House DHHS Subcommittee hearing on the opioid crisis
Local Prepaid Inpatient Health Plan (PIHP)

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Mr. Chairperson and distinguished members of the Subcommittee, my name is Christina Nicholas, Substance Use Disorder (SUD) Director Oakland Community Health Network (OCHN) and Chairperson, SUD Directors Group for the 10 Regional Substance Use Disorder entities.

I would like to discuss the impact Medicaid expansion has had on the opioid epidemic and how it's an integral part of combating this crisis.

- It allows for the leveraging of funding to create unique programs that are tailored to the needs of the region. The system was heavily under-funded for many years and the addition of the Healthy Michigan Plan (HMP) presented the opportunity to deliver more services in a timely manner.
- Prior to HMP (Medicaid Expansion), some regions had up to six month waiting lists for Medication Assisted Treatment (MAT) or withdrawal management /residential treatment. Oftentimes these are the most important services for people with opiate use disorders to begin the road to recovery.

Healthy Michigan Funding has been a great help, but we still require state and local general funds and other sources of funding to eliminate barriers to recovery. This has become a challenge recently as general fund dollars have been removed from the budget. Some of the barriers that this funding helps us overcome include:

- Transportation - HMP funding allows for the use of other fund sources to address the the needs in the community. Many people struggle with attending treatment due to transportation.
- Individuals in jail lose Medicaid while incarcerated. A high rate of individuals with SUDs are part of the criminal justice population. Adequate funding allows the development of specific treatment programs to assist this population, especially following release from jail. This is often where the highest rate of overdose occurs.
- Prevention services are extremely important. Funding for prevention can address concerns and issues that reduce the risk of an SUD.

- Recovery Housing

Local decision making is key to the success of treatment and recovery. Each region has it's own unique needs, and local Regional Entities are able to focus on those needs and ensure they are addressed. Local oversight allows individuals served to be involved in the decision making process and develop unique programming to better serve communities. and individuals receiving services.

Each region works tirelessly to build and collaborate on traditional treatment efforts that include:

- Women's specialty treatment specific
- Early intervention training
- Residential and detoxification services
- Outpatient treatment
- Case management services

It also allows for unique programming to meet the individualized needs of person's served such as:

- Innovative programing unique to the corrections population
- Informal but, crucial recovery support services
    - Engagement Centers
    - Recovery Housing
    - Recovery Coaches
- Enhance medication assisted treatment

Finally, many people want to do anything possible to assist their family members and loved ones. There is currently 2014-PA-0200 Sec. 281a-c which governs involuntary admissions of individuals with substance use disorders. In working with treatment providers, there is a belief that while the spirit of this law is wonderful, there are too many inconsistencies and ambiguities between the Act and 42 CFR Part 2. Health Professionals do not feel they can safely provide the information required by the Act without risking violations of 42 CFR Part 2 and subjecting the health professional to criminal sanctions.
Thank you for allowing me to provide this testimony today.

TEN16 recovery network

Life to the fullest. Free and clear.

At Ten16 Recovery Network, we are passionate about helping people live life to the fullest, free and clear. This is why we do everything that we do. We have services in Midland, Clare, Gladwin, Mt Pleasant , Alma, Big Rapids and will be starting in Saginaw later this month. Ten16 specializes in the delivery of substance use disorder services; able to address a full episode of care as people work toward recovery and wellness.

There are two key facts that drive our organization:

- Only 10% of the people with a substance use disorder come to a place like Ten16, so we are looking for ways to engage the missing 90%
- For the average person struggling with SUD to achieve one year of continuous recovery, it will take them 8 years of trying and 3-5 visits to treatment. And its not until a person has 5 years of continuous recovery that their relapse rate falls to less than 15%. So we are focused on the long-term, helping folks sustain their recovery.

In the Great Lakes Bay region, we are treating more people for opiate than we are for alcohol. In response to the growing opiate epidemic and the need to reach more people, Ten16 has experienced a tremendous amount of growth. In the last 5 years, Ten16 has:

- Increased our footprint from 6 sites to 19 service locations.
- Increased program staff by 49%.
- Increased persons served by 60%
- Increased client encounters by 98%

To share two quick examples of our initiatives, In the last three years, we have converted all of our outpatient clinics to a new model that we call the Center for Recovery and Wellness. Staffed by people who have experienced recovery first hand, the Center offers drop-in services and scheduled programs to address the critical Recovery Zones of Health, Support, Work and Home. The Center has casual and recreational space including a coffee shop, TV lounge and computer lab, plus meeting rooms, counseling and support offices. We have a recovery coach answering the phones as the first point of contact, and offer immediate access for anyone looking for help. Since pioneering this model, we have doubled the number of average sessions that a person attends and improved our completion rates by 12%.

Our Project Assert program has been a tremendous success. What started as an experiment in the Midland Emergency Department has led to an expansion in 7 different EDs now. In the last 12 months, we talked with 877 patients and 75% of them screened positive for a substance use disorder. Of those folks, 89% agreed to participate in a

brief intervention, which frequently lead a referral to a treatment and/or a peer support program. 53% of those patients followed through on that referral.

To give you a better idea of whom we are talking with,

- 46% are on Medicaid
- 19% have private insurance
- 17% had Medicaid/Medicare or Medicare alone
- 15% were uninsured
- 3% had VA benefits or TriCare

Barriers & Challenges

1. System Coordination

   When dealing with a community-wide crisis like this, coordination, communication and integration is critical; coordination between health systems, SUD providers, law enforcement, State and regional policy makers and others. We are fortunate to be involved with a 14 County Opioid Priority Workgroup, through MiHIA (Michigan Health Improvement Alliance). Here we are able to share resources for a common goal, and identify potential pitfalls of certain approaches. To use the old metaphor, it is important to understand that each of our systems is only touching a part of the elephant, and we need to stay mindful of the whole animal. As each system attempts to do their part to address this epidemic, it is important to look out for the unintended consequences of each good effort.

   For example, I am thankful that Narcan is available to save lives as an overdose intervention, and the Legislature is taking steps to ensure its availability. As health systems and community coalitions are looking at Narcan distribution, it is critical to develop corresponding programs that reach out to those who have Narcan administered to them, and attempt to engage people in some level of treatment and help break the cycle of addiction that they are trapped in.

2. System Design

   Unlike the CMHSPs in every community, there are very few SUD providers across the State that can offer a full continuum of interventions. This can lead to people falling between the cracks as they step down from one level of care to the next. We have our own internal issues with that as they step down from detox to residential to outpatient counseling, but it can be even more challenging when a person's episode of care is across multiple agencies.

Additionally, the SUD system has long been under-developed and underfunded. We are not built for crisis intervention or community-based work, where we can go to people's homes. For decades, we were limited to detox, residential and outpatient. It wasn't until the Healthy Michigan Plan that there were expanded benefits and program design opportunities that have long been available to our friends in the CMH world.

Since then, you are seeing small pockets of innovation, but it is limited by both funding and vision. Since most SUD providers live in a fee-for-service world, it is difficult to start them on our own.. It takes start-up capital to develop new programs. Thankfully OROSC (Office of Recovery Oriented Systems of Care) and some PIHPs have been offering many grant opportunities to support creative approaches. For mission driven agencies that are taking the risk to develop these programs, it comes with two cautions. First, what happens when these special funding sources go away? Will there still be funds available to sustain these efforts long term? Second as agencies try to keep up with the growing demands from our communities, we are running into significant capacity issues, both from a workforce and an infrastructure standpoint.

Contextually, it is important to understand during the back drop of the growing opioid crisis, the SUD system has been going through radical changes within our funding structure. Since 2013, when the Coordinating Agencies were legislatively eliminated, our agency has dealt with 3 different regional funding sources. With each change, we have noticed an erosion of institutional expertise in working with substance use disorders. While there might be some administrative efficiency that has been gained, it has come at a cost to understanding and supporting those that struggle with SUD and its provider network.

With the implementation of Section 298 looming, I fear that even more erosion could occur. While that the public system has its flaws, our agency only had to deal with one primary entity for our catchment area. Assuming the 298 pilots lead to funding being consolidated with the Medicaid Health Plans, for Ten16 to serve the same people in our 6 counties, we will have to contract with 8 different health plans, each potentially taking a different approach to population health and SUD.

3. Disease Complexity

In dealing with a complex, chronic, relapsing disease, there are no simple answers, no silver bullets. There is an active tension between the short-term

urgency of keeping people alive and the need to ensure programs and policies are infused with the messages of hope and long-term recovery. It is essential that we meet people where they are at, but not leave them there.

Arthur Evans, PhD, from Philadelphia's Dept. of Behavioral Health & Intellectually Disability Services, and one of the early pioneers in the ROSC (Recovery Oriented System of Care movement, once said, "*Traditional harm reduction programs have pioneered low threshold services, but they have often also been characterized by low expectations. Our vision is to expand low threshold services that at the same time elevate peoples' sense of what is possible for them. We do this by exposing them to living proof that recovery is possible even under the most difficult of circumstances, confirming that there are people who will walk this path with them, and offering stage-appropriate services to support people in their journeys from addiction to recovery.*"

From a treatment perspective, all options need to be available to the citizens of Michigan, including all forms of medication-assisted treatments as well as abstinence-based, drug-free options. There is no cure for this disease. But it is treatable and people do recover. None of the treatment options that are available are fool-proof. They each have their benefits. They each have their risks and limitations. Unfortunately, many providers and policy makers want to stress their preference by overselling those benefits and underselling the limitations. The most important focus of our current discourse should be centered on provide full and accurate information about options, ensure fully informed decision making for individuals and families, and not stigmatizing any single pathway even when it doesn't line up with a person or agency's core belief.

If our policies give in to a sense of pessimism or skepticism that there is little possibility of long-term recovery from opioid addiction, then we are ignoring the testimony of thousands living in our communities who have found a better way of living. I have the pleasure of working side-by-side with many of them at my agency. Dr George Valliant, a famed Harvard psychiatric researcher once said, "If you want to treat an illness that has no easy cure, first of all, treat them with hope."

4. Support for Families

Across our State, families are being devastated by this disease. They are desperately seeking information, advice and support as their loved ones are enslaved to their addiction. Community coalitions have been doing a

tremendous job of hosting summits throughout the region, educating people about the disease, treatment options and that there is hope in recovery.

Where we are limited as organizations is finding ways to offer consultation, counseling and support directly to those families. For example, we regularly get calls from parents who don't know how to help their son, daughter or spouse. They are looking for help, and don't know where to turn. Even though there is no State funding available for this type of consultation, our clinical staff have been offering free consultations to families. For the last 8 years, they have been meeting with 2-3 families a week, helping them make sense of this storm that they are trapped in. We do it because it is the right thing to do.

But there are limits on what we can offer families, especially those whose loved one is not in a treatment program. Because of how funding guidelines work, we can only bill for services for those with a substance use disorder diagnosis. Therefore, it is difficult for us to provide professional services to these families and get reimbursed for it. Without being able to provide them our collective expertise in dealing with this disease, they are left searching through the Internet looking for answer. Many times they are then allured to expensive, out-of-state, luxury rehab facilities that are preying on these families. Just last month, Google shut down the Google search ads for rehab facilities were taken down. "We found a number of misleading experiences among rehabilitation treatment centers that led to our decision, in consultation with experts, to restrict ads in this category," it was estimated by one expert that Google may have been raking in $1B a year from addiction treatment advertisers.

During the course of this hearing, you have heard and will hear lots of statistics. Here is one last set. One study in Australia, involved over 43,000 people, showed that those who struggled with an opiate addiction lost an average of 46 years of potential life! Nationally, it is estimated that 144 people die each day from an opiate overdose. In Michigan, we will lose 5 or 6 today.

More than likely, someone in your social circle has already been touched by this disease. I have far too many times. But these are more than numbers. These are sons, daughters, husbands, wives, sisters, brothers – with families who are trying to pick up the pieces of their shattered lives. There is a powerful website called 144aday.org. It is filled with the stories of lives cut short by opiate overdose; stories written by moms, dads and sibling. I leave with you today, their stories – the stories from Michigan families. Families who still need our help and are looking for our collective help.

www.144aday.org

Stories from Michigan

Trenton M.

Trenton Munn and his mother, Lynette
Ionia, Michigan

My son, Trenton Munn, died August 21, 2016, from an accidental heroin overdose. He was 31 years old. Trenton suffered from drug addiction since his late teen years. He first became addicted to Oxycontin, and when that became hard to come by, he turned to heroin. It was a cheaper, easier to find alternative.

When his son, Harley was born in May 2012, Trenton tried to quit cold turkey. He wanted to get clean for his son. Trenton also suffered from anxiety and depression. During the past four years Trenton tried repeatedly to get off heroin. This past March we discovered that Trenton had advanced to shooting up heroin. Even though he had said he would not stick a needle in his veins.

After many failed attempts in treatment, with everyone telling us we had to do tough love, we decided to remove Trenton from our home. It broke our hearts having to put our child out on the streets. Trenton was then taken in by a friend. The friend promised he didn't condone heroin and there'd be none of it in his home.

Throughout this past summer, Trenton would come to our house for his parental visits with his son. Since his son's mother had gotten in trouble with the law, Trenton was given full custody of Harley. Trenton also had just began a new job, was looking healthier and had gained some weight. We thought he was kicking his addiction. Things were looking up.

Due to Trenton not having a car, we were driving him to and from work. The last day we saw our son was Saturday, August 20, 2016. We picked him up from work at 4:00 p.m., as usual. Nothing really seemed out of the ordinary, other than Trenton not asking what I was making for supper. He normally would come have dinner with us.

When we arrived at the friend's house where Trenton was living, he told us he'd see us in the morning and that he loved us. He didn't text or call us that evening.

The dreaded call came at 4:21 a.m. from the friend Trenton was living with. The friend began with: "I think you need to come out here!" I asked him what was wrong and he replied, "I think Trent's overdosing!" I hung up the phone immediately, jumped out of bed screaming. I told my husband we had to go. His dad wasn't moving fast enough so my daughter and I left without him.

As we were getting into my car, the friend called again. My daughter asked him if he had called 911 - and he had not! So she called. She had 911 on one ear and the friend on the other. I drove as fast as I could. We arrived at the friend's home in a matter of minutes. The police and the ambulance were already there. We were met by an officer on the porch of the house. It was too late. My precious baby boy was dead.

My son was found by his friend, slumped over, leaning up against the couch, between the kitchen and living room. The friend had laid him out, to attempt CPR, but couldn't get his mouth open. Trenton was already gone. At that time, it became a criminal investigation because no one saw Trenton shoot the heroin up himself. In addition, the authorities had a feeling, and due to how the scene looked, that our child was placed there by others. They believe Trenton received what they call a "hot load": heroin laced with fentanyl.

That same weekend, over 75 overdoses were reported in Ohio. The heroin was laced with elephant tranquilizers. This has been the worse pain we ever felt. Nothing or no one can ever bring our son back. Our grandson is going to grow up without his father.

We have been waiting on the official toxicology report. It's now been 10 weeks.

Andrew A.

Andrew Angers
Saginaw, Michigan

Andrew was born April 5,1982, at 12:01 a.m. He was a beautiful baby and had a star quality about him as a toddler. Growing up Andrew was a happy, healthy boy with a kind heart and a brilliant smile. Then one day he was not so happy anymore.

As Andrew entered high school, he began to struggle with personal demons. As a result, he experimented with drugs as a way to cope with his emotions. Andrew was immediately taken hostage by addiction and his battle

progressed before he even graduated. Andrew did manage to graduate, although a year later than he should have. Regardless, it was a happy day.

For the years following, Andrew's struggles with addiction continued but at times it seemed he was gaining the upper hand. Andrew entered college and even married his high school sweetheart. Sadly, college went by the wayside and the marriage failed. Even throughout all the hardships, Andrew was still there - there were glimpses of the sweet, sensitive, kind-hearted man he was.

Andrew was a very talented musician and was often seen walking around wearing a banjo. He had the most wonderful smile and such a warm laugh. Andrew had hope right up until the end. In a final phone call he spoke of his future and being done with using. On June 18, 2009, Andrew was found dead from an overdose. It truly was the day the music ended.

Mike H.

Mike Hannay
Mason, Michigan

My brother Mike was, and still is, an amazing human being. He had the most contagious smile and the best hair. He was hilarious, sarcastic, and incredibly witty; he had the most amazing sense of humor. Mike had such a big heart and never spoke bad about anyone. He always had a carefree, laid back attitude. Mike was so intelligent - the kind of person who never had to study but still got A's and B's. He could answer any Jeopardy question - things that make most of us say "Huh?!" Mike could fix any computer problems in five minutes or less, make you feel better on your absolute worst days, make you laugh until you cried and your cheeks hurt. Mike loved going to car shows with our dad. Together, they restored a '57 Chevy the summer before we lost him. Mike and I were best friends since we were young and were always doing things together. We were a close, tight-knit family; seeing him suffer from addiction was heart breaking for all of us.

Mike hurt his back in a car accident and, like many who succumb to addiction, was prescribed pain medication and Xanax by his doctor. One day at the end of 2009, Mike crushed his hand at work in a 20-ton brake press, resulting in

the amputation of the tips of three of his fingers. He later underwent five surgeries to repair his hand. The severity of his injury, the numerous surgeries, and pain resulted in increased access to prescription medication that enhanced his addiction.

This was when Mike starting trying heroin. He overdosed twice but made it out alive on both occasions. The first time was in March of 2011 and the second in October of the same year.

For the next few years, Mike struggled off and on with addiction. Finally, things were looking up. He had a new job and was doing great. He was blessed with his first and only nephew six months prior to his passing. Mike had been clean for a year and four months before he relapsed and lost his life on September 20, 2013. None of us saw it coming, not his friends or his family.

Now, almost three years later, we still struggle with the loss of Mike every single day. He was just the most special human being. The world is a darker place without him. Our hearts go out to anyone who has lost someone to this terrible disease. We love you Mike, and miss you with every fiber of our beings.

We need to crush the stigma behind addiction. It is taking amazing souls who have so much life left to live and so many things to accomplish. My brother was destined to do great things; instead, heroin took him from us.

Jeff K.

Jeff Klik
Utica, Michigan

Jeff was a beautiful boy: sweet, kind, loving, smart, artistic, talented. He loved making music, snowboarding and developing his own photographs. Jeff was a smart child and learned quickly. At the same time, he was sensitive and had a way with others. He always seemed to befriend the kids in school that no one else would talk to. He was like that.

Like many of us, Jeff made some bad choices. When he chose heroin, his love for life disappeared.

I found pot in his room when he was mid-high school. At the time I had no idea that this would start us down the ugly road that was to come. I thought things were fine. I found out too late that when Jeff was abusing drugs it was hard to know how he was really doing.
He was enrolled in an accelerated program for high-achievers in high school. When his grades started dropping he told me it was "just too hard" for him. He dropped out of that program, graduated and headed off to college.

As his first year away from home went by, his grades dropped and the things he said weren't adding up. Something was wrong.

One day I got a call at the hospital where I work saying that my son was downstairs. Panicking, I ran down to the ER. Car accident? Appendicitis? No--a drug overdose. As Jeff came out of his drugged stupor, he said "I want to kill myself." He was admitted to a local mental hospital.

The two weeks he spent there were a nightmare--he worked the system expertly. At a counseling session he threw a chair against a wall. He didn't cooperate. They put him on antipsychotic medication. He didn't follow the rules when he came home either, and eventually I kicked him out because the situation became dangerous for everyone under that roof. His dad took him in.

He overdosed again but I didn't know about it until we got the ambulance bills.

He came to live with us again and seemed to be doing better. He was going to outpatient counseling daily and I thought--Hey, it's finally working!---before things started to get bad again. His behavior was erratic, he wasn't doing any of his favorite activities anymore and he always "had to work."

He signed himself into a rehab but got kicked out the next day for smoking a cigarette. It was New Year's Eve. Happy New Year. He missed Easter dinner, a movie date, his Grandma's birthday, etc. I went to see him at work once and he was in the bathroom for a long time. When he walked out he looked sick--his face was pale and broken out, his eyes were glassy. After giving Jeff a drug test that lit up like a christmas tree, his dad set an ultimatum: "it's either rehab or you're out of this house." He admitted himself again. It was April 4, 2015

After getting through detox he was doing well.
When I went to visit him he asked me, "Mom, what do you want?"
"I want my old Jeff back." I said.
"You'll get your old Jeff back, that's why I'm here."

On April 21st he was discharged--clean and happy--to a ¾ house close to home.

On April 29th, Jeff didn't show up for work and when his Dad went to the ¾ house looking for him, he found his son--dead. All of Jeff's beloved cameras were found in a local pawn shop.

My heart--forever torn to shreds.

He tried to right the wrong choices
He tried hard...so hard...
But those choices were too big...too hard for Jeff to overcome.
My Jeff died of an overdose of Heroin/Fentanyl.
Jeff was a good kid.
They are all good kids.
This is so wrong,
so unfair.