Opioid Epidemic Response Advisory Council Objectives and Strategies

Part One: Treatment

A. Treat Opioid Use Disorder (OUD)
   1. Expanding availability of treatment, including Medication-Assisted Treatment (MAT), for OUD and any co-occurring substance use or mental health issues.
      i. Underutilization of Medication Assisted treatment, we thought that the “One Call” could help and policy recommendations. “One Call” could be expanded to an app versus just a phone call.
      a. Do the “one call” for Medication Assisted Treatment (MAT), specific for all touchpoints in MAT not just providers (like a 1800#, statewide number, touchpoints like someone in crisis, someone in ems, would need to triage so there is someone to call).
   2. Supportive housing, all forms of FDA-approved MAT, counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it.
      i. Regulation of sober living and treatment programs to accept MAT.
   3. Screening and Treatment of mental health trauma issues that resulted from the traumatic experiences of opioid user (e.g., violence, sexual assault, human trafficking) and for family members (e.g., surviving family members after an overdose or overdose fatality).
      i. Increase identification of Mental Illness and Chemical Dependency (MICD) disorders through the use of screens. The screens to be used would be:
         a. GAD
         b. PHq-9
         c. PC-PTSD
      So you would get screened and then assessed in order to understand the correlation between substance abuse and co-occurring disorder.
      ii. Increase access to evidenced-based MH treatments contributing to the substance use disorder (i.e. evidence-based PTSD treatment).
      iii. Increase access of trained clinicians in varied settings (schools -specific training in the schools), child protection (child and parent), prisons/Jails, hospitals) using evidenced-based treatments for post-traumatic stress disorder (PTSD), depression and other co-occurring disorders.
         a. Thoughts about doing something as easy as looking at proposals from organizations to do a trauma informed care curriculum that allows agencies that can’t afford the more formalized trauma informed care training to go to it at a low cost and they can deploy that information at their agencies so more organizations are using a more trauma informed frame.
      iv. Ensure efficacy of program by measuring psychopathology, resiliency, sobriety, recidivism and reunification after completed protocol/follow-up included.
4. Expand telehealth to increase access to OUD treatment, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
   i. Lack of access to broadband and telehealth that would improve the ability to have virtual health visits. Access to telephones that meet criteria of not having access to broadband and opioid use disorder. We could use spots within communities that have broadband that individuals can easily access like the library.
5. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
   i. Lack of current funding to continue the addiction medicine fellowship. Potential to utilize state funding for this.
7. Training for health care providers, students, and other supporting professionals, such as peer recovery coaches/recovery outreach specialists, including by not limited to the following: Training relating to MAT, harm reduction, workforce development and self-care.
   i. Peer recovery specialist were the glue in everything related to collaboration to be utilized to be able to provide continuity of care, build up capacity, career laddering, and treatment coordination.
   ii. Turnover within the profession so lifespan of counselors is two years. There is burnout and reimbursement issues so we didn’t really know what to do with the burnout or reimbursement issue but we did think about a way to increase the supply like job corps programs. Taking people new in recovery, lifting them up and then training to be peer recovery specialists and then training them to be LADC to increase the workforce. We thought turnover was related to reimbursement.
   iii. Retention of trained professionals on every level:
      a. Developing resiliency
      b. Avoiding compassion fatigue
8. Development and dissemination of accredited curricula on addiction and pain.
   i. Lack of physician in primary care providers that are trained in addiction and chronic pain.
      a. The “One Call” number idea that came from the Minnesota Society of Addiction Medicine, came from child psychiatry that has one number where every pediatrician in the state can call and get a child psychiatrist on the phone. So we talked about all addiction medicine doctors could share in a call line but they would need it to be somehow supported. Having it available at multiple touch points, like providers, nursing homes, schools and mental health agencies.
      b. Training and holistic management of chronic pain and psychology of pain. In the bill there is a two hour requirement for prescribers. Maybe some sort of create training program for anybody that wanted to do it, but maybe licensed alcohol and drug counselors (LADC) and other people that are doing addiction training.
      c. Lack of funding for doctors to find the root cause of chronic pain and needing resources to do deep dive on patients. We talked a little bit about
incentives for wellness outcomes in reimbursements and having those conversations.

B. Connect people who need help to the help they need (Intervention)

1. Training, funding and long-term implementation of screening brief intervention and referral to treatment (SBIRT) for OUD and other risk factors in key systems (health, schools, colleges, criminal justice, and probation) and on the treatment and referral to treatment, as applicable, for patients with opioid use disorder and other mental health.
   i. Implementing screening tools within health care. So screening brief intervention and referral to treatment (SBIRT) training and reimbursement can be improved upon.

2. Assessment, training and reimbursement to determine and support workforce needs in their communities.
   i. Lack of training in professional workforce in communities that need it. Like how we take people out of communities for treatment. So we thought building on those community based programs that already do some workforce development and working with those organizations to administrate training for treatment providers or peer recovery specialist. Using a local community resource and seeing what workforce they need in each community. So we aren’t training a bunch of LADC’s where they don’t need LADC’s but they need peer recovery specialists so that is what we train. It is working with the community to identify the need and then training that specific workforce up.

3. Training for emergency personnel that treat opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management and/or support services.
   i. Lack of peer recovery specialists in the ER/hospital. Needing people in the hospital to transition people out of the hospital or out of there access/entry point because that is when they are in crisis and walking them to the next step. So people who can do the assessment, get the funding in place. Something like an ACT team for those with severe substance use disorder, someone that can track you in the community.
   ii. Support work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

4. Create school-based contracts who parents can engage to seek immediate treatment services for their child.
   i. Getting addiction treatment into schools. A pilot for getting addiction treatment in school to help with getting kids the acceptance they need in school. This would allow us to bring the treatment to them so they can go to treatment at the same time they are going to school The treatment would be part of their day to day curriculum while allowing for the kids to be part of the programming. This could allow the kids to become leaders within their own communities. They have a sober group within the high school which would be very powerful.

5. Entry/Touch Point Knowledge and Development
i. First thing we talked about was entry points, knowledge of entry points in various communities, especially American Indian and black communities about where do they access help when they need it. Focusing on our knowledge on where they would say they would access help and getting the knowledge out for them to access the structures and systems that are currently in place. Additionally a need to hear from our community members in order to get that right.

ii. Development of touchpoints, every touchpoint where professionals have with a patient representing the communities served and recognizing the differences there.

6. Discharge planning for those that accessed the system through crisis points like emergency departments, law enforcement, etc. Once they enter through these crisis points then what next?
   i. Enhancing those discharge planning services through those emergency type interventions in jail, law enforcement, detox.

C. Address the needs of criminal-justice-involved persons

1. Address the needs of persons involved in the criminal justice system who have opioid use disorder (OUD) and any co-occurring substance use disorders or mental health (SUD/MH) issues.
   i. Equitable access to those with felony histories
   ii. Family centered interventions.

2. Support pre-arrest, pre-trial diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH issues, including established strategies such as:
   i. Talked about law enforcement changes in education. Example of needles being taken away from law enforcement even when they are part of a naloxone kit if they don’t have a prescription and then being charged with a petty misdemeanor.
   ii. Law Enforcement receiving naloxone - working with policy recommendations and working with police unions on educational efforts.

3. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
   i. Transition services out of services, out of drug courts, out of programs, sustainability of recovery environments once they leave the programs. Like they might get daycare while in the drug court but once they transition out they no longer are eligible which creates a challenge that results in them funneling back through the system.

4. Support community convening where we bring together law enforcement under the criminal justice umbrella all of the law enforcement, providers, courts, and local communities to see what is available, what the gaps are and come up with some local solutions.

5. Embedding training and education in behavioral health and physical health in the criminal justice system and providing information sharing to build more partnerships.

D. Support people in treatment and recovery and reduce stigma
1. The full continuum of care of recovery services for OUD and any co-occurring substance use or mental health issues, including supportive housing, residential treatment, medical detox services, peer support services and counseling, community navigators, case management, and connections to community-based services.

2. Identifying successful treatment and recovery programs that are providing support and technical assistance to increase the number and capacity of high-quality culturally responsive, rural, medication assisted treatment programs to help those in recovery.
   i. Lack of access to best practices utilized by cultural communities. In the bill there is $2 million dollars for traditional cultural healing which we realize isn’t enough but maybe we could track outcomes on that work
   ii. Lack of diversity in the workforce, using community engagement programs to increase the workforce and cultural competency.

3. Engaging in community-wide stigma reduction and education about treatment, support and workforce readiness to reduce the stigma and provide support to the individual in recovery.
   i. Lack of opportunities for people in recovery. We thought incentive employers to hire people in recovery.

Part Two: Prevention

E. Prescribing tools, patient education, alternative medicine and prevention of opioid use disorder

1. Prescriber education on the risk of opioid prescriptions in the home
   i. Increase of the general public of the risk of opioid prescriptions in homes
   ii. Institute provider screening questions for opioids in the home and if yes, offer follow up resources for naloxone prescription/access, security storage and safe disposal.
   iii. After sharing with larger group it was suggested that the screening be inclusive of additional harmful substances/prescriptions

2. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
   i. Access to evidence based pain management, especially for those in our disparate populations,
   ii. Financial reimbursement for alternative medicine.
      a. Exploration of the alternative and complimentary medicine to learn more about and what is actually is and isn’t working in the first year of funding.
   iii. Physician education on pain management.

3. Development of Prescription Drug Monitoring Program and Electronic Health Interoperability
   i. Interoperability between electronic health records and prescription monitoring program (PMP). The technology is there and we are seeing more and more programs sign on. The question has been who should fund it? Does the private side continue to fund it or should the state fund it? The prescription monitoring program has partnered with Jpal to measure the effectiveness of PMP integration. As the results come in that might further guide us.
a. Look at the functionality of the prescription monitoring program and the electronic health records.

4. Public education relating to opioid prescriptions.
   i. Develop a resources of effective prevention messaging campaigns based on outcomes measures and evidence for consideration in MN
      a. After sharing with the large group Weston shared Weston shared that he has an extensive scan of treatment, prevention and other evidence-based resources from MDH and DHS created by MMB and the impact of the interventions/programming that have been shared below;

5. Drug take-back disposal or destruction programs.
   i. Disposal sites, we were thinking of a policy recommendation if you dispense you should have a disposal site as well to make disposal more community friendly and common. This would need some incentives for doing this as it costs for pharmacies to dispose of the drugs.

6. School-based programs that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
   i. Increase the resiliency in youth and families
      a. Develop resiliency programming for youth and families
         a. Reiterates with needs for a shorter school friendly, funded annual Minnesota Student Survey
         b. School based setting
         c. Based on Adverse Childhood Experiences (ACES)
         d. COPE/HOPE inventory measures identified as a resources for outcome/impact
         e. Social emotional learning training

7. School and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
   i. How to have Adverse Childhood Experiences (ACES) training or trauma training in schools.

F. Prevent Overdose Deaths and Other Harms (Harm Reduction)
   1. Increasing availability and distribution of naloxone and other drugs that treat overdoses to first responders, overdose patients, opioid users, families and friends of opioid users, schools, community navigators and outreach workers, drug offenders upon release from jail/prison, and other members of the general public.
      i. Access to naloxoboxes, also choosing settings where community members might go like when they are visiting in jails, libraries, schools, convenience stores, etc.
      ii. Deploying to grass roots locations that are out on the streets to use for hot spots.

2. Training and education regarding naloxone and other members of the general public.
   i. Access to education and kits materials in multiple language we think is pretty low hanging fruit.

**Part Three: Other Strategies**
G. Research
   1. Minnesota Student Survey only done every 3 years, doesn’t track with trends because they change so quickly. The thought is if we could streamline the focus and make it a more regular base survey (every year) that talks only about drug use trends. Sarah asked Increase resiliency through additional prevention education in schools.
   2. Lack of understanding of existing curriculum specifically around addiction that might be being done in schools nationally or locally we would begin that process by doing an assessment of the current curriculum in use and outcomes.

H. Reimbursement/Policy
   1. We talked about payment reimbursement and thought of some sort of block funding that is ties reimbursement to outcomes.
   2. Family programming because that is not well reimbursed.
   3. To explore and encourage alternative payment methods. Example, PCODE for Addiction Medicine providers.