussions about opioids can develop into struggles for control that turn providers and patients into adversaries rather than collaborative partners.[3]Without a collaborative relationship with their provider, patients often struggle to maintain their credibility and leave visits feeling "rejected, ignored, and belittled, blamed for their condition."[4]

Fast-Tracker.Org

The Know the Dangers website will support and promote creation of a Fast Tracker system for people experiencing opioid use disorder (OUD). The Minnesota Department of Human Services, Alcohol and Drug Abuse division will partner with the already established mental health 'fast-tracker' to include real-time information on OUD treatment openings. Fast-Tracker is Minnesota's searchable online tool to assist individuals, family members, health care providers find available mental health providers. We propose to develop a customized add-on search tool to this site so that individuals with opiate use disorder, family members, clinicians at various access points can find treatment opening statewide so that individuals in need can access the right services Fast-Tracker website

B7. Describe recruitment

Minnesota's expansion of web-based resources, especially the multiple web-based resources that will be used to help individuals in the community locate and access treatment resources (especially *Know the Dangers.org* and Fast Tracker) are part of the State of Minnesota's plan to assist community members in locating and accessing treatment resources at all stages of their experience of opioid use disorder – from crisis to recovery. In addition, Minnesota will request specific information from all grantees and contracted agencies related to their methods of recruitment, with particular interest in how populations experiencing identified disparities will be reached.

---

[1] Dobscha SK, Corson K, Flores JA, et al. Veterans Affairs primary care clinicians' attitudes toward chronic pain and correlates of opioid prescribing rates. *Pain Med* 2008;9:564-571.

[2] Couto JE, Romney MC, Leider HL, et al. High rates of inappropriate drug use in the chronic pain population. *Popl Health Manage* 2009. Aug;12(4):185-190.

[3] Eggly S, Tzelepis A. Relational control in difficult physician-patient encounters: negotiating treatment for pain. *Journal of Health Communication.* 2001;6:323-333.

[4] Werner A, Malterud K. It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. *Soc Sci Med*. 2003;57:1409-1419.

B8. Proposed unduplicated number of individuals who will be reached

Minnesota estimates that we will reach 109,612 individuals through our proposed strategies. The state proposes a variety of strategies, some of which have immediately identifiable budget predictors and outcomes. Some of the current strategic framework will be fleshed out in the RFP and sub-grantee process, particularly true for the proposed innovative strategies treatment grants and Minnesota's SPF Rx Prevention Strategy.

Table IX- Estimate Unduplicated Number of Individuals To Be Reached

Activity Type	Other Services & Expected Outcomes	Unduplicated Number Formula/ Method	Unduplicated Number of Individuals Served
EMS Education & Distribution	Expansion of geographic regions reached and linkage to treatment	$150,000 – 35% for overhead costs = $97,500/$55 per naloxone kit	**1773 individuals**
Distribution to Targeted Treatment Providers	Connection to treatment and tobacco cessation for people experiencing overdose	$200,000 – 35% for overhead costs = $130,000/55 per naloxone kit	**2364 individuals**
Naloxone Distribution RFP	Expanded availability of Naloxone in geographic areas currently lacking access	$100,000 – 35% for overhead costs = $65,000/55 per naloxone kit	**1182 individuals**
Fast Tracker System	Expedited access to treatment	35,000 people with Substance Use Disorder in Minnesota treatment annually with 19% having opioid use disorder (primary diagnosis) = 6,650 Estimated 25% of individuals with OUD will have expedited access via Fast-Tracker = 1,663 individuals	**1663 individuals**

Activity Type	Other Services & Expected Outcomes	Unduplicated Number Formula/ Method	Unduplicated Number of Individuals Served
Rule 25 Assessments for expedited access to OUD Treatment	Expedited access to treatment	$150,000 – 35% for overhead costs = $97,500 $150 per unit 1 unit per person $150,000/$150	609 individuals ***244 Unduplicated** *Reduced by 60% for overlap with Care Coordination and Peer Support #s
Care Coordination Services	Support and linkage to continuum of treatment and recovery support during periods of risk for relapse	$250,000 – 35% for overhead costs = $162,500 15 units per person served = $240 per client $250,000/$240	677 individuals ***271 Unduplicated** *Reduced by 60% for overlap with Rule 25 Assessments and Peer Support #s
Peer Recovery Services	Recovery support through specially trained opioid-specific peer recovery specialists	$300,000 – 35% for overhead costs = $195,000 15 units per person = $225 $300,000/$225	867 individuals ***347 Unduplicated** *Reduced by 60% for overlap with Rule 25 Assessments and Care Coordination #s
Opioid-Specific Detox Program Supports for Seamless Transition to Treatment	Extended stay and care coordination, peer support along with expedited assessments and access to treatment	$300,000 – 35% for overhead costs = $195,000 $690 overall cost per person $195,000/$690	283 individuals ***226 Unduplicated** * Reduced by 20% for overlap with care coordination, peer support and treatment assessments above
People Recently Incarcerated	Specialized care coordination, peer support and treatment access support for people released from corrections who face barriers to treatment	1200 people released from corrections annually x 19% average of people with SUD identified as having OUD	228 Individuals ***182 Unduplicated** * Reduced by 20% for overlap with care coordination, peer

Activity Type	Other Services & Expected Outcomes	Unduplicated Number Formula/ Method	Unduplicated Number of Individuals Served
	due to category of offenses.		support and treatment assessments above
Children & Women Recovery Sites		$575,000 – 35% for overhead costs = $373,750 $934 per individual served $373,750/934	**400 individuals**
Statewide Media Campaign	Disseminate information about the risk of opioid prescription misuse and abuse, as well as the risk for overdose deaths caused by prescription opioids Individuals with opiate use disorder, family members, clinicians at various access points can find treatment opening statewide so that individuals in need can access the right services.	Between July 2015 and December 2016 (18 months) Minnesota's Know the Dangers website received 100,000 total visits for synthetic drug facts.	**100,000 individuals**
OBOT/MAT (ECHO)	Access to Medication Assisted Treatment/Office Based Opioid Treatment in at least 20 new locations throughout the state of Minnesota	50 individuals per provider Site. (15 individuals per physician provider, estimated 3 physicians per site.) 24 Provider Sites	**1200 individuals**

Activity Type	Other Services & Expected Outcomes	Unduplicated Number Formula/ Method	Unduplicated Number of Individuals Served
		(4 OBOT/MAT Hub Sites, 20 OBOT/MAT Spoke Sites) 24 X 50 = 1200	

Total: 109, 852 individuals

Section C: Proposed Evidence-Based Service/Practice

C1. Proposed System Design and Implementation Models for Increased Access

Minnesota recognizes that the opioid epidemic is a public health epidemic that requires a coordinated response between medical, public health, and substance use treatment systems. Since 2012 and expected to be fully implemented by 2019, Minnesota has developed a substance use disorder system-wide transformation that provides the framework for Minnesota's Opioid STR strategy. Minnesota's strategy, referred to as "Minnesota's Model of Care," includes methods to provide direct access to individual treatment providers outside of traditional clinic and provider settings, access to peer support and care coordination. For people experiencing opioid use disorder, this MN Opioid STR grant will make opioid-specific Minnesota's Model of Care treatment and recovery services available to opioid users in 2017, two years prior to full implementation of the model for all Minnesotan's experiencing substance use disorder. Especially important will be efforts to weave together both the continuum of treatment resources (our model of care approach) and the integration of services at each point in the continuum (e.g. behavioral treatment and OBOT). Within the framework of Minnesota's Model of Care, Minnesota is proposing to expand access to Medication Assisted Treatment (MAT).

Prevention and Treatment Evidence-Based Practices (EBP)

Table X- Proposed Evidence-Based Practices (EBP)

EBP	Population Focus	STR Goals	Model Effectiveness
MN Strategic Prevention Framework Rx Project	American Indian Additional populations to be determined through completion of 2017 SPF Rx prioritization process in March 2017	Reduce opioid overdose related deaths Support a comprehensive response to the opioid epidemic	Applying the Strategic Prevention Framework (SPF) – SAMHSA SAMHSA Strategic Prevention Framework Website
Minnesota Model of Care Treatment and Recovery Services	Culturally Specific Communities – particularly communities identified as	Improve retention in care	Peer Recovery Supports Best Practices in Peer Support and Peer Recovery Supports Coaching Website Care Coordination SAMHSA Care Coordination website

EBP	Population Focus	STR Goals	Model Effectiveness
	having OUD disparities including: American Indian; African American People recently released from corrections facilities,	Increase access to treatment Reduce unmet treatment need Reduce opioid overdose related deaths Support a comprehensive response to the opioid epidemic	Comprehensive Case Management for Substance Abuse Treatment Fast-tracker Fast-Tracker website American Society of Addiction Medicine (ASAM) Opiate Withdrawal ASAM National Practice Support Guidelines For Use of Medications in Treatment of Addiction Involving Opioids; CBT/Motivational Interviewing CBT/Motivational Interviewing pdf hyperlink; Enhancing Motivation for Change in Substance Abuse Treatment hyperlink
Project ECHO	Rural office-based OUD treatment	Improve retention in care Increase access to treatment Reduce unmet treatment need Reduce opioid overdose related deaths Support a comprehensive response to the opioid epidemic Aligns and coordinates with CDC's state opioid program	Yes. Zhou C, Crawford A, Serhal E, et al. The impact of Project ECHO on participant and patient outcomes: a systematic review. *Acad Med.* 2016 Oct;91(10):1439-1461.

EBP	Population Focus	STR Goals	Model Effectiveness
Medication Assisted Treatment (MAT)/ Office Based Opioid Treatment	Opiate treatment providers and primary care	Reduce opioid overdose related deaths Support a comprehensive response to the opioid epidemic	Integration of Primary Care and Substance Use Disorder services SAMHSA Integrating Addiction and Primary Care Services website
Opioid Treatment Programs	Broader reach to rural and metro populations experiencing access gaps in Minnesota	Increase access to treatment Reduce unmet treatment need Reduce opioid overdose related deaths Support a comprehensive response to the opioid epidemic	Office-Based Opioid Agonist Treatment ASAM Public Policy Statement on Office-based Opioid Agonist Treatment (OBOT) hyperlink Naloxone Overdose Kits: SAMHSA Overdose Toolkit hyperlink ATTC An Overview of Evidence-Based Practices pdf hyperlink
Parent Child Assistance Program (PCAP)	American Indian Tribal Entities: Mille Lacs Lake, Fond Du Lac, Leech Lake, Red Lake Women's Recovery Program sites.	Improve retention in care Increase access to treatment Reduce unmet treatment need	Based on recognized EBPs: the Parent Child Assistance Program (PCAP), the Baltimore Healthy Start model, the Pathways Community HUB model, the Maternal Infant Health Outreach Worker (MIHOW) Program, Family Spirit home visiting model, and the Healthy Families America home visiting model. Parent-Child Assistance Program website

EBP	Population Focus	STR Goals	Model Effectiveness
		Reduce opioid overdose related deaths Support a comprehensive response to the opioid epidemic Aligns and coordinates with CDC's state opioid program	

C2. Effectiveness of Selected EBPs in addressing disparities

The state will use existing client authorization, payment, and surveillance data systems to measure utilization change for disparate populations. Additionally, for the pre- and post-natal peer support, it is anticipated that a workforce of paraprofessional maternal outreach workers cross-trained in recovery support will be significantly enhanced, by developing curricula and training criteria modeled after the PCAP program. Once trained, these workers will be incorporated into existing treatment programs that are already focused on high risk populations. The ICHRP program specifically supports collaborative care focused on maternal opiate use, and is targeted to the state's five largest tribal communities. The Women's Recovery Services initiative involves 13 sites, all of which provide comprehensive treatment for maternal substance use, and are targeted at high risk communities.

In addition, sub-grantees will be required to identify strategies appropriate to reach populations identified as having opioid-related disparities and show evidence of effectiveness for reducing those disparities. Sub-grantees will be asked to assess Culturally and Linguistically Appropriate Services (CLAS) activities, integrate CLAS measures into quality improvement efforts, and strengthen collaboration. The SEOW and SPF Rx Advisory Committee and evaluators will collaborate to use data on health disparities to raise awareness, build partnerships, and document impact.

C3. Proposed Modifications to EBPs

Currently there are no proposed modifications to proposed evidence based practices.

C4. Monitoring EBP Implementation Integrity

Each assigned clinical staff will be responsible for supporting and providing technical assistance to sub-grantees so that grantees are properly informed and trained in contract specifications and deliverables, including adherence to the evidence based practice implemented within their contract. Methods that be developed to guide implementation of the EBPs will include:

- Development of a rating system for determining evidence-level of grantee programs. The rating system will be used to describe and classify the evidence-base underlying each program's selected approach, e.g., programs may be deemed emerging, promising, or well supported by available evidence.
- Working with the developers of selected programs and/or curricula to identify the core elements of each program that must be implemented in order to obtain the expected outcomes. These core elements will be used to develop brief fidelity checklists, which will be reviewed with ADAD and program developers for accuracy.
- Implementation of fidelity assessments during the project period, based on the program and/or practice being implemented and reports describing funded partners' evidence-based programming levels and fidelity.

Section D: Staff and Organizational Experience

D1. Capabilities and Experience of Applicant Organization

The Alcohol and Drug Abuse Division (ADAD), housed within the State Department of Human Services, is the designated Single State Authority relative to Substance Abuse Prevention, Treatment and Recovery. ADAD has been the recipient and manager of the Federal Substance Abuse Prevention and Treatment Block Grant since the inception of the federal block grant system. The Alcohol and Drug Abuse Division has a long history of providing funding for and assistance to alcohol and other drug prevention and treatment programs, including problem gambling and tobacco prevention & control. ADAD maintains an ongoing focus on diverse populations – reserving block grant dollars for historically underserved populations. Our state has seen the addition of many new cultures and the ADAD has been in the forefront, helping community leaders' address issues around the use of alcohol, tobacco, and other drugs and problem gambling. The American Indian Section of the ADAD oversees all treatment and prevention funding for the eleven reservations in Minnesota. ADAD has an American Indian Advisory Committee, which complements our Citizens' Advisory Council. Additionally, the ADAD sponsors an annual Native American prevention conference and participates in a wide-range of community advisory groups and state-wide conferences. ADAD has been engaged in extensive reform of the substance use disorder prevention and treatment system in Minnesota. The goals include maintenance of best-practices, connecting policy with state-of-the art services that will enhance services for Minnesotans impacted by substance abuse, maximization of resources across government systems.

The DHS Core staff members have 15+ years of experience each in substance abuse, health care policy initiatives, contract development and management, budget oversight, and process, impact & outcome evaluation. Additionally Minnesota's Medicaid Medical Director, Dr. Jeff Schiff, brings both the strength of DHS' commitment to doing the right thing for the most vulnerable populations in Minnesota and the opportunity for dramatic, multi-system change given the power and authority of the Medicaid Program. DHS has a history of implementation of complex care models with measureable outcomes. These include the Minnesota patient-centered medical home program and an early elective delivery reduction program. Minnesota has a long-standing history of achieving significant improvement in health outcomes using our model for collaboration, convening multiple stakeholders to make clinical and health improvements across the state. DHS accomplishes this by embracing evidence-based best practices and by using measurement in a transparent, quality improvement approach.

D2. Capabilities and Experience of Partnering Organizations

Minnesota Department of Health: Minnesota Department of Health, Injury and Violence Prevention Section is in the Health Promotion and Chronic Disease (HPCD) Division. MDH and the regional EMS programs have developed a strong partnership. Mark Kinde, MPH, the Injury & Violence Prevention Section Supervisor, currently oversees current grant agreements with Minnesota's eight regional emergency medical services (EMS) programs to purchase opiate antagonists and educate and train emergency medical services persons. Mark Kinde, MPH, has 32 years of experience as an epidemiologist, program manager and oversees a section of 35 staff that includes physicians, programmers, statisticians, support staff, epidemiologists and policy planers. He will serve as the principal investigator from the MDH for this project; Dana Farley, MS, has 30 years of substance abuse clinical, management, teaching

and policy analysis experience will serve as co-principal investigator and will give day-to-day guidance to the project.

Health Care Administration, Minnesota Department of Human Services:
The DHS Health Care Administration (HCA) administers the Minnesota Medicaid program and oversees medical policy for the agency. Minnesota Medicaid serves about 1.1 million people in any given month. This includes enrollment, claims management, rate setting, contracting with Managed Care Organizations, benefit policy, delivery system design, many aspects of quality measurement and medical direction. In these roles the HCA develops programs to improve prescribing (the opioid prescribing improvement program), improve outcomes for affected newborns, and advance integrated office based treatment.

D3. Description of Project Staff and Roles

Project Manager (Dave Rompa) 40%

- Monitor grant compliance, report/data deadlines, and spearhead the strategic planning process. This position will develop, design and lead collaborative initiatives, projects and programs targeted in this grant application. This position will coordinate the operational logistics and related tasks for multi-agency initiatives, partner collaborative groups, and contracts.

Fiscal Management (Cher Vang, Vicki Radinzel, Deb Ambright) 10% each

- Set up sub-grantee payment system,/provide technical assistance to sub-grantees and create linkages with state administrative systems.

Contract Management .75 FTE (Grants Specialist) 60%

- Contract execution, compliance, and technical assistance with sub-grantees

Data Analyst/Evaluation 1 FTE (Data Analysis) 100%

- Develop data collection systems, monitor compliance, report to SAMHSA in accordance with grant requirements, and provide technical assistance to sub-grantees. This role is responsible to collect, analyze, and report health care data as part of the program and projects. Will provide leadership and support for data analysis and related activities. This position is responsible for the design, devise, administer and conduct the process, impact and outcome evaluation for this project. Once the project has started this position will also responsible to collect, analyze, and report health care data as part of the program and projects.

State Opioid Authority (Rick Moldenhauer) 20%

- Manage naloxone services, provide expert guidance to the entire project. This role will assist in provide subject matter expertise for the project direction: grant management and data collection and assessment coordination for sub-awardees. Rick has 15 + years serving as the treatment services consultant for 340 licensed chemical dependency treatment programs in Minnesota. Provide regulatory guidance to the 16 Opioid Treatment Programs in Minnesota as the State Opioid Treatment Authority and interface for 48 colleagues in similar positions across the country. Serves as the Minnesota liaison to other State and Federal agencies as a technical expert. Rick is the 2016 Nyswander-Dole award recipient and the 2014 Minnesota Association of Resources for Recovery and Chemical Health Ethics award recipient.

Report Writer (Jacob Owens) 5%

- Prepare all grant required reports

D4. Staff Experience Related to Project Implementation

Project Manager (Dave Rompa) – Program Management with HRSA, Office of Refugee Services, SAMHSA, State of Wisconsin and State of MN.
State Opioid Treatment Authority (Rick Moldenhauer) – Currently Treatment Services Consultant for the State of MN and the MN State Opioid Treatment Authority. Licensed Alcohol & Drug Counselor, Licensed Clinical Counselor, Masters in Education-Community Counseling.
Fiscal/Contract Staff – The staff members in this area have extensive experience with MN DHS billing systems, contract services and compliance.
Report Writer (Jacob Owens) – As an integral members of the ADAD Communications Team, Jacob handles required reports (state & federal), internal and external communications.
Vacant FTE (Data Analysis) – Will provide leadership, direction, and coordination of data collection and evaluation of and implementation of ADAD directed/sponsored activities in accordance with state and federal regulation, mandates priorities and contracted deliverables.

D4. Key Staff Demonstrated Experience

Project EDHO/Health Care Administration Linkages (Ellie Garrett) – Deputy Director of the Office of the Medical Director. Former Associate Director for Health Policy and Public Health at the MN Center for Health Ethics.

PCAP/OBOT-MAT (Fritz Ohnsborg) – Policy Development Affecting Perinatal Outcomes for the Office of the Medical Director for the State of MN Dept. of Human Services. Previously Senior Researcher for Medical Policy Development at Blue Cross/Blue Shield of MN.

State Opioid Treatment Authority (Rick Moldenhauer) – Currently Treatment Services Consultant for the State of MN and the MN State Opioid Treatment Authority. Licensed Alcohol & Drug Counselor, Licensed Clinical Counselor, Masters in Education-Community Counseling.

Media Campaign (Helen Ghebre) – As a Program & Policy Consultant for ADAD Helen has experience with the Know The Dangers Campaign and with that experience is postured to effectively create a new Know The Dangers campaign to address the opioid crisis.

SPF-RX (Darren Reed) – As the SPF Project Coordinator for ADAD, Darren is poised to integrate new targeted Opioid groups for inclusion in the SPF project sites.

Tobacco Cessation with Opioid Users (Collin Frazier) – Supervisor, Tobacco Prevention & Control Section/FDA Coordinator with the ADAD Division. Provides leadership, direction, and coordination for major service delivery design and implementation in the area of tobacco undercover inspections for tobacco purchases and advertising and labeling in accordance with Federal Food and Drug Administration's rules, regulations and mandates.

Medical Director (Jeff Schiff) – Currently the State Medicaid Medical Director and an Emergency Medicine physician with Children's Hospitals and Clinics. He provides leadership to MN Health Care Programs, coordinated with Medicaid Services in MN.

D5. Client, Consumer, Family Input

Opioid Listening Sessions & Advisory Committee Input

Building on models for incorporating participant and family feedback through Minnesota's substance use disorder Model of Care reform, Minnesota will conduct four listening sessions that are opioid-specific by the fall of 2017. These listening sessions will be one tool for gathering input into MN Opioid STR grant needs assessment and strategic plan. Minnesota has several advisory committees that inform our current strategy and this MN Opioid STR proposal: (list committees, including SPF Rx Advisory Committee). An MN Opioid STR advisory committee will be developed as part of implementation of this Opioid STR grant to inform and guide Minnesota's comprehensive approach to addressing the needs of our communities in this national-wide opioid epidemic. Minnesota will continue to use listening sessions, input from advisory committees, and, if funds are available, focus groups, to gain input regarding the effectiveness of proposed implementation strategies.

This application also builds on a wealth of public and stakeholder engagement regarding treatment and prevention of substance use disorder in general and OUD in particular. In 2012, at the direction of the state's legislature, ADAD convened a broad-based stakeholder steering committee to develop recommendations for a model of care to improve the effectiveness and efficiency of Minnesota's service continuum for substance use disorder. In fall 2015, ADAD facilitated nine listening sessions across the state, at which the recommended model of care was presented for public and stakeholder review, and additional input was gathered to inform the redesign. In summer 2016, ADAD continued its engagement efforts by convening three workgroups that represented chemical dependency providers, Tribes, counties, hospitals, consumers, culturally specific providers and others to discuss payment rates and methodologies for the proposed services. In fall 2016, six statewide community presentations were conducted to present on the final policy recommendations and gather additional feedback. These recommendations were included in the governor's budget for the 2017 legislative session. This grant proposal aligns with and advances this multi-year well-vetted and -supported model of care.
In 2016 DHS' Health Services Advisory Council (HSAC) issued evidence-based recommendations for critical components of well-designed OBOT. HSAC is a statutorily mandated, external clinical advisory body that provides leadership in designing health care benefit and coverage policies for Minnesota's public health care programs. A particular focus of HSAC is evidence-based coverage policy, in which recommendations regarding health care services paid for by public programs are made using the best available research on their effectiveness.

Section E: Data Collection and Performance Measurement

E1. Data Collection and Reporting Capacity

Minnesota's commitment to evaluation of its programs and services has ensured the establishment of processes and systems to collect prevention, treatment, and recovery data from the SUD provider community, its recovery grantees, and social services partners providing outreach and referral assistance to the client population. The data that will be collected will focus on addressing and meeting the requirements of the performance measures outlined by SAMHSA for the initiative as specified in Section I-2.2 of the FOA. The performance measures identified are:

- Number of people who receive OUD treatment.
- Number of people who receive OUD recovery services.
- Number of providers implementing MAT.
- Number of OUD prevention and treatment providers trained, to include nurse practitioners, physician's assistants, as well as physicians, nurses, counselors, social workers, case managers, etc.
- Numbers and rates of opioid use.

Minnesota currently collects treatment data on all private and public-pay treatment facility admissions and discharges in the state. Information is collected and submitted on clients using web forms at three points in time: Admission, Six-Month Review (opioid replacement therapy clients only), and Discharge. The data is submitted by the facilities into a data warehouse system known as the Drug and Alcohol Abuse Normative Evaluation System (DAANES). DAANES allows Minnesota to assess treatment resource needs, and track admissions trends by substance of abuse and by demographic. The DAANES is used to meet reporting requirements for the National Outcome Measures and the Treatment Episode Data Set.

In addition to treatment data, Minnesota currently collects data on recovery services provided through two special programs: (1) Women's Recovery Services and (2) Recovery Community Organizations (RCO) initiative. Each initiative includes a comprehensive evaluation that involves rigorous data collection at intake and closing. The evaluation includes data collection on demographics treatment history; primary substance of abuse/misuse; past 30-day use; mental health diagnoses; and source of referral. These data are submitted into secured password-protected systems that are programmed for an aggregate analysis of the data by any number of variables.

Besides these established systems, Minnesota will be implementing a quarterly system of data collection using a web-based survey program known as Snap Survey. The form will collect the aggregate-level data required by this grant funding from service partners not typically providing treatment or recovery services, but who provide services to the client population and who are directly benefitting from this funding. One potential user of this system may be Minnesota's first responder partners involved in the administration of naloxone.

Finally, Minnesota has established relationships with other entities with data collection resources such as a the Prescription Monitoring Program through the Minnesota Board of Pharmacy, and the Minnesota Center for Health Statistics, Vital Statistics records, to share their data on the rates of misuse, and rates and numbers of opioid mortality.

E2. Plan for Data Collection, Management, and Analysis

Opioid Treatment Data

Treatment data for opioid addiction will be collected and submitted by treatment facilities into Drug and Alcohol Abuse Normative Evaluation System (DAANES). Data will be collected from each client at admission, Six-Month Review (opioid replacement therapy clients only), and discharge. The Minnesota Data Practices Act requires that clients be informed that the treatment facility will be disclosing client information to DHS for the purposes of research and program evaluation. All facilities and grant funds recipients will be required to ensure client completion of the *Notification of Data Collection form*. This informs the client that the program will be collecting and disclosing client-specific information to the Department of Human Services for the purposes of research and program evaluation. The notice also informs the client that confidentiality will be maintained and that their identity will not be disclosed. This form is required prior to data collected:

- The Admission Form collects basic client demographic and background information at admission. The admission form also provides information on the client's substance use history details substance use frequency, age of onset, and route of administration for a variety of substances. The admission form should be completed within the first 5 days after admission to the program.
- The Six-month Review Form assesses the progress of the opioid replacement therapy client after every six months of treatment services. The form captures the current status of the six dimensions associated with the chemical health severity ratings and is completed at the end of every six-month period (approximately 180 days) that the client is in treatment.

- The Discharge Form collects information on the client's status at discharge. This form includes reason for discharge, clinical chemical dependency diagnoses, medication and other therapies provided. The discharge also captures the current status of the six dimensions associated with the chemical health severity ratings. The discharge form is completed on the day of the client's discharge.

Recovery Services Data

Women's Recovery Services. Program staff will collect and document information about clients and their children at intake, closing, and throughout their participation in the program in a common password protected database system. Program-level information around outreach and financial support provided to clients is also collected by staff semi-annually. Demographic and quantitative process data is uploaded semi-annually into a *Service Summary Form (SSF) that provides a snapshot of service provision by county of residence, age, race/ethnicity, and gender.* This data is aggregated by the evaluation vendor (Wilder Research, Inc.) contracted by DHS-ADAD into a site-specific annual report and a comprehensive program report.

Recovery Community Organizations Initiative. Program staff and volunteers will collect and document information about recoverees at initial contact; at service intake; for Telephone Recovery Support; and/or the provision of Recovery Coaching. This information is entered into a common, password-protected database system. Demographic and quantitative process data is uploaded semi-annually into a *Service Summary Form (SSF) that provides a snapshot of service provision by county of residence, age, race/ethnicity, and gender.* This data is aggregated by the evaluation vendor (Acet Inc.) contracted by DHS-ADAD into a site-specific annual report and a comprehensive program report.

As detailed in the Statement of Need, Minnesota recognizes significant disparity and high need among the American Indian community in the state. However persistent data gaps will pose evaluation and quality improvement challenges. To moderate the lack of consistent and reliable data with respect to the American Indian community, ADAD will be reaching out to our state and tribal partners to improve data-sharing and analysis on key related projects. For example, Minnesota is one of four states selected for the State Strategies for Reducing Overdose and Deaths from Heroin and Illicit Fentanyl. Some early goals are to (1) Utilize, expand and enhance current partnerships through the State Opioid Oversight Project (SOOP); (2) Expand and coordinate data collection and analysis from other agencies such as the Office of Justice, Minnesota Department of Health, the Bureau of Criminal Apprehension (BCA), and the Minnesota Board of Pharmacy/Prescription Monitoring Program.

ADAD will also reach out to key stakeholder groups such as the Minnesota Indian Affairs Council, and Indian Health Service Directors to strengthen and expand its existing SPF Advisory Council and SEOW to ensure greater representation from the American Indian community. The Great Lakes Intertribal Council's Epidemiology Center may also provide a helpful resource not only for data specific to the community, but also for cultural research expertise. Lastly, ADAD commits to conducting a series of key informant interviews with community stakeholders in addition to focus groups and informal listening sessions to supplement the quantitative data and provide details on the social, cultural, economic and other issues that may be influencing the disparity in prescription drug misuse and abuse. The urban-based American Indian Women's Resource Center may be recruited to help organize this component as they are very skilled in bringing the community together to explore difficult subjects.

Table XI- Data Collection Management Plan

Strategy/Treatment Intervention	Goals	Measurable Outcomes/Performance Measure
MN SPF Rx Project	▪ Reduce opioid overdose related deaths ▪ Support a comprehensive response to the opioid epidemic	▪ Percent of students reporting past 12-month pain reliever misuse. ▪ Percent of adults reporting past 12 month misuse of opioids. ▪ Number of prescribers registered in the PMP ▪ Rate of opioid and benzodiazepine prescriptions filled by population ▪ Rate overdose deaths due to opioid misuse
Data Collection System/Process	**Data collected**	**Data Management & Analysis**

Strategy/Treatment Intervention	Goals	Measurable Outcomes/Performance Measure
		Responsible Party(ies)
School event tracking form; Educator feedback survey; Prescription Drug Monitoring Program database	• Number of schools participating • Number of students reached • Number and types of year-round activities • Type of drug • Quantity • Prescriber	Board of Pharmacy *Data Analyst/Evaluation 1 FTE*
Strategy/Treatment Intervention	**Goals**	**Measurable Outcomes/Performance Measure**
Know the Dangers Media Campaign	Reduce the real or perceived barriers to contacting emergency medical services (EMS) Educate consumers on safe storage and disposal of prescription medications and potential consequences of misuse or abuse of prescription opioids.	▪ Extent of traffic and engagement with the opioid content ▪ Change in knowledge and awareness in the following: perceived barriers to contacting EMS, safe storage/disposal, and consequences of misuse and abuse. ▪ Number of printed resources and toolkits distributed statewide and in targeted communities.
Data Collection System/Process	**Data collected**	**Data Management & Analysis** **Responsible Party(ies)**
Google analytics	▪ Measure traffic and engagement ▪ Social media following, engagement and content sharing ▪ Track distribution of printed resources and toolkits	*Data Analyst/Evaluation 1 FTE*
Naloxone Distribution via EMS and OTPs	• Reduce opioid overdose related deaths	▪ Number of kits distributed; ▪ Number of kits utilized to administer naloxone; ▪ Number/rate of successful overdose reversal for kits used
Data Collection System/Process	**Data collected**	**Data Management & Analysis** **Responsible Party(ies)**
Snap Survey	▪ Number of kits distributed; ▪ Number of kits utilized to administer Naloxone;	*Data Analyst/Evaluation 1 FTE*

Strategy/Treatment Intervention	Goals	Measurable Outcomes/Performance Measure
	▪ Number/rate of successful overdose reversal for kits used ▪ Geographic region	
Expedite Minnesota Model of Care Resources	▪ Improve retention in care ▪ Improve long-term treatment and recovery outcomes ▪ Increase access to treatment ▪ Reduce unmet treatment need ▪ Reduce opioid overdose related deaths	Number of people who receive OUD recovery services. Number of opioid-specific peer recovery specialists trained Number of OUD prevention and treatment providers trained. Number of recoverees from opioid misuse/abuse referred for services Number of providers implementing MAT.
Data Collection System/Process	**Data collected**	**Data Management & Analysis** **Responsible Party(ies)**
1. DAANES 2. Women's Recovery Services (WRS) database 3. RCO Initiative database	• Number of women with opioid as primary substance of abuse	*Data Analyst/Evaluation 1 FTE*

For Naloxone Distribution:
The State will require standardized data collection of all three organizations involved. Items such as date dispensed, location (city/county), recipients self-reported age, race, gender, for self/friend/family member and other information as needed will be collected. This redacted data will then be compared with law enforcement, EMS and MDH data related to OD death and reversals by individual demographic and geographic area. Analysis will focus on increased distribution and utilization of kits with favorable outcomes (successful reversal), geographic and individual demographic compared to general population for use and utilization patterns. This data will be used for future allocations of monies and resources targeted on OD reversal and use of opioid specific treatment modalities.

E3. Minnesota's Quality Improvement Process for Project

Quality improvement is a key element in the process of sub-recipient performance assessment. Minnesota will regularly review required data collected in collaboration with providers and sub-recipient partners to identify opportunities for improvement. Quality improvement opportunities will focus on data collection process and protocol to ensure higher quality of data submitted by treatment providers and recovery entities. Other improvement opportunities may focus on the prevention area of the initiative including assessing and monitoring training quality; public and media education reach, and community and partnership engagement. While specific quality improvement concerns will likely have a provider/program-specific focus, the overall focus of the effort will be to ensure:

1. Fidelity to evidence-based practices and process.
2. Quality of the effort in terms of resources involved, timeliness of service provision, and client outcomes.