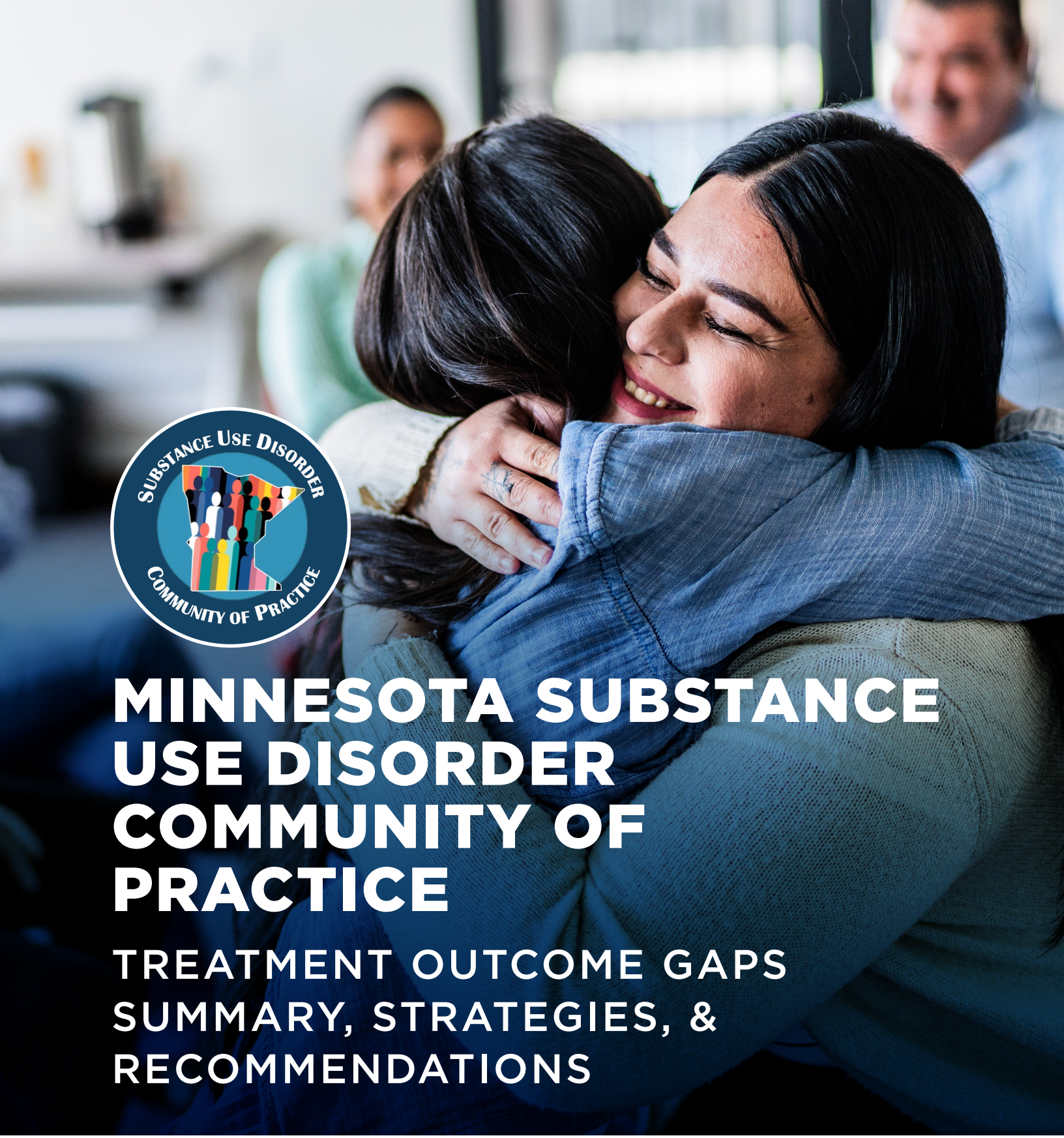

MINNESOTA SUBSTANCE USE DISORDER COMMUNITY OF PRACTICE

TREATMENT OUTCOME GAPS SUMMARY, STRATEGIES, & RECOMMENDATIONS

WRITTEN BY:

HMA

WITH INPUT FROM:

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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines substance use disorder (SUD) as the recurrent use of alcohol and/or drugs that "causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." Furthermore, SUD continues to be an underlying factor for drug overdoses. Exacerbated by the pandemic and changes in the formulation of widely available substances, overdose continues to be the leading cause of injury-related deaths in the United States.[1,2] In Minnesota, the rate of drug overdose deaths increased by 3% between 2020 and 2021, with a disproportionate impact on communities of color.[3]

Following Minnesota's enactment of legislation to address this issue (Minnesota Statutes 2021, Chapter 254B.151), the Minnesota Department of Human Services (DHS) sponsored the creation of the Minnesota Substance Use Disorder (SUD) Community of Practice (CoP), facilitated by Health Management Associates (HMA). The MN SUD CoP is composed of individuals who engage in SUD treatment and prevention in any capacity, including people with lived experience, providers, family members, researchers, recovery peers, state and local government representatives and advocates. The MN SUD CoP seeks to bring individuals from across the Minnesota SUD treatment continuum together to engage in information sharing, competence development, rich discussion, and mentoring. Amongst other topics of interest, the CoP works to identify gaps in the Minnesota SUD treatment continuum and to identify strategies and resources that mitigate those gaps.

Beginning in August 2023, the MN SUD CoP convened open CoP meetings during which participants:

- Engaged with individuals with lived experience
- Shared learnings and recommendations related to the Minnesota SUD treatment continuum
- Analyzed resources intended to assess the treatment continuum in their community
- Completed surveys on the state of the Minnesota SUD treatment system

The MN SUD CoP also convened office hour sessions and focus groups comprised of individuals with lived experience, state representatives, treatment providers, advocates, researchers and academics, and representatives from managed care organizations (MCOs). Attendees shared thoughts and experiences related to the state of the Minnesota SUD treatment ecosystem and provided recommendations for system improvement.

This report summarizes gaps in the Minnesota SUD treatment continuum identified by the CoP participants and provides recommendations to address those gaps. The identified gaps include but are not limited to a lack of culturally responsive and gender-specific care, lack of robust services in rural communities, difficulty transitioning between levels of SUD services,

[1] CDC. Understanding Drug Overdoses and Deaths. 2023. Available at: https://www.cdc.gov/drugoverdose/epidemic/index.html. Accessed December 29, 2023.
[2] National Institute on Drug Abuse. Drug Overdose Death Rates. 2023. Available at: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates. Accessed December 29, 2023.
[3] MN Dept. of Health. (n.d.). Drug Overdose Dashboard. MN Dept. of Health. https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html

and incomplete integration of peers and other recovery supports into the treatment system. To address these gaps, the report also includes recommendations for systems, provider, and community responses to eliminate and/or mitigate those gaps using information gathered from the CoP, focus groups, and pre-CoP convenings, in addition to publicly available information. Strategies and recommendations include developing agencies to support community providers in delivering culturally competent care, expanding family-based treatment services, enhancing the SUD workforce through training and increased peer support integration, and improving funding models to incentivize high-quality, person-centered care. The recommendations aim to target the specific challenges identified in each gap area, offering a comprehensive approach to building a more accessible, equitable, and effective SUD treatment system in Minnesota.

By implementing these recommendations and prioritizing the development of a culturally responsive continuum of care, Minnesota can make significant progress in addressing the SUD crisis and improving outcomes for all Minnesotans affected by SUD. In addition to the information available in this report, strategies and resources to mitigate gaps will also be available in subsequent reports generated by HMA through the course of the MN SUD CoP.

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Substance Use Disorder Community of Practice

SUMMARY OF FINDINGS: MINNESOTA SUD TREATMENT GAPS

SUD treatment gaps identified by the MN SUD CoP participants span the continuum of SUD treatment and related areas and are summarized below. Table 1 provides additional details on specific gaps within each category as discussed during MN SUD CoP meetings and workgroups.

- **Education, Prevention, and Early Intervention:** Participants agreed limited funding and staffing are available for general SUD education and prevention efforts, particularly as they relate to youth education, prevention, and early intervention practices.

- **Treatment Accessibility:** Although Minnesota has a relatively high number of treatment facilities compared to other states, MN SUD CoP participants noted that access to non-traditional or holistic services, tobacco cessation programs, mental health services, detoxification facilities, and culturally specific programs remains a challenge. Despite the overall treatment capacity, Minnesotans face barriers in accessing the specific types of care that best meet their needs. MN SUD CoP participants with lived experience also reported extended wait times to obtain treatment and experienced a lack of coordination and planning between various aspects of the system. Furthermore, treatment centers use generalized approaches and do not always adjust practices based on individual needs, highlighting a lack of person-centered care.

- **Cultural Competency and Gender-Specific Care:** People who have received facility-based care have reported traumatic experiences in treatment facilities and indicated some treatment facility staff were inadequately trained to provide competent and sensitive care related to cultural practices, gender identity, or sexual orientation.

- **Social Determinants of Health (SDOH) and Health-Related Social Needs (HRSN):** Sources noted that SUD can only be adequately treated when resources are available to respond to SDOH and HRSN, such as housing, food insecurity, and transportation. Providers need to create system partnerships with Case Managers and HRSN providers to assure that basic needs are met, and individuals have a recovery support system.

- **Workforce:** Mirroring national trends, Minnesota is experiencing SUD and medical workforce shortages and elevated levels of burnout among SUD and medical treatment providers.

- **Transitions of Care:** Participants noted that services across the SUD treatment continuum often operate in a silo, leading to loss of communication or relapse among individuals who are transitioning between levels of care.

- **Rural Care:** Participants agreed that treatment services across the continuum, with an emphasis on culturally competent care, are widely unavailable and understaffed in rural areas.

- **Behavioral Health:** Acknowledging the intersection of mental health and SUD is critical to achieving long-term recovery; however, SUD services in Minnesota were noted as lacking coordinated access to adequate mental health services in treatment centers.

- **Recovery Outcomes and Data Sharing:** Participants noted a lack of consensus as it relates to defining recovery, which leads to a lack of accurate data that identifies successful treatment programs.

- **Funding:** A general lack of funding was noted, particularly as it relates to reimbursement of SUD services, prioritization of culturally competent care, and development of innovative care models. Providers also agreed that lack of funding contributes to competition among treatment providers, often favoring larger treatment centers.

- **Administrative Burden:** Increased requirements for documentation have led to burnout among providers, who are having to prioritize administrative tasks over patient care.

Details related to the gaps identified in each category are provided in Table 1 below. Of note, the identified gaps are related to overall outcomes in the Minnesota SUD treatment continuum and do not include inefficiencies of treatment delivery as they relate to levels of care. Additional details on this topic will be available in the American Society of Addiction Medicine (ASAM) Implementation Roadmap Report scheduled for completion in 2025.

Table 1. Minnesota SUD Treatment Outcome Gap Trends Identified by MN SUD CoP Participants[4]

Topic	Gaps and Challenges
Education, Prevention, and Early Intervention	• Lack of awareness among individuals with SUD and providers about the availability and benefit of Peer Recovery Specialists • Lack of general SUD education outside of the residential treatment network, particularly related to early intervention efforts • Insufficient SUD advocacy within the community (partly because of workforce shortages) • Overlooking early prevention efforts, such as outpatient and residential youth programs • Lack of prevention efforts among Minnesota youth
Treatment Accessibility	• Access barriers to SUD treatment or non-traditional/holistic services • Lack of access to detox facilities and/or medications for opioid use disorder (MOUD) • Lack of access to smoking cessation programs in treatment facilities • Extended program wait times (particularly for culturally competent programs) • General disengagement from clients who are not ready for change • Siloed communities and treatment providers • Lack of resources and planning for previously incarcerated individuals • Lack of culturally specific youth programs and overall attention to the youth with SUD • Lack of individualized care • Loss of innovation in developing new methods to reach and treat clients • Lack of funding for person-centered or value-based care
Cultural Competency and Gender-Specific Care	• Lack of culturally competent and sensitive care (particularly in rural areas) for youth and adults • Lack of gender-specific care for youth and adults • Lack of tribal representation • High numbers of underserved populations (e.g., veterans, seniors, LGBTQ+, Hispanic population, tribal population, etc.) • Extended program wait times (particularly for culturally competent programs) • Lack of funding for culturally competent programs or increased competition for single funding sources • Highlighted instances of stigma and discrimination, particularly towards Native American culture, as well as other religious practices, race, and gender. • Disingenuous efforts toward culturally competent care • Insufficient representation and advocacy for women with SUD

[4] Identified gaps are related to overall outcomes in the Minnesota SUD treatment continuum, and do not include gaps in inefficiencies of treatment delivery as they relate to levels of care.

Topic	Gaps and Challenges
SDOH/HRSN	• Lack of resources and support for basic challenges (e.g., child support, financial management, transportation, food support, housing, health care and other benefits) for people with SUD and transitioning from treatment • Instances of individuals entering treatment to obtain HRSN supports
Workforce	• Overall workforce challenges, including shortages in case coordinators, providers, and Peer Recovery Specialists • Limited desire to enter the field due to wages/reimbursement rates • Increased burnout among SUD treatment providers
Transition of Care	• Loss of client participation in treatment during the transition between services, particularly when changing facilities, treatment providers, and services • Lack of available post-treatment and recovery resources • Lack of data available related to aftercare
Rural Care	• Immense SUD treatment disparities in rural areas, including fewer treatment locations, lack of access to withdrawal management, staffing shortages, transportation barriers, etc. • Difficulties motivating and engaging clients for treatment following long commutes to rural treatment settings • Lack of transportation to physical treatment centers • Inadequate internet access for virtual treatment • Lack of culturally competent and gender-specific care in rural areas • Loss of SUD treatment providers in rural areas • Accessibility challenges in rural settings and wait times for treatment beds • Lack of funding for prevention, education, staff turnover, and accessibility in rural areas
Behavioral Health	• Lack of treatment programs that can accommodate co-occurring SUD and mental illness • Lack of access to holistic or non-pharmaceutical interventions for mental illness
Recovery Outcomes and Data Sharing	• Lack of consensus on what constitutes recovery • Ineffective key performance indicators to track recovery • Loss of data collection following treatment and lack of data transparency • No centralized unit to track recovery outcomes or success of treatment programs

Topic	Gaps and Challenges
Funding	• Lack of overall funding for SUD efforts, particularly in Native American communities • High levels of competition for singular funding sources • Low reimbursement rates for SUD services • Little to no funding for SUD treatment innovation and/or newly established programs • Lack of motivation to initiate value-based care contracts by some SUD providers or payers prior to addressing foundational system issues
Administrative Burden	• High levels of burden on treatment providers to complete excessive paperwork and documentation, leading to burnout and less effective patient care

DATA COLLECTION METHODS

To identify and understand gaps within the Minnesota SUD treatment system, HMA aggregated findings from publicly available resources, literature, and previous Minnesota efforts (e.g., the MN SUD CoP pre-planning meetings and the MN SUD Summit) with those collected during the MN SUD CoPs, focus groups, and office hours. Table 2 describes data collection efforts included in the generation of this report.

Table 2. Minnesota SUD Treatment Gap Data Collection Sources

Source	Description
MN SUD Shared Solutions Summit	Additional information on the MN SUD Shared Solutions Summit is available on the Summit webpage.
MN SUD CoP Pre-Planning Meetings	The MN SUD CoP pre-planning committee met for a series of five planning sessions to discuss the objectives of the MN SUD CoP. Summaries from these meetings are available on the MN SUD CoP webpage.
Full MN SUD CoP Meetings (August, September, and October)	Full, public MN SUD CoP meetings took place in August, September, and October 2023. Each MN SUD CoP began by hearing from individual(s) with lived experience. The first CoP meeting focused on introducing participants to the CoP model and gathering base information from participants. The September MN SUD CoP introduced participants to the SUD Community Assessment Tool, originally developed for Indiana, to help stakeholders assess the needs and strengths of state and local systems as they address SUD in their communities. In October, participants discussed the value of engaging in community advocacy. Additional information on strengthening community advocacy efforts in Minnesota is available in the Community Advocacy Capacity-Building Strategy Report.
MN SUD CoP Office Hours	In October, HMA conducted three office hour sessions to allow MN SUD CoP participants to obtain additional information about the SUD Community Assessment tool. Because the tool guides analysis across various systems (e.g., behavioral health, child welfare, justice, public health, education, and human services), each of which contributes to true SUD system coordination, participants also had the opportunity to discuss the tool with individuals outside their practice area.

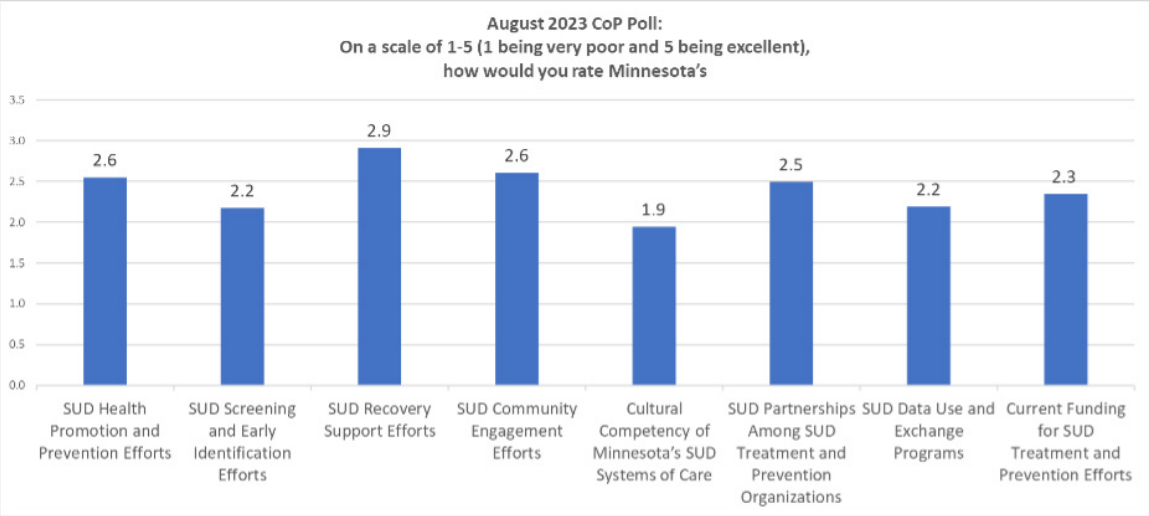
Source	Description
MN SUD CoP Focus Groups	To continue gathering information on the state of the MN SUD treatment system, HMA and the MN CoP convened four focus groups throughout November 2023 to elicit responses from key constituent groups. • Group 1 – DHS, county social services, and Department of Corrections (DOC) representatives • Group 2 – People or family members with lived experience, tribal nations or tribal social services representatives, and people from communities disproportionately impacted by SUD • Group 3- Recovery Community Organization (RCO) representatives, SUD treatment providers, and community advocates • Group 4 –MCO representatives, researchers, and members of the academic community. Sample questions for all groups included: • What are some of the biggest challenges in the SUD treatment space? • What do you feel is being done well in the SUD treatment space in Minnesota? • How could recovery support during and after treatment be improved? • How might perspectives and experiences of people with lived experience be incorporated into SUD treatment services? • How does stigma present a barrier to SUD treatment? • How do you envision building a culturally competent SUD support system? • What funding mechanisms can be used to enhance SUD services? • What role does regulation play in improving SUD services? • What role do innovative payer strategies play in improving SUD Services? • What treatment outcome metrics should be tracked to ensure the delivery of high-quality care? • What role does harm reduction play in the treatment environment? • What workforce development strategies can improve services? What do providers need to improve care? Attract new disciplines to the field?
Literature Review	To ensure full examination of the Minnesota SUD treatment landscape, HMA also reviewed publicly available literature related to challenges and best practices in the SUD treatment continuum. Literature details are cited throughout the report as applicable.

Based on the information and data gathered through these multiple sources, the following provides a more in-depth analysis of the 10 gaps and challenges identified and provides 16 recommendations to improve the Minnesota SUD continuum of care.

GAPS, STRATEGIES AND RECOMMENDATIONS

To obtain a baseline understanding of the Minnesota SUD treatment continuum, CoP participants were asked to rate (on a scale of 1-5, with 1 being very poor and 5 being excellent) the quality and access of various aspects of the system during the first MN SUD CoP. For a summary of the results, see Figure 1.

Figure 1. August MN SUD CoP Treatment Continuum Quality Poll



This poll served as a foundation for continued discussion throughout subsequent meetings, workgroups, and focus groups, where participants provided additional details on Minnesota SUD treatment gaps, as well as potential strategies for mitigating existing gaps. Through participant input, peer reviewed literature, evidence-based strategies, and subject matter expertise, HMA compiled the following strategies to assist the State of Minnesota in addressing gaps and improving outcomes in the SUD treatment continuum.

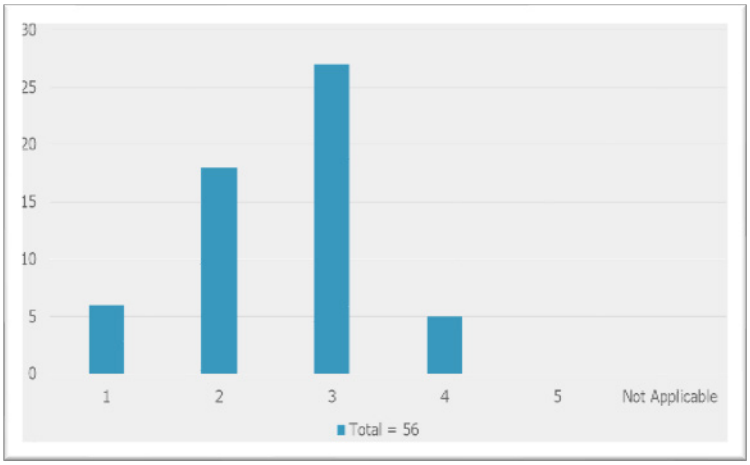
Recommendations are divided into categories that align with the gap categories listed in Table 2. **Gaps identified by the MN SUD CoP participants are also re-stated in each section in grey callout boxes.** In addition to recommendations, current and upcoming efforts by MN DHS to address SUD treatment gaps are provided within each section. Of note, these sections may not be inclusive of all current or past efforts by MN DHS and do not include efforts by other Minnesota state agencies, county and local governments, or other community entities. Though they are not listed by priority level, HMA does recommend that Minnesota prioritize addressing gaps in cultural competency of Minnesota's SUD systems of care, which was continually ranked as the largest gap by CoP participants (as indicated in Figure 1). Finally, while each of the gaps and recommendations indicated is centered around the Minnesota SUD treatment continuum, implementation of recommendations may require collaboration or coordination with other agencies or organizations. It is also important to recognize that the gaps identified in the Minnesota SUD treatment system are interconnected, and that addressing one gap can have a positive impact on others. For example, improving cultural competency in SUD treatment can help address gaps in treatment accessibility and transitions of care by ensuring that services are more responsive to the needs of diverse populations. By taking a comprehensive, integrated approach to implementing the recommendations outlined in this report, Minnesota can create a more effective, equitable, and sustainable SUD treatment system.

Education, Prevention, and Early Intervention

Gaps and Challenges

Most MN SUD CoP participants rated Minnesota's current SUD health promotion and prevention efforts as a 2 (poor) or 3 (average) in a poll conducted during the first MN SUD CoP (see Figure 2).

Figure 2. MN SUD CoP Poll Results: On a scale of 1-5 (1 being very poor and 5 being excellent), how would you rate Minnesota's SUD health promotion and prevention efforts?



During subsequent meetings and workgroups, MN SUD CoP participants agreed that they felt limited funding and staffing are available for general SUD education and prevention efforts, particularly for youth education, prevention, and early intervention services. Though Minnesota has prevention programs[5], described in greater detail below, few participants could identify prevention and early intervention programs in Minnesota. Participants who did discuss prevention and early intervention often told us too few programs were available. Other gaps identified include:

- Lack of awareness among individuals with SUD and providers about the availability and benefit of Peer Recovery Specialists
- Lack of general SUD education outside of the residential treatment network, particularly related to early intervention efforts
- Insufficient SUD advocacy within the community (partly because of workforce shortages)
- Overlooking early prevention efforts, such as outpatient and residential youth programs
- Lack of prevention efforts among Minnesota youth

[5] Minnesota Prevention Resource Center. About. 2018. Available at: https://mnprc.org/. Accessed December 27, 2023.

Current Minnesota Efforts

Recovery Community Organizations (RCOs) provide support and offer information about resources related to health promotion, prevention, and screening. For example, one of Minnesota's RCO's state-funded initiatives is Thrive Family which conducts workshops that focus on family education around addiction and SUD. Further information on current Minnesota prevention efforts, including trainings, resources, and organizations engaged in this work, are available on the Minnesota Prevention Resource Center (https://mnprc.org/). In addition, the Positive Community Norms frameworks aid in primary SUD prevention through an evidence-based approach to increase health behavior as it relates to substance use.[6] School-based SUD prevention allows students from as early as the 3rd grade to high school age to receive primary prevention information on the dangers of substance use in a school or community learning center setting.

Recommendations

Given the SUD crisis the country is facing, the creation and implementation of a prevention plan should be a priority. Too often the SUD system gears up support for individuals who are experiencing an SUD crisis, rather than working to prevent serious events from occurring.

Recommendation 1

Continue to build an EBP (evidence-based practice), promising and practice-based evidence plan around health promotion, prevention, screening, and early intervention. Dedicate time to educating the community on available promotion, prevention, and screening resources.

Additionally, dedicated SUD prevention funding source should prioritize the most affected populations and regions of the state. Part of the dedicated funding should require partnerships across systems that need to support whole families and individuals with an emphasis on the disparities in Minnesota.

A list of additional EBPs Minnesota can consider when implementing this recommendation are provided in Appendix A. For example, Delaware coordinated with professional communication specialists to launch a campaign that matched people with lived experience and communities interested in creating prevention approaches. They use a variety of strategies including videos with people from the community and in recovery to support this work and to educate people about SUD prevention efforts. Leading this work is Impact Life in Delaware, in partnership with 720 Strategies, and with funding from Delaware Division of Substance Abuse and Mental Health.[7,8]

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[6] Minnesota Department of Human Services. (2017, March 23). Positive Community Norms. Minnesota Department of Human Services. https://mn.gov/dhs/people-we-serve/adults/health-care/alcohol-drugs-addictions/programs-and-services/positive-community-norms.jsp

[7] Impact Life. Who We Are. 2023. Available at: https://impactlifetoday.org/. Accessed December 27, 2023.

[8] Minnesota Department of Human Services. Substance Use Disorder Community of Practice. Updated December 18, 2023. Available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/alcohol-drug-other-addictions/sud-cop/. Accessed December 27, 2023.

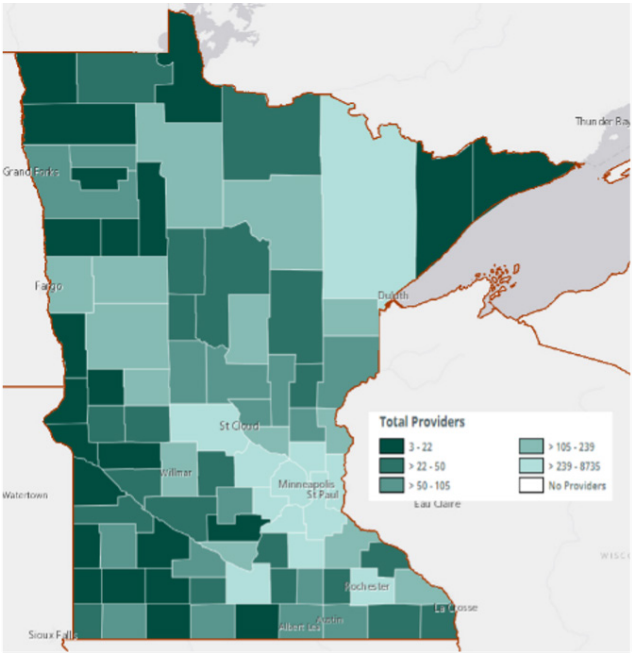
Treatment Accessibility

Gaps and Challenges

Though it is widely acknowledged that Minnesota has an abundance of treatment facilities, MN SUD CoP participants noted that access to non-traditional or holistic services, tobacco cessation programs, mental health services (addressed in detail below), detoxification facilities, and culturally specific programs are lacking. MN SUD CoP participants with lived experience also reported extended wait times to obtain treatment and experienced a lack of coordination and planning between various aspects of the system.

Figure 3 provides information on the number of behavioral health and SUD treatment providers within various Minnesota counties.[9] As indicated, people living in larger cities, such as St. Paul, Rochester, and St. Cloud, have access to larger numbers of providers than people in rural areas.

Figure 3. Behavioral Health and SUD Treatment Providers by Minnesota County (2020)



A Medication Assisted Therapy (MAT) Prescriber Capacity Assessment Report conducted on behalf of the State of Minnesota[10] indicates that there is capacity to provide MAT services to about 61,000 Minnesotans. This is enough prescribers to service all Minnesotans who need MAT services, approximately 55,000 individuals. However, less than half of the eligible prescribers in Minnesota are actively prescribing to Medicaid enrollees. The Report concluded that the data suggests the need for MAT services among Medicaid enrollees may exceed the availability of those services. Additionally, except for the two largest counties (Hennepin and Ramsey), there are few active buprenorphine prescribers in most Minnesota counties. In addition, there are 41 counties—home to about 200,000 Medicaid enrollees—that do not have a prescriber who is writing prescriptions for Medicaid enrollees for buprenorphine (as of June 30, 2019).

Methadone can only be administered or dispensed at an opioid treatment program (OTP) and there are currently 18 OTPs in Minnesota, located in nine counties, and 78 counties do not have an OTP provider. In addition, nine of the 18 OTP are in Hennepin and Ramsey Counties. The average distance to an OTP is 26 miles, but some Medicaid enrollees would have to travel

[9] Figure 3 was generated using HealthLandscape, a mapping software, to better understand access to SUD treatment in Minnesota using IQVIA data from January 1–December 31, 2020.

[10] Minnesota 1115(a) Substance Use Disorder System Reform Demonstration Project Evaluation: Examining Potential Disparities In Medication-Assisted Treatment (11/25/2020). https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8267-ENG

distances over 220 miles.[11] Over half of enrollees (55.9 percent) live within 10 miles of an OTP, while about 7 percent live over 100 miles from an OTP. American Indian enrollees live the farthest distance from an OTP, at an average of about 54 miles. [12]

MN SUD CoP participants also noted that treatment centers largely treat participants using generalized methods and do not acknowledge the need to adjust treatment practices based on the individual. In addition, person-centered care emphasizes that people are experts in their own care. Clinicians are seen as guides to facilitate and help people determine their own recovery journey. As individuals can select which level of care best meets their needs, a fully implemented ASAM compliant treatment system will facilitate this process. Additional information on the identification of implementation obstacles for ASAM, including the development of an ASAM Roadmap for eliminating or mitigating these challenges, will be available in 2025.

Additional gaps and challenges identified by MN SUD CoP participants include:

- Access barrier for SUD treatment or non-traditional/holistic services
- Lack of access to detox facilities and/or MOUD
- Lack of access to smoking cessation programs in treatment facilities
- Extended program wait times (particularly for culturally competent programs)
- General disengagement from clients who are not ready for change
- Siloed communities and treatment providers
- Lack of resources and planning for previously incarcerated individuals
- Lack of culturally specific youth programs and overall attention to the youth with SUD
- Lack of individualized care
- Loss of innovation in developing new methods to reach and treat clients
- Lack of funding for person-centered or value-based care

Current Minnesota Efforts

In 2020, Minnesota moved from counties being the gateway to treatment access through a formal screening process to a Direct Access model, with additional changes being made to the Direct Access Model during the 2023 Legislative Session. Direct Access allows an individual to go directly to a provider they choose to receive a comprehensive assessment and access care immediately and removes barriers of timing associated with going through a placing authority, allows for individual choice, and removes duplication of comprehensive assessments.[13] Though there are reported challenges related to assessment duplication and accessibility[14], this new

[11] Id. The report indicates 16 OTPs, but since publication, the number has increased to 18 OTPs.

[12] Ibid.

[13] Minnesota Department of Human Services. Direct Access. Updated December 12, 2023. Available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/alcohol-drug-other-addictions/sudreform/. Accessed December 27, 2023.

[14] CoP members representing the provider community reported multiple challenges to assessment duplication and accessibility including: Assessments are currently not "portable" to their electronic health record, so a new assessment is completed to build the treatment plan; and, difficulty obtaining previous assessments from other providers, previously this wasn't a challenge when requesting assessments from County. The Provider CoP members recommended the State provide a central repository for all assessments ensuring access across the system.

process allows for the individual to have a comprehensive assessment completed and then choose the provider and level of care they would like to participate in; up to the highest level of care determined necessary. Changes to the Direct Access Model implemented in the 2023 Legislative Session to reduce barriers included:

- Payment for SUD services starting at day of service initiation, when the comprehensive assessment is completed within the required timelines
- Revisions to Behavioral Health Eligibility Form with the intent of developing a universal form for providers when seeking treatment funding for individuals served.
- Removal of counties as placing authority for clients entering treatment
- Client choice as to where to get a comprehensive assessment completed

In addition, Minnesota is implementing an SUD System Reform Demonstration project that incorporates American Society of Addiction Medicine (ASAM) criteria to establish specific residential and outpatient levels of care for SUD treatment services for Medical Assistance (MA).[15] The demonstration is intended to enhance evidence-based assessment and placement criteria to match individual risk with the appropriate ASAM level of care. The demonstration also increases standards for treatment coordination to ensure transitions to needed services across a comprehensive continuum of care. In addition, the demonstration reflects Minnesota's effort to move toward a person-centered care model. ASAM 4th Edition Criteria has defined the system in a person-centered way and the levels of care/standards of care focus on meeting the needs of people where their recovery journey takes them. Part of the demonstration project includes the requirement for patient referral arrangement agreements to enhance transitions of care to appropriate levels of care for the individual. Sustainable change will depend upon how Minnesota builds the levels of care and ensures they are accessible when people need them.

The interim Evaluation Report for the SUD System Reform Demonstration project[16] shows mixed results related to making progress in meeting goals established for the project. The evaluation showed increased rates of identification, initiation, and engagement in treatment for SUD. However, the report also indicated limited availability for Level 3.1 clinically managed low-intensity and Level 3.3 clinically managed high-intensity and population-specific services (population-specific services was included ASAM 3rd Edition criteria and removed in 4th Edition). The evaluation also showed increased readmission rates for SUD treatment during the project period and no decrease in the number of opioid overdose or deaths, consistent with national trends in other states. The project showed mixed results related to emergency department

[15] Minnesota Department of Human Services. 1115 Substance Use Disorder (SUD) System Reform Demonstration. 2023. Available at: https://mn.gov/dhs/partners-and-providers/policies-procedures/alcohol-drug-other-addictions/1115-sud/. Accessed December 29, 2023.

[16] Minnesota Substance Use Disorder System Reform Section 1115(a) Demonstration Project Evaluation: Interim Evaluation Report (July 2023; Revised December 2023) https://mn.gov/dhs/assets/Interim%20Evaluation%20Report_12-15-23_508_%28PDF%29_tcm1053-609480.pdf

(ED) utilization including increases in follow-up visits after an ED visits; however, no change in ED utilization and an increase in ED visits following treatment. Project positive results included improved access to physical health care preventative visits as well as a significant increase, by nearly 13%, the number of individuals with an OUD initiating MAT. The report also indicated that given the challenges of the COVID-19 pandemic the results of this evaluation are likely atypical for the anticipated change for some measures.

Minnesota is also making a concerted effort to understand the gaps and barriers to accessing opioid treatment programs and improving quality of care.[17] MN DHS convened a work group of community partners to evaluate the opioid treatment program model and make recommendations on overall service design including simplification or improvement of regulatory oversight; increasing access to opioid treatment programs and improving the quality of care; addressing geographic, racial, and justice-related disparities for individuals who utilize or may benefit from medications for OUD; and other related topics, as determined by the work group. In addition, MN DHS is in the process of distributing capacity-building funding for safe recovery sites and withdrawal management programs to increase access to harm reduction and withdrawal management services.

Minnesota is also investing resources to increase services and supports to address co-occurring disorders as well as easing the identification of resources and supports. They have changed eligibility criteria for 245G and private practice providers allowing tobacco as a primary or single diagnosis for admission to service through various disciplines.[18] MN DHS has also published a request for proposal (RFP) aimed at creating a user-friendly online dashboard to help individuals identify behavioral health services that are right for them. Though the RFP has not yet been awarded, this will help to identify and link Minnesotans to appropriate care. [19] Finally, Minnesota is dedicating funding to improve access to SUD treatment services and reimbursement for holistic services (discussed further in the cultural competency section below).

Recommendations

Recommendation 2

Continue building and funding an accessible and integrated person-centered system of care. Evaluate and reinforce transitions of care, levels of care, and remove identified barriers to care. These system changes will create a more person-centered approach to care for people with SUD. The changes Minnesota has made put the state on a path that aligns with the direction of systems across the country including federal agencies like SAMHSA and CMS. Minnesota needs to assess the infrastructure funding needed to successfully integrate the system of care and fund it.

When expanding access to SUD treatment programs, it is critical that systems of care are inclusive of services which co-occur or influence efficacy of treatment or treatment outcomes. This may include culturally competent or gender-specific practices, MOUD, mental health

[17] Chapter 61, Article 4, Section 24 Opioid Treatment Program Work Group
[18] MN Stat. 256B.0625, Subd. 68.
[19] Request for proposals to develop or enhance an online behavioral health program locator. Minnesota Department of Human Services. (2023, December 8). https://content.govdelivery.com/accounts/MNDHS/bulletins/37efffc

services, or tobacco cessation programs. For example, though early tobacco initiation is a factor toward use of other substances and quitting smoking can increase the likelihood of SUD recovery, less than 50% of SUD treatment facilities in Minnesota include tobacco counselling or smoking cessation programs.[20,21]

Recommendation 3

Ensure that systems of care are inclusive of programs and services that address co-occurring disorders and improve treatment outcomes. This may include tobacco cessation programs, MOUD, mental health services*, and culturally and gender specific care*. It is recommended that the State provide trainings and/or incentivization for programs which incorporate additional evidence-based practices and services.

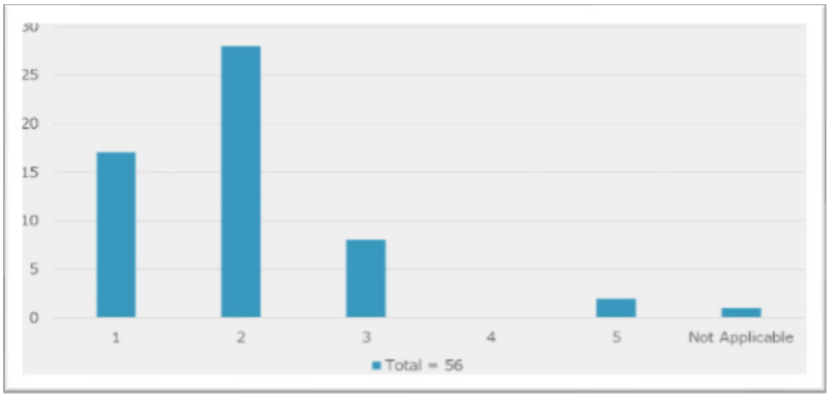
*Additional information on these topics provided below

Culturally Competent and Gender-Specific Care

Gaps and Challenges

Among feedback received from the various sources indicated above, the lack of a robust system of culturally competent and gender-specific care was consistently identified as a gap within the Minnesota SUD treatment system by MN SUD CoP participants, as indicated in Figure 4. Lack of access to culturally and gender specific programs has led to racial and gender inequities in SUD related outcomes and overdose rates. Additional information on this topic will be available in the MN SUD CoP Culturally Specific SUD Treatment Report in June 2024.

Figure 4. MN SUD CoP Poll Results: On a scale of 1-5 (1 being very poor and 5 being excellent), how would you rate the cultural competency of Minnesota's SUD systems of care?



[20] Minnesota Department of Health. Behavioral Health and Tobacco Use in Minnesota. Updated November 2022. Available at: https://www.health.state.mn.us/communities/tobacco/behavioral/index.html. Accessed December 29, 2023.

[21] American Lung Association. Professional Education and Resources. Updated November 16, 2023. https://www.lung.org/local-content/mn/lung-mind-alliance/lung-mind-alliance-resources. Accessed December 29, 2023.

Individuals with lived experience reported traumatic experiences in treatment facilities in which staff were not adequately trained to provide competent and sensitive care related to cultural practices, gender identity, or sexual orientation. Additional gaps identified by MN SUD CoP participants include:

- Lack of culturally competent and sensitive care (particularly in rural areas) for youth and adults
- Lack of gender specific care for youth and adults
- Lack of tribal representation
- High numbers of underserved populations (e.g., veterans, seniors, LGBTQ+, Hispanic population, tribal population, etc.)
- Extended program wait times (particularly for culturally competent programs)
- Lack of funding for culturally competent programs or increased competition for single funding sources

Although many programs have made strides in incorporating aspects of culturally specific elements into their programming (e.g., specific groups for minority populations), people from culturally diverse groups often feel as though their cultural practices and rituals are omitted from the SUD care they receive. Specific examples include the lack of multi-lingual and ethnically matched therapists, the lack of American Indian/Native American programming that incorporates key components of tribal culture such as sweat lodges and smudging, and interventions that are grounded in African American communication styles. Additionally, MN SUD CoP participants noted that measures that appear culturally competent are often insufficient, such as hiring one diverse employee rather than implementing full-scale organizational changes.

Current Minnesota Efforts

Examples of recent state efforts to address the cultural gaps in SUD care include:

- **Community-based participatory research for pregnant and parenting persons:** The aim of this **project is to expand people-specific and family-centered behavioral health program services through the Women's Culturally Responsive Recovery Services.22 A toolkit is being developed with this** information to disseminate to providers and the public.

- **Women's Recovery Services:** The Amherst H. Wilder Foundation serves as an evaluator for the Women's Recovery Services (WRS) grant aimed at collecting data around women's SUD recovery services in Minnesota. The aggregate report will be available at the end of the WRS grant in 2026. [23] Additionally, Minnesota current has eight grantees throughout the state that provide outpatient, residential, and community-based services to women and children. In addition, funding was awarded to three grantees to provide prevention and community engagement initiatives to women and children. An example of grantee work is provided at https://www.rseden.org/family-recovery-project.

- **Women's Culturally Responsive Recovery Services:** This grant was created to develop culturally responsive SUD services for diverse women through partnership with spirituality-based organizations. Eight grantees have been selected for these funds and contracts are currently being drafted.

- **Family Residential Grant:** DHS issued a legislative proposal to expand family residential programming for women's substance use disorders and was awarded $10 million for this effort which includes allowance for structural expansion. More information on next steps is anticipated by the third quarter of 2024.

- **American Indian Section Initiatives:** The American Indian Team Strategic Plan is working on or has completed the following 1) The American Indian Summit, held in August 2023[24], 2) The American Indian Team Strategic Plan, which will focus on what MN will provide to Tribes and American Indian urban areas for both Mental Health and SUD, and 3) Medical Assistance Behavioral Health System Transformation Study to evaluate traditional healing under the medical assistance program.[25] Additionally, MN has dedicated about two million dollars per year in general fund dollars for traditional healing services.

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[22] Minnesota Management Analysis and Development. (n.d.-a). MN Families. https://www.mnfamilies.org/
[23] Wilder Foundation. (2024, March 20). https://www.wilder.org/
[24] https://www.eventbrite.com/e/moving-our-relatives-forward-in-a-good-way-american-indian-sud-summit-tickets-667771912767
[25] Sec. 23. MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM TRANSFORMATION STUDY. Minnesota Session Laws - 2023, Regular Session. (2023). https://www.revisor.mn.gov/laws/

- **New MN DHS Funding and Staff Positions:** Minnesota is allocating up to four million dollars in funding and hiring additional staff to assist organizations with navigating systems, including a position dedicated to providing technical assistance to culturally specific organizations.

- **Rate Enhancement Eligibility:** Per Minnesota legislation 254B.01, subd 4a, programs that meet these culturally specific or responsive care guidelines are eligible for a reimbursement rate enhancement.[26]

- **Culturally Specific Mental Health and Substance Use Disorder Services Grants:** The Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program is to provide and expand culturally specific, trauma-informed mental health and SUD services for African, African American, American Indian, Hispanic, Latino, Asian, Immigrants, Refugees, and Lesbian Gay Bi-sexual Transgender Queer (LGBTQ+) populations.

- In addition to the cultural and ethnic population of focus, the Department of Human Services recognizes the importance of providing access to not only our urban areas, but greater Minnesota and rural areas which are rapidly growing with a diverse population of ethnic and cultural minorities. The goal is to ensure SUD and mental health services in the state are culturally responsive and meet the cultural needs of the target communities served.[27]

Recommendations

Though significant funding has been dedicated to culturally competent and gender-specific care recently in Minnesota, the funding is generally one-time and spread thinly without regard to building a statewide, sustainable infrastructure that ensures individualized care for all. Several recommendations are provided below further improve funding, training, and requirements for cultural- and gender-specific care.

Recommendation 4

Enhance culturally competent and gender-specific care by contracting with community-based agencies that are successfully providing expert care to these populations.

Minnesota could improve cultural competency by making it easier for small, culturally competent agencies to apply for grants, contract with DHS and the Minnesota Department of Health (MDH) and obtain Medicaid reimbursement.

[26] https://www.revisor.mn.gov/statutes/cite/254B.01
[27] https://mn.gov/dhs/partners-and-providers/policies-procedures/behavioral-health/cemig/

Recommendation 5

Develop and fund more programs that allow parents to care for their children while receiving SUD care. Integrating parenting skills and family reunification strategies into SUD treatment has demonstrated promising outcomes and enhanced engagement.[28] Specific programming may include family-centered therapy, trauma-informed parenting skills training, and multisystemic family therapy.

Behavioral health professionals recognize family-based residential treatment as having better outcomes for women and their children; however, such programs often struggle to stay afloat because of staffing shortages and volatile funding.[29] Consequently, families in rural areas are less likely to find such a residential treatment program in their communities. Only four family residential treatment programs are operating in the state.

Recommendation 6

Using the Collective Impact approach, Minnesota should fund backbone agencies that may apply for and manage grants, bill Medicaid, and track and monitor outcomes for small agencies with limited capacity.[30] This strategy would provide culturally specific community-based organizations (CBOs) or tribal governments and organizations with a sustainable path to leading culturally competent care efforts while they continue to support people and families.

Though CBOs have received mini-grants and other grant funds previously, they have not led to sustainable infrastructure development for agencies that are neighborhood-based, culturally competent, and trusted community partners.

Though funding partners with expertise to advise and deliver culturally competent care are key, existing treatment providers across the Minnesota SUD continuum must work to improve efforts to provide culturally competent care. This responsibility includes ensuring providers receive adequate training and can implement culturally responsive evaluation and treatment plans. The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a Treatment Improvement Protocol that provides evidence-based strategies for improving culturally competent care. Tips for training culturally competent treatment counselors include teaching counselors to[31]:

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[28] National Center on Substance Abuse and Child Welfare. Implementing a Family-Centered Approach (Companion Modules) Series. 2021. Available at: https://ncsacw.acf.hhs.gov/topics/family-centered-approach/fca-modules-series/. Accessed December 28, 2023.

[29] Saint Louis C. Despite Successes, Addiction Treatment Programs for Families Struggle to Stay Open. KFF Health News. September 13, 2023. Available at: https://kffhealthnews.org/news/article/family-addiction-treatment-centers-scarce-rural-minnesota-north-dakota/. Accessed December 28, 2023.

[30] Collective Impact Forum. What Is Collective Impact? Available at: https://collectiveimpactforum.org/what-is-collective-impact/. Accessed December 28, 2023.

[31] Substance Abuse and Mental Health Services Administration. A Treatment Improvement Protocol: Improving Cultural Competence. 2014. Available at: https://store.samhsa.gov/sites/default/files/sma14-4849.pdf. Accessed December 28, 2023.

- Frame issues in culturally relevant ways
- Allow for complexity of issues based on cultural context
- Make allowances for variations in the use of personal space
- Be respectful of culturally specific meanings of touch (e.g., hugging)
- Explore culturally based experiences of power and powerlessness
- Adjust communication styles to the client's culture
- Interpret emotional expressions considering the client's culture
- Expand roles and practices as needed

Steps for developing culturally responsive evaluation and treatment planning are also provided in Appendix B.

Though these practices can improve delivery of culturally competent care across various cultural and gender identities, the MN SUD CoP recognizes that additional efforts are needed to improve care for American Indian/Native Americans within Minnesota, who experience higher rates of health disparities and increased mortality rates.[32]

Recommendation 7

Require treatment facilities to adopt national standards for delivering culturally competent and sensitive care, including trauma-informed training, to the American Indian/Native American community. It is recommended that free trainings or programs are available for treatment facilities, with incentive programs for organizations which adopt additional protocols for delivering culturally sensitive care for the American Indian/Native American populations. Considerations for developing training programs are provided below.

The National Institute of Health (NIH) has developed objectives to improve culturally competent care among American Indians/Alaskan Natives (not specific to SUD care).[33] Objectives include:

- Identify the unique cultural and historical factors that influence the healthcare experiences and outcomes of American Indian/Alaska Native patients.
- Screen for the prevalence of other chronic conditions, including diabetes, cardiovascular diseases, and mental health disorders, among American Indian/Alaska Native patients and understand their impact on health outcomes.
- Implement culturally competent preventive measures, such as nutritionist referrals, blood glucose monitoring, and early screening for hypertension and cancer, to address specific health needs for American Indian/Alaska Native patients.
- Coordinate care with interdisciplinary healthcare teams, including traditional healers, to ensure holistic and culturally competent care plans for American Indian/Alaska Native patients.

[32] Nahian A, Jouk N. Cultural Competence in Caring for American Indians and Alaska Natives. National Institutes of Health. Updated October 30, 2023. Available at: https://www.ncbi.nlm.nih.gov/books/NBK570619/. Accessed December 28, 2023.
[33] Ibid

In addition, the National Indian Council on Aging, Inc. (NCOA) has recommendations for improvement of healthcare among aging American Indians, which include[34]:

- **Create a Welcoming Facility for Elders:** American Indian and Alaskan Native elders often are overlooked in efforts to improve culturally competent care. Understanding the belief systems of natives, particularly elders, can help improve care outcomes.
- **Recognition:** SUD treatment systems must acknowledge the presence of Natives living both on and off tribal land. It is critical to recognize that the United States has hundreds of federally recognized tribes, all with differing beliefs and practices. Because an individual's identity is not always obvious or apparent, organizations need to be open and regularly practice culturally competent care techniques.
- **Involvement:** It is critical that programs engage tribal members to understand their specific beliefs and care preferences. Native people may choose to look toward Western medicine to address the symptoms of an ailment while also pursuing spiritual guidance from traditional healers in their communities to recover from an imbalance between the mind, soul, and body. Non-native treatment providers will need to seek guidance and expertise from Native partners to ensure practices are managed with cultural sensitivity.
- **Taking Action:** American Indians and Alaskan Natives have experienced systemic racism and historical neglect for centuries, leading to trauma and mistrust of the healthcare system. Treatment centers need to listen to the American Indian community to design effective and culturally sensitive service delivery systems.
- **Storytelling Patient-Centered Native Healthcare:** Stories not only reflect knowledge of communities but also highlight core values that are important to tribal society. They offer tribes an auditory record of their traditional spirituality and history and can be a valuable tool for emphasizing health and wellness.

Social Determinants of Health and Health-Related Social Needs

Gaps and Challenges

Sources noted that SUD cannot be adequately addressed among individuals without resources to also address Social Determinants of Health (SDOH) and Health-Related Social Needs (HRSN), such as housing, food insecurity, or transportation. Gaps observed in Minnesota by MN SUD CoP participants include:

- Lack of resources and support for basic challenges (e.g., child support, financial management, transportation, food support, housing, health care and other benefits) for people with SUD and transitioning from treatment
- Instances of individuals entering treatment to obtain SDOH/HRSN that cannot be accessed elsewhere

CoP participants and national trends consistently note that unaddressed HRSN represented barriers to engaging and remaining in SUD treatment.

[34] National Indian Council on Aging. Culturally Competent Healthcare. 2023. Available at: https://www.nicoa.org/elder-resources/culturally-competent-healthcare/. Accessed December 28, 2023.

Recommendations

National emphasis has been placed on the importance of understanding SDOH and addressing HRSN, particularly following the pandemic. A Call to Action, published by the US Department of Health and Human Services (HHS) in November 2023 details the importance of addressing HRSN to improve population health and provides information on recommended partner roles in addressing HRSN, such as community-based organizations, health systems, treatment providers, payers, and public health departments.[35]

Recommendation 8

Incorporate programming and support for individuals with HRSN, including people who are transitioning out of the criminal justice system. Specific intervention areas include providing child support assistance, basic income or financial education, transportation resources, food insecurity prevention, housing assistance, and identifying primary health care resources. SUD treatment sites can become hubs of social services delivery, ensuring that people who enter their centers can have access to resources that will truly facilitate their recovery.[36]

Meeting HRSN is even more acutely needed for individuals transitioning out of carceral settings. Research has demonstrated that providing housing, skill development, mentorship, and engagement with community networks reduces recidivism and facilitates a better adjustment back into society[37]. Various reimbursement methods can be explored to obtain payment for provision of HRSN, including Housing Stabilization Services and Section 1115 demonstration waivers.[38,39] Minnesota DHS is exploring an 1115 reentry waiver, and contingency management study which we recommend they continue to pursue. Also, MN currently funds treatment coordination services within SUD treatment sites which includes assistance with coordination and facilitation of referrals to other services and supports such as medical, mental health, and other social services. Of note, considerations on workforce and provider capacity (see below) will need to be evaluated in relation to addressing HRSN, however, providers can explore use of alternative providers, such as community health workers (CHWs) and other community-based organization (CBO) partnerships to help address HRSN.

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[35] US Department of Health and Human Services. Call to Action. Addressing Health-Related Social Needs in Communities Across the Nation. November 2023. Available at: https://aspe.hhs.gov/sites/default/files/documents/3e2f6140d0087435cc6832bf8cf32618/hhs-call-to-action-health-related-social-needs.pdf. Accessed December 28, 2023.

[36] Carnevale Associates, Inc. Info Brief: Addressing the Social Determinants of Health in Substance Use Prevention. June 2021. Available at: https://www.carnevaleassociates.com/file_download/inline/c18c74f3-26a8-440a-ab9b-c5fb6949bb87#:~:text=interventions%20can%20address%20the%20SDOH,and%20Social%20and%20Community%20Context. Accessed December 28, 2023.

[37] Goger A, Harding DJ, Henderson H. A Better Path Forward for Criminal Reentry. Brookings. April 2021. Available at: https://www.brookings.edu/articles/a-better-path-forward-for-criminal-justice-prisoner-reentry/. Accessed December 28, 2023.

[38] Minnesota Department of Human Services. Housing Stabilization Services. Updated December 8, 2023. Available at: https://mn.gov/dhs/partners-and-providers/policies-procedures/housing-and-homelessness/housing-stabilization-services/housing-stabilization-services.jsp. Accessed December 29, 2023.

[39] Hinton E. A Look at Recent Medicaid Guidance to Address Social Determinants of Health and Health-Related Social Needs. Kaiser Family Foundation. February 22, 2023. Available at: https://www.kff.org/policy-watch/a-look-at-recent-medicaid-guidance-to-address-social-determinants-of-health-and-health-related-social-needs/. Accessed December 28, 2023.

Workforce

Gaps and Challenges

Mirroring national trends, Minnesota is experiencing SUD workforce shortages[40] and elevated levels of burnout among SUD treatment providers, including the following gaps identified by MN SUD CoP participants:[41]

- Overall workforce challenges, including shortages in case coordinators, providers, and Peer Recovery Specialists
- Limited desire to enter the field due to wages/reimbursement rates
- Increased burnout among SUD treatment providers

Current Minnesota Efforts

Minnesota has recently or is currently implementing multiple initiatives related to building and retaining the SUD workforce, including:

- **Minnesota 1115(a) Substance Use Disorder System Reform Demonstration Project Evaluation Provider Capacity Assessment:** Conducted to assess the availability of Minnesota Health Care Programs (MHCP) that were accepting new patients on Medicaid at the critical levels of care.[42] *Of note, the report indicated a lack of reliable methods for identifying credentialed professionals due to inadequate tracking systems.*
- **SUD System Reform Efforts:** The state has continued to increase access to SUD services through expansion of services and eligible provider types that are able to deliver SUD services including RCOs, counties, individuals in private practice, hospitals, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics.[43]
- **Rate Study:** A Minnesota Health Care Programs Outpatient Services Rates Study is underway and will specify recommendations related to changes to payment rate methodologies for mental health, SUD, and acute care community services.[44]

[40] 80% of Minnesota counties qualify as mental health professional shortage areas. Minnesota Department of Health, Division of Health Policy: Rural Health Care in Minnesota: Data Highlights (November 16, 2023). https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmn.pdf

[41] Minnesota Department of Health. Minnesota's Health Care Workforce: Pandemic-Provoked Workforce Exits, Burnout, and Shortages. March 28, 2023. Available at: https://www.health.state.mn.us/data/workforce/docs/2022workforcebrief.pdf

[42] Minnesota Department of Health and Human Services. (2020). Minnesota 1115(a) Substance Use Disorder System Reform Demonstration Project Evaluation Provider Capacity Assessment: Baseline Assessment . MN DHS. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG

[43] Sec. 254B.15 SUBSTANCE USE DISORDER SYSTEM REFORM. 2023 Minnesota Statutes. (2023). https://www.revisor.mn.gov/laws/

[44] Minnesota Department of Health and Human Services. (n.d.). Minnesota Health Care Programs Fee for Service Outpatient Services Rates Study. MN DHS. https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/behavioral-health/mhcp-outpatient-services-rates-study/

Recommendations

One of the most consistent suggestions from all sources of information in this report is enhancing the SUD workforce. HMA and the National Council for Mental Wellbeing recently released a series of three issue briefs that offer states immediate policy actions to expand current capacity and build a more stable future workforce.[45] These include:

- Policy, Financial Strategies and Regulatory Waivers (October 2021)
- Clinical Care Delivery Models and Digital Solutions with an Emphasis on Leveraging the Certified Community Behavioral Health Clinic Model (October 2021)
- Strategies to Address Diversity, Equity, and Inclusion (November 2021)

Recommendations include:

Recommendation 9

Review and implement best practices related to behavioral health workforce development, including:

- Leverage strategies states have used for emergency preparedness and response.
- Increase funding and financial incentives to attract and retain the workforce.
- Optimize access to the available behavioral health workforce.
- Maximize use of Medicaid Graduate Medical Education (GME) for training the behavioral health workforce.

Additional details for each recommendation are provided in the issue briefs above.

In addition to national best practices, CoP participants also noted Minnesota's lack of education, access, and integration for peer recovery support services throughout levels of SUD care.

Recommendation 10

Develop true integration of peer recovery support, including salary enhancements for SUD staff who work in under-resourced communities.

Peer recovery support providers maintain the concept of "keeping recovery first" by meeting individuals where they are in the recovery process as they help the individual with SUD along their journey. Peer providers can fill a gap that often exists in both formal and informal treatment for individuals with SUD by focusing on recovery first and helping to rebuild and redefine the individual's community and life.[46]

[45] https://www.healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf. Accessed December 28, 2023.

[46] Substance Abuse and Mental Health Services Administration. Peer Support Workers for Those in Recovery. Updated October 3, 2023. Available at: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers. Accessed December 28, 2023.

Transitions of Care

Gaps and Challenges

Sources noted that services across the SUD treatment continuum often operate in a silo, leading to loss of communication or relapse among individuals who are transitioning between levels of care. Many participants spoke of the difficulty in receiving immediate treatment access and transitioning between distinct levels of care (e.g., outpatient after residential treatment), indicating a need for enhanced resources to provide continuity of care and continued support after treatment concludes. Additional gaps identified by MN SUD CoP participants included:

- Loss of clients during transition between services, particularly when changing facilities, treatment providers, and services
- Lack of available aftercare resources
- Lack of data available related to aftercare

Current Minnesota Efforts

As stated under the Treatment Accessibility section of this report, Minnesota is implementing an SUD System Reform Demonstration project that incorporates American Society of Addiction Medicine (ASAM) criteria to establish specific residential and outpatient levels of care for SUD treatment services for Medical Assistance (MA).[47] The demonstration increases standards for treatment coordination to ensure transitions to needed services across a comprehensive continuum of care. Also, part of the demonstration project includes the requirement for patient referral arrangement agreements to enhance transitions of care to appropriate levels of care for the individual. Sustainable change will depend upon how Minnesota builds the levels of care and ensures they are accessible when people need them.

Recommendations

To reduce barriers to treatment entry, evidence-based solutions suggest:

- **Enhancing telehealth resources** and ensuring telehealth regulations (audio and telehealth) become permanent

- **Shifting to an integrated model of care** (integrating primary care with treatment for mental health and substance use challenges increases efficiency, saves money, and improve outcomes)

- **Continued investment in Certified Community Behavioral Health Clinics (CCBHCs)**, which provide a full array of SUD and mental health services and supports. Of note, current legislative efforts in Minnesota have been enacted to establish and strengthen the CCBHC services in Minnesota.[48]

[47] Minnesota Department of Human Services. 1115 Substance Use Disorder (SUD) System Reform Demonstration. 2023. Available at: https://mn.gov/dhs/partners-and-providers/policies-procedures/alcohol-drug-other-addictions/1115-sud/. Accessed December 29, 2023.

[48] Sec. 245.735 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES. 2023 Minnesota Statutes. (2023). https://www.revisor.mn.gov/statutes/2023/cite/245.735?keyword_type=all&keyword=certified+community+behavioral+health+clinic

Recommendation 11

Increase care coordination capacity post-discharge to facilitate better transitions of care.

When integrated with primary care and coordinated with other social service providers, these efforts can result in reduced wait times, expanded capacity to address the overdose crisis, and establish innovative partnerships with law enforcement, schools, and hospitals to improve care, reduce recidivism, and prevent hospital readmissions.

Rural-Based Care

Sources agreed that SUD treatment and mental health services across the continuum, especially those that emphasize culturally competent care, are widely unavailable and understaffed in Minnesota's rural communities. Insufficient access to behavioral health services causes increased strain on other aspects of the system and reduces overall population health in rural communities[49,50]. Gaps and challenges that MN SUD CoP participants identified include:

- Immense SUD treatment disparities in rural areas, including fewer treatment locations, lack of access to withdrawal management, staffing shortages, and transportation barriers
- Difficulties motivating and engaging clients for treatment following long commutes to rural treatment settings
- Lack of transportation to physical treatment centers
- Inadequate internet access for virtual treatment
- Lack of culturally competent and gender specific care in rural areas
- Loss of SUD treatment providers in rural areas
- Accessibility challenges in the rural settings and wait times for treatment beds

Current Minnesota Efforts

The report and recommendations published by the Minnesota Rural Health Advisory Committee (RHAC) workgroup in 2021 and initiatives supported by Minnesota's Office of Rural Health and Primary Care (ORHPC) are aimed at enhancing and supporting the mental health workforce in greater Minnesota. However, the final outcomes of these efforts is still largely unknown and disparities continue to exist in SUD services.[51]

[49] Center for Rural Policy and Development. Mental Health Services in Greater Minnesota. May 2017. Available at: https://www.ruralmn.org/mental-health-services-in-greater-minnesota/. Accessed December 28, 2023.

[50] Lister JJ, Weaver A, Ellis JD, Himle JA, Ledgerwood DM. A Systematic Review of Rural-Specific Barriers to Medication Treatment for Opioid Use Disorder in the United States. *American Journal of Drug and Alcohol Abuse.* 2020;46(3):1–16. doi: 10.1080/00952990.2019.1694536

[51] Minnesota Department of Health. Recommendations on Strengthening Mental Health Care in Rural Minnesota. Workgroup Of The Rural Health Advisory Committee. 2021. Available at: https://www.health.state.mn.us/facilities/ruralhealth/rhac/docs/2021rhacmhealth.pdf. Accessed December 28, 2023.

Recommendations

Despite the increased burden of substance use in rural areas, access to harm reduction and treatment services in rural communities is often limited because of transportation barriers and a dearth of providers that accommodate all levels of care. This gap in services was consistently identified as a barrier to truly effective substance abuse system of care in greater Minnesota.

Recommendation 12

To enhance SUD programming for rural communities, consider the recommendations put forth by the MN Rural Health Advisory Committee and draw on strategies other states have made to improve care in rural areas. Examples include increasing training and access to community health workers (CHWs), training and equipping mobile case managers, and developing a mobile nurse navigator and recovery outreach specialist program.[52]

A full listing of programs to consider, funded by the HRSA Federal Office of Rural Health Policy to implement improvements and access to rural SUD treatment programs, is available on the Rural Health Information Hub (RHIhub).

Mental Health

Gaps and Challenges

Understanding the intersection of mental health and SUD is critical to achieving long-term recovery; however, SUD services in Minnesota were noted as lacking access to adequate mental health services in treatment centers. For instance, individuals with co-occurring disorders may require integrated treatment that addresses both their SUD and mental health conditions simultaneously. Without access to comprehensive mental health services, individuals may not receive the full spectrum of care needed for sustained recovery. Moreover, untreated mental health conditions can increase the risk of relapse and hinder overall treatment progress. Gaps identified by MN SUD CoP participants included:

- Lack of treatment programs that can accommodate co-occurring SUD and mental illness
- Lack of access to holistic or non-pharmaceutical interventions for mental illness
- Participants consistently identified the lack of individualized SUD treatment that can adequately treat individuals with co-occurring mental health conditions and SUD. As much of the SUD workforce has been trained and practiced within the siloed SUD treatment ecosystem, many do not have the requisite training to screen, identify, and treat mental health diagnoses.

[52] Rural Health Information Hub. Module 3: Program Clearinghouse. 2020–2023. Available at: https://www.ruralhealthinfo.org/toolkits/substance-abuse/3/program-clearinghouse. Accessed December 28, 2023.

Recommendations

National experts acknowledge that mental health conditions and SUD are commonly co-occurring and therefore coordinating treatment of the two can improve outcomes.[53]

Recommendation 13

To enhance current SUD treatment providers' capacity to deliver co-occurring SUD and mental healthcare, change staffing regulations of SUD providers to mandate that programs have trained mental health professionals. Minnesota can also assist SUD providers in developing enhanced referral relationships with mental health providers in their communities.[54],[55]

In implementing this recommendation, Minnesota will complement and expand upon current efforts to improve equity and access to behavioral health services in Minnesota.[56] As part of 1115 Demonstration efforts, SUD providers in Minnesota are expected to develop Program Outreach Plans.[57] Currently, 1115 Demonstration providers (there are now more than 230) are required to have a co-occurring designation. Additionally, Minnesota efforts to implement ASAM 4th Edition Criteria will be critical in improving the coordination between mental health and SUD services in the state. Additional information on this topic will be available on the MN SUD CoP ASAM Implementation Roadmap Report (2025).

Recovery Outcomes and Data Sharing

Gaps and Challenges

Understanding and improving treatment outcomes in Minnesota is contingent upon defining recovery outcomes, obtaining data to support and/or understand challenges within each level of care, and ensuring transparent access to treatment data where applicable. During data collection efforts, sources noted a lack of consensus as it relates to defining recovery, as well as a lack of accurate data used to identify successful treatment programs. Figure 6 highlights responses from MN SUD CoP participants as it relates to SUD data use and exchange programs.

[53] Substance Abuse and Mental Health Services Administration. Mental Health and Substance Use Co-Occurring Disorders. Updated April 24, 2023. Available at: https://www.samhsa.gov/mental-health/mental-health-substance-use-co-occurring-disorders. Accessed December 28, 2023.

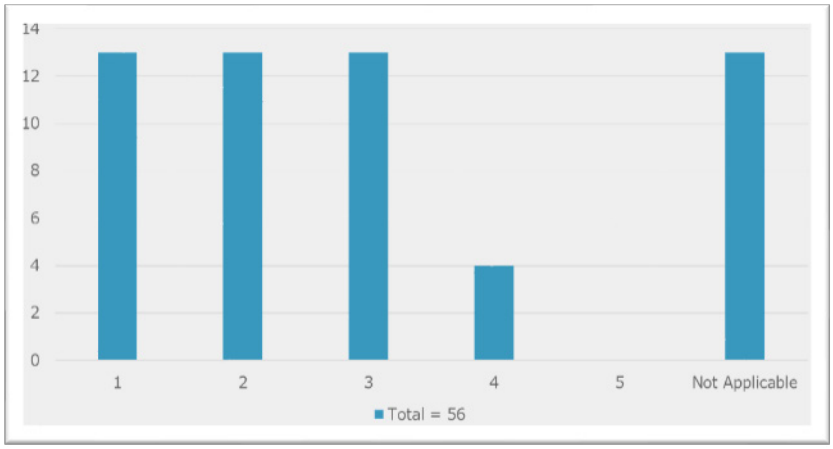
[54] Mental Health Commission of Canada. Collaborative Care for Mental Health and Substance Use Issues in Primary Health Care: Overview of Reviews and Narrative Summaries. Available at: https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/PrimaryCare_Overview_Reviews_Narrative_Summaries_ENG_0.pdf. Accessed December 28, 2023.

[55] Alina Health. Enhancing Mental Health Care Transitions Reduces Unnecessary Costly Readmissions. Health Catalyst. Available at: https://www.healthcatalyst.com/wp-content/uploads/2021/05/Enhancing-Mental-Health-Care-Transitions-Reduces-Unnecessary-Costly-Readmissions.pdf. Accessed December 28, 2023.

[56] Minnesota Department of Human Services. Behavioral Health Care: Improving Equity and Access. August 2023. Available at: https://mn.gov/dhs/assets/2023-08-Behavioral-health_tcm1053-586768.pdf. Accessed December 28, 2023.

[57] Sec. 245B.19, Subd.4 Program Outreach Plan requirements.

Figure 6. MN SUD CoP Poll Results: On a scale of 1-5 (1 being very poor and 5 being excellent), how would you rate Minnesota's SUD data use and exchange programs?



Additional gaps associated with recovery outcomes and data sharing identified by MN SUD CoP participants included:

- Lack of consensus on what constitutes recovery
- Ineffective key performance indicators to track recovery
- Loss of data collection following treatment and lack of data transparency
- No centralized unit to track recovery outcomes or success of treatment programs

Current Minnesota Efforts

Recent efforts by the state of Minnesota to improve user interface and data sharing processes within the Drug and Alcohol Abuse Normative Evaluation System (DAANES) system include:

- Changed the language in DAANES from comprehensive assessment to service initiation
- Removed redundant data entry
- Improved the data flow for DAANES and claims
- Auto population of 'unknown' response choice
- Updated the manual to help providers navigate the system

Additionally, through the 1115 demonstration, Minnesota is working to determine how to implement successful outcomes of the demonstration once the project concludes.[58] Currently, the 1115 Demonstration reports quarterly to CMS on SUD metrics, including beneficiaries newly initiated into SUD treatment, readmission to SUD treatment, and time to referral to SUD treatment following a hospital encounter. Further, the 1115 demonstration disseminates treatment successes as they arise. Additional recommendations for improving the DAANES system will be provided in a 2024 SUD Paperwork Reduction & Systems Improvement report.

[58] Minnesota Department of Health and Human Services. (n.d.-a). 1115 Substance Use Disorder (SUD) System Reform Demonstration. MN DHS. https://mn.gov/dhs/partners-and-providers/policies-procedures/alcohol-drug-other-addictions/1115-sud/

Recommendations

The National Academy for State Health Policy (NASHP) lists a wide range of commonly available data sets and best practices used at the state level.[59] Minnesota has traditionally relied on the Drug and Alcohol Abuse Normative Evaluation System (DAANES); however, stakeholders are concerned about the limited key performance indicators and the lack of data transparency within the DAANES system. Hence, it is recommended that Minnesota explore the use of DAANES data and how it can be improved and shared more readily outside of the improvements listed above.

Recommendation 14

Adopt the data best practices NASHP has identified. Evaluate DAANES data and how it can be improved and shared more readily. Areas for consideration include using data to:

- Target resources where needed and provide actionable data to treatment providers
- Quantify and optimize capacity and understand utilization
- Provide relevant data to providers to better understand racial, ethnic, and cultural disparities and HRSN

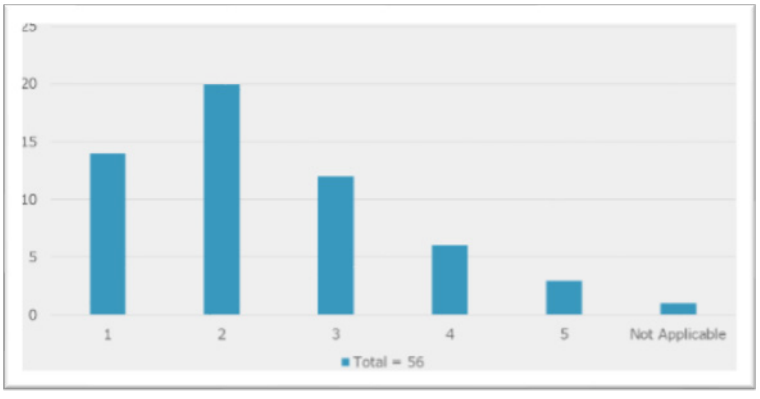
NASHP highlights the importance of leadership, engaging both technical and policy expertise, and providing time and resources to address data governance.

Funding

Gaps and Challenges

MN SUD CoP participants noted a general lack of funding, particularly regarding reimbursement for SUD services and prioritization of culturally competent care and innovative care models, as shown in Figure 7.

Figure 7. MN SUD CoP Poll Results: On a scale of 1-5 (1 being very poor and 5 being excellent), how would you rate Minnesota's current funding for SUD treatment and prevention efforts?



[59] National Academy for State Health Policy. How States Access and Deploy Data to Improve SUD Prevention, Treatment, and Recovery. January 29, 2021. Available at: https://nashp.org/how-states-access-and-deploy-data-to-improve-sud-prevention-treatment-and-recovery/. Accessed December 28, 2023.

Providers also agreed that lack of funding contributes to competition among treatment providers, often favoring larger treatment centers. Additional gaps identified by the MN SUD CoP participants include:

- Lack of overall funding for SUD efforts, particularly in Native American/American Indian communities
- High levels of competition for singular funding sources
- Low reimbursement rates for SUD services
- Little to no funding for SUD treatment innovation and/or newly established programs
- Lack of motivation to initiate value-based care contracts

To ensure a truly effective SUD treatment system in the future, funding and financial sources need to shift the focus toward funding collaborative relationships and value-based partnerships between providers.

Current Minnesota Efforts

The Minnesota Health Care Programs (MHCP) Outpatient Services Rates Study was approved to conduct a study of rate-setting for MHCP outpatient services, including behavioral health (BH) outpatient services, disability services, and health care administration services. Preliminary findings from the study are available for review in the Legislative Report and recommendations have been supported by MN DHS.[60]

Recommendations

Value-based payment (VBP) models pay health care providers based on the value rather than the volume of services. Use of these models has been concentrated in physical health services; however, because of the magnitude of SUD diagnoses in the United States, a growing movement toward using VBP for SUD treatment and recovery services has surfaced.

Recommendation 15

As part of the full implementation of ASAM criteria, adjust funding to incorporate value-based payment (VBP) arrangements and supplements for overburdened staff.

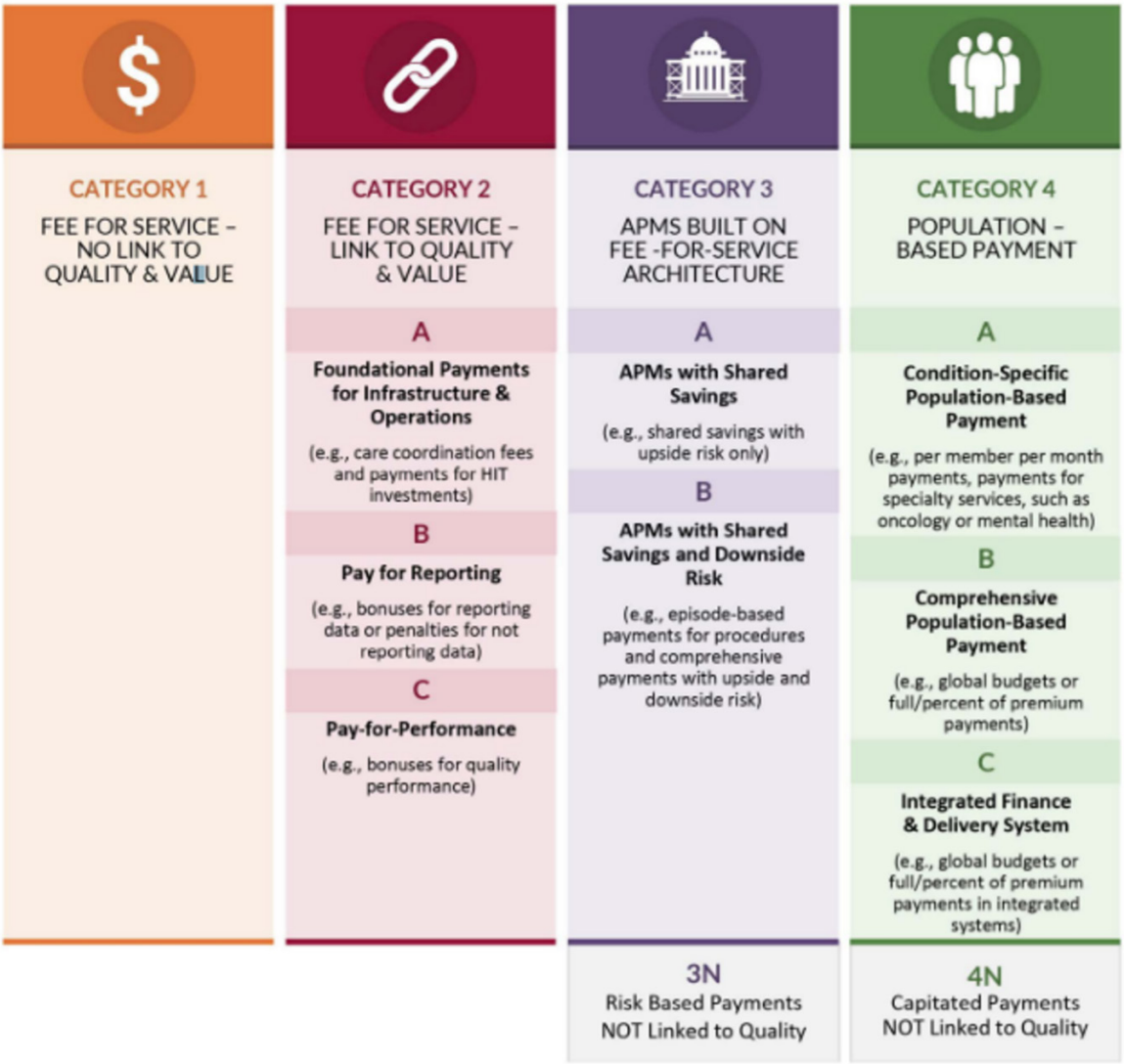
According to a recent SAMHSA report, VBP models can improve delivery of the integrated and coordinated care necessary for the complex and continuing needs of individuals with SUDs. The emergence of VBP for SUD services allows integration of the distinct levels of care to address needs and provide the best care possible. Also, VBP use for SUD services offers a means to improve the cost-efficiency and quality of care necessary to improve SUD patient outcomes.

The Health Care Payment Learning & Action Network (HCPLAN) developed a multi-dimensional Alternative Payment Model (APM) Framework (Figure 8) to categorize the continuum of APMs. This framework is becoming widely used and simplifies the process of making comparisons and measuring progress.[61]

[60] https://mn.gov/dhs/assets/Final%20Rate%20Study%20Report_tcm1053-610638.pdf

[61] Health Care Payment Learning & Action Network. APM Framework. Updated July 17, 2017. Available at: https://hcp-lan.org/apm-framework/. Accessed December 28, 2023.

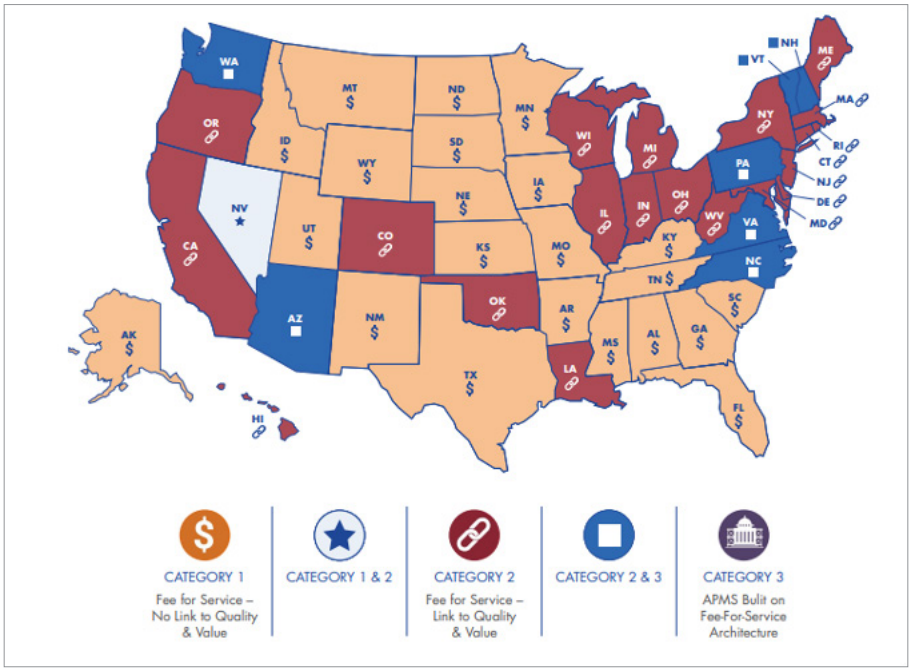
Figure 8. HCPLAN Alternative Payment Model (APM) Framework



A state-by-state review of the current use of VBP for SUD by SAMHSA classifies state's VBP activity using this framework. Figure 9 depicts the classification of states based on their use of VBP for SUD treatment and recovery services, using the HC-LAN APM Framework.[62]

[62] Center for Financing Reform and Innovation. Exploring Value-Based Payment for Substance Use Disorder Services in the United States. Substance Abuse and Mental Health Services Administration. 2023. Available at: https://store.samhsa.gov/sites/default/files/pep23-06-07-001.pdf. Accessed December 28, 2023.

Figure 9. SAMHSA Classification of States Based on Use of VBP for SUD Treatment and Recovery Services (2023)



Of the states reviewed, 20 were classified in Category 1, including Minnesota, which indicates the use of traditional fee-for-service methods to pay for SUD treatment and recovery services. A total of 21 states were placed in Category 2, as they use a VBP strategy for SUD that links value or quality to fee-for-service payments. Examples of these VBP strategies include payments for infrastructure or operations to enhance the availability of MOUD and bonus payments to providers reporting treatment quality outcomes.

The Alliance for Addiction Payment Reform has developed an innovative APM model for SUD service reimbursement which the State of Minnesota may want to consider for APM for SUD implementation. The Addiction Recovery Medical Home Alternative Payment Model (ARMH-APM) is built on five key elements that represent its most foundational principles:[63]

- **Payment:** Carving out financial resources for treatment and recovery services at all levels
- **Quality Metrics:** Tying payment to evidence-based quality metrics
- **Integrated Treatment and Recovery Network:** Establishment of a network that wires key clinical resources with broader community assets
- **Care Recovery Team:** Developing a recovery team with a care coordinator, a peer recovery coach, behavioral health specialists, licensed counselors, and primary care professionals
- **Treatment and Recovery Network:** Collaborating with patients to develop recovery capital in their communities

[63] Alliance for Addiction Payment Reform. The ARMH-APM Model. Available at: https://incentivizerecovery.org/armh-apm-model/. Accessed December 28, 2023.

Implementing value-based payment arrangements and other recommended funding models will take significant investment and resources by the State, however, VBP arrangements not only improve the quality of SUD treatment in Minnesota but also generate a positive return on investment. Early results of VBP arrangements have resulted in reduced readmission rates, inpatient costs of care, and retention in MOUD.[64] By aligning financial incentives with outcomes and investing in high-quality, person-centered care, Minnesota can reduce the long-term costs associated with untreated or ineffectively treated SUD.

Administrative Burden

Gaps and Challenges

MN SUD CoP participants suggested that increased requirements for documentation have led to burnout among providers, who are often expected to prioritize administrative tasks over patient care. For example, providers may spend a significant portion of their time completing extensive paperwork, such as detailed treatment plans, progress notes, and billing documentation, which can reduce the time available for direct patient care. Additionally, the complexity and variability of documentation requirements across different payers and funding sources can create confusion and further strain provider resources. These levels of burnout lead to providers exiting the workforce, further contributing to workforce shortages (as addressed in the Workforce section above).

Current Minnesota Efforts

As part of the SUD Treatment Program Systems Improvement and Paperwork Reduction efforts, Minnesota is working- with the input of counties, tribes, managed care organizations, SUD treatment associations, and other relevant stakeholders- to develop a plan, proposed timeline, and summary of necessary resources to make systems improvements to minimize the regulatory paperwork for substance use disorder programs licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes.[65]

As such, MN DHS is required to contract with a vendor experienced in developing statewide system changes for multiple states at the payer and provider levels. Within 2 years of contracting with qualified vendor, DHS must take steps to implement paperwork reductions and systems improvements within DHS' authority and submit a report to the legislature that includes recommendations for changes in statutes that would further enhance systems improvements to reduce paperwork.

As part of this work, MN DHS has contracted with Advocates for Human Potential to conduct site visits, key informant interviews, research within the SUD field, and lead Monthly Steering Committee Meetings and focus groups. Their final report of recommendations is expected in December 2024.

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[64] Center for Financing Reform and Innovation. Exploring Value-Based Payment for Substance Use Disorder Services in the United States. Substance Abuse and Mental Health Services Administration. 2023. Available at: https://store.samhsa.gov/sites/default/files/pep23-06-07-001.pdf. Accessed December 28, 2023.

[65] Minnesota Department of Health and Human Services. (2020b, March). Legislative Report: Substance Use Disorder Treatment Program Systems Improvement. MN DHS. https://www.house.mn.gov/comm/docs/_8FMrHp16EOJ-0Ej527y9A.pdf

Recommendations

Provider administrative burden refers to tending to a range of administrative activities including receiving prior authorization, completing lengthy forms or documentation requirements, navigating unclear processes, completing lengthy credentialing processes, and addressing unclear reasons for denials or auditing.[66] Research indicates that administrative burdens can impede provider insurance acceptance, particularly if the administrative burdens are disproportionate for Medicaid relative to other payers. Varying administrative burdens may be particularly challenging for smaller behavioral health providers/organizations. Thus, addressing administrative burdens could reduce time associated with unbillable provider time and resources and result in higher rates of Medicaid acceptance.[67]

Recommendation 16

Build upon the work of the legislature (described above under Current Minnesota Efforts as it aligns with the national trends to reduce administrative burden.[68] Review and incorporate the recommendations from the College of Behavioral Health Leadership[69] (described below) in SUD treatment practice requirements.

The College of Behavioral Health Leadership recommendations include:

- Create parity of behavioral health intake materials with physical health and other parts of healthcare.
- Remove the requirement for service planning or provide for flexibility such as allowing payment for one to three sessions without a service plan. Include service planning in treatment progress documentation.
- Align data requirements across funding streams to reduce providers needing to count the same metric in separate ways for different payers. Improve accountability through development of more robust quality measures focused on outcomes rather than process measures (such as having a service plan in place).
- Minimize intake requirements and streamline documentation requirements that reduce access to care and create administrative burden.
- Facilitate data sharing agreements to allow treatment records from previous treatment episodes to be utilized for intake information.
- Shift oversight from process measurement to outcome measurement.
- Address regulation resulting in an imbalance between time spent on administrative paperwork and clinical care.

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[66] Saunders H, Guth M, Eckart G. A Look at Strategies to Address Behavioral Health Workforce Shortages: Finding from a Survey of State Medicaid Programs. Kaiser Family Foundation. January 10, 2023. Available at: https://www.kff.org/mental-health/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/#:~:text=Given%20the%20substantial%20behavioral%20health,requirements%20(such%20as%20telehealth%20or. Accessed December 28, 2023.

[67] Ibid

[68] Minnesota Legislature. Approved plan to eliminate paperwork could help providers combat addiction. 2021. Available at: https://www.house.mn.gov/sessiondaily/Story/15801. Accessed December 29, 2023.

[69] The College for Behavioral Health Leadership. https://www.leaders4health.org/journal-articles-commentaries-toolkits/

CONCLUSION

Minnesota leaders and stakeholders have an opportunity to come together to build a SUD support ecosystem that is understandable, impactful, and most importantly, equitable. Minnesota continues to lose individuals to SUD each day. Minnesota has an array of committed and talented providers, but gaps in care remain. In Minnesota, Black/African American and Native Americans/American Indian people are dying of overdoses at much higher rates than White people.

By implementing these recommendations and building upon Minnesota's solid foundation and history of creatively solving problems, we can create a meaningful, actionable state health plan that has a significant impact on the lives of individuals, families, and communities affected by SUD. The time to act is now, and the need for an equitable, accessible, and effective SUD treatment system has never been more urgent.

This report is a call to action, urging stakeholders to prioritize the recommendations outlined, particularly those related to building a culturally competent system. Key strategies include developing agencies to support community providers in delivering culturally responsive care, expanding family-based treatment services, enhancing the SUD workforce through training and increased peer support integration, and improving funding models to incentivize high-quality, person-centered care.

Next Steps and Implementation Considerations

Implementing the recommendations outlined in this report will require a concerted effort from a wide range of stakeholders, including policymakers, state agencies, treatment providers, and community organizations. Key considerations for successful implementation include:

- Securing buy-in and support from key stakeholders through ongoing communication and collaboration
- Developing a clear, actionable implementation plan with specific timelines and responsibilities
- Allocating sufficient resources, including funding and staff time, to support implementation efforts
- Establishing clear metrics and data collection processes to track progress and identify areas for improvement
- Providing ongoing training and technical assistance to support providers and other stakeholders in adopting new practices and models of care

By addressing these implementation considerations and working collaboratively towards a shared vision of an accessible, equitable, and effective SUD treatment system, Minnesota can make considerable progress in addressing the gaps identified in this report and improving outcomes for individuals, families, and communities affected by SUDs.

For additional questions related to the MN SUD CoP, how to improve community advocacy, community engagement, or collective impact efforts, visit the MN SUD CoP webpage or email mnsudcop@healthmanagement.com.

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- researchers or members of the academic community who are SUD subject matter experts and who do not have financial relationships with treatment providers
- SUD treatment providers
- recovery community organizations
- the Minnesota Department of Human Services
- the Minnesota Department of Health
- the Minnesota Department of Corrections
- county social services agencies
- tribal nations or tribal social services providers
- managed care organizations
- individuals who have used SUD treatment services
- individuals from other communities that are disproportionately impacted by SUD

A special thank you to the following CoP members, who are participating as full, contributing CoP members of the MN SUD CoP.

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APPENDIX A: EVIDENCE-BASED PROGRAMS

Research on treatment outcomes validates a collective understanding among clinicians that not all assistance is equally effective. Implementing evidence-based programs (EBP) ensures that programs result in improved outcomes. EBP fidelity is often a challenge associated with change management and implementation science.

EBP Examples

Children and Youth

- **Botvin LifeSkills Training (LST)**[70] is a research-validated substance abuse prevention program proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. The program provides school aged children and adolescents with the confidence and skills necessary to successfully handle challenging situations. LST is designed to: (1) increase knowledge of the adverse consequences of substance use; (2) promote anti-drug attitudes and norms; (3) teach personal self-management skills; (4) teach general social skills; and (5) teach skills for resisting social influences on smoking, drinking, use of illicit drugs, and engaging in aggressive or violence-related behaviors.
- **Active Parenting of Teens (research informed)**[71]: Families in Action is a school- and community-based intervention for middle school-aged youth designed to increase protective factors that prevent and reduce alcohol, tobacco, and other drug use; irresponsible sexual behavior; and violence. Family, school, and peer bonding are important objectives. The program includes a parent and teen component. The parent component uses the curriculum from Active Parenting of Teens. This curriculum is based on Adlerian parenting theory, which advocates mutual respect among family members, parental guidance, and use of an authoritative style of parental leadership that facilitates behavioral correction. A teen component was developed to complement the parent component.
- **Creating Lasting Family Connections® (CLFC)**[72] is a family-focused program that aims to build the resiliency of youth aged 9 to 17 years and reduce the frequency of their alcohol and other drug (AOD) use. CLFC is implemented through a community system, such as churches, schools, recreation centers, and court-referred settings.
- **keepin' it REAL (kiR)**[73] Middle School Program is a 10-week classroom-based universal substance use prevention program for youth ages 10-13. kiR is designed to reduce the risks of alcohol, tobacco, and other risky drug use as well as promote social and emotional competencies such as drug refusal efficacy. The weekly lessons are 45 minutes each using a "from kids, through kids, to kids" approach, kiR increases students' confident communication skills, decision-making skill, resistance skill efficacy, emotional intelligence (e.g., empathy, perspective taking, self-control), and awareness of social support. Program examples, role-plays, and videos feature personal experiences of early adolescents. To help reinforce the messages from the 10 weekly lessons, there are 3 optional lessons on "how to make your own refuse, explain, avoid, and leave (kiR) videos." Multicultural program videos address

[70] Botvin LifeSkills Training | Evidence-based preventionBotvin LifeSkills Training | Evidence Based Prevention Programs for Schools, Families, and Communities
[71] https://www.cebc4cw.org/program/active-parenting-of-teens-families-in-action/
[72] CEBC » Program › Cmca Communities Mobilizing For Change On Alcohol (cebc4cw.org)
[73] CEBC » Program › Keepin It Real Kir (cebc4cw.org)

e-cig use, vaping, and use of prescription medication. There are three culturally grounded versions: Multicultural, Rural, and Spanish.

- **Project Towards No Drug Abuse (TND)**[74] is an interactive classroom-based substance abuse prevention program for youth who are at risk for drug use and violence-related behavior. It focuses on three factors that predict tobacco, alcohol, and other drug use, violence-related behaviors, and other problem behaviors among youth, including: (a) Motivation factors (e.g., students› attitudes, beliefs, expectations, and desires regarding drug use); (b) Skills (e.g., effective communication, social self-control, and coping skills); and (c) Decision-making (i.e., how to make decisions that lead to health-promoting behaviors).
- **Strong African American Families (SAAF)**[75] is a seven-week program targeting rural African American families with children from 10 to 14 years old. It is a parental training program that works to strengthen attachments between parents and children, reducing alcohol and drug use. SAAF has been rated as an effective program for reducing child alcohol use and other youth risk behaviors by the National Institute of Justice.
- The **Nurse-Family Partnership Program**[76] involves trained nurses who provide intensive, in-home visits to at-risk, first-time mothers during their pregnancy. The Surgeon General's Report on Alcohol, Drugs, and Health describes the Nurse-Family Partnership Program as an evidence-based prevention program because a study showed that children who received the intervention were less likely to use alcohol in their teens than those who did not. The Rural Services Integration Toolkit provides additional information about the Nurse-Family Partnership Program, including implementation considerations. Learn more about the benefits and costs of the Nurse-Family Partnership program.
- **Communities That Care (CTC)**[77] is a program of the Center for Substance Abuse Prevention (CSAP) in the office of the United States Government's Substance Abuse and Mental Health Services Administration (SAMHSA). CTC is a coalition-based prevention operating system that uses a public health approach to prevent youth problem behaviors such as violence, delinquency, school dropout and substance abuse. Using strategic consultation, training, and research-based tools, CTC is designed to help community stakeholders and decision makers understand and apply information about risk and protective factors, and programs that are proven to make a difference in promoting healthy youth development, to address the specific issues facing their community's youth most effectively.
- **Familias Unidas**[78] is a family-based intervention for Hispanic families with children ages 12-17. The program is designed to prevent conduct disorders; use of illicit drugs, alcohol, and cigarettes; and risky sexual behaviors by improving family functioning. Familias Unidas is guided by eco-developmental theory, which proposes that adolescent behavior is affected by a multiplicity of risk and protective processes operating at various levels (i.e., within family, within peer network, and beyond), often with compounding effects. The program is also influenced by culturally specific models developed for Hispanic populations in the United States. Pairs at risk youth with adult mentors. Programs are designed to reduce risk factors (e.g., anti-social behavior) by enhancing protective factors (e.g., health beliefs, social reinforcement). Evidence supports long-term mentorships.

[74] https://www.cebc4cw.org/program/project-towards-no-drug-abuse-project-tnd/
[75] Strong African American Families Program | Center for Family Research (uga.edu)
[76] Nurse-Family Partnership - Helping First-Time Parents Succeed (nursefamilypartnership.org)
[77] The Center for Communities That Care
[78] familias_unidas_4-21-12.pdf (theathenaforum.org)

Adults

- **SBIRT**[79] (Screening, Brief Intervention, Referral to Treatment) is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels. The goal is to reduce and prevent related health consequences, disease, accidents, and injuries, and if a need for treatment is identified, a referral to a higher level of care. SBIRT can be performed in a variety of settings. Screening does not have to be performed by a physician.
- **Healthy Workplace**[80] is a set of substance abuse prevention interventions for the workplace that are designed for workers who are not substance-dependent and still have the power to make choices about their substance use. The five Healthy Workplace interventions--SAY YES! Healthy Choices for Feeling Good, Working People: Decisions About Drinking, the Make the Connection series, Healthy Life 2000 (formerly Prime Life 2000), and Power Tools--target unsafe drinking, illegal drug use, prescription drug use, and the healthy lifestyle practices of workers. Cast in a health promotion framework and grounded in social-cognitive principles of behavior change, Healthy Workplace interventions integrate substance abuse prevention materials into popular health promotion programs, thereby defusing the stigma of substance abuse and reducing barriers to help-seeking behavior. Intervention materials are designed to raise awareness of the hazards of substance use and the benefits of healthy behaviors and to teach techniques to live healthier lives. The interventions are delivered in small group sessions using videos and print materials that can be used in any order and are selected based on the organization's goals and workforce composition (construction workers, office workers, technical/professional staff, etc.).
- **PRIME For Life (PFL)**[81] is a motivational intervention used in group settings to prevent alcohol and drug problems or provide early intervention. PFL has been used primarily among court-referred impaired driving offenders, as in the two studies reviewed for this summary. It also has been adapted for use with military personnel, college students, middle and high school students, and parents. Different versions of the program, ranging from 4.5 to 20 hours in duration, and optional activities are available to guide use with various populations.

[79] Screening, Brief Intervention, and Referral to Treatment (SBIRT) | SAMHSA
[80] healthy_workplace_4-21-12.pdf (theathenaforum.org)
[81] coping_with_work_and_family_stress_3-26-12.pdf (theathenaforum.org)

APPENDIX B: CULTURALLY RESPONSIVE EVALUATION AND TREATMENT PLANNING

SAMHSA Treatment Improvement Protocol: Improving Cultural Competence (Chapter 3)[82]

- Step 1: **Engage clients.** Because the intake meeting is often the first encounter clients have with the behavioral health system, they must leave the meeting feeling understood and hopeful.
- Step 2: **Familiarize clients and family members with the evaluation and treatment process**. Often, clients and family members are not familiar with treatment jargon, the treatment program, the facility, or the expectations of treatment; furthermore, not all clients will have had an opportunity to express their expectations or apprehension. Clinical and other treatment staff must not assume that clients already understand the treatment process. Instead, they need to take sufficient time to talk with clients (and their families, as appropriate) about how treatment works and what to expect from treatment providers.
- Step 3: **Endorse a collaborative approach in facilitating interviews, conducting assessments, and planning treatment.** Counselors should educate clients about their role in the interview, assessment, and treatment planning processes. From first contact, they should encourage clients and their families to participate actively by asking questions, voicing specific treatment needs, and being involved in treatment planning. Counselors should allow clients and family members to give feedback on the cultural relevance of the treatment plan.
- Step 4: **Obtain and integrate culturally relevant information and themes.** By exploring culturally relevant themes, counselors will better understand each client and will be better equipped to develop a culturally informed evaluation and treatment plan. Areas to explore include immigration and migration history, cultural identity, acculturation status, health beliefs, healing practices, and other information culturally relevant to the client.
- Step 5: **Gather culturally relevant collateral information.** Such information is a powerful tool in assessing clients' presenting problems, understanding the influence of cultural factors on clients, and gathering resources to support treatment endeavors. By involving others in the early phases of treatment, providers will likely obtain more external support for each client's engagement in treatment services.
- Step 6: **Select culturally appropriate screening and assessment tools.** In selecting evaluation tools, counselors should note the availability of normative data for the populations to which their clients belong, the incidence of test item bias, the role of acculturation in understanding test items, and the adaptation of testing materials to each client's culture and language.
- Step 7: **Determine readiness and motivation for change.** Although few studies focus on the use of motivational interviewing with specific cultural groups, its theories and strategies may be more culturally appropriate for most clients than other approaches.

[82] https://store.samhsa.gov/sites/default/files/sma14-4849.pdf

- Step 8: **Provide culturally responsive case management.** Many core competencies for counselors are also relevant to case managers. Like counselors, case managers should possess cultural self-knowledge and a basic knowledge of other cultures. They should possess traits conducive to working well with diverse groups and the ability to apply cultural competence in practical ways. Case management includes the use, as necessary, of interpreters who can communicate well in the specific dialects spoken by each client and who are familiar with behavioral health vocabulary relevant to the specific behavioral health setting in which service provision will occur.
- Step 9: **Integrate cultural factors into treatment planning.** Counselors should be flexible in designing a treatment plan to meet the cultural needs of clients and should integrate traditional healing practices into treatment plans when appropriate, using resources available in the clients' cultural communities. Treatment goals and objectives need to be culturally relevant, and the treatment environment must be conducive to client participation in treatment planning and to the gathering of client feedback on the cultural relevance of the treatment being provided.


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