

Substance Use Disorder System Reform

Report and Recommendations

Alcohol and Drug Abuse Division

January 2017

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I. Executive Summary

In 2016, the Legislature enacted Minnesota Statutes, section 254B.15, directing the Department of Human Services (DHS) to design a reform of Minnesota's substance use disorder treatment system to ensure a full continuum of care is available for individuals with substance use disorders.

In support of this, the Alcohol and Drug Abuse Division (ADAD) convened a core stakeholder workgroup, which met for five 3-hour work sessions in June 2016. The workgroup incorporated and built on the recommendations of the 2013 Legislative Report: Minnesota's Model of Care for Substance Use Disorder ([Minnesota's Model of Care for Substance Use Disorder](#)) and the input collected during listening sessions held in fall 2015 (see appendix 1). Workgroup membership included representation from consumers/families, Tribal Nations, counties, providers, health plans, hospitals, prevention, problem gambling, culturally-specific providers and recovery care organizations (Appendix 1).

A fiscal stakeholder workgroup was also convened and made recommendations related to funding, including the responsibilities of the state and counties in funding substance use disorder services.

In order to gather input on the policy recommendations reflected within this report, a series of six community presentations was completed statewide, starting in October 2016.

This report reflects ADAD's current policy recommendations following multiple years of stakeholder engagement and ADAD's review of the discussions and feedback provided by stakeholders. Some of the policy recommendations require legislative action and some are within ADAD's existing authority.

The Alcohol and Drug Abuse Division has developed this report for presentation to the Legislature during its 2017 regular session. The report consists of the following:

- I. Description of Minnesota Statutes, section 254B.15
- II. Introduction
- III. Description of the Stakeholder Engagement Efforts
- IV. Legislative and Agency Recommendations
- V. Appendices

II. Legislation

The Substance Use Disorder System Reform Report and Recommendations is submitted to the Governor and the Minnesota State Legislature pursuant to Minnesota Statutes, Section 254B.15, and subdivision 4.

Section 1.

[254B.15] SUBSTANCE USE DISORDER SYSTEM REFORM.

Subdivision 1. **Authorization of substance use disorder treatment system reform.** The commissioner shall design a reform of Minnesota's substance use disorder treatment system to ensure a full continuum of care is available for individuals with substance use disorders.

Subd. 2. **Goals.** The reform proposal in subdivision 3, shall support the following goals:

(1) improve and promote strategies to identify individuals with substance use issues and disorders;

(2) ensure timely access to treatment and improve access to treatment;

(3) enhance clinical practices and promote clinical guidelines and decision-making tools for serving people with substance use disorders;

(4) build aftercare and recovery support services;

(5) coordinate and consolidate funding streams, including local, state, and federal funds, to maximize efficiency;

(6) increase the use of quality and outcome measures to inform benefit design and payment models; and

(7) coordinate treatment of substance use disorder primary care, long-term care, and the mental health delivery system when appropriate.

Subd. 3. **Reform proposal.** (a) A reform proposal shall include systemic and practice reforms to develop a robust continuum of care to effectively treat the physical, behavioral, and mental dimensions of substance use disorders. Elements of the reform proposal shall include, but are not limited to:

(1) an assessment and access process that permits clients to present directly to a service provider for a substance use disorder assessment and authorization of services;

(2) mechanisms for direct reimbursement of credentialed professionals;

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(3) care coordination models to link individuals with substance use disorders to appropriate providers;

(4) peer support services to assist people with substance use disorders who are in recovery;

(5) implementation of withdrawal management services pursuant to chapter 245F;

(6) primary prevention services to delay the onset of substance use and avoid the development of addiction;

(7) development of new services and supports that are responsive to the chronic nature of substance use disorders; and

(8) exploration and implementation of available options to allow for exceptions to the federal Institution for Mental Diseases (IMD) exclusion for medically necessary, rehabilitative, substance use disorder treatment provided in the most integrated and least restrictive setting.

(b) The commissioner shall develop a proposal consistent with the criteria outlined in paragraph (a) and seek all federal authority necessary to implement the proposal. The commissioner shall seek any federal waivers, state plan amendments, requests for new funding, realignment of existing funding, and other authority necessary to implement elements of the reform proposal outlined in this section.

(c) Implementation is contingent upon legislative approval of the proposal under this subdivision.

Subd. 4. Legislative update. No later than February 1, 2017, the commissioner shall present an update on the progress of the proposal to members of the legislative committees in the house of representatives and senate with jurisdiction over health and human services policy and finance on the progress of the proposal and shall make recommendations on any legislative changes and state appropriations necessary to implement the proposal.

Subd. 5. Stakeholder input. In developing the proposal, the commissioner shall consult with consumers, providers, counties, tribes, health plans, and other stakeholders.

EFFECTIVE DATE. This section is effective the day following final enactment

III. Introduction

This report is submitted to the Governor and the Minnesota State Legislature pursuant to Minnesota Statutes, Section 254B.15, subdivision 4. The report was prepared by Alcohol and Drug Abuse Division staff members in 2016.

It is necessary to transform our state's substance use disorder (SUD) treatment system from an acute, episodic model of treatment to a chronic disease, longitudinal model of care. Creating a person-centered recovery-oriented system of care in Minnesota will expand and enhance the nature of services available for substance use disorder, while improving integration and coordination with the rest of health care.

In order to ensure timely access to services, direct access to providers will be a necessary part of the redesign. To effectively address the chronic nature of substance use disorders, we must make available the right level of service at the right time in the right amount. Services that support a person's recovery process over time, such as care coordination and peer recovery support services, must be included in the state's continuum of care.

Access to services will be enhanced by a system that supports services outside of treatment centers, such as at recovery community organizations or other facilities, including schools, clinics, hospitals and jails. This will allow for increased access by decreasing geographic and transportation barriers. Expanded access points would be made possible by permitting SUD services to be provided in the community and through direct reimbursement of appropriately credentialed professionals, who will be eligible for reimbursement of services provided independent of a licensed program.

The availability of culturally specific, special population and inclusive programs and culturally and linguistically appropriate services across the care continuum, is essential to ensure effective treatment for every individual in the state. Adequate availability of these services will help decrease disparate outcomes for cultural and other special populations. Recent legislation that further defined SUD programs serving culturally specific/special populations has laid an important foundation for continuing this effort.

Another important priority for the state is to address the stigma of SUD and its harmful impact on individuals in need of services and support. Stigma creates a barrier for people seeking treatment, can influence funding priorities, often results in prosecution and incarceration (when prevention and treatment may be a more appropriate and effective response), and at times can result in an uninviting reception from non-SUD health care providers who might be unfamiliar with the population, which is a problem that may increase as more SUD clients are moved into integrated health care. Achieving parity for SUD services can also be challenged by stigma.

Reduced duplication, streamlined paperwork requirements and a sustainable rate structure are priorities identified by stakeholders and are important to sustain an effective continuum of care. In order to be truly client-driven, person-centered care will require treatment plans to evolve and be prioritized according to client need and focus. System reform efforts will be informed by these priorities and should be reflected in any modifications or additions to SUD program requirements.

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In addition, ADAD is pursuing available avenues to address any impact of lost federal Medicaid funding due to certain residential SUD programs being newly designated as Institutions for Mental Diseases (IMD). Currently, federal Medicaid funding cannot be used for residential substance use disorder treatment programs with more than 16 beds, which are designated IMDs pursuant to federal law.

On July 27, 2015, the Centers for Medicare and Medicaid Services (CMS) announced a new opportunity for demonstration projects under Section 1115 of the Social Security Act, and ADAD is currently preparing to submit an application to be a demonstration site. One component of the 1115 demonstration project is the opportunity to request authority for federal financial participation for SUD treatment provided to individuals in an IMD. ADAD has begun an ongoing analysis of the substantial changes that will be needed to the current substance use disorder treatment system to achieve the requirements for the 1115 demonstration project. These proposals, over time, will help align Minnesota's service continuum to maximize federal funding.

The Alcohol and Drug Abuse Division (ADAD) is in good position to implement the goals of the reform proposal, and has been working proactively with our partners, providers, stakeholders and citizens of Minnesota to identify strategies to ensure that everyone who needs treatment can access the right service, at the right time, and in the right amount. These efforts will provide a foundation for meeting the goals set forth in Minnesota Statutes, section 254B. 15 for system reform. Since 2012, the Division has sponsored several collaborative efforts with stakeholders including:

1. In 2012 convening of a steering committee to develop a model of care to improve the effectiveness and efficiency of Minnesota's current service continuum for chemically dependent individuals. Subsequent legislation was passed during the 2013 session that directed the Department to establish pilot projects to begin implementing the measures recommended in the report. The first pilot site began operating in late 2014 and the second site began in early 2015.
2. In August 2015 a Pain. Pill. Problem symposium was held. This event brought a US senator to speak on the problem of prescription pain medication abuse, as well as the governor of Minnesota and several experts on the topic of preventing and treating opioid addiction.
3. In 2015 DHS facilitated nine statewide listening sessions designed to hear from the public and gather input to inform the redesign of the chemical health system.
4. In the summer of 2016 three workgroups were convened that represented chemical dependency providers, counties, hospitals, consumers, culturally specific providers and others to improve the continuum of services from prevention, early intervention, treatment and recovery, and to discuss payment rates and methodologies for services.
5. In the fall of 2016 six statewide community presentations were conducted to present on the policy recommendations and gather additional input.

IV. Stakeholder Engagement and Input

A. Model of Care and Model of Care Pilot

The 2012 Legislature directed the Department of Human Services (DHS) to collaborate with counties, tribes, and other stakeholders to develop a model of care to improve the effectiveness and efficiency of Minnesota's current service continuum. The proposed model would update Minnesota's treatment system from an acute care model to a chronic care model that is comprehensive, integrated and designed to support recovery across the lifespan.

A steering committee met bi-weekly from September 2012 until February 2013 to develop the recommendations, which are contained in the March 2013 legislative report *Minnesota's Model of Care for Substance Use Disorder*.

Model of Care Priority Areas

- Direct access to treatment via a clinical assessment and placement
- Telehealth
- Recovery coach/peer support services
- Care coordination
- Direct reimbursement for credentialed professionals

Subsequent legislation was passed during the 2013 session that directed the Department to establish pilot projects to begin implementing the measures recommended in the report. The first pilot site began operating in late 2014 and the second site began in early 2015.

The main features of the Pilot are:

- **Direct Access.** Direct access via a provider-conducted comprehensive assessment, completed by a licensed professional. Direct access eliminates the use of the Rule 25 assessment, and reimburses programs for the comprehensive assessment. Pilot assessments are completed within 7 days of request, and placement determinations and authorization of services are within 3 days. Timelines from requesting an assessment to placement approval is 10 days, down from 30 days in the current access framework.
- **Peer Support:** Peer recovery support services are available and reimbursable in the pilots. Pilot sites are identifying culturally specific considerations, recruiting, training and retention opportunities and challenges.
- **Care Coordination:** Care coordination is provided in the pilots by individuals credentialed to provide treatment services. The service is reimbursable in the pilots in 15 minute increments

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- Early and Ongoing Access to Care Coordination and Peer Support services - Both services are available in the pilots before, during, and/or after engagement in formal treatment, both of which are available in the pilots at symptom severity levels that in our current system do not result in approval to treatment services.
- Telehealth Technology: Pilot services are reimbursable via telehealth. DHS has provided pilot sites training and support for utilization of telehealth services in the pilots.
- Systems: The Pilots are testing measurement and payment systems.

B. Listening Sessions

The Alcohol and Drug Abuse Division facilitated nine listening sessions throughout the state. The listening sessions were held throughout the state to continue evaluating the ideas put forth in the Model of Care report such as direct access via a clinical assessment, care coordination, peer recovery support services, direct reimbursement for qualified professionals, withdrawal management, and other ideas to improve prevention, early intervention, treatment and recovery services for all Minnesotans.

Input was collected to inform redesign of the chemical health system in the state in the following areas:

- Effect of substance abuse on participants' daily life.
- How can DHS better meet the needs in the community and for those affected and living with substance abuse?
- Integration of substance use disorder prevention, screening and treatment services with primary care and the rest of behavioral health.
- How to reduce disparities and improve outcomes to ensure cultural and ethnic communities have the same access and outcomes for health care.

Listening sessions were conducted in the following regions and Tribal communities.

- American Indian Forum—Onamia
- Metro Region—St. Paul and Minneapolis
- Northeast Region—Duluth
- Northwest Region—Thief River Falls
- Southeast Region—Rochester
- Southwest Region—Granite Falls

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- West Central Region—Fergus Falls
- Youth Listening Session—Health Occupations Students of America (HOSA) Conference-St. Paul

The general public, individuals affected by substance use disorders and their family members, providers, advocates and others, who were concerned about the issue, and who wanted to share their insights, and knowledge, were encouraged to attend the listening sessions. To promote the sessions: fliers were distributed throughout local communities, a news release was issued, an email invite was sent from DHS Commissioner, and announcements were made at meetings and events.

As a result of these communication efforts, 325 people participated in the listening sessions, including 74 youth. The attendees represented a variety of local stakeholders from multiple sectors and organizations. The diverse insights provided by listening session attendees proved invaluable and resulted in the consistent themes identified through the project.

Seven consistent themes were identified from the listening sessions:

1. Recognize the importance of culture, tradition, and spirituality. Focus funds on these concepts throughout the services continuum: prevention, intervention, withdrawal management, treatment, care coordination, and recovery support.
2. DHS should improve the availability of and funding for transportation, mental health services and sober housing. DHS should address related workforce shortages, especially in rural areas.
3. Address the consistent themes within a larger conversation of how to normalize substance misuse and substance use disorder prevention, intervention, treatment, and recovery services within healthcare.
4. Integrate prevention, intervention, treatment, and the recovery oriented service continuum into behavioral and physical health care by challenging stigma that has historically kept it separate.
5. Safe affordable housing.
6. Invest in services to: 1) families with children and adolescents, 2) partner with schools, 3) faith communities, and 4) other local supports.
7. The state should lead the way with collaborative efforts among state agencies and partnering with local agencies and providers.

C. Core, Fiscal and Internal DHS Workgroup

In 2016, the Alcohol and Drug Abuse Division (ADAD) convened three workgroups to continue stakeholder engagement to redesign the chemical health system. A core stakeholder workgroup, fiscal workgroup, and internal DHS workgroup. The core workgroup met for five face meetings and incorporated and built on the recommendations of the 2013 Legislative Report: Minnesota's Model of Care for Substance Use Disorder and the input collected in the fall 2015 ADAD listening sessions.

Fiscal workgroup members met for seven face to face meetings to make recommendations related to funding, including the responsibilities of the state and counties in funding substance use disorder services. A combined meeting between the Core Workgroup and Fiscal Workgroup was held in December of 2016.

In addition, an Internal DHS workgroup was convened that was comprised of DHS staff in multiple administrations such as Community Supports, the Office of Inspector General, Health Care, Financial Operations, and Community and Partner Relations.

The Core Stakeholder Workgroup (20 representatives) and Fiscal Stakeholder Workgroup (13 representatives) were comprised of representatives from the following organizations, associations and constituent interests:

1. Consumers/Families
2. Counties
 - Minnesota Inter-County Association (MICA)
 - Minnesota Association of County Social Service Administrators (MACSSA)
3. Minnesota Association of Resources for Recovery and Chemical Health (MARRCH)
4. Minnesota Association of Treatment Directors (MATD)
5. MN Detox Association
6. MN Council of Health Plans & County-Based Purchasing
7. Minnesota Hospital Association
8. Recovery Community Organizations
 - Minnesota Recovery Connection
 - Recovery is Happening
 - ReGroup
9. Tribal representation
10. Culturally-Specific Providers

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- Turning Point
- South East Homes Inc.

11. Representatives from a cohort of Nine Culturally-Specific ADAD Grantees

12. Problem Gambling

13. Regional Prevention Coordinators

D. Outreach and Engagement Activities

In addition to the workgroups, the Division conducted outreach and engagement activities to key stakeholders. Key stakeholders were provided with potential reform changes and asked for feedback, and key stakeholders were invited to meet with the Division to discuss their priorities for transforming the system to meet the needs of their constituents. These key stakeholders included but were not limited to: Alcohol and Drug Abuse Division's advisory councils, members, mental health organizations and licensing boards.

E. Community Presentations

In October 2016, the Alcohol and Drug Abuse Division facilitated community presentations on Minnesota's Plan for the Prevention, Treatment and Recovery of Addiction policy recommendations that are included within this report. These policy recommendations reflected the ongoing stakeholder engagement and policy recommendation work and the recommendations of ADAD. As a result of these outreach and engagement efforts, 127 people participated in the community presentations. Input was collected to inform redesign of the chemical health system in the state. Community presentations were conducted in the following regions and Tribal communities.

- Bois Forte Reservation
- Brainerd
- Mankato
- Minneapolis
- St. Cloud
- St. Paul

V. Reform Recommendations

Model of Care

- **Direct access/comprehensive assessment.** Modify the access system to allow clients to go directly to a provider for a comprehensive assessment by a credentialed professional to determine intensity and duration of client placement in treatment services. Placements should be subject to utilization review to measure for appropriateness of level and duration of care recommended. The comprehensive assessment would serve the dual purposes of placement and informing the development of a treatment plan. This process eliminates the placing authority function. Seek CMS approval to bill the comprehensive assessment under a new service code reimbursable when performed by an appropriate clinician.
- **Direct reimbursement.** Add appropriately credentialed individuals as eligible vendors of SUD treatment services and change rule and statutory requirements to permit use of the Consolidated Chemical Dependency Treatment Fund (CCDTF) to support the provision of SUD services in settings other than treatment programs, such as in schools, primary care settings, jails.
- **Care coordination.** Add care coordination as a reimbursable treatment service billable in 15-minute increments. Identify eligible vendors. Care coordination treatment services should be available to a person early, potentially preventing the need for more intensive outpatient or inpatient programming. If care coordination were available to individuals at early stages of progression, we would expect to see a decrease in the number of individual treatment sessions required, and an individual may not need to attend a 12-week or 20-week program, for example. We also recommend availability of care coordination as a treatment service for those persons who present at a lower level of risk ratings in the dimensions on the Minnesota Matrix than would historically permit treatment services to be delivered. Early intervention via care coordination could address mild SUD severity to prevent progression to moderate or severe SUD and avoid future, higher-intensity services.
- **Peer support.** Add peer support as a reimbursable treatment service billable in 15-minute increments. Identify eligible vendors—such as Rule 31, detox and withdrawal management programs, recovery community organizations—equipped to provide appropriate supervision of these services and the individuals providing the service. Direct reimbursement is not recommended for this service.
- **Withdrawal management.** Add Minnesota Statutes, Chapter 245F withdrawal management services to the state’s Medicaid benefit set. Withdrawal management services include the provision of treatment services, including care coordination and peer support services. Withdrawal management programs will increase linkages for clients and provide support through either more treatment or connection to support in their community. In addition to freestanding withdrawal management

programs, opportunities for programs to provide 245F services in Rule 31 and other appropriate settings will be explored.

Culturally Specific/Special Populations

- **Stakeholder engagement.** Conduct meaningful stakeholder engagement that is transparent and committed to honestly and persistently working through conflicts and challenges.
- **Quality assurance for enhanced rates.** Commit to ongoing stakeholder engagement to identify quality assurance methods for the enhanced rate for culturally specific/special population services. Seek any necessary statute or rule changes to require that clients seeking treatment services be screened for culturally specific needs and ensure that those requesting culturally specific treatment services are provided access to them.
- **Funding for culturally specific providers.** Seek non-Medicaid funding opportunities for culturally specific providers such as traditional healers or other unlicensed individuals who provide cultural services to support a client's treatment goals.
- **Decrease disparities in outcomes.** Support the development of culturally appropriate and effective treatment modalities that decrease disparities in outcomes.
- **Develop standards with stakeholders.** Work with stakeholders to consider external standards that could be undertaken to improve the quality and inclusiveness of a program. Explore how culturally competent and inclusive services could also be achieved through staff training requirements and specific attention to clients' needs and desires.
- **Workforce development.** Work with stakeholders to support workforce development that increases the number of providers competent to provide culturally specific services and encourages a workforce with increased demographic diversity.
- **Prevention funding for underserved communities.** Seek increased prevention funding to target underserved communities experiencing disparities. Develop prevention efforts with a holistic and tailored focus for different populations.

Opioid Related Recommendations

- **Per diem reimbursement.** Eliminate the per diem reimbursement methodology of opioid treatment programs, but retain the basic per diem for the medications and allow opioid treatment programs to bill hourly for non-residential behavioral support services.
- **Positive drug test reporting.** Require opioid treatment programs to report to DHS how many clients receiving "take-home" doses have unexpected drug test results and mandating under what circumstances the program must revoke client's right of "take-homes" following problematic drug tests.

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- **Support persons on medically assisted treatment.** Identify incentives for providers to accept people receiving medically assisted treatment (MAT) for opioid dependence. Currently clinics treating people using MAT may not offer a full range of behavioral treatment services. Meanwhile, many treatment providers who focus on behavioral strategies may feel a disincentive to accepting MAT patients. Therefore, treatment providers who focus on behavioral strategies need to be incentivized to accept MAT clients to ensure people receive a full range of needed services.
- **Expanded definition of opioid treatment programs.** Expand the definition of opioid treatment programs to include both agonist and antagonist medications and to serve not only intravenous drug users.
- **Naloxone availability.** Support the increased availability of naloxone and support providing clients with access to Naloxone upon discharge.
- **Barriers to behavioral support.** Monitor barriers to behavioral support services for individuals who use medication-assisted treatment. Continue stakeholder engagement to ensure appropriate access to behavioral supports across the state for all clients, including those engaging in medication assisted treatment.

Primary Prevention

- **Prevention planning and implementation.** Expand the Prevention Planning and Implementation Program, which focuses on environmental strategies and has demonstrated positive outcomes and improved health.
- **More Regional Prevention Coordinators.** Increase the number of Regional Prevention Coordinators (RPCs), which provide training and technical assistance on substance use prevention. Currently, the state is divided into seven large geographical areas covered by RPCs. Increased investment in this program would allow each RPC to have a smaller geographical area and permit more concentrated efforts.

Problem Gambling

- **Cross-addiction education.** Support increased education regarding the risks of cross-addiction when treating gambling disorder or substance use disorder. Support increased cross-referral, integrated treatment services and continuing care when providing services to individuals with gambling and substance use disorder.
- **Ensure best practices.** Work with stakeholders to enhance the current requirements to ensure the use of best practices and person-centered recovery-driven outcomes.
- **Telehealth.** Support increased use of telehealth to expand access to problem gambling treatment. Increase awareness of telehealth technical assistance opportunities and the availability of teleconferencing services.

- **Research.** Establish and develop research to provide data-driven decision-making.

Tobacco Prevention

- Screening for and addressing nicotine addiction. The department will provide external communication to SUD treatment providers about screening for and addressing nicotine addiction in treatment as part of an integrated treatment process. Communication will include information on the effectiveness and value of including tobacco cessation as a part of the individual's treatment plan.
- Support smoking cessation. Alcohol and Drug Abuse Division will continue to work with treatment providers to explore initiatives to support smoking cessation and to increase awareness of the nicotine cessation services available to all Minnesotans.

VI. Section 1115 Demonstration Project

On July 27, 2015, the Centers for Medicare and Medicaid Services (CMS) informed State Medicaid Directors of a new opportunity for demonstration projects approved under Section 1115 of the Social Security Act focused on improving access to a continuum of care for individuals with substance use disorder (SUD). This includes reforms that will “better identify individuals with SUD in the Medicaid population, increase access to care for these individuals, increase provider capacity to deliver effective treatments for SUD and use quality metrics to evaluate the success of these interventions.”

One component of this new opportunity is a waiver of federal rules prohibiting federal financial participation (FFP) for SUD treatment provided to individuals residing in Institutions for Mental Diseases (IMDs) that meet American Society of Addiction Medicine (ASAM) levels of residential service. The Minnesota State Legislature directed the Department include in its reform proposal, an exploration of implementation of available options to allow for exceptions to the federal Institution for Mental Diseases (IMD) exclusion for medically necessary, rehabilitative, substance use disorder treatment provided in the most integrated and least restrictive setting.

ADAD has analyzed the changes necessary to achieve such a waiver in Minnesota. In addition to the standard application process for a demonstration project, under section 1115 of the Social Security Act, CMS is requiring states to meet additional expectations or conditions that demonstrate a broader reform effort for SUD treatment delivery systems. Many of these requirements do not require states to seek a section 1115 waiver. Instead, CMS is requesting that the state agree to meet these conditions through changes to state laws, state plan, alternative benefit sets, or other applicable waivers.

Minnesota’s SUD system is currently aligned with some of the requirements outlined by CMS. However, DHS has determined that the state and providers will need to come into compliance with the following in order to submit an application for an IMD waiver under section 1115:

- **Comprehensive, evidence-based benefit package:** Development of a comprehensive evidence-based benefit package. The benefit package must include a full continuum of evidence-based best practices designed to address the immediate and long-term physical, mental and SUD care needs of the individual. The benefit package must incorporate industry-standard benchmarks for defining medical necessity criteria, covered services and provider qualifications;
- **ASAM standards:** Implement a process to assess and demonstrate that residential providers meet ASAM criteria prior to participating in the Medicaid program under the demonstration project and rendering services to beneficiaries;
- **Provider networks:** A statewide provider network and resource plan to ensure sufficient access for individuals seeking SUD treatment and sufficient capacity to accommodate a provider’s exit from the system;

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- **Information sharing:** Development of processes that ensures seamless transitions and information sharing between care providers and collaboration between primary, mental health, pharmacological and long-term care;
- **Integration of physical and behavioral health services:** Creation of a plan and timeframe for coordinating physical and behavioral health services (including section 2703 homes, integrated care models, accountable care organizations and primary care medical homes, including a commitment to implementation of such approach within two years after the demonstration;
- **Program integrity standards:** Use of program integrity safeguards in SUD, including risk-based screening of newly enrolling providers and a revalidation of existing providers and ensure that there is a process to address billing and other compliance issues;
- **Utilization review for medical necessity:** Use of a regular utilization review process to ensure services are medically necessary in clinically intensive settings. For example, prior authorization, targeted post-payment claims review and billing system edits to deny claims beyond a time span;
- **Mental health and SUD parity:** Demonstrated compliance with Mental Health Parity and Addiction Equity Act (if financial or treatment limitations are introduced);
- **Community integration:** Development of plans to incorporate requirements of Home and Community Based Services regulations for person-centered planning;
- **Strategies to address prescription drug abuse:** Creation of a plan to implement proven strategies to address prescription drug abuse at the state, plan, patient, pharmacy and provider level;
- **Services for youth and adolescents with SUD:** Demonstrated compliance with benefit, services and timely access requirements for youth and adolescent populations with SUD; and
- **Reporting of quality measures:** Report relevant quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD, including:
 - the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (National Quality Forum (NQF) #0004);
 - Substance Use (SUB): *SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge*; and
 - Substance Use (SUB): *SUB-3a Alcohol and Other Drug Use Disorder Treatment Discharge*.
- **Evaluation of impact:** CMS also asks that states measure the impact of providing SUD service on
 - readmission rates to the same level of care or higher,
 - emergency department utilization, and
 - inpatient hospital utilization.

Many of these reforms are consistent with DHS' goal to improve access to quality SUD services. However, it is important to note that the requirement to use an independent third-party assessment

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could conflict with DHS' effort to establish reforms that allow people to choose their provider directly without having to be assessed by a county or tribe.¹ As well, while the demonstration project provides potential opportunities, there is not a guarantee of the state's ability to maintain CMS approval of the waiver for the proposed duration of the project.

Another consideration that the Department plans to address is how to ensure budget neutrality requirements for the section 1115 waiver are met. Because waiving the IMD exclusion would require the federal government to match state funds for payment to these providers that are not otherwise matchable under federal law, the IMD waiver would essentially cost the federal Medicaid budget more. Therefore, DHS is exploring reform opportunities through a section 1115 for SUD that could be used offset such costs such as new models of care that improve access to appropriate and timely care in an effort to reduce costs related to relapse or readmission rates, or emergency care.

The IMD waiver would be considered a component of a larger reform package for SUD delivery as referenced herein.

¹ In the CMS State Medicaid Director letter (SMD#15-003), CMS provides that an IMD waiver should include among other reforms the requirement that individuals seeking SUD services be evaluated for such care through a third-party assessor, an entity other than the rendering provider, who is certified to use ASAM placement criteria. This assessor should also make recommendations regarding appropriate levels of service and length of care.

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ALCOHOL AND DRUG ABUSE DIVISION 2015 LISTENING SESSIONS SUMMARY REPORT

LIST OF AGENCIES, ORGANIZATIONS, ENTITIES, AND INDIVIDUALS CONSULTED TO INFORM THIS REPORT AND RECOMMENDATIONS BY THE ALCOHOL AND DRUG ABUSE DIVISION, DEPARTMENT OF HUMAN SERVICES

SEE ADDITIONAL MATERIALS AND INFORMATION ABOUT THE STAKEHOLDER ENGAGEMENT ON THE DHS ALCOHOL AND DRUG ABUSE WEBSITE AT: [HTTPS://MN.GOV/DHS/SUDREFORM/](https://mn.gov/dhs/sudreform/)

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ALCOHOL AND DRUG ABUSE DIVISION 2015 LISTENING SESSIONS SUMMARY REPORT



Minnesota Department of Human Services
March 2016

Community listening sessions about the prevention
of substance use and improvement of services for
individuals with substance use disorders

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Substance Use Disorder and Prevention Listening Sessions

Project Overview

The Substance Use Disorder Listening Sessions Project was developed by the Minnesota Department of Human Services (DHS), Alcohol and Drug Abuse Division (ADAD). Listening sessions are a type of public forum where communities are engaged and citizens discuss important issues with a facilitator. Each session was opened by Commissioner Lucinda Jesson or Assistant Commissioner Jennifer DeCubellis. The Substance Use Disorder Listening Sessions Project was designed to hear from the public in developing a model of care to improve the effectiveness and efficiency of Minnesota's current service continuum for individuals with substance use disorders and the prevention of substance abuse. The message to participants was **"Your Opinion Matters."**

Throughout the summary report we have included comments from listening session participants.

DHS-ADAD facilitated nine listening sessions. Input was collected to inform redesign of the chemical health system in the state in the following areas:

- Effect of substance abuse on participants' daily life.
- How can DHS better meet the needs in the community and for those affected and living with substance abuse?
- Integration of substance use disorder prevention, screening and treatment services with primary care and the rest of behavioral health.
- How to reduce disparities and improve outcomes to ensure cultural and ethnic communities have the same access and outcomes for health care.

In addition, the listening sessions provided a forum to continue stakeholder engagement on the recommendations for consideration identified in the Model of Care 2013 Legislative Report:

- direct access to treatment via a clinical assessment and placement;
- telehealth;
- recovery coach/peer support services;
- care coordination;

- direct reimbursement for credentialed professionals;
- workforce development needs.

Listening sessions were conducted in the following regions and Tribal communities.

- American Indian Forum—Onamia
- Metro Region—St. Paul and Minneapolis
- Northeast Region—Duluth
- Northwest Region—Thief River Falls
- Southeast Region—Rochester
- Southwest Region—Granite Falls
- West Central Region—Fergus Falls
- Youth Listening Session—Health Occupations Students of America (HOSA) Conference-St. Paul



“DHS SHOULD DO MORE OF THESE (FORUMS).”

—ATTENDEE COMMENT

Small Group Facilitation

Small group facilitation was used to facilitate group dialogue and gather feedback from participants. Questions for the listening sessions can be found in **Appendix A** of this report.

Communication

The general public, individuals affected by substance use disorders and their family members, providers, advocates and others, who were concerned about the issue, and who wanted to share their insights, and knowledge, were encouraged to attend the listening sessions. To promote the sessions: fliers were distributed throughout local communities, a news release was issued, an email invite was sent from DHS Commissioner Lucinda Jesson, and announcements were made at meetings and events.

As a result of these communication efforts, 325 people participated in the listening sessions, including 74 youth. The attendees represented a variety of local stakeholders from multiple sectors and organizations. The diverse insights provided by listening session attendees proved invaluable and resulted in the consistent themes identified through the project.



Background

Minnesota has a long and respected history of providing effective substance use disorder treatment. Most Minnesotans who complete treatment show considerable improvement in substance use, employment, housing, criminal behavior and participation in recovery support groups. Studies that follow Minnesotans after treatment show that abstinence from substance use and other benefits tend to persist. Updating Minnesota's treatment system from an acute care model to a chronic care model that is comprehensive, integrated and designed to support recovery across the lifespan, would expand the continuum of care, and improve integration and coordination within the system.

In 2012, legislation passed that directed the Minnesota Department of Human Services (DHS) to collaborate with counties, tribes, and other stakeholders to "develop a model of care to improve the effectiveness and efficiency of Minnesota's current service continuum for chemically dependent individuals." A steering committee met bi-weekly from September 2012 until February 2013 to develop a Model of Care report. The Model of Care report included recommendations in the areas of direct access, telehealth, recovery coach/peer support services, care coordination and direct reimbursement.

Direct Access

Timely access to a thorough assessment for the right services at the right place and time is vital. Failure to facilitate a quick and accurate assessment can literally mean the difference between life and death.

Telehealth

The use of telehealth for substance use disorder services continues to evolve in areas around the country, and offers Minnesota the opportunity to explore these services in the future.

Recovery Coach/Peer Support

Recovery coach/peer support services before, during, and after treatment where clients are connected to peers in recovery who act as mentors and connect clients to resources that support their ongoing recovery process.

Care Coordination

Care coordination includes service planning, referral and linkage with follow-up, life skills training and advocacy support in an ongoing professional relationship.

Direct Reimbursement

Currently, publically funded substance use disorder services are provided at a Rule 31 licensed treatment program, and the program must be who submits for reimbursement. Individuals who are credentialed professionals are not able to submit for reimbursement.



Consistent Themes

Seven consistent themes were identified from the listening sessions.

1. Recognize the importance of culture, tradition, and spirituality. Focus funds on these concepts throughout the services continuum: prevention, intervention, withdrawal management, treatment, care coordination, and recovery support.
2. DHS should improve the availability of and funding for transportation, mental health services and sober housing. DHS should address related workforce shortages, especially in rural areas.
3. Address the consistent themes within a larger conversation of how to normalize CD prevention, intervention, treatment, and recovery services within healthcare.
4. Integrate prevention, intervention, treatment, and the recovery oriented service continuum into behavioral and physical health care by challenging stigma that has historically kept it separate.
5. Safe affordable housing.
6. Invest in services to: 1) families with children and adolescents, 2) partner with schools, 3) faith communities, and 4) other local supports.
7. The state should lead the way with collaborative efforts among state agencies and partnering with local agencies and providers.



Recognize the importance of culture, tradition, and spirituality. Fund services focused on these concepts throughout the services continuum: prevention, intervention, withdrawal management, treatment, care coordination, and recovery coaches.

“What works in the metro areas does not necessarily work in the rural areas.”

“Cultural adaptations and approaches are often minimal, often just translation of treatment materials, which have not been truly made culturally responsive.”

“Develop relationships with refugee/migrant communities.”

“Increase the treatment options for deaf and hard of hearing.”

“Support a multi-media campaign that allows people to ask for help.”

“DHS must realize that new cultures and language are HERE.”

1. Tribal member participants felt that managed care entities need to recognize Tribal Sovereignty in providing Rule 25 assessments, placements and cultural traditions.
2. Provide recovery programs for youth (e.g. Sober High, Step up).
3. Provide special population services (e.g. LGBTQ, youth, American Indian youth/ adolescent services).
4. Meet people where they are: emergency and support services, and harm reduction— not everyone can meet the expectation of complete sobriety but they can reduce their use of substances.
5. Increase the availability of service to diverse people of color, and assure that treatment staff are culturally diverse and are representative of the population they serve.
6. Address language/cultural/religious barriers.



DHS should improve the availability of and funding for transportation, mental health services and sober housing. DHS should address related workforce shortages, especially in rural areas.

“Provide Peer support prior to or as a part of prevention services.”

1. While participants from rural areas cited shortages in resources and trained staff to be one of the biggest barriers to the current system, participants at all forum locations were clear that resource shortage is a major concern.
2. The current system of rates, funding, siloed payment systems, and low wages were seen as the driver of the current workforce and professional service shortage.

Address the consistent themes within a larger conversation of how to normalize CD prevention, intervention, treatment, and recovery services within healthcare.

“The current detoxification system is not adequate to meet the current need.”

“Begin services in pre-natal care, include services in early childhood education and screening and to inform community intervention, limit availability of substances, and collaborate with the MN Department of Health to bring about changes in the marketing of mind altering substances.”

“The fact that counties are currently solely financially responsible for detox services is the driver behind underfunding and loss of detox beds and facilities.”

“There is need for “readiness counseling”, such as “pre-treatment groups.”

“We currently treat an individual by assessing his/her needs based on siloed service structures and funding, when what we need to do is to provide for basic human needs, individualized comprehensive assessment,



and then provide SUD, mental health, and physical health services to meet the changing needs of the individual.”

“The working poor and individuals in the National Guard (and other branches of service) cannot access affordable funding for these services.”

“DHS needs to re-think what outcome measures count.”

1. Participants at all forum locations mentioned the need for life long availability of services at all levels.
2. Build partnerships between environmental prevention, intervention, treatment, education and community areas. Incentivize ‘fun’ events, cash stipends, food, childcare and transportation. Continue through middle school, high school, collegiate, young adult, middle age, and the aging population for a lifetime continuum of care.
3. Integrate prevention, intervention, treatment, and the recovery-oriented services into a complete continuum of care with physical and mental health services. Rather than treating an individual by separating him/her into service structures that are artificially siloed by funding streams, provide for basic human needs, utilize an individualized comprehensive assessment, and holistically layer services to meet the changing needs of the individual.
4. Strategize new ways to address health and safety life issues for those with **chronic** co-occurring substance use disorder (SUD), MH, and physical health issues. The needs of these individuals differ from the needs of those who are not yet at a chronic use stage.
5. There are not enough detoxification centers. Those currently operating are not located in areas that best serve the needs of the people.
6. Encourage more suboxone prescribers and medication-assisted therapy
7. Substance use disorder services that need to be part of the continuum of care includes all of the following:
 - **Prevention:** There are excellent environmental prevention efforts in place, but they are localized and grant funded. Forum participants asked for universal efforts and open funding in more areas across the state. Prevention



efforts need to be age appropriate and begin at an earlier age within all communities. The recovery community was seen as a resource to help communities provide services to families both in the recovery community and to those at risk for developing SUD issues.

- **Intervention:** Participants saw the need to expand detox services and for additional services under withdrawal management across the state. The basic concept of detoxification needs to include outpatient sobering facilities, and withdrawal management services that also offer medically modeled services that serve to intervene and engage individuals within a continuum of service.
- **SBIRT – Screening, Brief Intervention, and Referral to Treatment:** was seen as a critical link to primary health care at all age levels. It requires that healthcare professionals are well trained and that funding is available to pay for the service for clients in all income levels.
- **Treatment services:** need to be less traditional, more innovative, more holistic, client focused, and not based on "programs" of pre-determined or artificially limited length. Funding needs to follow the client, not outdated concepts of programmatic care or pre-authorization schedules. Comments from all forums supported the department's current policy initiatives of moving forward with open access to service and away from county and managed care pre-authorizations. Doing so would eliminate duplication of assessment, barriers to timely treatment access, and county budget concerns that can at times deny or limit treatment service.

County and Managed Care funding authority was seen as contributing to insufficient treatment that requires the individual to re-access the system because of multiple placements of insufficient care.

Participants also advocated for an appropriate rate structure, improved technology and simplified and efficient charting and data collection operations. They also supported state led efforts to provide technical assistance and monitoring that holds providers and care givers accountable for providing appropriate care and for meeting outcome-based, individualized client goals.

In addition, lack of access to mental health services, services for clients with children, culturally appropriate services, and coordinated healthcare were identified as deficits in the service system, which also complicates pay for performance standards. Providing financial rewards to programs in areas that



have sufficient resources also penalizes programs in areas where these resources are not available. Forum participants suggested offering incentives to draw professionals to work in rural and disadvantaged communities.

Most forum locations noted the need for data informed/driven services and care. Participants in two of the forum locations specifically mentioned that other states successfully used client risk-profiles with associated rate methodology.

- **Care Coordination and Peer Recovery Support:** Participants in all locations referred to these services as being crucial to appropriate and successful service delivery and positive outcomes. This is in line with previous studies. DHS' Treatment Accountability Protocol (TAP) report from 1997 showed that regardless of how "completion" was defined, treatment "completion" was a positive predictor of future success. Completion is an indicator that a client has been engaged in their treatment process. Retention in treatment, or engagement, is seen as a major indicator of future success according to SAMHSA.

Furthermore, for those who were engaged in treatment, 82% who participate in both aftercare or peer support were abstinent at 6 months, 72% who participate in either aftercare or peer support were abstinent at 6 months, but only 52% of "completers" who participate in neither aftercare nor peer support were abstinent at 6 months. While the terminology of "aftercare and peer support" has been changed to "care coordination" and "peer recovery support", these services are expected to show similar beneficial effects.

- **Telehealth:** Most locations referenced expanding the delivery mode for prevention and treatment service to include telehealth and social media. Another universal theme was the need to educate primary health professionals, doctors, nurses, pharmacists, public health workers, not only to appropriately care for individuals in treatment, but also to inform prescribing practices for pain management and persons in recovery.



Integrate prevention, intervention, treatment, and the recovery oriented service continuum into behavioral and physical health care by challenging stigma that has historically kept it separate.

“Stop criminalizing people and the issue: frame substance abuse and addiction as a public health concern rather than a criminal justice issue.”

“Teach people about brain development, function, and disorders.”

1. The need to address stigma surrounding mental health (MH) and SUD service was a topic at each forum. Stigma was seen as the pervasive untruth that keeps communities from understanding the need to address prevention. Stigma keeps communities from providing age appropriate early intervention for those at risk for SUD and MH issues and from connecting with those in treatment and in recovery. Stigma exists because of people think that those with SUD/MH issues are unlike the rest of the community, that the issues are a matter of choice, and that those in recovery cannot be successful.
2. Students from the Healthcare Occupations Students of America (HOSA) conference candidly stated that if SUD and Mental Health services were offered in the schools, there wouldn't be stigma about walking through the MH services door, but there would be stigma associated with walking through the SUD services door.
3. In addition, all forums were passionate about the long term barriers for recovering individuals who also had been convicted of a felony. This combination of inadequately treated healthcare condition and disproportionately harsh legal consequence results in the often insurmountable challenge of securing appropriate work, housing, and abstinence based social activities that lead to a positive, productive life.

Safe (sober), affordable housing.

1. Access to safe (sober), affordable housing was the most commonly cited requirement leading to current and future success of individuals and families. This is not a complicated concept. Basic truths rarely are.



Invest in services to: 1) families with children and adolescents, 2) partner with schools, 3) faith communities, and 4) other local supports.

“Invest in safe, sober activities for communities for everyone. Include the recovery community in these efforts.”

“Begin with pre-natal care - Early childhood education, community intervention, limit the availability of substances, collaborate with the MN Department of Health to motivate changes in the marketing of ‘mind altering substances’, bring environmental prevention and education areas together - Incentivize ‘fun’ events, provide monetary stipends, food, childcare and transportation. Continue activities into high school and middle school, to build a continuum of care throughout a lifetime. Also include older individuals who are at risk of developing SUD related to over-prescription of pain medication.”

The state should lead the way with collaborative efforts among state agencies and partnering with local agencies and providers.

“DHS should do more of these (forums).”

“Professionals working in the communities know their clients and their resources.”

1. DHS was repeatedly asked to lead the way with other agencies, to remove stigma laden laws and punitive policies and protocols that are barriers to an effective continuum of service and success for those in recovery.
2. Forum participants suggested that the state offer incentives to draw professionals to work in rural as well as disadvantaged communities.



3. DHS was asked to include the recovery community to promote positive messages across the state. This includes cultural messages, and messages that recognize the importance of American Indian traditional values in creating healthy lifestyles.
4. The state should invest in telling the stories, educate the general public about brain disease, champion the concepts of early identification, intervention, prevention efforts, improve holistic treatment, and include community strategies and involvement in the continuum of service.
5. Develop materials/collection and analysis systems that provide current data, direction and motivation as to the cost efficiency of providing this type of care.

Final Comments

The Alcohol and Drug Abuse Division is committed to ongoing communication about these issues. “*Your Opinion Matters*” in these areas and in other matters related to substance abuse disorders and substance use prevention. More work needs to be done to build off the great work of the steering committee and listening sessions. Please share your ideas, thoughts and concerns with us. We have created a specific email box, YourOpinionMatters.DHS@state.mn.us for you to submit your ideas and feedback about the service continuum for individuals with substance use disorders and the prevention of substance abuse in Minnesota.

If you would like to view the Model of Care executive summary, please visit the Alcohol and Drug Abuse Division Website: [ADAD Website](#).



Acknowledgements

DHS-ADAD thanks the many participants who took time to share their knowledge, ideas and experiences. The key insights that emerged from these listening sessions are valuable in developing a model of care to improve the effectiveness and efficiency of Minnesota's current service continuum for individuals with substance use disorders and the prevention of substance abuse.

Additionally, DHS-ADAD thanks the Tribal Nations, Health Occupations Students of America, Regional Prevention Coordinators, and the Minnesota State Community and Technical College (Fergus Falls) who helped to find locations for the listening sessions and publicized them in communities.

Appendix A-Small Group Facilitation Questions for Listening Sessions

1. What do you see as the current challenges for people affected and living with substance abuse and those living in recovery?
2. What are the future opportunities DHS should consider to provide support for people affected and living with substance abuse and those living in recovery?
3. What can DHS do to better intervene with those who are at-risk for substance use disorders?
4. What else would you like us to know?

**AGENCIES, ORGANIZATIONS, ENTITIES, AND INDIVIDUALS CONSULTED TO
INFORM THIS REPORT AND RECOMMENDATIONS BY THE ALCOHOL AND
DRUG ABUSE DIVISION, DEPARTMENT OF HUMAN SERVICES**

2012 MODEL OF CARE STEERING COMMITTEE

1. Alcohol and Drug Abuse Division/DHS
2. American Indian Advisory Council/DHS
3. County Relations/DHS
4. Board of Behavioral Health and Therapy (BBHT)
5. Minnesota Association of Treatment Directors (MATD)
6. Minnesota Council of Health Plans
7. Mental/Chemical Health Licensing/DHS
8. Minnesota Association of Resources for Recovery and Chemical Health (MARRCH)
9. Minnesota Society of Addiction Medicine
10. MACSSA (2 reps.- metro and rural)
11. Office of Indian Policy/DHS
12. Cultural Services

LISTENING SESSIONS

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- Northeast Region—Duluth
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- Southeast Region—Rochester
- Southwest Region—Granite Falls
- West Central Region—Fergus Falls

Substance Use Disorder Reform Efforts Report Recommendations

- Youth Listening Session—Health Occupations Students of America (HOSA) Conference-St. Paul
- Minnesota State Community and Technical College (Fergus Falls)

CORE WORKGROUP MEMBERS

1. Consumers/Families (2 representatives)
2. Counties (2 representatives)
 - Minnesota inter-county association (MICA)
 - Minnesota Association of County Social Service Administrators (MACSSA)
 - Association of Municipal Commissioners
3. Minnesota Association of Resources for Recovery and Chemical Health (MARRCH) (2 representatives)
4. Minnesota Association of Treatment Directors (MATD) (1 representative)
5. MN Detox Association (1 representative)
6. MN Council of Health Plans & County-Based Purchasing (2 representatives)
7. Minnesota Hospital Association (1 representative)
8. Regional Prevention Coordinator (1 representative)
9. Problem Gambling (1 representative)
10. Culturally-Specific Providers
 - Turning Point (1 representative)
 - South East Homes Inc. (1 representative)
11. Nine Culturally-Specific ADAD Grantees (2 representatives)
12. Recovery Care Organizations (1 representative)
 - Minnesota Recovery Connection
 - Recovery is Happening
 - ReGroup
13. Tribal Nations (2 representatives)

FISCAL WORKGROUP MEMBERS

1. Counties (3 representatives)

Substance Use Disorder Reform Efforts Report Recommendations

1. Minnesota inter-county association (MICA)
2. Minnesota Association of County Social Service Administrators (MACSSA)
3. Association of Municipal Commissioners
2. Minnesota Association of Resources for Recovery and Chemical Health (MARRCH) (2 representatives)
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