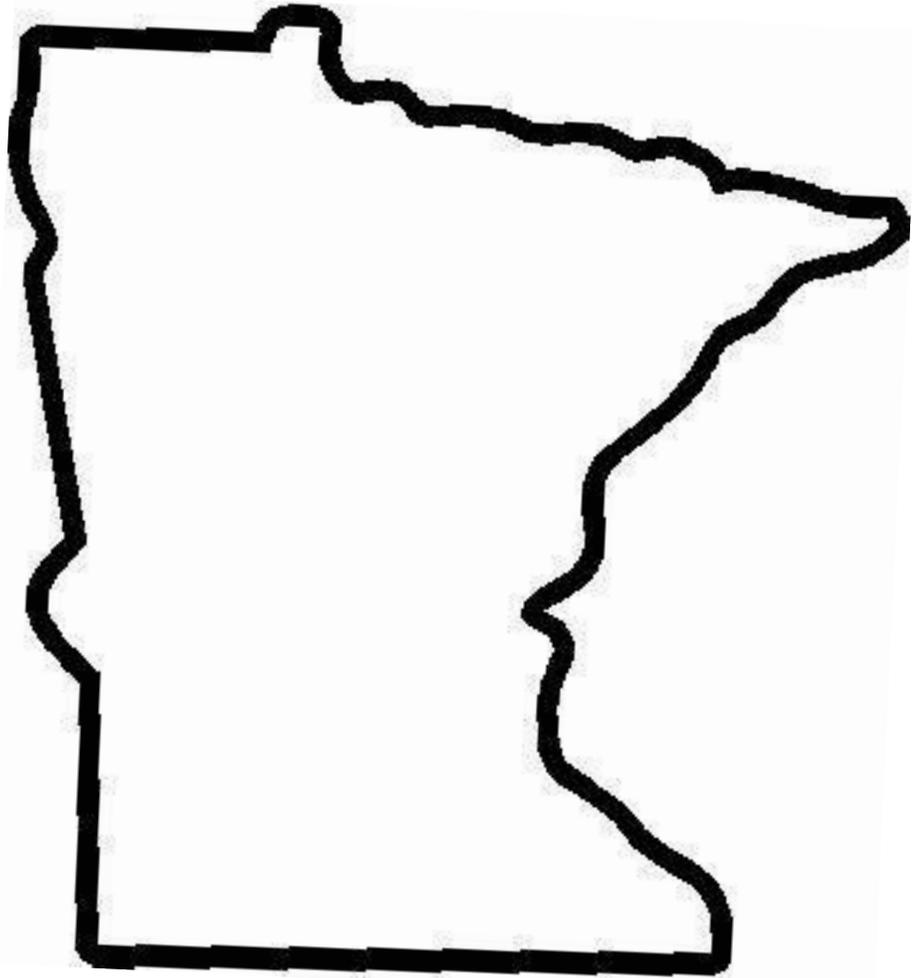




DEPARTMENT OF
HUMAN SERVICES

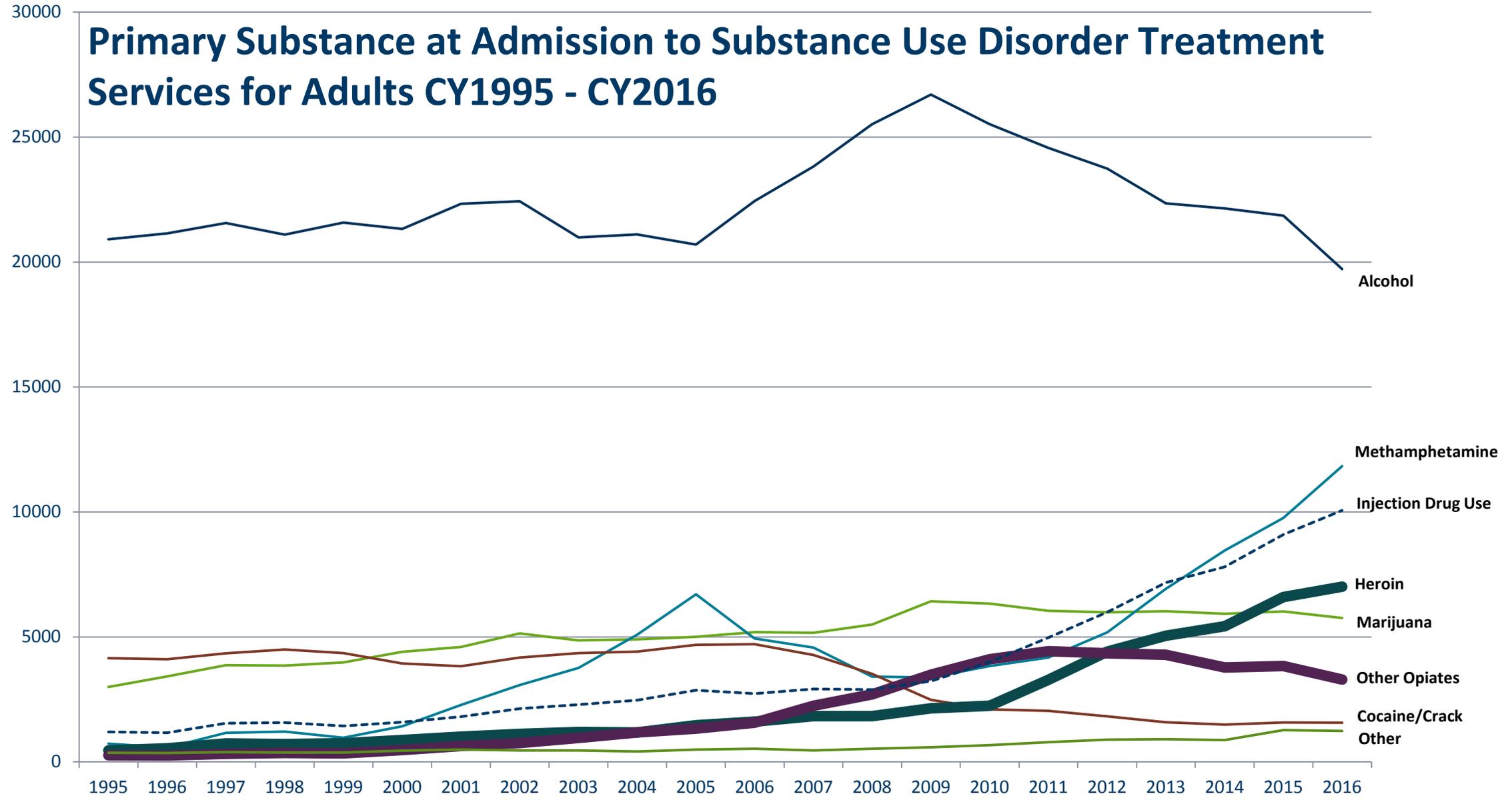
State Treatment Court Conference: Substance Use Disorder Reform

Charlie Mishek, Agency Policy Specialist: Alcohol & Drug Abuse Division
Brian Zirbes, Deputy Director: Alcohol & Drug Abuse Division



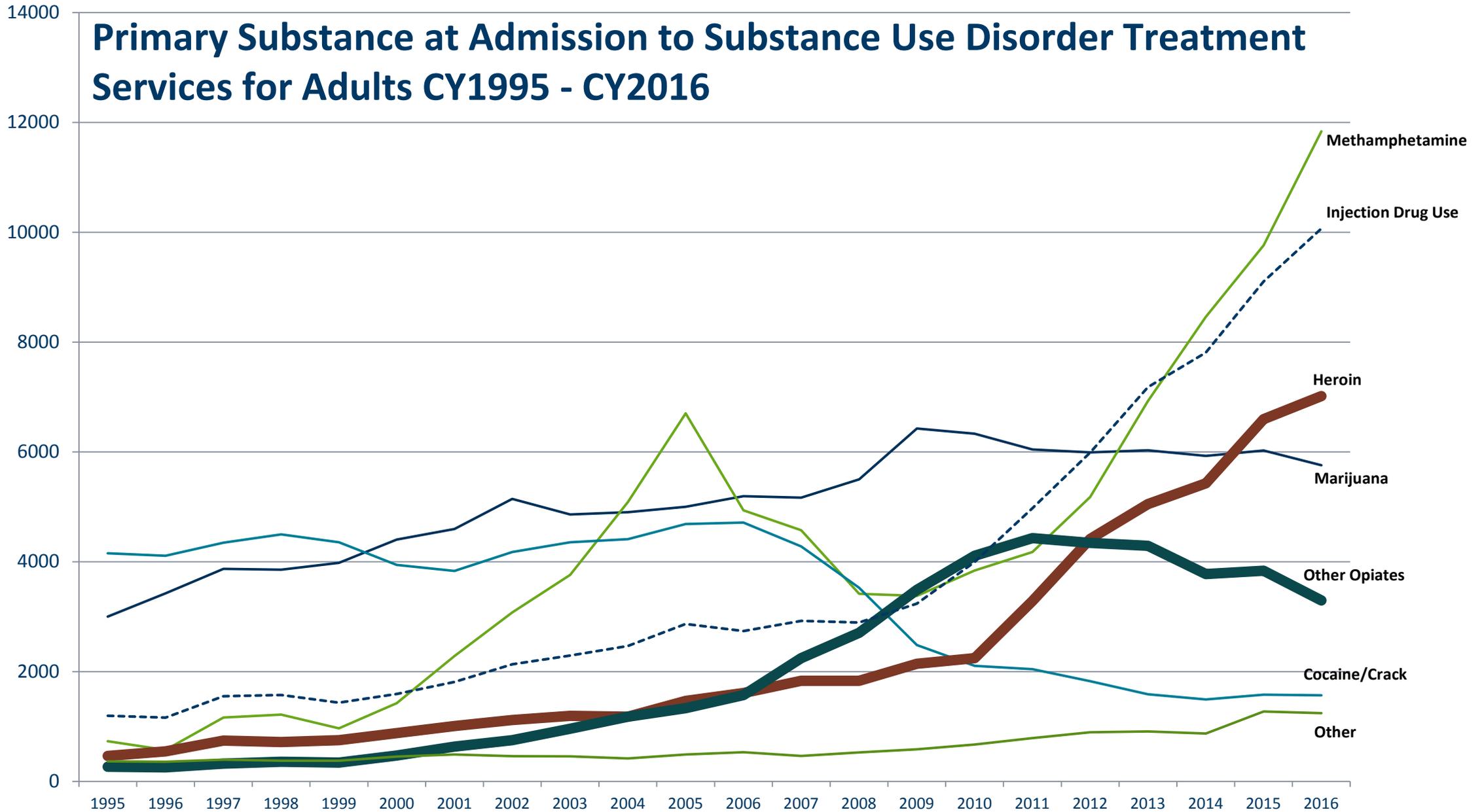
- ❖ Scope of the issue
- ❖ New Services
- ❖ Timelines for Change

Primary Substance at Admission to Substance Use Disorder Treatment Services for Adults CY1995 - CY2016



Source: Minnesota Department of Human Services, ADAD, DAANES (5/2/2017)

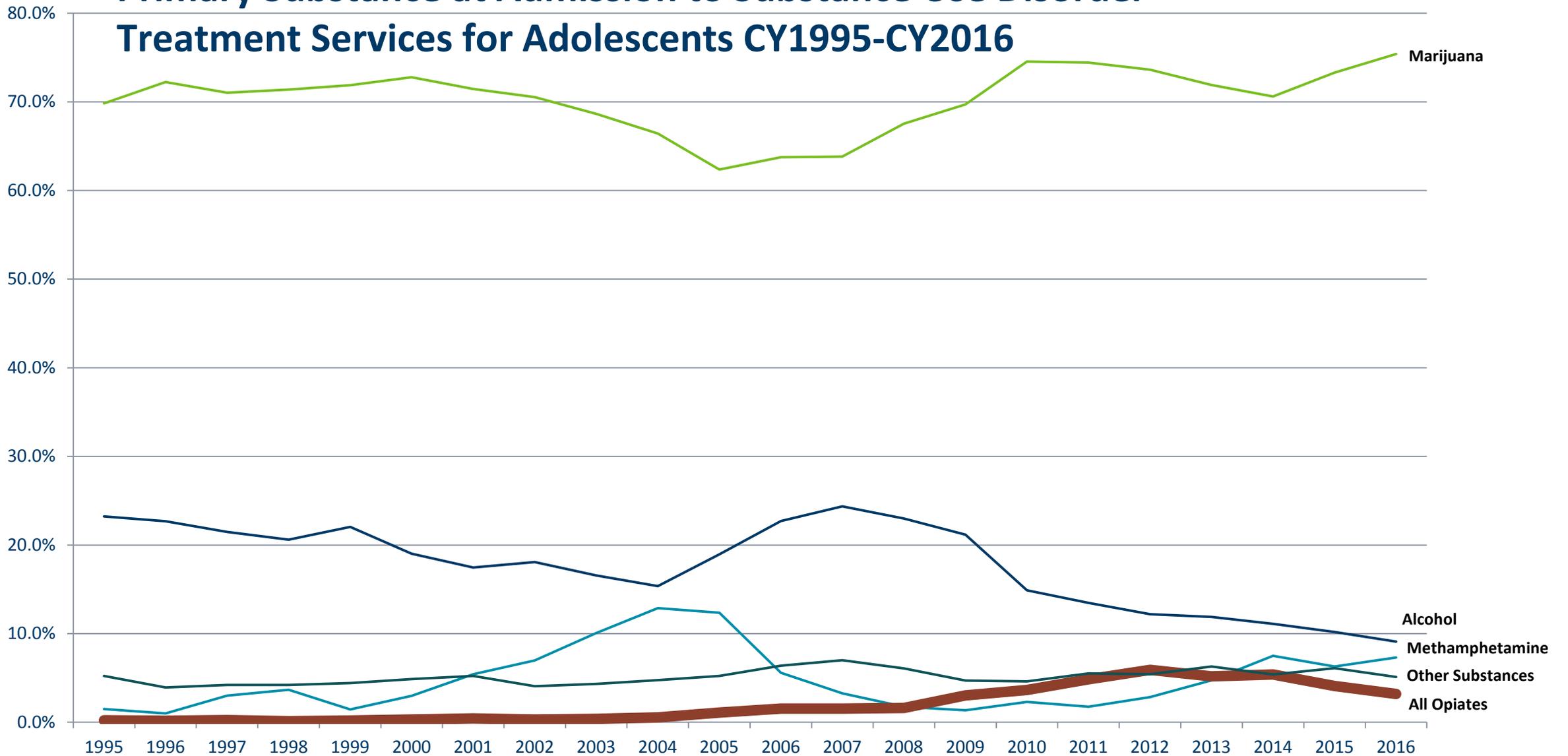
Primary Substance at Admission to Substance Use Disorder Treatment Services for Adults CY1995 - CY2016



Alcohol Not Presented

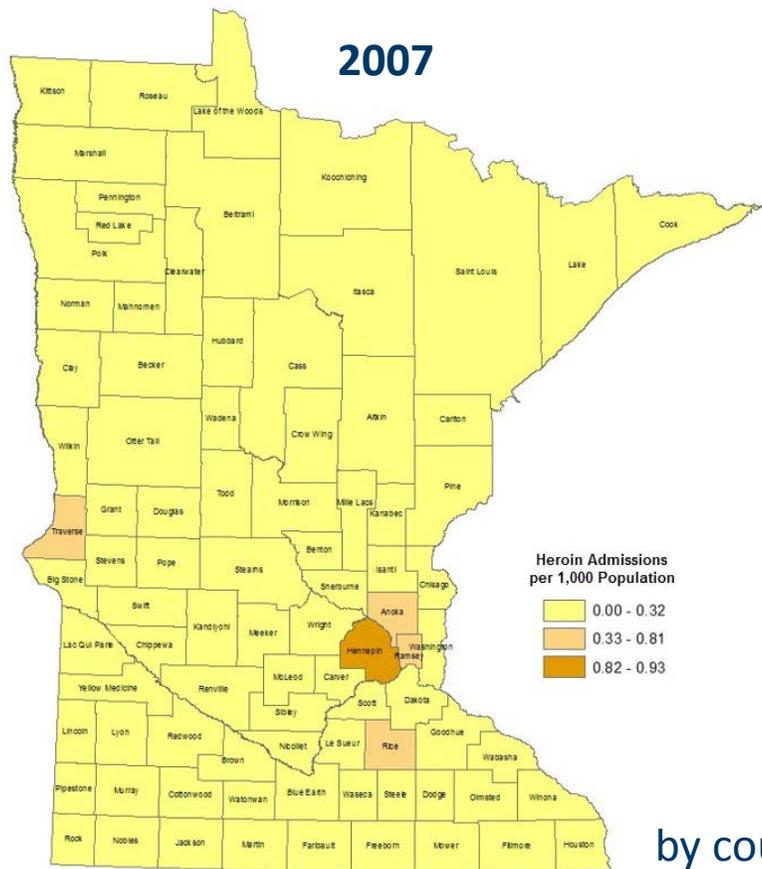
Source: Minnesota Department of Human Services, ADAD, DAANES (5/2/2017)

Primary Substance at Admission to Substance Use Disorder Treatment Services for Adolescents CY1995-CY2016

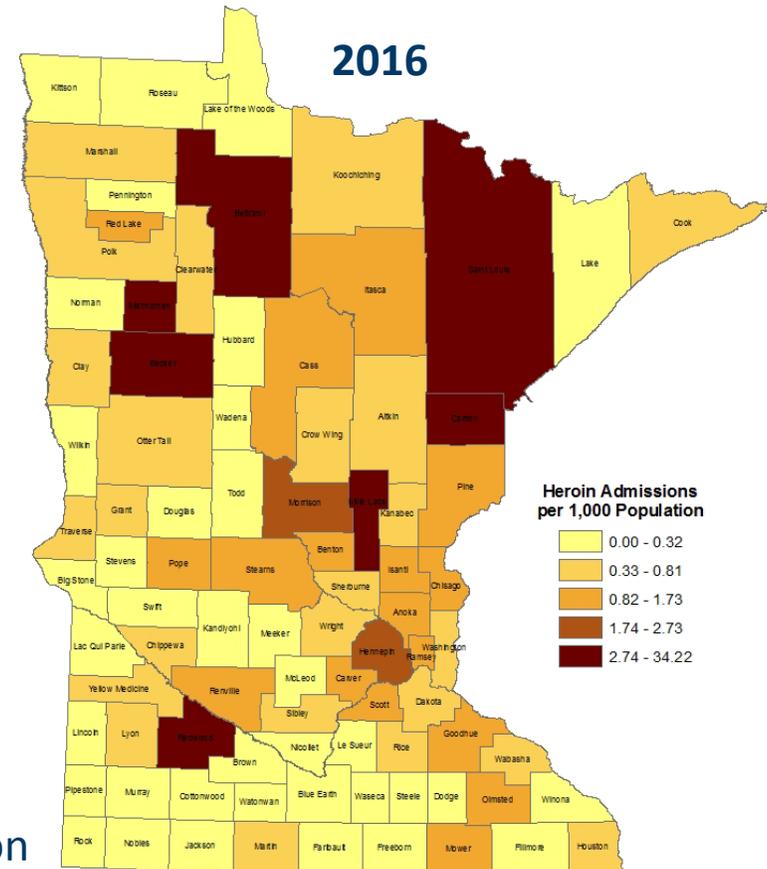


Source: Minnesota Department of Human Services, ADAD, DAANES (5/2/2017)

Treatment Admissions: Heroin



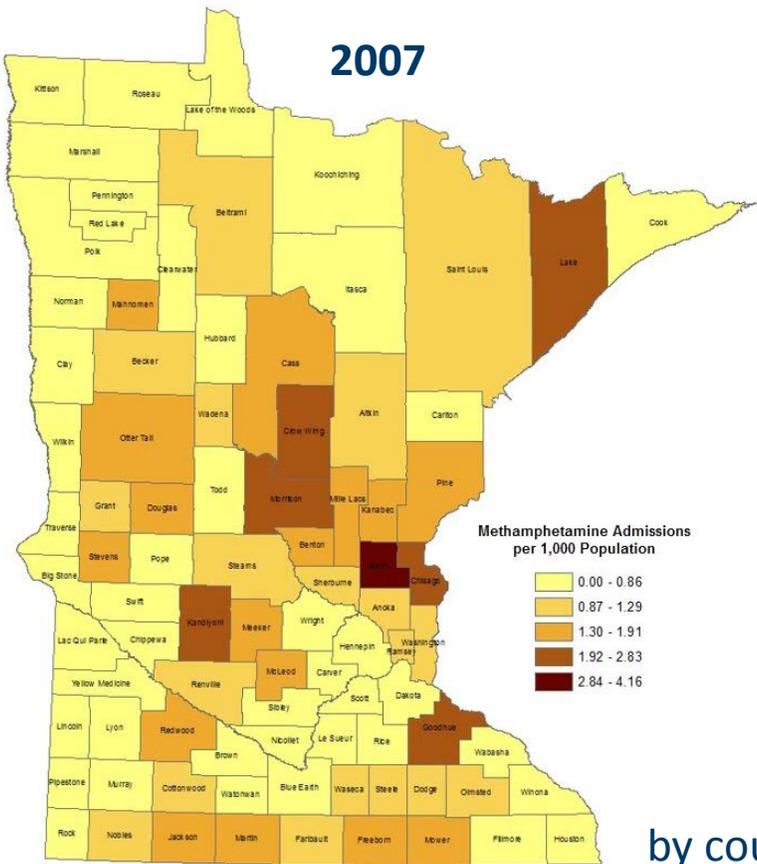
Source: Minnesota Department of Human Services, ADAD, DAANES (5/14/2015)



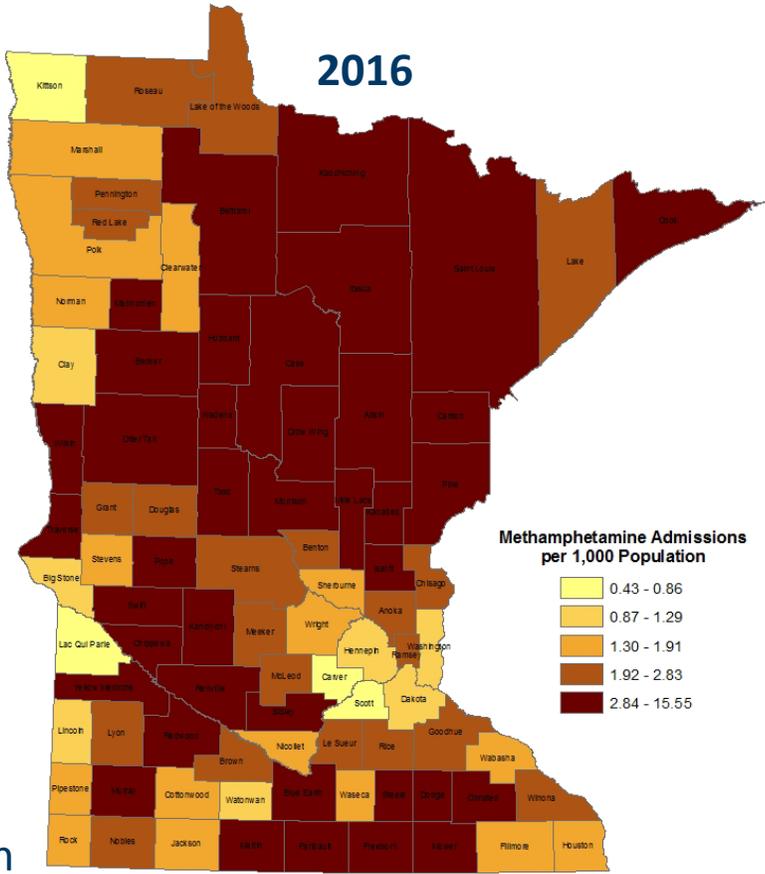
Source: Minnesota Department of Human Services, ADAD, DAANES (5/3/2017)

by county of admission

Treatment Admissions: Methamphetamine



Source: Minnesota Department of Human Services, ADAD, DAANES (4/24/2015)

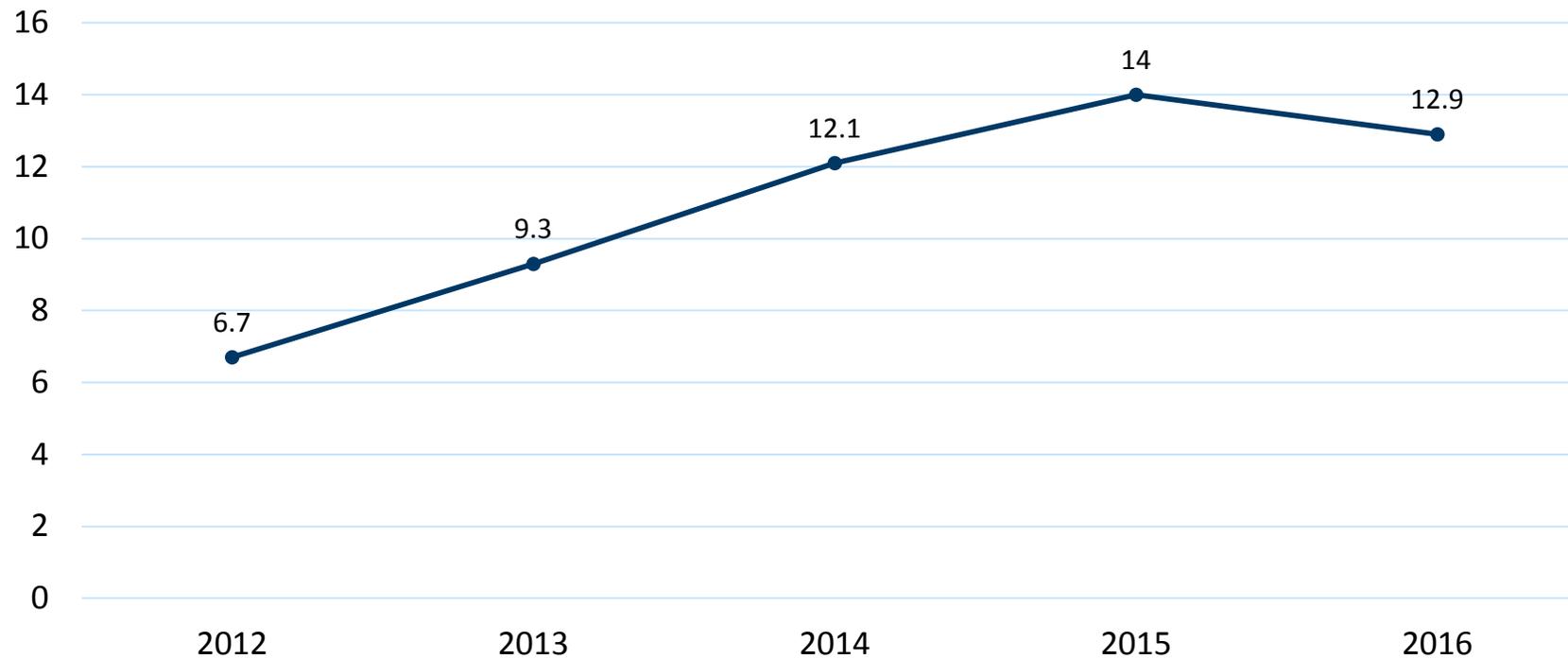


Source: Minnesota Department of Human Services, ADAD, DAANES (5/3/2017)

by county of admission

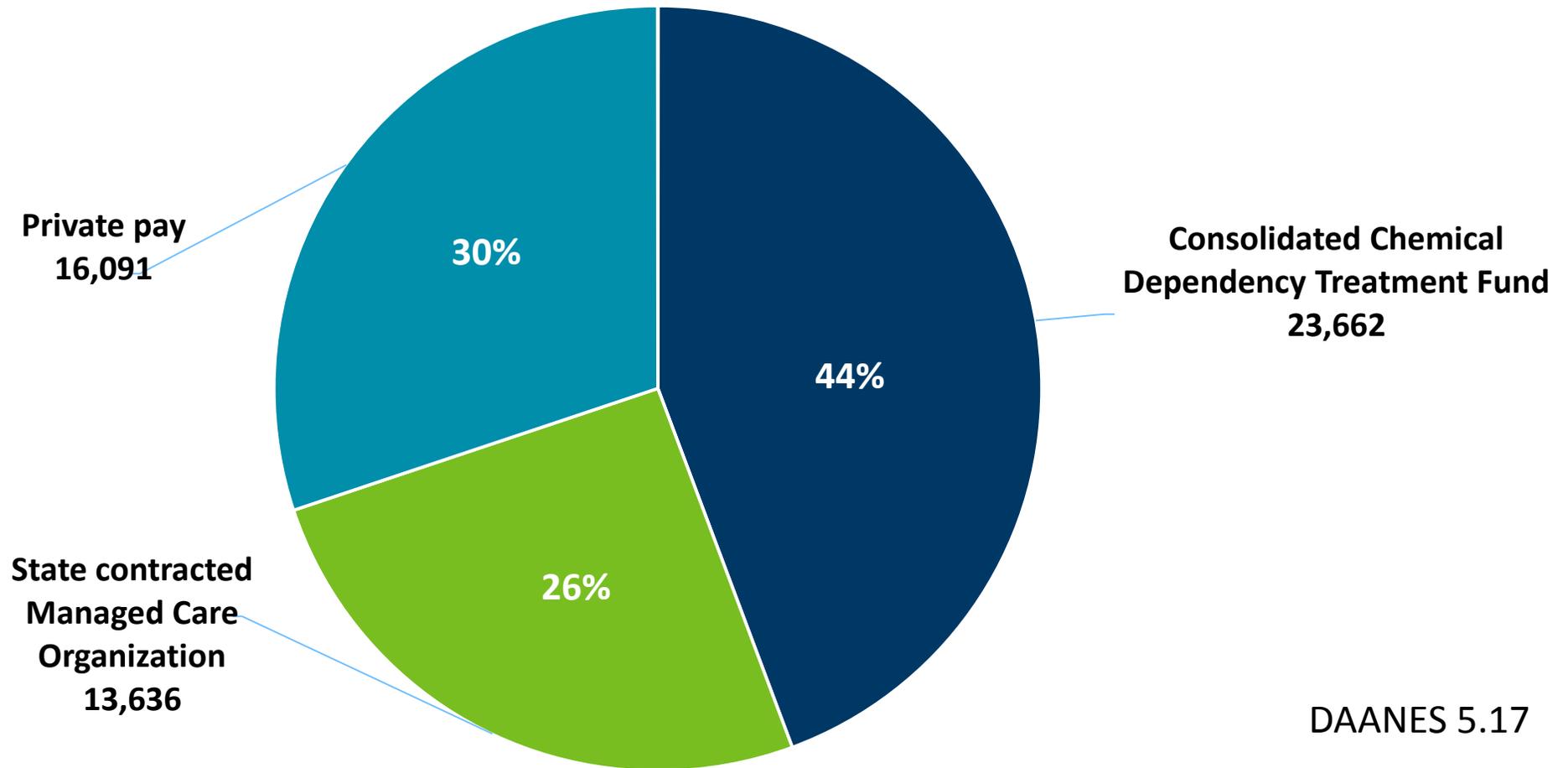
Effects of Opioid Crisis on Pregnancies

Neonatal Abstinence Syndrome per 1,000 live births



Treatment Admissions all Funding Sources

CY 2016

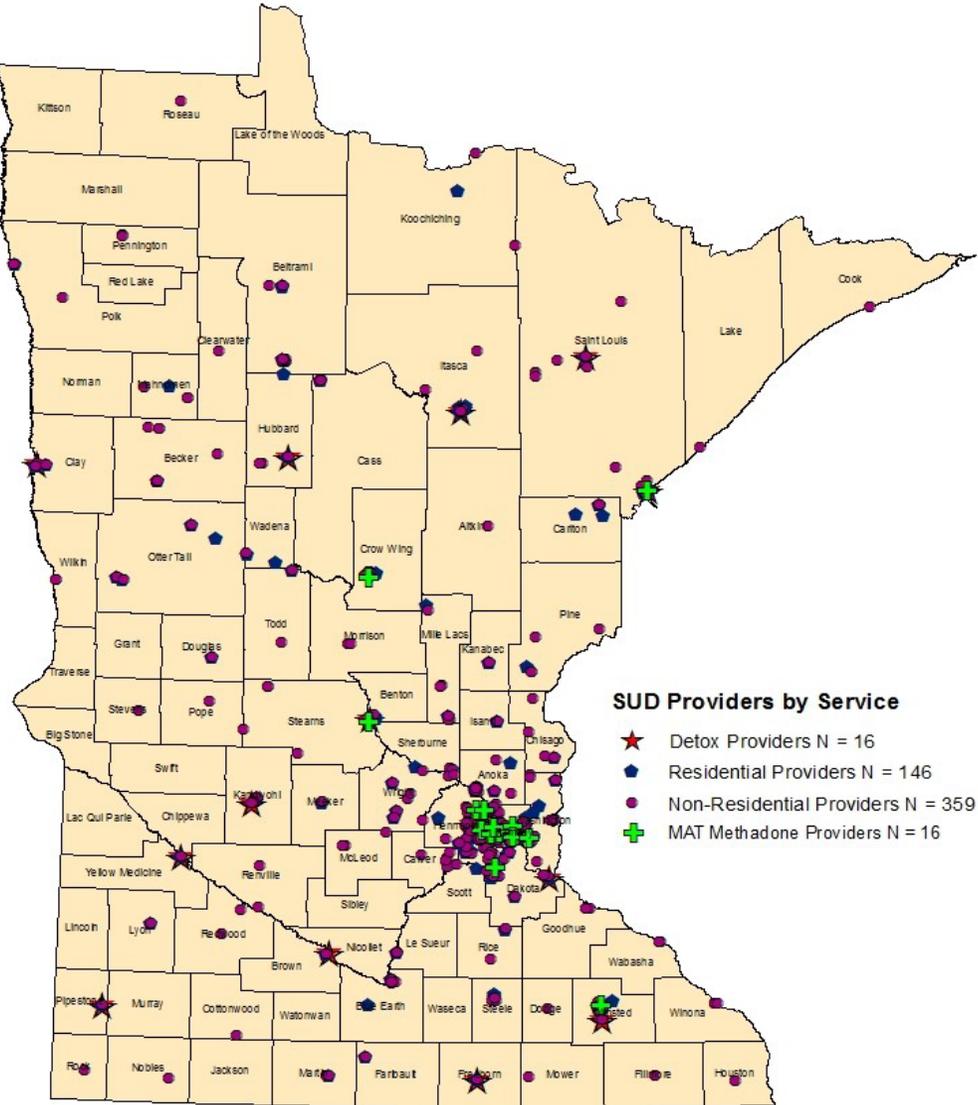


DAANES 5.17

The Minnesota Continuum of Care

- Today there are more than 400 treatment programs, ranging from small outpatient programs to large providers with a full range of the continuum from withdrawal management to residential services.
- To support access to these services, the Department of Human Services developed the Consolidated Chemical Dependency Treatment Fund (CCDTF), which is a unique funding tool in the U.S.
- The CCDTF ensures that all public assistance eligible individuals who need treatment, have access to chemical dependency treatment through a state-operated, county managed system.

Substance Use Disorder Treatment Providers



Source: Minnesota Department of Human Services, ADAD, DAANES (5/4/2017)

Why Was Reform Needed?

- While the basic Minnesota Model continues to serve us well, the level of complexities that clients are presenting with has grown more and more complex, resulting in service gaps.
- The Minnesota Model is influenced by the philosophy of Alcoholics Anonymous, which doesn't work for all clients.
- It is an abstinence-based model, with the goal of treatment being abstinence from all mood-altering drugs, which may not always be possible, or appropriate, especially when treating opioid withdrawal.

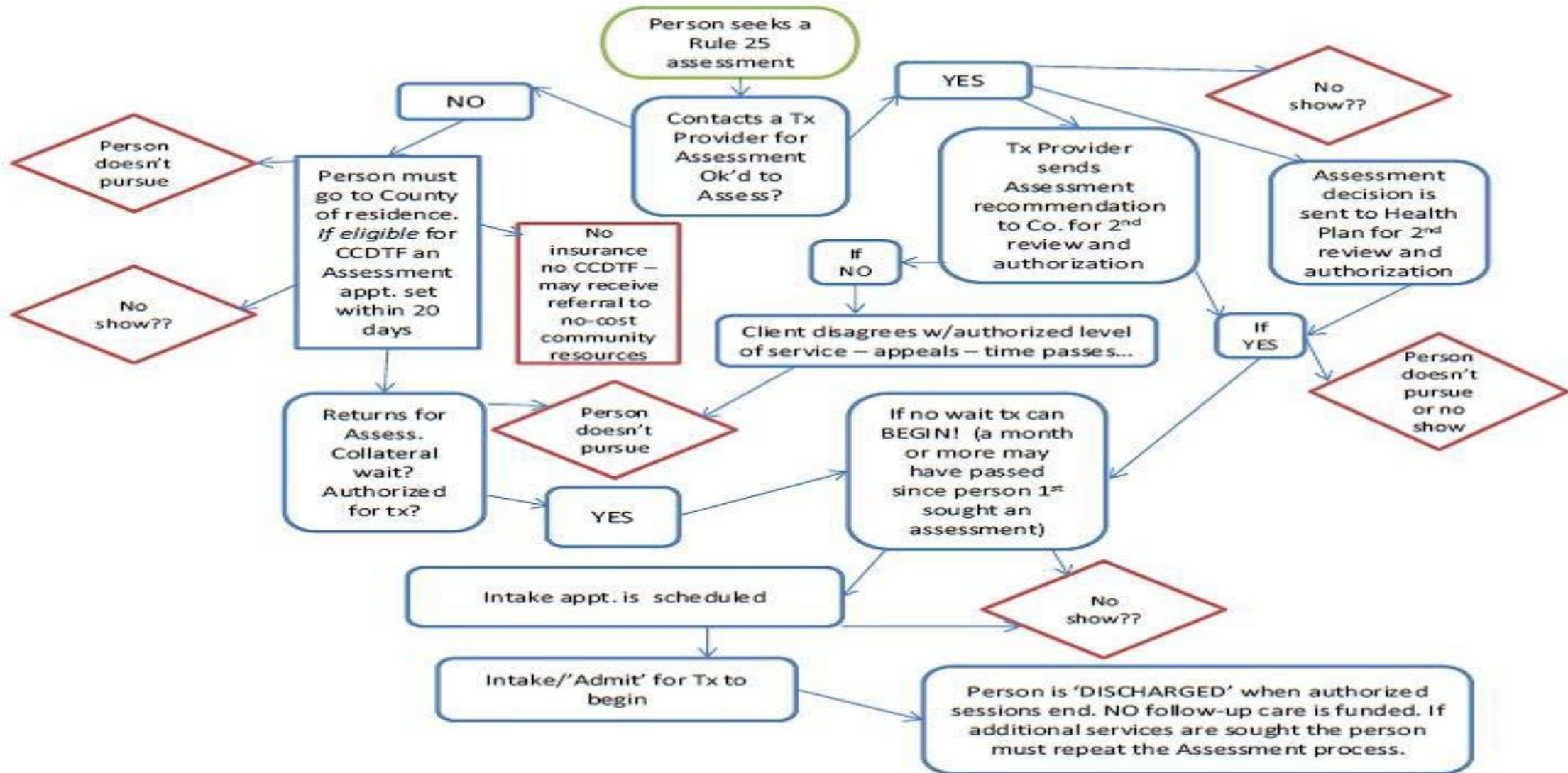
Changes Needed- Conflicts within the Model

- Clients who have co-occurring mental health problems, may need to take prescribed medications as part of their care which are considered habit forming. Not all treatment centers are open to allowing these medications in their facilities.
- Clients who have an Opioid Use Disorder, may need to take prescribed medications that could be abused by others, and are seen as addictive for some. This has resulted in clients receiving medication assisted treatment to be denied access to an abstinence only facility.
- The Harm Reduction approach that a number of states have moved to because it doesn't require abstinence, has not been a good fit with the Minnesota Model.

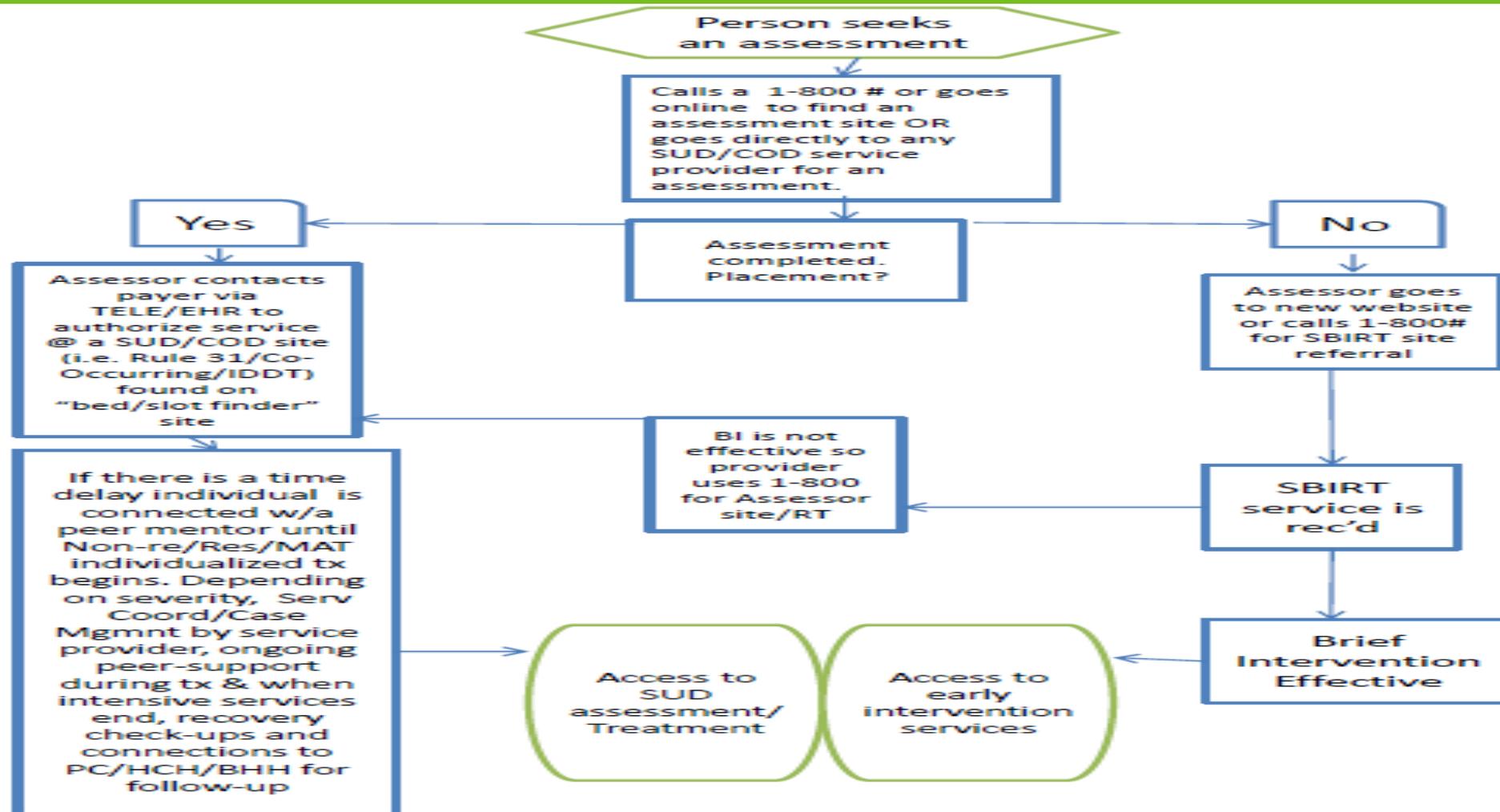
Medication Assisted Treatment

- Substance use disorder treatment which utilizes a medication as part of the treatment plan is called “medication assisted treatment”.
- Historically used primarily for the treatment of Opioid Use Disorder, and has been carefully regulated by the Federal Government.
- The medications used are Methadone and Buprenorphine for stabilization and maintenance, and in some cases, withdrawal.
- Another medication used is naltrexone, which is used when the person is opioid-free, to continue to support their recovery efforts.

Access to Services Now



Access to Services Coming Soon



2017 Legislature: Substance Use Disorder Reform Passed

- Substance Use Disorder Reform
 - Direct Access
 - Care Coordination
 - Peer Recovery Support
 - Direct Reimbursement
 - Withdrawal Management

Substance Use Disorder Reform

Expand Access

- People go to program of choice
- Get assessment and treatment directly

Continuum of Care

- Working with people without gaps in access to support
- Care Coordination

Peer Recovery Services

- Providing links to recovery services
- Accessing peer services early on and throughout treatment and recovery journey

- The current system of access to services through Counties does not always allow for the immediate access to care that is needed.
- Goal is to allow for access to services as quickly as it can be done to the right service.
- Direct access will allow a person to directly go to the provider of their choice, get an assessment, and enter services.

Comprehensive Assessment

- The comprehensive assessment will be reimbursable service!
 - required under Rule 31/245G instead of Rule 25.
 - is a more complete assessment
 - leads to the development of the treatment plan, not simply a placement recommendation
- This will reduce the paperwork a client must go through

Direct Reimbursement

- The SUD reform plan also allows for credentialed providers to provide assessments and other treatment services outside of the Rule 31 program.
- Counties will have the ability to be an eligible vendor for these comprehensive assessments when they are provided by appropriate staff.
- Comprehensive assessments could be done in a variety of locations, including clinics, drug court offices, hospitals, etc.
- **Bring the service to the person vs. bring the person to the service**

Care Coordination

- Since SUD is a chronic illness, those building a viable recovery often need support over a long period of time, and this can be provided by care coordination
- Care coordination is also reimbursable under the SUD reform, in 15 minute increments.
- By supporting and linking a person to the resources they need, as they need them, their recovery is strengthened, and they can avoid reoccurrence of symptoms and need to go back into treatment.

Care Coordination in the Community

- Once a person is finished with their initial treatment services, care coordination can continue to support their recovery as long as is needed.
- Counties and Tribes will also have the opportunity to become eligible vendors to provide care coordination, and receive reimbursement
- Qualifications for care coordinators are similar to Rule 25 assessor qualifications.
- Linking a person to all the services they need for their recovery can help them navigate the obstacles that, in the past, have sometimes resulted in relapse.

Peer Recovery Support

- The use of peer support as a resource to further help persons in recovery link up with the community is effective
- The SUD reform adds peer recovery support to the menu of services available to help a person, and is reimbursable in 15 minute increments
- Programs can also connect with other providers who offer those services so they can insure they are available for their clients.
- Eligible vendors are licensed SUD programs, withdrawal management programs, and Recovery Community Organizations.

Recovery Community Organizations

- RCOs also provide the bulk of the training for persons interested in acting as recovery peers.
- Under the supervision of RCOs, peers could be placed in a variety of locations, such as clinics, drug court offices, emergency rooms, etc.

- The implementation of the new services will occur in stages.
- While the legislation is effective on January 1, 2018, the new services will require CMS approval
- This process can take time, so the projected date of the implementation is July 1, 2018, or upon federal approval, whichever is later.

Direct Access Implementation

- Moving from the current system of County-based referral to the system of direct access will start no earlier than July 1, 2018
- There will be a “parallel process” in place for two years, where both systems can operate simultaneously
- In areas where the providers are ready, the move to direct access can happen immediately
- In areas where the providers are not ready, or there are few to none, the county system will continue as the process is developed.

Withdrawal Management

- Withdrawal Management standards were approved in the 2015 Legislative session.
- The 2017 SUD Reform legislation will allow DHS to work with the Centers for Medicare and Medicaid Services (CMS) to develop and get approval for a rate structure for the new Withdrawal Management services
- The implementation of the new standards and rates is slated for July 1, 2019

Strategies for the Future

- State Targeted Response to the Opioid Crisis Grants (STR)
- Supporting and expanding both medication-assisted treatment and increased access to buprenorphine through Office-Based Opioid Treatment (OBOT)
- Addressing the Institutions for Mental Disease (IMD) exclusion
- Application for the CMS 1115 Demonstration Project

DHS has identified 5 spending priorities for the \$5.4M:

- 1) Overdose prevention via providing naloxone
- 2) Expedited access to treatment
- 3) Increase infrastructure for MAT in primary care settings and OBOT
- 4) Primary prevention for youth
- 5) Statewide media campaign

Institution for Mental Disease (IMD) Exclusion

- The purpose of the IMD exclusion was passed in 1965 to prevent the “institutionalization” of people receiving care for “mental disease”.
- Substance use disorders clients are not in danger of “institutionalization”, and usually need Residential care for less than 30 days
- We do not think care for SUD fits under the IMD exclusion and is not in accord with Parity
- We appreciate the U.S. Congress’s efforts to have CMS examine this and remove SUD treatment and facilities from the IMD exclusion.

1115 Demonstration Project

- CMS is providing an opportunity to support SUD system transformation in states that want to improve their services.
- This would allow for a process to move toward integration with healthcare, continue the development of a “Recovery-Oriented System of Care”.
- Participation in this project permits a waiver of the IMD exclusion for some residential programs to allow them provide needed care.
- It would support efforts to use data to validate and further inform our efforts to improve and transform our system.
- However, our substance use disorder system is not set up to meet the required conditions of the project at this time.

- Efforts to expand early intervention and education through prevention activities are ongoing statewide
- Strategic Prevention Framework- Prescription Drugs
- Planning and Implementation Grants

- SUD Reform Plan: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7269-ENG>
- ADAD description: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3765-ENG>
- 2013 Legislative Report: Model of Care for SUD: http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_195241.pdf
- Positive Community Norms: <https://mn.gov/dhs/people-we-serve/seniors/health-care/substance-abuse/programs-and-services/positive-community-norms.jsp>

State Treatment Court Conference: Substance Use Disorder Reform



Thank you!

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