



# Minnesota's Plan for the Prevention, Treatment and Recovery of Addiction

Behavioral Health Division

November 2018



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## Executive Summary

The 2018 Minnesota's Plan for the Prevention, Treatment and Recovery of Addiction report provides a summary of the current substance use disorder (SUD) policy recommendations put forth by the Department of Human Services, Behavioral Health Division.

Minnesota took a major leap forward in our vision to transform our state's SUD treatment system from an acute, episodic model of treatment to a chronic disease, longitudinal model of care, with the passing of the 2017 legislation that created a streamlined process for accessing SUD services and added comprehensive assessments, peer recovery support, and treatment coordination services to the SUD care continuum.

The first [Minnesota's Plan for the Prevention, Treatment and Recovery of Addiction](#) report was published in August of 2016 and provided a road map for this transformation, building on the recommendations of the [2013 Legislative Report: Minnesota's Model of Care for Substance Use Disorder](#).

The 2018 recommendations further the vision by supporting workforce development and sustainability; primary prevention coordination, planning and implementation; smoking cessation; person-centered care; access to withdrawal management services; and improved care for persons seeking medication-assisted treatment and problem gambling services.

Stakeholders clarified the way forward, during the 2018 stakeholder engagement process, by identifying the policies where there was ongoing support or where there were barriers and challenges related to access and delivery of SUD services. WebEx session attendees, American Indian Advisory Council members, Minnesota Association of County Social Service Administrators, and stakeholders who provided input by email provided feedback that will inform our policy development in 2019 and beyond.

The 2018 stakeholder engagement process began in July of 2018 with a series of WebEx sessions. Clinical, Primary Prevention, and Problem Gambling WebEx sub-workgroups were organized with the goal of obtaining stakeholder input on new policy initiatives under consideration and to review recommendations from the 2016 report that had not passed into law in 2017. Additionally, stakeholders reviewed bill language from the 2018 legislative session that did not pass into law.

WebEx collaboration provided us the ability to obtain input from a broad spectrum of stakeholders geographically and professionally. 510 people participated in the WebEx sessions. 53% of attendees were from the non-metro and 47% of attendees were from metro areas. See [Appendix A](#) for a summary of stakeholder comments and [Appendix B](#) for attendance graphs and charts.

We have made great strides working together to reform the SUD care continuum and we look forward to the opportunity to continue our work with you in 2019 and beyond to serve the individuals, families, and communities affected by substance use disorder.

## 2018 Stakeholder Engagement

### Background

2018 represented a new opportunity for the Behavioral Health Division to reach out to stakeholders with the WebEx collaborative software. WebEx sessions provided the Division with the ability to obtain input from a broad spectrum of stakeholders geographically and professionally.

WebEx sessions began in July of 2018 and were organized into Clinical, Primary Prevention, and Problem Gambling sub-workgroups with the goal of obtaining stakeholder input on policy initiatives, including reviewing recommendations from the 2016 report that had not passed into law in 2017 and bill language from the 2018 session that did not pass into law.

The Clinical Services Sub-Workgroup hosted four WebEx sessions:

- Workforce and Withdrawal Management
- 245G Recommendations
- Opioids and Opioid Treatment Programs
- Cultural Recommendations and Additional Topics

The Primary Prevention Sub-Workgroup hosted four WebEx sessions:

- Planning & Implementation (P&I) Grants
- Regional Prevention Coordinators (RPC's), Minnesota Prevention Resource Center (MPRC), State Epidemiological Outcomes Workgroup (SEOW)
- Strategic Prevention Framework Partnership for Success Grant

- Strategic Prevention Framework for Prescription Drugs (SPF Rx)

The Problem Gambling Sub-workgroup hosted two WebEx sessions that included the following topics:

- Problem Gambling Program Overview
- Cross Addiction Education
- Ensuring Best Practices
- Telehealth
- Research
- Behavioral Health Division integration and co-occurring disorders

Additional stakeholder engagement efforts include:

- Six Department of Human Services (DHS) community listening events in the fall of 2017, across Minnesota that informed the development of the [Making Connections](#) report.
- County videoconferencing
- 40 county, managed care organization and provider meetings around the state.
- American Indian Advisory Council feedback
- Stakeholder comments obtained through [YourOpinionMatters.DHS@state.mn.us](mailto:YourOpinionMatters.DHS@state.mn.us)

## 2018 Policy Recommendations

### Assessment and DWI

**Comprehensive assessment for individuals with DWI:** Ten years ago, DHS and the Minnesota Department of Public Safety (DPS) met to discuss what type of assessment would be appropriate to require of individuals convicted of DWI. The Rule 25 Assessment was the agreed-upon assessment at that time and this requirement was enacted in Minnesota Statutes, section 169A.70. To prepare for the upcoming phase-out of the Rule 25 Assessment, this proposal would change the statute to require comprehensive assessment for individuals convicted of DWI instead of the Rule 25 Assessment. DHS, Counties and DPS continue to engage in conversations and will all need to support this change, and this may need to come from a DPS agency bill.



### Insurance Plan Coverage

**Substance use disorder treatment for court-ordered or committed:** Require plans to provide coverage for substance use disorder treatment for enrolled members who are court-ordered or committed. This proposal is modeled after 62Q.535 which requires plans to cover mental health services.

## Opioid-Related

**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.

**Support persons on medication-assisted treatment:** Review legalities related to refusing clients on medication-assisted treatment (MAT) for opioid use disorder. 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 may need to be required to accept MAT clients to insure people receive a full range of needed services.

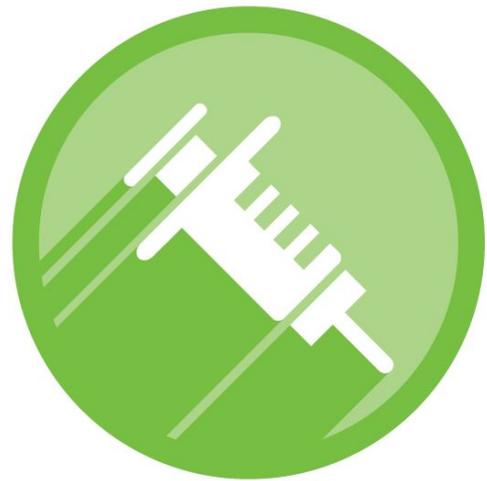
**Naloxone availability:** Support the increased availability of naloxone and support providing clients with access to naloxone upon discharge.

**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 RPCs:** 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.



## SUD Treatment Program Standards Minnesota Statutes, chapter 245G

**Discharge summary:** Ensure that the discharge summary contains current information. Require that the discharge summary be done within 5 days of discharge, irrespective of the date of the decision to discharge. Expand requirements for certain information to be contained in a discharge summary to include all clients instead of just those that complete the program.

**Educational groups and alcohol and drug counselor to client ratio:** Permit educational groups to exceed 16 if a 16:1 client to alcohol and drug counselor ratio is maintained for the number of clients that exceed 16.

**Therapeutic recreation:** Clarify that therapeutic recreation does not include planned leisure activities.

**Treatment service, including therapeutic recreation, must be provided by an alcohol and drug counselor:** Require the Behavioral Health Division to maintain a list of individuals who do not meet the staff qualification requirements for alcohol and drug counselor but who are still qualified to provide treatment services by a different credential. Provide clarity that individual and group counseling services must always be provided by an individual who meets the staffing qualification requirements of an alcohol and drug counselor.

**Eliminate statement of need requirement:** Amend Minnesota Statutes, section 254B.03 and repeal Minnesota Rules 9530.6800 and 9530.6810 statement of need requirement for a proposed substance use disorder program regulated by chapter 245G. This requirement has been in place since 1987, and requires a commissioner determination of need for an additional or expanded substance use disorder program in a county prior to a license being issued. This requirement has become antiquated and cumbersome over the years, losing much of its original intent and purpose. Substance use disorder programs are the only licensed programs required to get a commissioner-issued statement of need prior to issuance of a license.

**Peer support services technical fix:** Remove peer support services as a service that an individual in private practice can provide. This is correcting a mistake, not changing policy, as individuals in private practice eligible for direct reimbursement as an alcohol and drug counselor are not permitted to have the dual role of peer.

**Paperwork reduction:** Remove the annual requirement for licensed SUD programs to provide financial information to DHS indicating the costs of their program operation.

**Naloxone training:** Clarify that the intent of Minnesota Statutes, section 245G.08, subdivision 3 includes injectable naloxone.

## **Nicotine Treatment and Point of Sale Prevention and Control**

**Support Nicotine Treatment in SUD and Mental Health Treatment Programs:** The department will provide technical assistance to SUD and Mental Health Treatment Providers who are interested in offering nicotine treatment in their Programs.

**Tobacco Point of Sale Prevention and Control:** The Behavioral Health Division will continue to provide point of sale tobacco prevention by offering and expanding the Congratulate and Educate Tobacco Merchant Education Program. The division will also continue conducting tobacco inspections under a contract with the Food and Drug Administration to determine tobacco retailer compliance with the Federal Family Smoking Prevention and Tobacco Control Act.

## Withdrawal Management

**Add withdrawal management services to the state's Medicaid benefit set:** 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 245G and other appropriate settings will be explored. **This is in process, and we expect that it will be added to the benefit set summer 2019.**

**Delete requirement for statement of need for a new or expanding withdrawal management program:** Deletes requirement for statement of need for a new or expanding withdrawal management program to facilitate quicker implementation, reflects the reality that programs receive clients from statewide geographic areas and reduces paperwork.

**Reimbursement for tribally and DHS licensed withdrawal management programs that are participating in the 1115 waiver project:** Allow tribally and DHS licensed withdrawal management programs that are participating in the 1115 waiver project and are eligible for federal financial participation to begin providing and be reimbursed for withdrawal management services. **This is not something that we are able to do until the service is added to the state's Medicaid benefit set.**

**Remove requirement to submit an annual financial statement:** Remove requirement to submit an annual financial statement.

## Workforce

**Increasing diversity and capacity of the SUD Workforce in collaboration with essential boards, associations and licensing agencies:** Increasing diversity and capacity of the SUD Workforce in collaboration with essential boards, associations and licensing agencies (Minnesota Certification Board, Social Work, Nursing, Board of Behavioral Health and Therapy (BBHT), Department of Employment and Economic Development, Minnesota Association of Resources for Recovery and Chemical Health (MARRCH)). The 2016 Workforce/Licensing workgroup recommended that DHS examine disparities in education and the potential to revise licensing requirements to include tiered licensing options.

**Increase cultural competence through education and training:** In collaboration with stakeholders [treatment providers, Minnesota Certification Board, consumers, Minnesota Coalition of Addiction Studies Education (MN CASE)], increase cultural competence through education and training.

**Rule 25 Assessor Workforce Preservation:** After July 1, 2020, Rule 25 assessments will no longer be administered. Many current Rule 25 Assessors already meet the qualifications for completing a comprehensive assessment, although many do not. If enacted, this recommendation will allow certain Rule 25 assessors the ability to provide comprehensive assessments effective immediately and until June 30, 2021, and if the individual completes required coursework by June 30, 2021, they are exempt from the internship requirements when working for a county, MCO or tribe doing comprehensive assessments July 1, 2021 and beyond. However, an individual would need to complete the internship requirement prior to providing any other substance use disorder service in any other setting.

**Improve longitudinal collection regarding demographics:** DHS in collaboration with other state agencies and stakeholders, improve longitudinal data collection regarding demographics (cultural/ethnicity) of clinical workforce, client population, outcome measures [Board of Behavioral Health and Therapy, Drug and Alcohol Abuse Normative Evaluation System (DAANES), Minnesota Association of Resources for Recovery and Chemical Health (MARRCH), and Minnesota Alliance of Rural Addiction Treatment Programs.

In 2017 legislation was enacted that modifies policy requirements for personnel policies to permit programs increased discretion to respond to individuals who may participate in treatment for substance use disorder or in other ways may experience symptoms of substance use disorder during employment, where previously programs were required to remove staff from direct access for two years following an incident or treatment participation.

**Tiered workforce system:** Coordinate efforts with Minnesota's Board of Behavioral Health and Therapy regarding current legislation to examine a tiered workforce system capable of providing the entire continuum of effective efficient SUD treatment and recovery support services.

## Appendix A: 2018 Stakeholder Engagement Comments and Feedback

WebEx sessions began in July of 2018 and were organized into Clinical, Primary Prevention, and Problem Gambling sub-workgroups with the goal of obtaining stakeholder input on policy initiatives, including reviewing recommendations from the 2016 report that had not passed into law in 2017. Additionally, stakeholders reviewed bill language from the 2018 legislative session that did not pass into law.

Stakeholder comments and feedback were collected during the WebExs. In addition, DHS obtained feedback from stakeholders through the [YourOpinionMatters.DHS@state.mn.us](mailto:YourOpinionMatters.DHS@state.mn.us) email.

Below is a summary of the 2018 stakeholder engagement feedback collected.

**Note:** Comments are from stakeholders and do not reflect an endorsement or approval from DHS.

### Primary Prevention Sub-workgroup

Stakeholder feedback included:

- Increase community awareness of primary prevention efforts across Minnesota, including community initiatives, opportunities and funding options such as grants.

### Problem Gambling Sub-workgroup

Stakeholder feedback included:

- Engage stakeholders about barriers and funding opportunities.
- Increase problem gambling communications (e.g. Behavioral Health Division email updates through GovDelivery).
- Include problem gambling in discussions about treatment for co-occurring disorders.
- Increase discussion about treatment coordination and peer supports for individual and families in treatment and recovery for problem gambling.

**Note:** Comments are from stakeholders and do not reflect an endorsement or approval from DHS.

## **Clinical Sub-workgroup**

### **A. 245G**

Stakeholder feedback included:

- Don't overburden counselors with a requirement to document treatment service within 24 hours. This may not be possible for providers who dictate their notes.
- Increase client-centered language in the statute.
- Increase support and leadership for curriculum development for training treatment coordinators and provide additional definition and functional clarification for "treatment coordination."
- Do not change any requirements for group size this year.
- Celebrate the legislative successes around the 2016 policy recommendations for direct access/comprehensive assessment, withdrawal management, direct reimbursement, peer support and treatment coordination.

### **B. Culturally Specific/Special Populations**

Stakeholder feedback included:

- Recruit and retain alcohol and drug counselors through the Upper Midwest Indian Council on Addictive Disorders (UMICAD).
- Keep the Rule 25 assessment to maintain the ability to conduct assessments in light of attrition rates.
- Provide leadership to help develop a road map towards certification with UMICAD and the identification of scholarships. Scholarships can be provided to assist in the payment of the fee for initial certification and ongoing recertification.
- Build a roadmap to allow cultural practices, including healing ceremonies as a billable service.
- Research the possibility of bringing back the prevention training with UMICAD. Continue peer support and prevention funding.

### **C. DHS Licensors and Stakeholders**

Stakeholder feedback included:

- Increase collaboration between the Behavioral Health Division and Licensing. View licensing reviews and investigations as an opportunity to improve programs as opposed to an opportunity for punitive actions.
- Provide monthly training on 245G.
- Recognize the value of the services being delivered for patients that are increasingly more ill and require increased clinical intervention resources, and acknowledge the impact this has on programs.

**Note:** Comments are from stakeholders and do not reflect an endorsement or approval from DHS.

#### **D. Insurance Plan Coverage**

Stakeholder feedback included:

- Hold payers responsible for providing reimbursement for substance use disorder treatment for enrolled members who are court-ordered or committed.

#### **E. Opioid Treatment Program (OTP) Related**

Stakeholder feedback included:

- Consider workforce shortages when revising staff ratio requirements.
- Consider the financial implications to OTPs when considering legislation to increase drug testing frequency.
- Consider an implementation timeline for proposed legislative changes, so that providers can build up the capacity to meet any new requirements.

#### **F. Withdrawal Management**

Stakeholder feedback included:

- Allow 245G residential programs to provide withdrawal management services at the withdrawal management rate once it's approved. Reimbursement should be available to 245G residential programs for these services from the time period that the patient was in need of these services, for up to 7 days. These services should be reimbursed by Prepaid Medical Assistance Programs (PMAPs), the Consolidated Chemical Dependency Treatment Fund (CCDTF), and commercially insured patients.
- Patients receiving withdrawal management services in a residential program should be exempt from attending the 30 hours of programming during that week.
- Delete the statement of need requirement as it biases against programs that treat addiction.
- Require that withdrawal management organizations participating in the 1115 waiver project provide at least two forms of medication-assisted treatment (MAT) to be eligible for federal participation and to begin providing and be reimbursed for withdrawal management services July 1, 2018, or upon approval of the federal waiver, whichever is later.
- Submitting an annual financial statement adds a cost burden to organizations and the requirement to do this should be eliminated.

**Note:** Comments are from stakeholders and do not reflect an endorsement or approval from DHS.

## **G. Workforce**

Stakeholder feedback included:

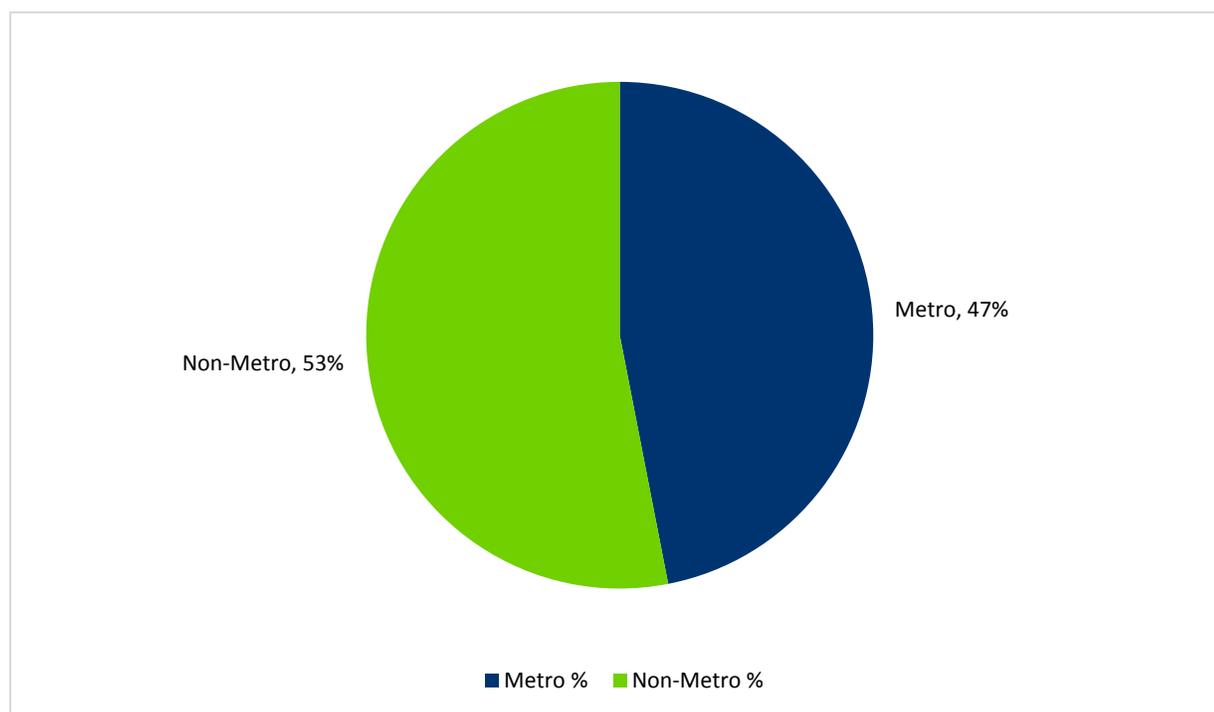
- Allow grandfathering of Rule 25 Assessors and permit them to do Comprehensive Assessments for direct access.
- Do not require alcohol and drug counselor coursework, for experienced Rule 25 assessors.
- To help with workforce shortages, allow Rule 25 assessors who are exempt from licensure to provide comprehensive assessments.
- Allow Rule 25 assessors to work as treatment coordinators.
- If non-licensed alcohol and drug counselors administer comprehensive assessments, this will cause a negative clinical impact.
- If non-licensed alcohol and drug counselors administer comprehensive assessments without completing the required coursework and internship requirements to be an alcohol and drug counselor, this will be a disincentive to others who are considering an alcohol and drug counselor license.
- Allow experienced assessors to complete the comprehensive assessment without billing for it.
- Collaborate with and provide infrastructure support, if desired, to the Upper Midwest Indian Council on Addictive Disorders (UMICAD) board.
- Increase resources for licensing agencies.
- Consider supporting the reduction of costs associated with testing and licensing for Licensed Alcohol and Drug Counselors (LADC's).
- Do not tier licensing.
- Support a decrease in the amount of time it takes to become active and licensed as an LADC.
- Make the requirements to become an alcohol and drug counselor that is exempt from licensure under chapter 148F easier for Licensed Social Workers, Licensed Professional Counselors, etc.
- Explore solutions to decrease barriers for people entering the SUD field with past felony convictions.
- Collaborate with the Upper Midwest Indian Council on Addictive Disorders (UMICAD) to increase cultural competence through education and training, and provide any desired support to the organization.
- Provide a certification in cultural competency and increase access to education and training.
- Provide a tiered licensing track starting with a certificate in substance abuse counseling and co-occurring disorders, followed by licenses for applicants with an associates, bachelors and master's degree.
- Include UMICAD in conversations about a tiered workforce.

## Appendix B: WebEx Attendance Graphs and Charts

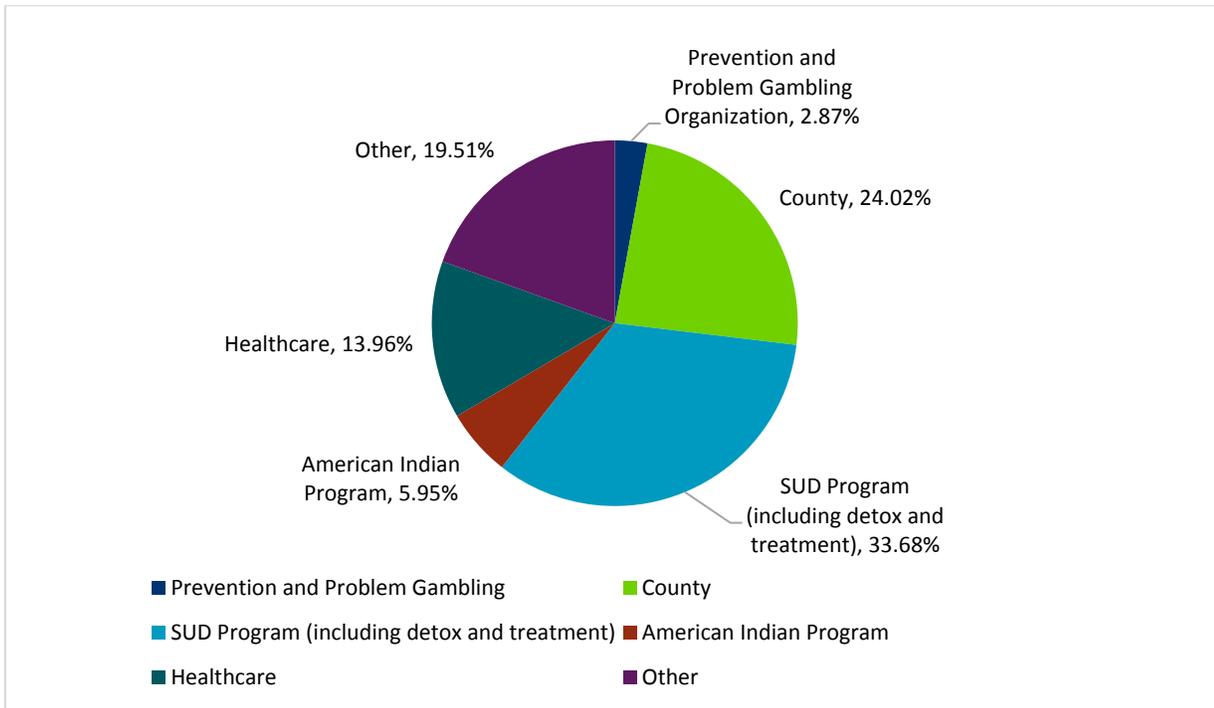
510 people participated in the WebEx sessions.

**Note:** Appendix B graphs and charts reflect WebEx attendance. Graphs and charts do not reflect the attendance from other stakeholder engagement efforts, such as meetings with Tribes, Counties, Managed Care Organizations and Providers.

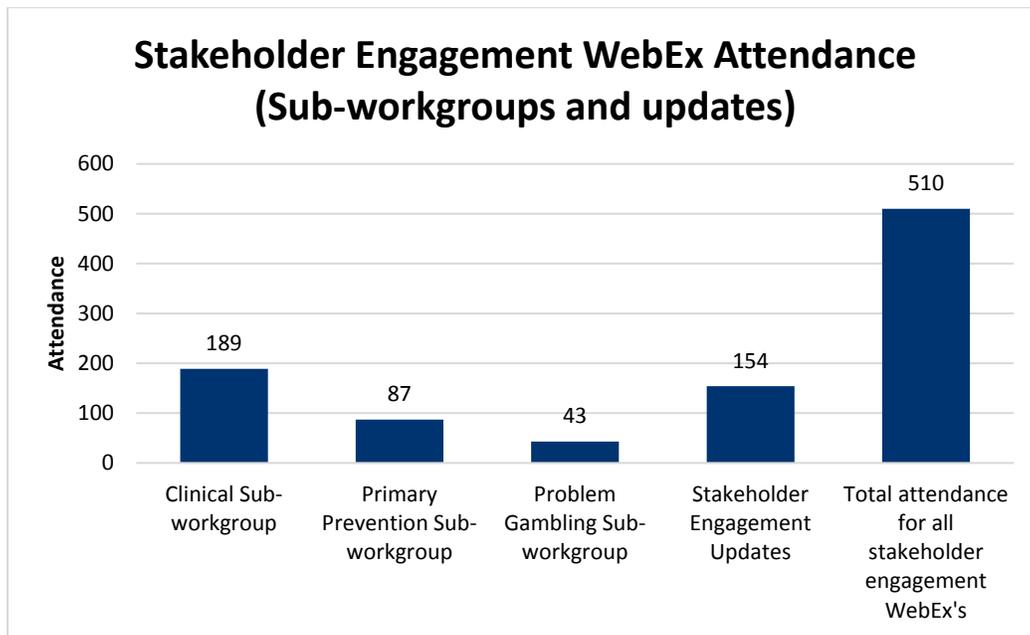
### Metro and Non-Metro



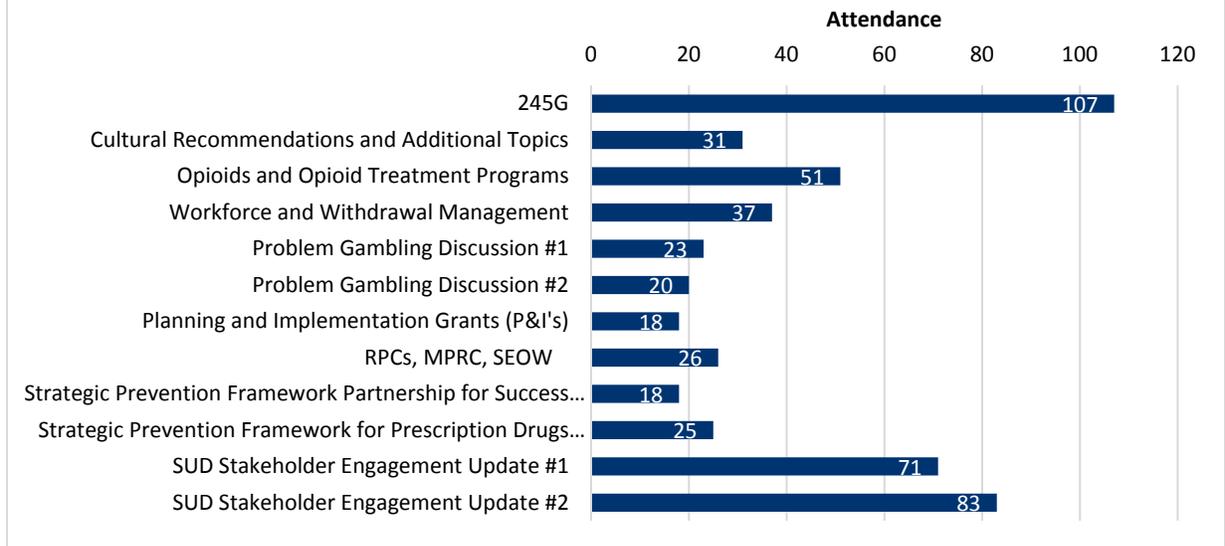
**Attendance by Work Location**



Attendance All Sessions



### Stakeholder Engagement WebEx Attendance (All sessions)



**Sub-workgroups**

