

## 1/24 Meeting Notes

Attendees – Chair Anne Pylkas, Nikki Vilender for Dr. Halena Gazelka, Karina Howard, Jolene Rebertus, John Sutherland, Boyd Brown, Darin Prescott, Sarah Grosshuesch, Toni Napier, Dave Baker, Mark Waters for Nicole, Erin Koegel, Chris Eaton, Dana Farley, Korey Wahwassuck, Mark Koran

Phone – Shelly Elkington

### Guests

Dominic Wilson –DOC, Kelly Enders – Opioid response coordinator dept. of corrections, XXX release planner, Ben Carlson and Ashly fitness clinic in St Paul to reduce recidivism, Dawn Allina, Amanda Calmbacher -

Joe Torgerson Wright County, Wright County, Sadie Holland teen challenges, Amy Koch – Teen Challenge, Brittany CMHC, Wright County, PUBLIC Health Nurse, Becky Graham – Wright County

### ACCUPUNCTURE –

Notes from Omar session

### AG overview

How do we leverage the work we are doing here in a fund that we are in the only one in the country that gets litigation dollars, most states will just put it into a general fund. A lot of what should we do with this, attorney fees will come off the top. Dave spoke with City of Duluth – maybe we out to get together and work something out for us. Attorney General office is setting up meeting about dialoguing likely going to be settlements, lots of folks throwing out asset, longer process to see significant dollars, we have to be focused on the \$20 million we have from the council.

Dana asked about sharing about

Sarah talked about what we collecting about the local burden for evidence. Interesting idea to see if collective can be achieved.

Multistate opioid settlement – publically announced but not finalized.

Focus should be on what we can do.

Nikki Thompson – Ethics of Officer

Everyone on the council filled out a conflict of interest forms, can always be updated. Basic thing about conflicts of interest – the more closely related your job is the more likely there is a conflict of interest. The very nature of your participation gives you a conflict of interest. If you have a special interest

MAT treatment provider services can you participate and vote in these services –Treatment readily available at other, sole provider of that service – disclose that and be more carefully, when we get to funding to the entity – she could participate in the discussion but can't vote. IF you are not the direct beneficiary of the grant/funding then you would want to disclose but not refrain from voting. John asked if we could consult with me and Nikki.

Benefit financially – personal stake and that is when you must recuse.

Group norm on ethics conflict of interest. Group would like to have that discussion as we go forward. Public input could bring something up and then the group could talk about it at that time. IF you wonder if you have a conflict then put it out there. Group adopted it as a norm for ethics. Sometimes we aren't comfortable let Tara and Anne know.

Culture – we know there needs to be a more voices once we have a framework, but we have to get the framework first. Language is really powerful. Need to be careful about using culture and individual differences. Understand culture, individual differences – additional steps. Our subcommittee then that gets compiled so we can blend all of that. Wanted to do look at this and hand to subcommittee to see this through a more refined cultural lenses.

Who and the why – trust them know what they are talking about. Subject matter experts on the workgroup.

Jolene clarified priorities and not defining strategies – do we want RFP to define the strategies, How to leave the how to others. What are we talking about, how to leave the how to others. DO we get bogged down in the details or be more open when we put out the rfp.

Darin – rfp is the opportunity with mindful that evidence based is not always in cultural processes.

John – evidence based treatment – we typically know they work, not for all cultures, but we need to know if they work or not. However we need to be accountable that the programs we fund will work, especially if they are items that haven't been shown to work. Want to make sure that we are careful on how we describe how grant proposals are evaluated – quantitated, qualitative. Korey added that knowledge on the ground that alternatives work in terms of traditional hearing – but they can show through outcomes works but we need to design it to show that in our RFP that we can't do that know.

Anab – drop in center – this council has the opportunity to do that so we do the research we are doing

## Grant Framework

### Objective

- Supported strategies
- Measures

### Grant Application

How they will meet the objective in their cultural context

How do we measure the reach (here is the example)

### Fund allocation

Katrina – we may be getting too granular and might find that we don't get any grant applications

John – content person, look at the measures to make sure we are doing that.

Weston – DHS, MDH, MMB, etc will be looking and bringing ways to measure items.

MAT – discussion about adding including specific groups and populations with strategies we would like to see added in.

Dave – asked if we could have ECHO physicians weigh in on one call ideas

John – creating access to unique patient populations including cultural and or individual identification groups.

## Part One Treatment

### A. Treat Opioid Use Disorder (OUD)

1. Expanding availability of treatment, included medications and behavioral health treatments for OUD and co-occurring substance use or mental health issues and creating access to unique patient populations including cultural, individual differences or varied settings. (Need to go away from evidence based – what she does is energy work which is traditional native healing, we need to leave that wording to communities) balance we both say driven by data and be evidenced based and allow for things that are not or culturally specific/based. Toni suggested looking at applications about surveys or documents– Anne said just need to be evaluable. Anne – if you what you are proposing in science you create a data driven measure with it. Korey – term for promising practices, - John doesn't want to get rid of evidence based so if we used promising practices. Weston says not to use promising practice as that is defined, suggest evidence formed or emerging evidence. – this should be all of us. Jolene said there is a definition called evidence based and/or practice based evidence.
2. Expand access to supportive housing for opioid use disorder with language above.  
Policy – Regulation of sober living and treatment programs to accept MAT  
Dana talked about it is not single agency responsible for sober living, hearing to take a look at supportive living.
3. Expanding access to screening and treatment of mental health trauma issues that resulted from the traumatic experiences of opioid user and for family members. (Anne, John, Korey agree to this, Dave doesn't agree with this, Chris said if they are part of the OPIP don't have to do the training – I guess not) (Potential policy objective if you are treating oud you are required to train and learn about mh) and objective – Dana – so often the folks end up in DOC they end up don't know they have undiagnosed mh. Some suicides are oud and some od are suicides, one thing not here is the moving upstream and doing it for youth. MH precedes the OUD, recently released student survey they have huge concerns. Although mission creep this one might be one thing that can move the needles. Darin – PHQ9 first then moved to pHq2 done but it has helped.
  - a. Increase identification of Mental illness and Chemical Dependency (MICD) disorders through the use of screens. The screens to be used would be
    - i. GAD
    - ii. PHq-9
    - iii. PC-PTSDPolicy recommendation if you treat oud in MN you must do these screenings. Objective that says expanding access to screening to oud and chronic pain patients.

John – chronic disease model where first stabilization by specialist then move to primary care.

4. Access and expansion to telehealth to increase access to OUD treatment, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

a. Lack of access to broadband and telehealth that would improve the ability to have virtual health visits. Access to telephone that meet criteria of not having access to broadband and opioid use disorder. We could use spots within communities that have broadband that individuals can easily access like the library. – Opportunity for a pilot of a telehealth, all need metrics

Jolene – language in bup for face to face that you can't do some of the activities – Anne said they took it out (we need to look into that). Anab suggested to ask people who are already doing it to see what is working and not working. Korey said that once the barriers are identified we could use them to make a policy recommendation.

Telehealth and telemedicine – how do we get to the point so that we have the meeting on the phone or in their home vs in the clinic? How do we get based barriers – Anne and John will talk to telehealth folks and then report back on the barriers. Mark Koran spoke about mobile access to MAT.

Lunch Break – Wright County Opioid Misuse Prevention

April 2018 SHIP funds to address opioid epidemic one of two counties, started immediately convening the opioid action team – see handout. They have seen expansion of MAT providers, MEADA (worksheet) youth substance, drug disposal, expanding times they are available and

Current work is on Neonatal abstinence syndrome. They were able to get the jail, local clinic – offer MAT in jail will continue post incarceration. Big deal, public health has been able to bring the collaboration and introductions together. Jolene added that they are working on a jail ECHO series with Brian Grahnan.

Anne – 3 1/2 hours to get through the list and then we

5 & 6 going under number 7, Anne said that those two train everyone else

Objective – Fits under training (Darin talked about requiring them in rural

Strategy – policy recommendation to put through policy and grant for fellowships for addiction medicine specialists for direct patient care, instructors and clinical resources

Maybe make this a workforce development objective (includes 5, 5 & 7). Mark says under 7 we mat definition – all federal approved MAT,

Workforce development in this group– Expand the addiction workforce by providing developmental opportunities, (scholarships for these increase capacity for those working with rural, individual differences, etc. but this area is so limited that we might not want to limit) might want to be broad and say we could peer support. Jolene says we need to call out peer support – more connection than otherside. John said addiction med drs, ladcs and peer recovery specialist – sub categories for funding for all of these. Anne talked about turnover. We could call out all of these. John said policy issue for LADC's about paperwork reduction to DHS, burnout because so much paperwork they get burnt out.

Dave asked what drove that paperwork – John MARCH working on paper reduction with partnership with DHS. John asked us to walk in the steps of the LADC. Mark is going to shadow, Anne said they have a lot of patients, work, with complex patients that they are not prepared for. John six dimensions, progress notes, discharge notes and that is why they are leaving. Another policy that addresses policy – Review process that removes barriers from treatment. DHS needs to work on that with MAARCH. Dave – workforce impact. Darin talks about UMICAD licensure for American Indian workforce so they are not forgotten in training.

LADC/UMICAD license more emphasis on mh aspect to address more complex patient. When they go as dual licensed they work as MH so they get better reimbursement.

Objective - retention of training professionals on every level by creation of a resiliency program in the addiction workforce

8. Development and dissemination of accredited curricula on addiction and pain – question on who accredits, could be creep, could be CME's. We need to distinguish accredited curricula and education. Chris says the main barrier she comes in is for reimbursement for pills vs. treatment cost for alternatives to cover. Anne/John – not enough resources to support the client – motive for organization to get more trained staff. Maybe get paid more for oud patient than other. Anne – some of it primary care doesn't want to attract, time but if you pay them more they will do it. John – said universities that mandate being waived. 8 hours of unpaid time to get waived. John – lots of primary care, waived they can prescribe suboxone, Dana – more doctors waived is important but not about pain, b & c is about pain. Dave – workforce conversation includes this as the waived part of this problem. John said Allina created a model where TX folks are stabilizing them and then transfer to primary care. Dave said to move this to workforce. Anne said it is not supported and not reimbursed. John said when we get more docs they started doing that. Anne says ECHO has done a good job but not enough. Korey thinks it is a workforce issue that needs to go with 5, 6 and 7. The policy recommendation is that dr doesn't have enough resources to be waived. Dave suggests bringing big group to answer that question to come up with a workforce policy issue. Dana talked about system change needed and ICSI could be a piece of that conversation, Anne – said ICSI does have a workgroup which Anne is part of so we could share that with it. Anne will bring that report back to that, Increase wavering and access to chronic pain resources. Darin said primary care they have seen alternatives, is their access, 6 week wait for PT , toni holistic management – no access to non-doctors because insurance doesn't cover it, reimbursement of these and have them be part of the team.

Objective - Improve access to holistic to alternative medicine for chronic pain. (no policy recommendations, but easier to have a pilot with holistic medicine for chronic pain). (Policy and pilot)

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

1. Training, funding etc. SBIRT more flexible when they move to a policy recommendation. Evidence there and if it was reimbursed it would covered so it will be a policy recommendation for reimbursement. Someone other than doctor can do/should be sbirt.
2. Training for emergency personnel that treat opioid overdoes patients on post-discharge

Shelly - #3 add to that care coordination model under peer recover, community care nurses, social workers, that engage in that model so there is the start to finish so we don't have the gap. Shelly wants it as an objective and ~~potential pilot(don't want to limit this to objective without funding it)~~– improve

care coordination for people in crisis situation and connecting care to long-term. Care coordination start at emergency point, discharge, transitions to care, finish treatment – healthcare do a good job of this. Combine 3 & 6. Pete talked about transitions representing EMS are essential)

Spirit of 5 is figuring out where they accessing care because we don't know. Touchpoint – community mapping about where people access treatment/resources. Could build off of information we already have. Jolene says organizations that have already done this in some communities. We should access this information to make informed decision. Maybe invite Clarence to the meeting about the Human Project – so maybe this one is for second round funding.

Korey is talking about SBIRT in general the objective should allow for some difference – Shelly - #6 is about emergency personnel than we are being too specific. Anne says she hears the worry but not sure it applies to SBIRT. If it was reimbursed there would not be a need for startup costs.

#4 school – sounds like a pilot, agreed upon. Erin – brought up kids dealing with parents who are addiction. Schools is where everyone goes to, maybe using schools as hub for care coordination. Anab-good policy recommendation for middle school and high school. Anab – using schools as telemedicine for ladc (add idea under the rfp). John – one problem with that need policy issue is there LADC's lead it, it isn't covered by statute, one-on-one's limited funding for LADC's to do telemedicine so would need a policy change. Outside of program reimbursement for services are not covered expect for care coordination. Leave this as a pilot with suggestion of telehealth at schools. Schools are accessible for everyone. Dana talked about years ago when we had counselors in the school. Objective increase access to treatment, prevention and education to counselors. In wright county – have ladc but school pays for it. Telemedicine – just not a covered service for reimbursement. Improving access to

Objective - Increasing access to prevention and treatment for youth through schools.

Policy ask for change in statute that would allow reimbursement at a secondary location for telemedicine in schools. We need conversation with MDE.

Resources for youth are separate

Anne spoke about do we really have what we need to have at least Feb meeting to report to the legislature by March 1<sup>st</sup>. A report in March that say to where we are at but doing it methodically and collaboratively. We could do a follow up report. Concrete policy discussions and deeper dive for funding recommendations. Report of policy ideas, currently licensing dollars where funding is, in licensing, lawsuit ideas, about work they are doing and where we are going.

Subd. 4.Grants.(a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming fiscal year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by March 1 of each year, beginning March 1, 2020. We could have it by April

C. Address the needs of criminal-justice involved persons

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

b. Family-centered interventions

Objective – Expanding access by removing barriers for those with criminal justice involved or high level felonies for those that currently access to treatment.

Policy – Removing barriers (housing etc.) for those who criminal justice involved histories, example drug court,. Sub group recommendation by John because these folks need treatment options but when you talk about breaking down the barriers there are huge implications. Vulnerable adults, trauma background, staffing need, etc., so we can mitigate the unintended consequences. Dana talked about drug courts have demonstrated success. Using that we want to have really good recommendations so they need to be fine-tuned with impact analysis. Anne thought – creating programming for those experiencing barriers. John – talked about drug courts funding issues and people who have served their time but yet they are still not allowed to have treatment. So another option for treatment center that meets the needs for their needs. Subgroup – access and barriers subgroup – thought about immigration, (Olmsted set where we are addressing these disability issues). Anne – discussion about disability accessibility. Wheelchair accessibility is required for Maisha. Wait to create objective until workgroup meets which is Jolene, Korey and DHS representation.

Alternative to incarceration

#2 adds in #1

Need to know the law about needles – the law requires a prescription for naloxone the needle itself (is there a need for a law to change the need for needles). The barrier in MN

Policy recommendation that you can't deny someone life insurance for having a naloxone proposal.

Education piece for Naloxone. Sarah – said that in order to have the naloxone there is a standing order to have the needle as part of the kit.

Needles would be legal policy recommendation – Katrina said they can go to pharmacy and get needles.

Korey read the law – ask her for the law. It is a misdemeanor because they have the needles without naloxone. Education with law enforcement

Former 3 Objective – Continuity/Long term supports for those with criminal justice interventions for longer term supports under care coordination group and subgroup.

Support community convening where we bring together law enforcement under the criminal justice umbrella...remove this one.

Dana talked about convening piece , Kris summarized – part of the rfp to discuss their community criteria about

Former #5 Embedding training and education in behavioral health and physical health in the criminal justice system and providing information sharing to build more partnerships. Does this go to workforce? How we are building partnerships with community partners for those with – what if we make a policy recommendation for law enforcement officers like we do for medical providers. Create the education, train it and – pilot law enforcement curriculum echo (talk to law enforcement)

Katrina – you can legally get them from a pharmacy but you can get picked up by law enforcement for possession of having the needles.

D. Support people in treatment and recovery and reduce stigma

#1 add some of the language full continuum of care under care coordination piece

2i. under number 1 on first page

2ii. Under workforce

2. Engaging in community-wide stigma reduction and education about treatment, support and workforce readiness to reduce the stigma and provide support to the individual in recovery ---under workforce. Policy - State provisional license for these folks. DWI not alcohol related you have an intermission interlock in his vehicle,  
Workforce – toolkit business community is handling this so not in our role

Part Two Prevention

E. Prescribing tools, patient education, alternative medicine and prevention of opioid use disorder  
Create objective to reduce stigma about general public and opioid prescriptions in the home.  
Encourage youth to apply for this grant.

3. Support for non-opioid pain treatment #1 covered under holistic but #2 is policy recommendations  
#3 Physician education on pain management covered above

3. PMP – little agencies may not be able to do this for a year. Weston spoke about evaluating but Jpal is doing the work. Do we want this to be a pilot project to integrate (some systems have integrations issue – not EPIC). Dana brought up integration is expensive, Westin added that EPIC may be cheaper – move it forward it as pilot project.

4. Public education relating to opioid prescriptions – may be the same (Dave talked about 4 and 6). Need to do something like that. Public school based or senior prevention messaging.

Change to community based public education

Six – curriculum listed are mental health curriculum. Majority of the sud in schools is been a big scientific failure, this is a proposal is about overall health. Piece of 6 don't go with 4. Community one based on getting rid of drugs, what does your grandkid looks like when they are high.

Elevate our level of school based

Public program that is substance addiction based and school program that is more social emotional piece. Piece for the parents – wouldn't need to be more public based.

Policy change to take back unless they put the take back is outside of the facility. Dig deeper later. Can ask the

7 and 6 are together.

F. Prevent overdose deaths and other harms (harm reduction)



a. Policy naloxoboxes – where does it need to be. Policy item for RFP

MSS – Funding sustainability that would need to drugs and mh. Streamlined version contingent on evaluations – make it available online. MDH not supportive.

Assessing what is being taught – this dove tails as no drug education standards, state law that says they can't be standards due to local community.

Remove 2

Reimbursement/Policy

1. Pcode pilot

Cultural Subgroup – anyone from here wants to be involved and they decide who they want to invite with members.

Legislative update – Matt Burdick, developing our potential legislative package for upcoming session. Anything that impacts the council we get feedback to this – there may be some technical changes that we may support, council operation – 3 year terms the council voted on, mha appointment from DHS appointment, community seat membership – 1<sup>st</sup> one governor order for gov't to gov't consultation that each tribes have a seat at the table to recognize sovereignty, conversation represented Somali community. Anne asked for input, Chris clarified that we would add 9 people – too many, I would hope that we add a couple more and not 9, no one from latino, Asian community, my hope was to add American born and African born. Darin disagreement as tribal sovereignty discussion that each tribe is not the same, every community – ai significantly impacted on this, Judge – govt to govt consultation – disparate numbers it makes sense, nobody wanting to exclude from the tribes – Dave suggested that we identify solid culture subgroup and bring those voices together. Bigger than a subgroup – maybe they vote proportionately, this request came from day long summit with the tribal nations for a list of legislative changes – voted on by tribal nation based on collated list by the tribes based on DHS. Give us feedback – nothing needed for legislative session by March. Toni said – white earth tribe but not representing the tribe so will exclude self from the vote, council need a united feedback – Darin spoke about this issue being a Medicaid which the tribes don't.

Public comment –

My name is Ben spoke about how to keep people sober that do through fitness programs that can be delivered to treatment centers – thrown this by treatment center. Some have signed letters of intent.