

Minnesota's Model of Care for Substance Use Disorder

Alcohol and Drug Abuse Division
Minnesota Department of Human Services
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Minnesota Department of **Human Services**

Legislative Report

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I. Executive Summary

The 2012 Minnesota Legislature passed legislation directing the Commissioner of the Department of Human Services (DHS) to collaborate with counties, tribes, and other stakeholders to “**develop a model of care to improve the effectiveness and efficiency of Minnesota’s current service continuum for chemically dependent individuals.**” In response, the Director of the Alcohol and Drug Abuse Division, along with DHS Deputy Director of Indian Policy and DHS Director of County Relations, established a Steering Committee of statewide representative stakeholders and constituents. The Steering Committee met bi-weekly from September 2012 until February 2013. The Committee examined extensive relevant topic resources, along with in-depth workgroup Issues Analyses on each of the five priority areas identified by the Committee. **The priority areas of focus are:** 1) Improve access to treatment and the assessment process for Substance Use Disorder (SUD) treatment; 2) Improve care coordination and continuing care for people with SUD; 3) Increase diversity and capacity of SUD workforce; 4) Support adoption of electronic records by SUD treatment providers; 5) Promote telemedicine as one SUD treatment and recovery support strategy

The Committee provided oversight and guidance throughout the entire process. The expertise and contributions of the Steering Committee were essential to identification of issues, possible strategies and overall development of this report.

Key Facts and Findings:

The Affordable Care Act (ACA) and parity law create new opportunities for substance use disorder treatment.

- The ACA identifies substance use disorder (SUD) services as one of the 10 elements of essential health benefits.¹ All health insurance sold on Health Insurance Exchanges or provided by Medicaid to certain newly eligible adults starting in 2014 must include services for SUD. The ACA and Mental Health Parity and Addictions Equity Act provide the opportunity to address health care disparities for persons with SUD and to develop and design improved services and supports to meet the health, behavioral health and long-term services and support needs of individuals with substance use and mental health disorders.²

Treatment is cost-effective

- Economic benefits from treatment include direct reduction in health care costs and indirect cost reductions resulting from reduced crime and improved employment.³ A

¹ http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf

² <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³ 2005 Belenko, Patapis, French. *Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers*, University of Pennsylvania: Treatment Research Institute

2005 study of Washington State's Medicaid program⁴ found that the provision of SUD treatment was associated with an annual reduction of medical expenses of approximately \$2,500, which was about the cost of the treatment. Other studies have also shown that medical expenses decrease after SUD treatment, with both Medicaid and non-Medicaid patients showing a 30 percent reduction in total medical costs between the year prior to treatment intake and three years following treatment initiation.

- SUD treatments are as effective as treatments for other chronic conditions, such as diabetes and hypertension that require behavior change for optimal recovery.⁵ Compared with other health care costs, the cost of providing effective SUD treatment is low. The average cost for a non-residential treatment episode in Minnesota is \$3,600 and the average cost for a residential episode is \$8,600.

Minnesota has a long and respected history of providing effective SUD treatment.

- Most Minnesotans who enter treatment complete it and show considerable improvement in substance use, employment housing, criminal behavior and participation in recovery support groups. Studies that follow Minnesotans after treatment show that abstinence from substance use and other benefits tend to persist.⁶
- Approximately 350 programs are licensed (Rule 31)⁷ to provide SUD treatment services in Minnesota. Of these, 145 are located in rural areas of Minnesota. Treatment settings include free-standing for-profit and not-for-profit organizations, hospitals, tribal governments and state-operated treatment services. Specialty SUD treatment services are also provided in some county jails, adolescent correctional facilities and one rural nursing home.
- Approximately 175 of these programs provide integrated co-occurring services, and others coordinate mental health services via collaborative partnerships with community resources. DHS integrated dual disorders treatment (IDDT) rule will expand services for persons with severe mental illness and SUD, and ensure comprehensive care.
- Population-specific programs provide both gender-specific SUD services, and culturally-specific SUD to Native American, African American, Hispanic, Deaf & Hard of Hearing, lesbian/gay/bisexual/transgender, Hmong, Somali and Senior citizens with substance use disorders.

⁴ 2012 Wickizer, Mancuso, Huber, *Evaluation of an Innovative Medicaid Health Policy Initiative to Expand Substance Abuse Treatment in Washington State*. <http://www.ncbi.nlm.nih.gov/pubmed/22618867>

⁵ McLellan, A.T., et al. 2000. *Drug dependence, a chronic medical illness; Implications for treatment, insurance and outcomes evaluation*, Journal of the American Medical Association.

⁶McRae, James A., 2012, *The Benefits of Treatment for Substance Use Disorders, Performance Measurement and Quality Improvement*, Minnesota DHS

⁷ Minnesota Rules 9530.6405 - 9530.6505.

Updating Minnesota’s treatment system from an acute, episodic model of treatment to a chronic, longitudinal model of health care would expand the continuum of care and improve integration and coordination with primary care, health care homes, behavioral health homes, health homes, mental health services, peer support and other recovery-support services.

- Historically, addiction treatment has been provided as an acute episode of care. The conceptual model has been that an addicted person seeks treatment, completes an assessment, receives treatment and is discharged, all in a period of weeks or months. Unlike health care for other chronic illness, addiction treatment is expected to provide a “cure,” as well as a wide array of services to address housing, employment, legal and family issues. The traditional acute care approach to substance use disorder has encouraged people to suppose that patients entering addiction treatment should be cured and able to maintain lifelong abstinence following a single episode of specialized treatment. Current evidence recommends moving away from this episodic model of treatment for addiction to a chronic disease model of health care.⁸
- These changes would align Minnesota’s model of care with current research-informed practices set-out by SAMHSA, described as a *Recovery-Oriented System of Care (ROSC)*, to facilitate earlier intervention and re-intervention for the individual and family, quicker access to the appropriate levels of care and intensity of research-supported treatment services, access to comprehensive case management services when indicated, access to peer recovery coaches, follow-up services, ‘Recovery Management Check-ups’, and other recovery management strategies shown to significantly improve outcomes.

Current wait times for an assessment and for authorization to access SUD treatment are significant deterrents to individuals seeking help.

- The Steering Committee identified redesign of the assessment process to be the most pressing opportunity for improving the SUD continuum of care. Timely access to a thorough assessment for the right services at the right place and time is vital because the window of opportunity frequently subsides and failure to facilitate a quick and accurate assessment can literally mean the difference between life and death.
- The 2012 Substance Abuse and Mental Health Administration Center for Substance Abuse Treatment review of Minnesota’s treatment continuum highlighted Minnesota’s current assessment and placement process by placing authorities as a potential ‘bottleneck’ for timely access to SUD treatment services. Currently, entry into publically-funded treatment in Minnesota is determined by the county, tribe or prepaid health plan responsible for providing a timely assessment; determination of the level, intensity and duration of treatment service; and treatment authorization. DHS, statewide stakeholders and consumers are aware that cost-containment policies enacted by some placing authorities prevent timely access to assessment and treatment, have created barriers that impede access to services, and can result in harm to individuals seeking treatment, their families and communities.

⁸White, W., Boyle, M., & Loveland, D. (2003). *Addiction as Chronic Disease: From Rhetoric to Clinical Application*.

- Despite rules, statues and efforts to address these issues and to improve the assessment process, barriers continue to impede access to SUD services in Minnesota. While DHS continues to work toward solutions to problems with the current process, this report identifies opportunities to improve Minnesota's assessment process and service continuum, and look to effective process improvement models that address state regulations and policies that affect SUD treatment wait times, rapid access to care, client engagement, flexible services, quality care and improved outcomes.⁹

Continuing care and peer support expansion could address a gap in Minnesota's continuum due to lack of availability of enough services to meet the current need.

- Continuing care and recovery support services involve additional case coordination and peer recovery support during treatment and at service termination, where treatment clients are connected to peers in recovery and provided continuing care through volunteer peer mentors, and connections with mutual-help support groups and service providers in the community.

Diversity and capacity of the SUD treatment workforce needs to be increased.

- The majority of individuals who enter SUD treatment in Minnesota identify as Caucasian. However, the numbers of American Indians and African Americans in treatment are disproportionate to their representation in the general population, and American Indians and African Americans have the highest proportion of readmissions and Hispanics the lowest. The Board of Behavioral Health and Therapy licenses and regulates alcohol and drug counselor practice, and emphasizes the importance of addressing culture and population-specific issues related to SUD recovery. Alcohol and drug counselor licensure requires 18 hours of continuing education in seven areas of cultural diversity: African American, Native American, Chicano/Latino, Asian American, Deaf & Hard of Hearing, and Disability, as well as specific populations: Women, Men, LGBT, Adolescents and Elderly. In addition, one of the Department's priorities is to implement effective strategies to increase SUD workforce diversity to more accurately reflect populations served, and improve treatment outcomes for all SUD treatment populations.

Treatment-related technology is promising.

- The implementation of electronic health records for all SUD treatment providers is expected to result in improved information management, increased administrative efficiency, and an improved treatment experience for the client. The use of telehealth for the provision of SUD services continues to evolve in areas around the country, and offers Minnesota the opportunity to explore telecommunication-based service delivery in the future. Electronic health records and innovations in telemedicine and other recovery-support technologies are exciting tools available to address geographical and other barriers to effective efficient SUD treatment.

⁹ NIATx is an organization that exists to serve people facing the challenges of addiction and mental health by making improvements to the cost and effectiveness of care delivery systems, including by helping payers and behavioral healthcare providers remove barriers to treatment and recovery. <http://www.niatx.net/Home/Home.aspx>

Key Recommendations:

Health care reform provides Minnesota the ability to capitalize on the strengths of the current treatment system while presenting an opportunity to identify and test promising treatment practices in the field. Practices that are confirmed to be effective at treating substance use disorder could be integrated into the current system to improve the effectiveness, efficiency, and versatility of Minnesota's service continuum for individuals with substance use and mental health disorders. DHS envisions development of a recovery-oriented system of care that provides a full range of high-quality services to provide effective treatment support while promoting the integration of primary care and behavioral health. Improvements in the system will be guided by the triple aim of healthcare reform: care, health and cost.

As initial steps toward improving the substance use disorder treatment system, DHS recommends:

- Implementing effective strategies to increase SUD workforce diversity to more accurately resemble all populations served.
- Changing current rules requiring discharge or service termination of service to allow ongoing monitoring and early re-intervention. This practice shows improved long-term outcomes for a range of other chronic conditions, including asthma, cancer, diabetes, depression and severe mental illness. When Recovery Management Checkups (RMC) are practiced in substance use disorder treatment, staff members do not wait for patients to recognize that they need help but instead conduct quarterly checkups to assess patient status.¹⁰ Widening the continuum of care to include RMC monitoring, expanded Comprehensive Case Management¹¹ services by providers¹² during and post-treatment, and supports such as peer mentoring pre, during and post treatment are shown to improve treatment engagement and retention. In addition, these practices promote early re-intervention to prevent or address a lapse of illness and encourage resumption of recovery.
- Implementing a pilot between the Department of Human Services Alcohol and Drug Abuse Division and three counties representing northern, central and southern regions to test a new assessment and access process. Rule 31, primary care clinics, health care homes or behavioral health homes with qualified assessment staff would facilitate quicker access to clinically driven recommendations and ensure clients have access to the right service, at the right time, in the right amount. Clients will be able to access follow-up care and support, and progress will be quantified and measured for future policy-making purposes.

¹⁰ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797101/>

¹¹ <http://www.ncbi.nlm.nih.gov/books/NBK64863/>

¹² These services are not currently reimbursable for Rule 31 providers.

Other features of the pilot will include:

- Following the initial SUD assessment, clinically-appropriate treatment, continuing care/case management, and recovery/peer support services will be made available to clients on a longitudinal basis and will be reimbursable to service providers. Clients will not be required to obtain reauthorization or a new assessment each time a client is in need of services of a different intensity or nature. Clients will have access to an updated assessment upon request or if clinically indicated. Service providers will not be required to complete a service termination and a discharge summary will be completed only when clinically appropriate to meet client need.
- Financial incentives for county participation in the pilot will be determined prior to a county's agreement to participate. The pilot is expected to yield information related to assessment/access process efficiencies/inefficiencies to inform future decisions in modifying the infrastructure of the SUD continuum in Minnesota.
- It is recommended that the project begin by August 2013 and operate for three years. Outcome measures will be developed in collaboration with the DHS Performance Measurement and Quality Improvement Division and will quantifiably and qualitatively measure cost expenditures, services provided and clinical decisions made, client outcomes and satisfaction, impact and strain on providers and the SUD workforce, and what effect the elimination of the gate-keeper function has on reducing delays to accessing treatment.

Identify potential funding streams to ensure the longitudinal availability of continuing care and recovery support services in Minnesota.

- Some examples of other states that have begun funding peer support services for substance abuse clients include Florida, Kansas, Missouri, New Mexico, New York, Oregon, Pennsylvania, South Carolina and Wyoming. Some states maintain the services in their care continuum as a Medicaid reimbursable services, others reimburse through block grant funds or State general funds. Developing and maintaining a funding structure in Minnesota that permits reimbursement for peer recovery support and flexible continuing care services will ensure that this needed support is an embedded component of the state's SUD continuum of care.

II. Introduction

During the 2012 Legislative Session, the Minnesota Legislature enacted a law directing the Commissioner of Human Services to collaborate with counties, tribes, and other stakeholders to develop a community-based integrated model of care to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals in Minnesota (Appendix A). The legislation requires the Commissioner to present the model of care in a Legislative Report due to the Legislature no later than March 15, 2013.

To implement the legislative directive, the SUD Model of Care Planning Project was initiated. The project was led by Kevin Evenson, DHS Alcohol and Drug Abuse Division (ADAD); Monte Fox, DHS Deputy Director of Indian Policy; and Kate Lerner, DHS Director of County Relations. Goals of the project were articulated based on the statutory language and were guided by ADAD's current knowledge base, state and national data, research-supported recommendations from SAMHSA, Center for Substance Abuse Treatment, input from the Minnesota Board of Behavioral Health and Therapy, DHS Licensing, addiction professional organizations, service provider organizations, as well as past and current input from counties, tribes, health plans and other stakeholders.

A Steering Committee was formed with members representing the interests of stakeholders and constituents statewide, as well as culturally-specific concerns and the issues of disparate impact. The Committee provided oversight and guidance throughout the process. The Steering Committee included:

- Kevin Evenson, DHS Director of ADAD
- Henry G. Fox, White Earth Nation, representing the ADAD American Indian Advisory Council (former chair)
- Monte Fox, DHS Deputy Director of Indian Policy
- Judi Gordon, C.R.E.A.T.E, Inc., representing the Board of Behavioral Health and Therapy (BBHT)
- John Henderlite, Haven Chemical Health Systems, LLC, representing the Minnesota Association of Treatment Directors (MATD)
- Paul Heyl, DHS Adult Mental Health Division
- Kate Lerner, DHS Director of County Relations
- Anne Pylkas, MD, Hennepin County Medical Center, Minnesota Society of Addiction Medicine
- Julie Reger, DHS Licensing, Mental Health/Chemical Dependency Unit Manager
- Cindy Rupp, Washington County, representing the Minnesota Association of County Social Service Administrators (MACSSA)
- Sam Simmons, The Family Partnership
- Brad Vold, Morrison County, representing MACSSA's rural counties
- Deb Wamsley, Vice President of the Minnesota Association of Resources for Recovery and Chemical Health (MARRCH)
- Cary Zahrbock, Medica Behavioral Health, representing the Minnesota Council of Health Plans

GUIDING PRINCIPLES OF THE CD MODEL OF CARE PLANNING PROJECT

The work of the CD Model of Care planning project was guided by SAMHSA's definition of recovery, principles of recovery and identified elements of recovery-oriented systems of care, which were collaboratively developed in 2005, at the National Summit on Recovery convened by SAMHSA and attended by consumers, persons in recovery, family members, advocates, policy-makers, administrators, providers and others. Recently, the urgency of health care reform compelled SAMHSA to review the work that was done at the summit. In December 2011, SAMHSA updated the guiding principles of recovery and in March 2012, SAMHSA issued the slightly revised version. The revised principles address individuals in recovery from a mental health disorder, a substance use disorder, or both. [Appendix B]

On April 18, 2011, in preparation for the implementation of health care reform, SAMHSA issued a draft article titled *Description of a Modern Addictions and Mental Health Service System*, which provides additional guiding principles for a mental health and substance use system.

SAMHSA's Identified Service Elements of a Mental Health and Addictions Service System Health Promotion.

- Prevention.
- Screening and Early Intervention.
- Care Management.
- Self Help and Mutual Support.
- Proposed Continuum of Services, including:
 - Health Homes.
 - Prevention and Wellness Services.
 - Engagement Services.
 - Outpatient and Medication Assisted Treatment.
 - Community Supports and Recovery Services.
 - Intensive Support Services.
 - Other Living Supports.
 - Out-of-Home Residential Services.
 - Acute Intensive Services.

SAMHSA's Core Structures and Competencies for a Modern System

- Workforce
- Empowered Health Care Consumers
- Information Technology
- Funding and Payment Strategies
- Quality and Performance Management
- Sustainable Practice Improvement
- Continued Partnerships.

The Steering Committee spent several meetings discussing the scope and goals of the planning project and articulating a set of principles that should drive Minnesota's SUD Model of Care. The committee generated a long list of opportunities and challenges in Minnesota's current service continuum, and prioritized five (5) of these challenges as focal points for this first phase of planning. Workgroups of stakeholders and DHS staff were formed to explore each of these issue areas. Open invitations for workgroup participation was disseminated to stakeholders statewide via Committee members, ADAD's website, email lists, stakeholder organizations, networking and personal contacts. Workgroups were co-facilitated by a Steering Committee member and a DHS ADAD staff member and reported their progress to the Committee bi-weekly. Each workgroup prepared a written Issues Analysis that included a review of the issue and recommendations to the Steering Committee for improvements to Minnesota's service continuum. The workgroup Issues Analysis reports are all available on the DHS website.

Based on the guidelines developed by SAMHSA and the Steering Committee and workgroup recommendations, DHS designed a Model of Care for SUD treatment that will meet the goals laid out in the legislative mandate. This report describes that Model of Care and suggests a pilot project that could be undertaken to begin implementation of the proposed measures.

III. Overview of Minnesota's Care System for Substance Use Disorder

A. A Primer on Substance Use Disorder

Minnesota's current continuum of care provides treatment services for individuals who meet diagnostic criteria for either 'substance abuse' or 'substance dependence' as outlined in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM) IV-TR. Revisions of the DSM (DSM-V), recently approved by the American Psychiatric Association and scheduled for release in May 2013, will combine the categories of substance abuse and substance dependence into one overarching disorder of substance use disorder (SUD). Criteria determine three categories of SUD as either 'mild', 'moderate' or 'severe'. Addiction treatment services address all levels of SUD. (Note: Substance use disorder (SUD) and 'addiction' are used interchangeably throughout this report.)

The American Society of Addiction Medicine defines addiction as a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. The exact cause of addiction is not known. The resulting repeated physical, emotional, psychological and social suffering is not a choice.

Active addiction is characterized by the inability to consistently abstain, impairment in behavioral control, experience of craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic conditions, addiction may involve cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction progresses, resulting in disability or premature death for the individual and negative impacts on families and society. Based on a

2004/2005 Minnesota treatment needs assessment survey, it is estimated that about 9% of adults in Minnesota met the criteria for substance abuse or dependence, but less than one in ten of them actually receive treatment.¹³

People with substance use disorder may not seek treatment on their own for a variety of reasons, including denial of a problem, a belief that they should be able to solve the problem without help, shame or fear about entering treatment, fear of potential physical withdrawal from drug use, and fear of failure to recover. In addition, the stigma of addiction and shame about what one's family, friends, and employers might think prevents many individuals from being open to seeking help for SUD.

Entry into publically-funded treatment in Minnesota is now determined by the County, Tribe or Prepaid Health Plan (i.e. Placing Authority), which is responsible for providing a timely assessment, determination of the level, intensity and duration of treatment service, and treatment authorization. Significant complications exist with this current process.

The lack of or inadequacy of health insurance is another barrier to access to treatment. Some people don't qualify for publically-funded care or cannot afford the co-pays or deductible required to access care. For individuals who can afford health insurance, denial and stigma play a part in not electing coverage for addiction services when they are separate from other types of health coverage. Fear of being denied a policy if they request coverage for addiction or the belief that coverage will never be needed can also affect an individual's choice to purchase healthcare coverage for substance abuse disorders.

Individuals with addiction who do access treatment have usually experienced significant family, legal, employment and health problems prior to entering treatment. Many individuals have previously made multiple unsuccessful attempts to moderate, decrease or stop consumption of alcohol or illicit drug use. Some have tried to reduce the harm of their use by altering use patterns, switching from 'hard' liquor to wine or beer, replacing drug use with alcohol or vice versa.

Despite periods of abstinence, resuming substance use with the intended goal of moderate substance use is often unsuccessful for individuals with SUD, and addiction eventually escalates to previous levels of severity or further progression of illness and consequence. Some people hold onto the mistaken belief that a period of time in treatment and away from active addiction equals "cure" or absence of illness.

Many individuals with SUD sincerely promise themselves and others that they will quit, and sometimes do abstain for periods of time. However, for individuals with addiction, the problem is not 'quitting', the problem is staying quit. SUD treatment addresses the physical, emotional, cognitive and behavioral components necessary to 'stay quit' and enhances the likelihood of long-term recovery. Completion of treatment is the most consistent predictor of post-treatment abstinence.¹⁴

¹³ Park, Eunkyung, 2006, Substance Use Treatment Need and Receipt of Treatment in Minnesota: Results from Minnesota Student Survey, Minnesota Survey on Adult Substance Use, and DAANES. St. Paul, DHS

¹⁴ Id.

Minnesota addiction expert, Gregory Amer, MD, University of Minnesota Medical Center Fairview, Family Practice physician and member of the American Society of Addiction Medicine, explains with this analogy, “The disease of addiction is never cured, it never goes away – the “pilot light always stays on”. So strategies to maintain behaviors that support ongoing recovery are vital to avoid re-igniting the destructive ‘flames’ of addiction. Like other chronic illnesses (diabetes, asthma, hypertension), addiction recovery requires lifelong attention, and periodic professional care/services may be necessary.¹⁵

Due to the physical, cognitive, and emotional effects of addiction, abstinence from alcohol and from illicit use of other drugs is optimal *recovery* for individuals diagnosed with SUD. ADAD understands that behavioral health is essential to health, prevention works, treatment is effective, and people do recover. ADAD policies promote recovery as defined by SAMHSA.

SAMHSA’s Definition of Recovery

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA delineated four (4) major dimensions that support a life in recovery:

- **Health:** Overcoming or managing one’s disease(s) or symptoms—for example, **abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem**—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- **Home:** A stable and safe place to live;
- **Purpose:** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community:** Relationships and social networks that provide support, friendship, love, and hope.

Facts:

- Most Minnesotans who enter treatment complete it and show considerable improvement in substance use, employment, housing, criminal behavior, and participation in recovery support groups. Studies that follow Minnesotans after treatment show that abstinence from substance use and other benefits tend to persist.¹⁶
- For Minnesotans who completed their last episode of treatment in 2005, 84% remained out of treatment in the following year. The high percentage of individuals NOT re-entering treatment suggests that lives do improve after treatment. It is important to

¹⁵ <http://www.ncbi.nlm.nih.gov/pubmed/11015800>

¹⁶ McRae, James A., 2012, *The Benefits of Treatment for Substance Use Disorders, Performance Measurement and Quality Improvement*, Minnesota DHS

emphasize that if the need arises, a return for treatment services is optimal since addiction is a chronic (not acute) medical illness.¹⁷

- Economic studies across settings, populations, methods and time periods consistently find the primary economic benefits of SUD treatment result from post-treatment reductions in health care costs and reduced crime.¹⁸
- An innovative policy established in 2005 in Washington State provided funding to expand access to addiction treatment for Medicaid beneficiaries. The aggregate annualized estimated savings was 16.8 million and equaled the cost-saving goal of the effort.¹⁹
- Addiction treatment is as effective as treatment for other chronic disorders with behavioral components (i.e. asthma, diabetes, hypertension).²⁰
- The disease of addiction, like other illness, is most successfully treated and arrested in its early stages.²¹
- Minnesota spent almost \$3 billion on substance abuse and its consequences in 2005. About 98% of this amount covered the burden to public programs that resulted from the consequences of substance use, such as health problems and costs to the criminal justice system. The National Center on Addiction and Substance Abuse estimates that treatment accounted for about 2% of spending, and prevention activities accounted for less than 1%.²²
- A 2006 Minnesota study indicates that about 9% of adults in Minnesota met the criteria for substance abuse or dependence, but less than one in ten of them actually received treatment that year.²³ An even higher percentage of high school students (17.6% of 12th graders) exhibited a need for treatment, and a little over one in ten of them (13%) received it.²⁴ Minnesota has more unmet treatment needs than over half of the states in the U.S.²⁵

¹⁷ Rodgers, Alan G., 2009, *Addiction Treatment in Minnesota: Treatment Readmissions and Detox Admissions*, June 2009. Minnesota DHS.

¹⁸ 2005 Belenko, Patapis, French. *Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers*, University of Pennsylvania: Treatment Research Institute

¹⁹ 2012 Wickizer, Mancuso, Huber, *Evaluation of an Innovative Medicaid Health Policy Initiative to Expand Substance Abuse Treatment in Washington State* <http://www.ncbi.nlm.nih.gov/pubmed/22618867>

²⁰ McLellan, A.T., Lewis, D.C. and Kleber, H.D. (2000), *Journal of the American Medical Association*, 284 (13) <http://drugabuse.gov/PDF/PODAT/PODAT.pdf> &

http://www.hbo.com/addiction/thefilm/bios/647_michael_dennis.html

²² National Center on Addiction and Substance Abuse, 2009. *Shoveling Up 11: The Impact of Substance Abuse on Federal, State and Local Budgets*. New York: Columbia University.

²³ McAlpine, Donna D., Timothy Beebe, Kim McCoy, and Michael Davern. *2006 Estimating the Need for Treatment for Substance Abuse Among Adults in Minnesota: 2004/2005 Minnesota Treatment Needs Assessment Survey Final Report*. St. Paul. DHS

²⁴ Park, Eunkyung. 2006, *Substance Use Treatment Need and Receipt of Treatment in Minnesota: Results from Minnesota Student Survey, Minnesota Survey on Adult Substance Use, and DAANES*. St. Paul, DHS

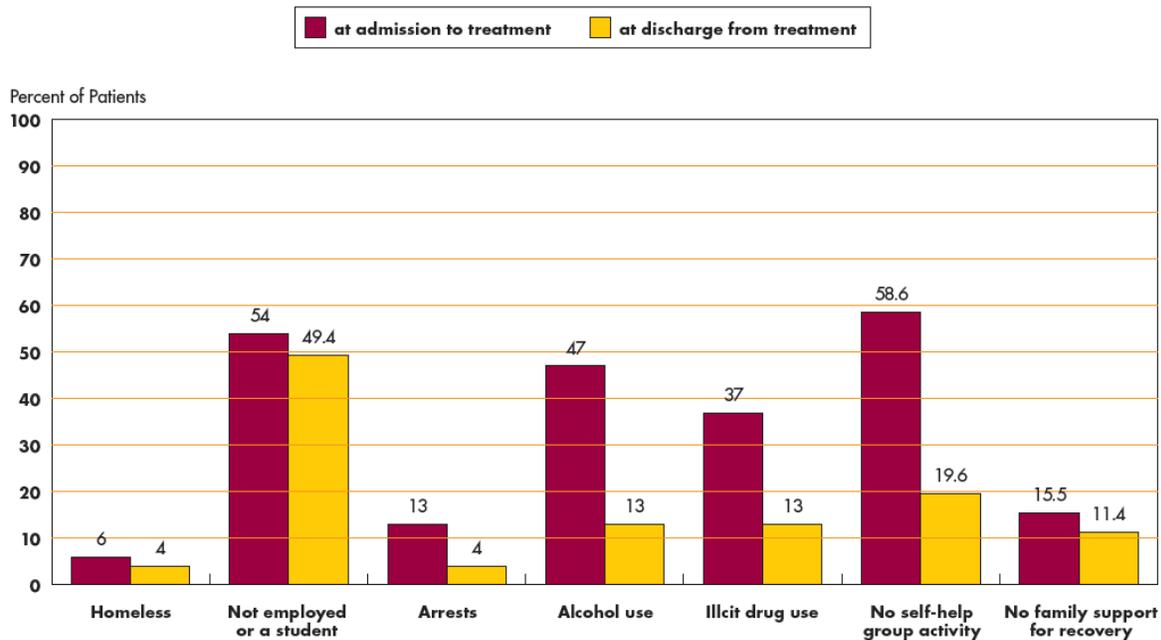
²⁵ Raske, Wayne, 2006. *Analysis Report: The Consolidated Chemical Dependency Treatment Fund*.

- Data from Minnesota show that most individuals who enter treatment complete it and show considerable improvement in housing, employment, use of substances, criminal behavior, and participation in self-help groups.

The Substance Abuse and Mental Health Services Administration has developed six National Outcomes Measures (NOMS) to be administered at treatment admission and discharge in order to determine functioning in six critical domains in the thirty days prior to admission and discharge. According to SAMHSA, NOMS “are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities.”

The graph on page 13 displays the percentage of individuals in Minnesota who experience problems on the different dimensions in the 30 days prior to admission and at discharge, as well as the percentage improvement from admission to discharge. Improvements are striking, as over half of the problems with arrests, alcohol or illicit drugs use, and failing to participate in a self-help group are eliminated by treatment. Improvements in participation in the economy, either as a worker or a student, are modest.

Performance Outcome Measures



Source: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2008. Based on over 45,000 statewide treatment admissions during calendar year 2007 with discharges as of September 1, 2008. All categories are in reference to the past 30 days. Employed includes employed or student. Self-help group refers to participation in AA or similar self-help groups that supports recovery.

“Recovery from a substance use disorder is more the norm than an anomaly... **The central problem is the long duration of time between problem and intervention onset and successful recovery stabilization and maintenance—and the significant harm that can accrue to individuals, families, and communities in the interim.**” 2012 Substance Abuse and Mental Health Service Administration (SAMHSA) report by William L. White, *Recovery/Remission from Substance Use Disorders: An analysis of Reported Outcomes*

Table 1 shows that in 2011, 89% of people had only one span of treatment and another 10% had two spans.²⁶ The average number of spans per person was 1.1.

Table 1: Number of Spans of Treatment among Minnesotans Admitted to Residential, Non-residential, or Methadone treatment in 2011

Spans of treatment per person	# People	% People	# Spans	% Spans
1	32,694	89.4	32,694	80.1
2	3,525	9.6	7,050	17.3
3	336	0.9	1,008	2.5
4	18	0.0	72	0.2
Total	36,573	100.0	40,824	100.0

B. Minnesota’s Substance Use Disorder Continuum of Care

Minnesota residents who meet financial eligibility guidelines and demonstrate a prescribed level of clinical need are eligible for publically funded SUD treatment services, which are reimbursed from Minnesota’s Consolidated Chemical Dependency Treatment fund (CCDTF). The CCDTF is a blended fund consisting of county, state and federal investments. The CCDTF is managed by ADAD, but counties, tribes and Minnesota pre-paid health plans are responsible for providing assessments (Rule 25 assessments)²⁷ to individuals seeking to access CCDTF-paid treatment services. The counties, tribes and pre-paid health plans are referred to as “placing authorities” for CCDTF purposes. The Rule 25 assessment determines an individual’s eligibility for CCDTF-paid treatment services and the appropriate level/intensity of services indicated by the client’s condition and circumstances. An individual is not able to access publically-funded treatment in Minnesota without first obtaining a Rule 25 assessment and authorization of services by a placing authority. Use of a standardized, uniform, State-developed assessment tool was implemented in July 2008.

²⁶ DAANES, Minnesota Department of Human Services.

²⁷ Rule 25 refers to the administrative rule that addresses chemical use assessment, administrative requirements, and appeal and fair hearing rights of the client. Minnesota Rules 9530.6600 – 9530.6655

In Minnesota, the continuum of care can be organized into the following categories:

- Prevention
- Intervention
- Detoxification
- Treatment
- Recovery Support and Continuing Care Management

Prevention: Primary prevention methods are employed *before* SUD develops. In order to reduce the prevalence of alcohol and other drug use/abuse among the state’s population and delay the age of first ‘use’, ADAD promotes evidence-based *primary* prevention strategies to “identify and address high-risk” substance *use* long before addiction develops (MN State Substance Abuse Strategy, pgs. 26 & 46).

In more than 20 years of drug abuse research, the National Institute on Drug Abuse has identified important principles for *primary* prevention programs in the family, school and community. In accordance with this research, prevention programs are often designed to enhance “protective factors,” (those associated with reduced potential for substance use), and to reduce “risk factors,” (those that make substance use more likely). Research-based primary prevention programs can be cost-effective, recent research shows that for each dollar invested in primary prevention, a savings of up to ten dollars in SUD treatment costs can be seen.

As the Minnesota Single State Authority for alcohol and drug abuse prevention and treatment, ADAD is required to expend 20 percent of its SAMHSA Block Grant award on primary prevention. Comprehensive primary prevention programs include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse. Prevention services are provided through a combination of individual and population-based programs and strategies, though much emphasis is put on changing the local environments in which substance use occurs. At the state level, ADAD collaborates with other state agencies and stakeholders in data-driven planning around the delivery of prevention services throughout Minnesota.

Through the Block Grant and the SAMHSA-funded Strategic Prevention Framework State Incentive Grant, ADAD currently funds the following:

- Eighteen community-based prevention grants that utilize a public health approach to preventing alcohol problems among young people.
- Seven Regional Prevention Coordinators who deliver capacity building prevention services to local communities.
- A statewide prevention resource center.
- Tobacco sales to minors compliance activity.

Between 2006 and 2011, ADAD provided grants for community-based Planning & Implementation programs. Prior to receipt of the grants, the communities had a past 30-day alcohol use rate that was not only increasing while the rate for the rest of state was decreasing, it was also 8.7 percentage points higher than the rest of MN. Six years later, with ADAD oversight and management, these communities not only reversed the trend from increasing to decreasing, but also closed the gap between them and the rest of the State by over 50% (to just 3.9

percentage points). The communities, as a group, reduced youth 30-day alcohol use by 30% between 2004-2010. The rest of the State of Minnesota saw a 21% reduction in youth 30-day alcohol use between 2004 and 2010. This is a statistically significant difference.

ADAD supports culturally-specific prevention efforts in Minnesota. In 2010, ADAD contracted with a consultant to develop the *Native American Curriculum for Substance Abuse Programs in Minnesota* to support SUD prevention in the tribes and urban American Indian communities in the state. The curriculum was adapted from the *Native American Curriculum for State Licensed Substance Abuse Programs in South Dakota*, which was developed by Duane Mackey in 2004. The primary purpose of the Minnesota curriculum is to provide an educational experience for prevention specialists and substance abuse staff of licensed SUD programs in Minnesota. The adapted curriculum contains elements that are specific to the tribal makeup of American Indians in Minnesota, and the curriculum reflects the historical experiences of American Indians in Minnesota.

The tribes and urban American Indian communities in Minnesota conduct culturally-specific prevention efforts. For example, Red Lake Nation has adopted evidence-based prevention and education curriculums in its schools and conducts a variety of activities that holistically and comprehensively engage youth in activities that promote cultural values and include traditional practices and the guidance of elders. The activities are intertwined with measures to prevent and address substance abuse in youth. Activities include multiple youth camps based on traditional ways of life, such as berry-picking, fishing, and harvesting rice. Red Lake Nation also convenes an Annual Drug and Gang Summit. The summit's focus is to educate and mobilize tribal agencies, professionals, schools and community members to help prevent or reduce alcohol and other drug use and gang activity on the Red Lake Reservation.

Intervention: Currently, publically funded individuals enter SUD treatment after the development of personal, family/relationship, legal or social service consequences. Half of all admissions to SUD treatment in Minnesota in 2011 were prompted by individuals themselves or by a relative or friend, forty-percent from legal interventions and the remainder from employer or social service interventions.

Another prevention and early intervention strategy, Screening, Brief Intervention and Referral to Treatment (SBIRT), has been utilized in Minnesota trauma hospitals, emergency departments, primary care and community health settings since 2007. ADAD is continuing with strategies to expand SBIRT in Minnesota since it is an evidence-based practice that is successful in modifying the consumption/use patterns of at-risk substance use *before* more severe consequences occur, and also identifies individuals who need more extensive, specialized treatment.

The ACA will significantly enhance access to prevention, treatment, and recovery support services for people with, or at risk of, mental and/or substance use disorders. According to a SAMHSA 2010 National Survey of Drug Use and Health, there will be an additional 30 million previously uninsured people with behavioral health problems who will be eligible for coverage. The ACA will provide resources to expand prevention and address *harmful substance use* and early intervention for those at-risk for developing SUD.

Detoxification:

Detoxification is distinct from substance abuse treatment. Detoxification is a medical intervention that manages an individual safely through the process of acute withdrawal. Detoxification services²⁸ are an integral component of the SUD continuum of care, and the longitudinal availability of detoxification services is essential for responding to SUD as a chronic disease. There are currently 23 detoxification programs in the state of Minnesota, two of which do not provide services for publically-funded clients. In 2011, the number of admissions to a detoxification program was 30,662.

Each county in Minnesota is required by statute to provide detoxification services for drug dependent persons,²⁹ (the mandate permits utilization of existing services to meet this responsibility). The county of financial responsibility is the county where the client is physically present when the need for services is determined,³⁰ although an individual who receives detoxification services at a hospital-based detoxification program may be eligible for Medicaid-reimbursed services.

The American Society of Addiction Medication identifies five levels of care for detoxification services and sets universal standards for each. The intensity of the levels varies from minimally intensive services to hospital-based medically-managed intensive inpatient programs. Minnesota Rules permit the top two intensity levels of detoxification programs to be operated in Minnesota; both are inpatient, though only the highest intensity level is hospital based.

In response to identified gaps in the state's framework for detoxification services, as well as a shrinking availability of detoxification services across the state, ADAD currently facilitates a workgroup to look at expanding the state's capacity to provide detoxification services to ensure quality detoxification services are available to individuals at the right time, in the right amount, and at the right intensity. The work group is also identifying barriers to accessing existing detoxification services and will make recommendations for the seamless integration of detoxification services into the State's SUD continuum of care. Finally, the workgroup will examine and make recommendations as to the desirability and feasibility of expanding the intensity levels of detoxification services available in Minnesota. The workgroup consists of stakeholders statewide representing the state, tribes and counties; health plans; law enforcement; and detoxification service providers.

Multiple issues in the detoxification service delivery system have been identified by the workgroup, such as:

- There is a lack of availability of lower-intensity services for individuals who are in need of detoxification services, but for whom the existing levels are unnecessarily intense.
- Geographic obstacles exist in rural areas when an individual is identified as in need of detoxification services while physically located a prohibitive distance from the nearest detoxification facility. This can result in either excessive transportation obligations to law enforcement and other responding personnel, or the diversion of the individual to a

²⁸ The standards for the operation of detoxification programs are prescribed in Minnesota Rules 9530.6510-9530.6590 (Rule 32).

²⁹ Minnesota Statutes 254A.08, subdivision 1

³⁰ Minnesota Statutes 256G.06

nearby emergency department for ad hoc detoxification services, which provides for the safety of the detoxifying individual but is nonetheless often a fiscally irresponsible option if the individual is not in need of this level of care. This issue and the impact of this service gap has been recently exaggerated following a detoxification program closure in rural Minnesota. The workgroup will likely recommend a standard for the minimal distance permitted between the availability of detoxification services across the state.

- Limited service capacity in more densely populated areas is also a concern. In some highly populated areas, the need for detoxification services is greater than the services available and an overflow of need occurs on a daily basis. In some areas, individuals are systematically diverted to emergency departments on a daily basis, at a cost that is significantly more expensive than had the individuals been treated in a lower intensity detoxification program.
- Programs that provide detoxification services to individuals eligible for publically-funded services report challenges obtaining reimbursement for services provided. In addition, the statutory provision that assigns the county of financial responsibility for publically funded services has resulted in an uneven distribution of financial expenditures for detoxification services among counties across the state. The workgroup is evaluating whether this policy should be reconsidered.

Treatment:

Currently there are 348 programs in Minnesota that are licensed to provide SUD treatment services. Chemical dependency treatment facilities (Rule 31)³¹ are licensed and monitored by the Licensing Division of DHS. The Board of Behavioral Health and Therapy licenses and regulates alcohol and drug counselors (LADC). The SUD programs in Minnesota provide a continuum of effective research-based treatment services for individuals in need of SUD services. Treatment services include individual and group therapy in outpatient or residential settings. Outpatient treatment may include integrated or parallel co-occurring mental health services in the community, and/or medical services, medication-assisted therapies with/without adjunct behavioral services, and service coordination/case management.

Depending on client motivation and preference, and likelihood of clinical effectiveness, treatment providers utilize and combine various evidence-based practices, including twelve-step facilitation, cognitive behavioral therapies, dialectical behavioral therapy, motivational interviewing and motivational enhancement therapy. Depending on an individual's need, willingness and prescription coverage, addiction medications such as naltrexone, buprenorphine, topiramate, and methadone, may be recommended and incorporated into treatment services as an adjunct to behavioral treatment.

Individual clinical needs may indicate that room and board services be provided in tandem with outpatient services. Low, medium and high intensity residential treatment services are provided for individuals with advanced illness severity. Residential SUD treatment services may include integrated or parallel co-occurring services in the community, medical services, adjunct medication therapy, and service coordination/case management. Some outpatient and residential programs serving women also provide childcare and/or children's services.

³¹ Minnesota Rules 9530.6405 - 9530.6505.

Approximately 175 of the 348 licensed SUD programs in the state are licensed to provide integrated co-occurring services for persons who are diagnosed with both a SUD and a low, moderate, or managed severe co-occurring mental disorder. The majority of the remaining providers address client mental health needs via coordinated collaborative partnerships with mental health providers in their communities. ADAD and the Adult Mental Health and Children's Mental Health Divisions of DHS have begun the rule-making process for creating a certification for integrated dual disorders treatment (IDDT). This rule will help ensure that persons with SUD and severe mental illness receive the most effective and comprehensive care available. This will not replace the current SUD delivery system, but it will enhance and promote the expansion of effective and efficient evidence-based treatment services available in the state to meet the complex needs of persons with co-occurring disorders.

Treatment settings include free-standing for-profit and not-for-profit organizations, hospitals, tribal governments and state-operated treatment services. Some SUD treatment programs contract with county jails and adolescent correctional facilities to provide non-residential SUD treatment services onsite, and one rural treatment program provides outpatient addiction treatment in a nursing home facility. Currently there are a variety of population-specific programs serving females, males, Native American, African American, Hispanic, Deaf & Hard of Hearing, lesbian/gay/bisexual/transgender, Hmong, Somali and senior populations, and there are 17 licensed adolescent-specific residential service providers in Minnesota.

Recovery Support and Continuing Care:

Continuing care and peer recovery supports are an emerging service area in Minnesota's continuum of care but there is a significant gap in the continuum due to lack of availability of enough services to meet the current need. Continuing care and recovery support services involve additional case coordination and peer recovery support during treatment and at service termination, where treatment clients are connected to peers in recovery and provided continuing care through volunteer peer mentors, and connections with mutual-help support groups and other service providers in the community.

Continuing care and recovery support are important interventions for individuals with substance use disorder. Individuals with SUD are commonly experiencing problems in other areas of their lives as well, and treatment outcomes are improved if other related issues are addressed concurrently.³² For example, many individuals would benefit from continuing care/case management services and recovery support in the following areas:

- Medical health/mental health
- Employment
- Accessing connection and support in the recovery community
- Criminal justice matters
- Educational needs
- Housing concerns or homelessness
- Spiritual needs
- Financial issues

³² <http://www.ncbi.nlm.nih.gov/books/NBK64863/>

- Child care issues and other concerns related to children.
- Relationship challenges
- Transportation needs

Ongoing recovery support services can help an individual avoid a lapse, which can in turn prevent the need for detoxification or intensive treatment services. Conversely, some individuals leaving a detoxification or treatment program may benefit from case management and recovery support services. Individuals who complete a detoxification program commonly return to the community for a short period of time before entering treatment, or don't follow-up at all with treatment. Individuals in either group would benefit from peer support. Under the present continuum of care, this type of peer recovery service may not be available to these individuals.

It should be noted that recovery supports may include a wide range of practices that fall under the umbrella of harm reduction. Harm reduction policies and practice should follow from good evidence and thorough clinical assessment. Motivational interviewing, a specific counseling technique, can support change in small increments, over time. Other people may need to secure basic needs like safe housing and food before they can even contemplate other changes. Evidence suggests treatment needs to be individualized and grounded in the real life circumstances and situation of the person.

C. Strengths and Weaknesses of the Current System

Minnesota has a long and respected history of providing effective SUD treatment. Most Minnesotans who enter treatment complete it and show considerable improvement in substance use, employment, housing, criminal behavior, and participation in recovery support groups. Studies that follow Minnesotans after treatment show that abstinence from substance use and other benefits tend to persist.³³ For Minnesotans who completed their last episode of treatment in 2005, 84% remained out of treatment in the following year. It is important to emphasize though, that if the need arises, a return for treatment services is optimal since addiction is a chronic (not acute) medical illness, and the high percentage of individuals NOT re-entering treatment suggests that lives do improve after treatment.³⁴

Over 345 service providers located throughout Minnesota offer a continuum of individualized SUD treatment provided by licensed professionals. 49% of these facilities are private non-profit, 40% private for-profit, 2.5% are State facilities and 5.7% are Tribal. 37% utilize pharmacotherapies in the treatment process and 40% have specific groups for co-occurring disorders.³⁵ The majority of providers include family/significant others in the treatment process and offer coordinated, combined or integrated services for SUD and co-occurring mental disorders. Integrated Dual Diagnosis Treatment (IDDT) will expand the continuum of care in

³³ McRae, James A., 2012, *The Benefits of Treatment for Substance Use Disorders, Performance Measurement and Quality Improvement*, Minnesota DHS

³⁴ Rodgers, Alan G., *Addiction Treatment in Minnesota: Treatment Readmissions and Detox Admissions*, June 2009, Minnesota DHS.

³⁵ http://www.dasis.samhsa.gov/webt/state_data/MN11.pdf

Minnesota to meet the needs of individuals with severe mental illness and SUD. In addition, ADAD continues efforts to integrate with primary care physicians and increase access to, and awareness of, the effectiveness of medications as an adjunct to behavioral therapies for some individuals.

Since 1988, Minnesota's Consolidated Chemical Dependency Treatment Fund (CCDTF), a unique blend of federal, state and county dollars, has been the primary fee-for-service payment system for publically-funded SUD treatment for eligible individuals with no insurance or who are not covered by Medicaid or Medicare. ADAD manages the CCDTF and gathers performance and outcome data to continuously assess and improve policies that affect access, and the provision of effective cost-efficient treatment and recovery supports.

Minnesota is fortunate to have a robust network of no-cost non-professional community recovery supports (i.e. AA/NA, other cultural/population specific mutual recovery support groups, faith-based support groups, etc.) that are available statewide to provide recovery support pre, during and post-treatment. The importance of this infrastructure is a significant component in Minnesota's continuum of care. Among patients who started the year in recovery, the major predictor of whether they maintained abstinence was their level of self-help group participation. The odds ratio of relapse went down 0.55 for every 77 days of self-help group attendance.³⁶

Despite Minnesota rules and statutes governing SUD assessment and treatment access, barriers exist that prevent timely access to an assessment and ultimately prevent individuals from getting the "right SUD services at the right place and time". Some of these include:

- Locally-enacted policies that result in denied or delayed access to an assessment or appropriate treatment.
- Arbitrary client fees to receive an assessment.
- Failure to recognize client consent when exercised by minors.

Current state policies prevent reimbursing licensed treatment providers for the provision of Comprehensive Case Management³⁷ during the treatment process, a practice which is shown to improve SUD treatment outcomes for specific populations. In addition, Minnesota's current system does not provide flexibility to access or fund follow-up services, monitoring, check-ups or re-intervention services after initial treatment services end.

The Affordable Care Act (ACA) will provide one of the largest expansions of coverage for substance use and mental health disorders in a generation.³⁸ This expansion necessitates a need for Minnesota to assess workforce capacity and determine specific strategies to address all workforce needs while increasing diversity of the workforce to better reflect populations served.

³⁶ White, W., Boyle, M., & Loveland, D. (2003). *Addiction as Chronic Disease: From Rhetoric to Clinical Application*.

³⁷ <http://www.ncbi.nlm.nih.gov/books/NBK64863/>

³⁸ http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf

Access to services in Greater Minnesota are another priority and DHS needs to continue to explore how innovations in telemedicine, and electronic health record implementation could increase efficiencies in care and equitable access to the SUD service continuum statewide.

IV. Designing a Recovery-Based Model of Care for Substance Use Disorder

A. Characteristics of a Recovery-Oriented System of Care

To fulfill the legislative mandate for this report, which calls for a model of care for individuals who have already developed SUD, the remainder of this report will focus on the intervention, detoxification, treatment, and recovery service support components of the continuum of care. Education and prevention services will be discussed only as they affect individuals with SUD (e.g., education on treatment options or prevention of lapse). The focus is on the individual in the center of the recovery process and acknowledges that SUD is most effectively treated in a chronic disease model of care.

Implicit in several of the characteristics of recovery-based systems of care is the notion of a “continuum”. The term “continuum of care” is used to emphasize the importance of both a complete range of services (education, prevention, intervention, detoxification, treatment, recovery supports) and adequate transitional supports to aid people as they move from one type or level of service to another. This continuity is essential for a recovery oriented system of care. Integration among physical health, mental health, and SUD services is a key mechanism for achieving this continuity. DHS treatment outcomes monitoring system (1993-1999) study recommended that providing a continuum of care consistent with a chronic disease model, and integrating SUD treatment with mental health services and the criminal justice system would improve treatment outcomes and use resources most efficiently.

The education and prevention dimensions of the service continuum are focused on general populations; the other dimensions are focused on individuals who have been identified as being in need of SUD services. DHS collaborates with a wide range of agencies and stakeholders who are involved in education and prevention efforts. DHS considers education and prevention to be the cornerstones of a public health approach to delaying use and preventing abuse. Early intervention and research-based treatments for individuals with SUD promote recovery and maximize scarce treatment resources. Information about Minnesota’s prevention activities are summarized in the State Substance Abuse Strategy report.³⁹

Specialty SUD treatment programs in Minnesota currently provide a continuum of care that may include service coordination/case management, continuing care and on-going recovery support services. The effectiveness and efficiency of Minnesota’s current system could be improved by widening the continuum of care to include partnerships with primary care, healthcare homes, behavioral health homes, and added coordination with other community-based resources. Expansion of comprehensive case management services by treatment providers⁴⁰ during and post treatment, as well as monitoring and the provision of recovery supports such as peer mentoring

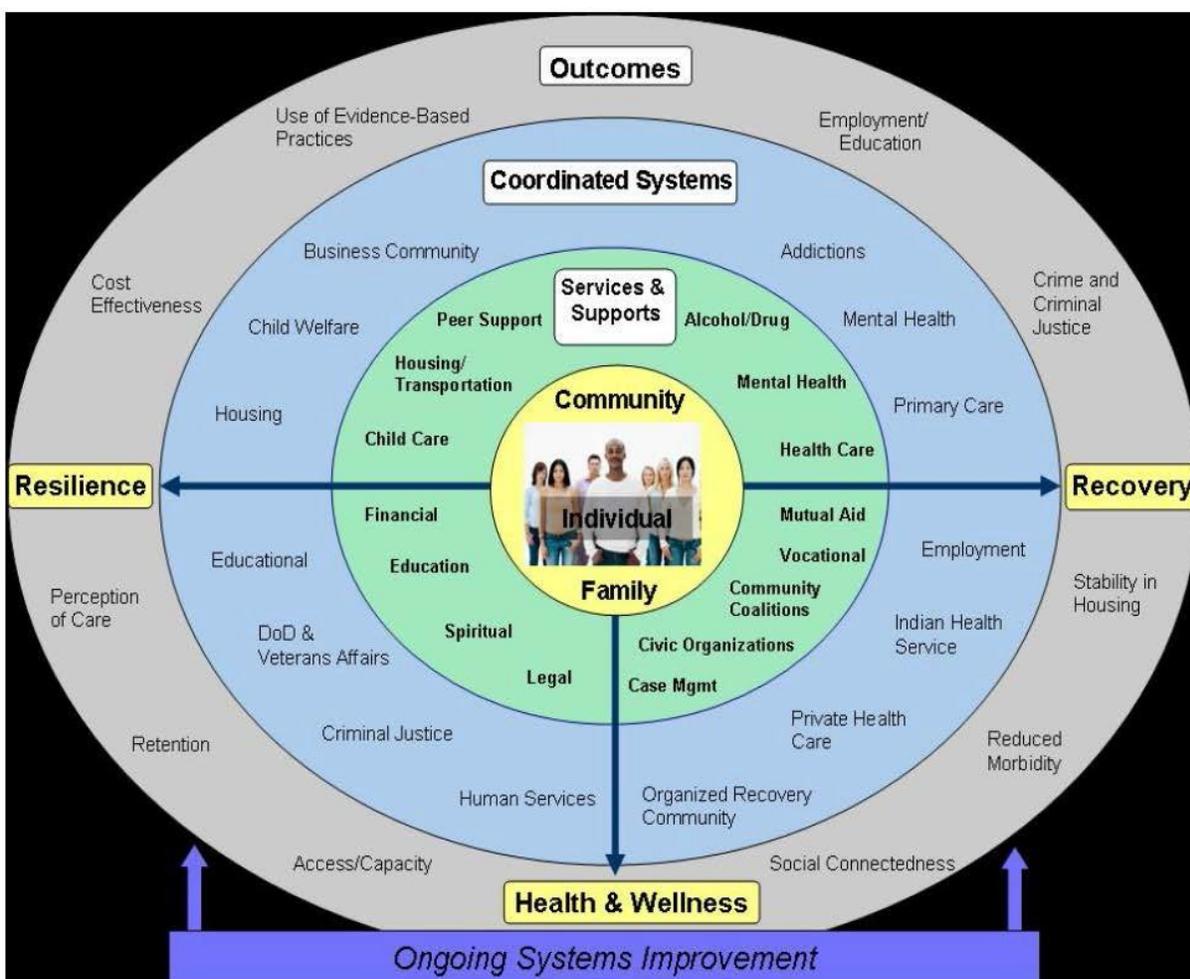
³⁹ Minnesota State Substance Abuse Strategy,” op. cit., pp. 26-28.

⁴⁰ These services are not currently reimbursable for Rule 31 providers.

and pre, during and post treatment coaching will improve engagement and retention and promote early reintervention to prevent or address a lapse and encourage resumption of recovery. The feasibility and effectiveness of telephonic recovery supports should also be explored.

Figure 1 is a SAMHSA diagram that shows the complexity of the continuum of care needed to promote recovery. It places the individual at the center of his or her family and community, and surrounds him or her with a complete range of services and supports that are provided by coordinated systems. The outcomes of a high-functioning continuum are shown in the outer circle. The figure highlights the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, etc. It recognizes that the system includes publicly and privately funded organizations and managed care components that must work well together to produce desired outcomes.

Figure 1: Conceptual Framework of a Recovery-Oriented System of Care



B. Priority Identification

The Minnesota State Substance Abuse Strategy report, released by DHS in 2012, provides an overview of substance abuse in Minnesota, the prevention and treatment services available, and the activities of Minnesota state agencies to promote recovery.⁴¹ The report emphasizes the importance of a continuum of services for people with SUDs and recommends a wide range of activities to reduce substance abuse in the future. The SUD Model of Care Steering Committee, taking up where the Substance Abuse Strategy left off, looked specifically at Minnesota's continuum of care for people with SUD. They emphasized the importance of retaining the Consolidated Chemical Dependency Treatment Fund (CCDTF) in the future, so that Minnesota does not lose the safety net that has been effective at providing access to SUD services for so many individuals, for so many years

However, the Steering Committee felt that there are many opportunities for significant improvement to Minnesota's system. They identified sixteen possible planning projects that they thought DHS should pursue with stakeholders in order to achieve a truly recovery-based continuum of care:

- **Access:** Identify and address barriers that prevent timely access to an assessment.
- **Assessment:** Identify ways to improve the assessment process to ensure individuals have access to appropriate levels of treatment, delivered in a timely manner and at a geographically feasible location.
- **Electronic Records:** Develop a plan to streamline the paperwork involved in CD treatment and assure providers in the state are positioned to comply with the 2014 Affordable Care Act (ACA) mandate to bill electronically.
- **Tele-health:** Explore new technologies to improve the availability, efficiency and effectiveness of intervention, treatment and recovery.
- **Workforce Issues:** Develop strategies to ensure a qualified, culturally-competent, and sustainable CD workforce in Minnesota to adequately meet the needs of all individuals with chemical dependency.
- **Continuing Care/Recovery Supports/Care Coordination:** Improve care coordination to promote recovery in accordance with a chronic disease model, and increase the availability and funding of long-term community recovery supports to minimize the need for repeated treatment.
- **Integration:** Achieve an integrated array of services across a range of providers and payers, including integration of physical and behavioral health, integration of mental illness and chemical dependency services and integration with other sectors, such as education and corrections.
- **Cultural Competency:** Integrate cultural sensitivity and capability into the infrastructure of the service continuum.
- **Disparities:** Address disparities in services and outcomes for discrete populations, including racial/ethnic, language, cultural, geographic and military groups.

⁴¹ Minnesota State Substance Abuse Strategy, Minnesota Department of Human Services.

- **Adolescents:** Ensure the continuum of care includes adequate services to effectively serve adolescents who abuse substances.
- **Detox:** Integrate detox into the rest of the CD continuum of care
- **SOS-CARE/Chemical Dependency Commitments:** Lay out an appropriate role for SOS-CARE in the state's continuum of care and identify a funding strategy to support that role. Review the chemical dependency commitment process and its ramifications, and recommend changes for improvement, if indicated.
- **Transportation:** Develop strategies to ensure transportation is not a barrier to accessing assessments, treatment or recovery supports, particularly in rural Minnesota, where transportation needs are more pronounced.
- **Outcome-Based Model of Care:** Articulate a plan for implementing a care system that has increased flexibility related to processes, while balancing the need for evidence-based practices and requiring greater accountability for demonstrated outcomes.
- **Funding:** Develop fair, robust, and sustainable payment mechanisms to fund services within the changing environment of health care reform. This includes consideration of changes to the Consolidated Chemical Dependency Treatment Fund (CCDTF).
- **Innovative Treatment:** Explore innovative treatment approaches to increase access, serve individual needs, improve outcomes and promote efficiency.

DHS agreed that all sixteen of these items present opportunities for improvement and requested the Steering Committee's help in prioritizing them in order to develop a phased plan for improving the continuum of care. After much discussion and re-combining of issues, the Steering Committee identified five projects that should be undertaken immediately by DHS to improve the continuum of care.

- Improve **access to treatment**, including the **assessment process** for SUD treatment
- Improve **care coordination** and **continuing care** for people with SUD
- Increase **diversity and capacity of SUD workforce**
- Support adoption of **electronic records** by SUD treatment providers
- Promote **telemedicine** as one SUD treatment and recovery support strategy

The Steering Committee also agreed to work with DHS to explore funding possibilities posed by the ACA to drive improvements related to system integration, outcomes-based decision making, and sustainable funding. The ACA put in place comprehensive health insurance reforms that will make health insurance available to many more people, will lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. The ACA includes substance use disorders as one of the ten elements of essential health benefits. This means that all health insurance sold on Health Insurance Exchanges or provided by Medicaid to certain newly eligible adults starting in 2014 must include services for substance use disorders.

Thomas McLellan, PhD, CEO of the Treatment Research Institute and former Deputy Director of the Obama Office of National Drug Control Policy, noted the following after the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act:

"The decision by the Supreme Court upholding the Constitutionality of the Affordable Care Act (ACA) is an extremely uplifting one for the substance abuse field. The debates and research around the ACA produced two facts that were startling to all involved.

First, unaddressed substance use now costs mainstream healthcare upwards of \$100 billion annually, particularly in areas such as ER and trauma care, but also in the treatment of virtually every chronic illness. Because of the severity and complexity of their conditions, the 23 million "addicted" Americans are disproportionately costly - but it is the 40 - 45 million Americans with lower severity but still significant "harmful substance use disorders" who comprise the largest burden of illness and cost to healthcare.

The second realization produced in the ACA debates is that while there is provision to treat "addiction" in specialty care programs (though clearly more coverage is needed) there had never been healthcare benefits or reimbursement options for those with "harmful substance use."

Thus, one of the historic aspects of ACA is the requirement that care services for the full range of substance use disorders be part of the "essential benefit design" in all health plans.

By including these benefits in health insurance packages, more health care providers can offer and be reimbursed for these services, resulting in more individuals having access to treatment. The specific substance abuse services that will be covered are currently being determined by the Department of Health and Human Services, and will take into account evidence on what services allow individuals to get the treatment they need and help them recover.⁴²

The following Chapters describe the proposed SUD Model of Care that includes additions and improvements to the State's SUD continuum of Care.

V. An Improved Continuum of Care

DHS will undertake efforts to make the system ready for healthcare reform and more efficiently address the identified gaps in the current system (the assessment/access process, workforce, continuing care/recovery supports, electronic records, and telehealth).

A. Transform the system to a chronic model of care and expand the services available in the continuum.

1. The benefits of transforming the system and expanding services.

There is an immediate need to update Minnesota's treatment system from an acute, episodic model of treatment, to a chronic, longitudinal model of health care, and to expand the State's continuum of care to include improved integration and coordination with primary care, health homes, behavioral health homes, mental health services, peer recovery, and other support

⁴² <http://www.whitehouse.gov/ondcp/healthcare>

systems in the community. These changes will align Minnesota's model of care with the current best practices identified in SAMHSA's Recovery-Oriented System of Care and also prepare the State to capitalize on opportunities brought forward by the ACA.

Maintaining a continuum of care that includes the essential elements of a recovery-oriented system of care will result in earlier intervention and reintervention for the individual and family when necessary, quicker access to the appropriate level and intensity of research-supported treatment services, and access to follow-up care to sustain behavioral changes that support long-term recovery.

To advance the continuum's evolution to a chronic model of care and expand the nature of services available in the continuum, it will be necessary for the State to conduct an analysis of the existing payment structure for publically funded treatment services, and then identify changes in the current funding framework that are necessary to affect the proposed shift and expansion of services.

There is promising evidence that expanding access to SUD treatment saves money. A study of Washington State's Medicaid program⁴³ found that the provision of SUD treatment was associated with an annual reduction of medical expenses of approximately \$2,500, which was about the cost of the treatment provided. Other studies have also shown that medical expenses decrease after SUD treatment, with both Medicaid and non-Medicaid patients showing a 30% reduction in total medical costs between the year prior to treatment intake and three years following treatment initiation. Data like these provide the basis for a financial argument that Minnesota could save state costs in the long run by moving SUD services into Medicaid. Current incentives (for example, the 100% match for benefits for childless adults that decreases gradually to 90%) in the ACA provide the opportunity to make these changes now. Increased federal participation in funding SUD services decreases the state's costs. Amending the State's Medicaid Plan has the potential to expand the nature of SUD services available in Minnesota's continuum of care.

Currently, all SUD services provided in the state must be provided by a Rule 31 program (with some exceptions,)⁴⁴ and reimbursements must be paid directly to the program. Subject to the same exceptions, individual professionals and non-Rule 31 programs are prohibited from providing⁴⁵ and billing the CCDTF for the provision of chemical dependency treatment services to an individual who has a substance use disorder. Due to the existing limitations, changes to Rule 31 will likely be required if the current funding structure is modified.

Changes to Rule 31 and the statutes applicable to the occupational regulation of LADCs⁴⁶ would permit individual, appropriately-credentialed providers to bill directly for the provision of a drug

⁴³ 2012 Wickizerweb b, Mancuso, Huber, *Evaluation of an Innovative Medicaid Health Policy Initiative to Expand Substance Abuse Treatment in Washington State*. <http://www.ncbi.nlm.nih.gov/pubmed/22618867>

⁴⁴ Minnesota Rules 9530.6410, subparts 1 and 2. Certain activities and certain hospitals are excluded from the license requirement.

⁴⁵ Minnesota Rules 9530.6410, subpart 1.

⁴⁶ Minnesota Statutes Chapter 148F

and alcohol counseling services and would permit these services to be provided at a site other than within a Rule 31 program. This would permit the provision of drug and alcohol services to be integrated into mental and medical health. Individuals could access SUD services at a variety of sites when accessing services for primary health care needs, such as at a primary care clinic, medical or behavioral health home, pain clinic or mental health facility. This change could also result in increased service accessibility for individuals living in rural communities that do not have a Rule 31 program in the community, and services could be provided in an individual's home.

The following SUD services are presently available to individuals whose treatment is publically-funded through Medicaid (via the States Prepaid Health Plans or general assistance medical care or the CCDTF):

- Outpatient treatment services.
- Medication-assisted therapy services.
- The clinical services portion⁴⁷ residential treatment programs.
- Hospital-based treatment services.

In addition, detoxification services are publically-paid with reimbursement provided by the county within which an individual is physically present when the need for detoxification services is identified.

DHS envisions the development of a recovery-oriented system of care that provides a full range of high quality services to provide effective treatment and support services, while promoting the integration of primary care and behavioral health and provide support and linkage for individuals who present housing, employment and other ancillary needs.

For example, a key component of New York State's recent overall effort to reform Medicaid reimbursement in the state included the implementation of Ambulatory [outpatient] Patient Groups for behavioral health services. For the addiction field, the implementation of Ambulatory Patient Groups is an integral part of the move towards an outpatient *system* of care. Ambulatory Patient Groups support a range of medically necessary clinic services for patients based on the evidence of what works to promote recovery from SUD.

Following the example of state's like New York and others that have implemented Ambulatory Patient Groups for behavioral health services, consideration of the following as possible Medicaid state plan services in Minnesota could be explored as part of a transformation work group:

- Prevention and wellness services.
- Screening and early intervention.
- Standardized screening and assessment.
- Engagement services.

⁴⁷ Under Medicaid regulations, the room and board portion of residential SUD programs are not a reimbursable expense unless provided at a hospital-based program. The CCDTF pays the room and board portion of residential SUD treatment for individuals on Medicaid.

- Collateral visits in support of treatment or admission of a client.
- Medication administration and observation
- Medication management routine/complex
- Comprehensive case management (including during a treatment episode) and continuing care services.
- Intensive support services.
- Peer support services.
- Clinical drug testing for client monitoring in SUD treatment programs.
- Expanded level of detoxification services.
- Tele-health services.
- Health Homes.

2. Steps for transforming the system to a chronic disease model of care and expanding the available services in the continuum.

The evolving implementation of health care reform promises to provide Minnesota the ability to capitalize on the strengths of the current treatment system, while simultaneously presenting the State an immense opportunity to efficiently and effectively address priority areas and move Minnesota's treatment system from an acute, episodic model of treatment, to a chronic, longitudinal model of health care. This will significantly improve the continuum of care through integration and coordination with primary care, health homes, behavioral health homes, mental health services, and other recovery support systems in the community. These changes would align Minnesota's model of care with research-informed practices set-out by SAMHSA, described as a *Recovery-Oriented System of Care (ROSC)*, and facilitate earlier intervention and re-intervention for individuals and families, quicker access to the appropriate levels and intensity of research-supported treatment services, access to Comprehensive Case management Services⁴⁸ when indicated, access to peer support/recovery coaches, follow-up services, 'recovery check-ups', and other recovery management strategies shown to significantly improve outcomes.

With statewide stakeholder collaboration, DHS will continue to analyze pertinent demographic, treatment, policy, and financial data to estimate needs, forecast program costs, and lay out workforce and licensing requirements to expand Minnesota's service continuum for individuals with substance use and mental health disorders. DHS will begin to address the identified gaps in the continuum of care with a focus on the priority areas of Assessment & Access; Continuing Care & Recovery Supports; Diversity & Capacity of Workforce; Electronic Health Records and Telemedicine.

B. Improving Access by Redesigning the Assessment Process

Entry into publically-funded treatment in Minnesota is now determined by the County, Tribe or Prepaid Health Plan (i.e. Placing Authority), which is required to provide a timely assessment, determine the level, intensity and duration of treatment service based on assessment, and then authorize treatment at a specific location.

⁴⁸<http://www.ncbi.nlm.nih.gov/books/NBK64863/>

The Steering Committee identified the need to improve access by redesigning the assessment process to be the most pressing opportunity for improving the SUD continuum of care. Timely access to a thorough assessment for the “right services at the right place and time” is vital because the window of opportunity—the urgency and motivation to seek treatment—frequently subsides, and failure to facilitate a quick and accurate assessment can literally mean the difference between life and death. Currently wait-times for an assessment and for authorization to access SUD treatment is a significant deterrent to individuals seeking help.

1. The current assessment process.

Significant complications exist with the current assessment process that are exacerbated by occasional local jurisdictional enactment of pre-determined blanket cost-containment policies that prevent timely access to assessment, treatment, and restrict the number of hours, days, types and modalities of research supported services appropriate to the severity of illness. Funding mandates for treatment have influenced placement decisions in some areas and this has resulted in inconsistent placement decisions across the state. The current process has created barriers that impede access to appropriate services and can result in significant harm to individuals seeking treatment, their families and communities. The 2012 Substance Abuse and Mental Health Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) review of Minnesota’s current Placing Authority assessment and placement practices highlighted these issues and described it as a potential ‘bottleneck’ for timely access to SUD treatment.

In 2007, in response to the February 2006 Office of the Legislative Auditor report⁴⁹ on Substance Abuse Treatment Key Recommendation that “**DHS should strengthen its oversight of local assessment and referral practices**”, DHS and statewide community stake-holders developed, tested, trained-on, implemented, reviewed and improved the Rule 25 Assessment⁵⁰ instrument and accompanying Rule 25 Risk Descriptions Guide (MN Matrix).⁵¹

The assessment process⁵² and format *prescribed by the commissioner*,⁵³ establishes use of the Rule 25 Assessment for counties, tribes, prepaid health plans. In addition, all health plan companies must use the prescribed assessment criteria⁵⁴ when assessing and placing enrollees for chemical dependency treatment.”⁵⁵

The placing authority must provide a Rule 25 assessment within 20 days of an individual’s request.⁵⁶ Within 10 days of completing the assessment interview, the placing authority must complete the assessment, make determinations, and authorize services.⁵⁷

The rules applicable to Rule 25 Assessments require that individuals previously assessed and treated need to be re-assessed, re-admitted and discharged each time they need to access a SUD

⁴⁹ *Substance Abuse Treatment*, February 2006. Evaluation Report, Office of the Legislative Auditor.

⁵⁰ http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=135230

⁵¹ Id.

⁵² <https://www.revisor.mn.gov/rules/?id=9530.6615>

⁵³ <https://www.revisor.mn.gov/rules/?id=9530.6600>

⁵⁴ [https://www.revisor.leg.state.mn.us/statutes/?id=9530.6600 to 9530.6660](https://www.revisor.leg.state.mn.us/statutes/?id=9530.6600%20to%209530.6660)

⁵⁵ <https://www.revisor.leg.state.mn.us/statutes/?id=62Q.1055>

⁵⁶ Minnesota Rules 9530.6615, subpart 1(A)

⁵⁷ Minnesota Rules 9530.6615, subpart 1(B)

service. The current process prohibits treating SUD in a chronic illness model of care, impedes the provision of follow-up care, ‘recovery maintenance check-ups,’ brief interventions and re-treats. Changing this process could provide individuals easy access to the service(s) they need *before* a lapse occurs, or earlier in a lapse episode if one occurs.

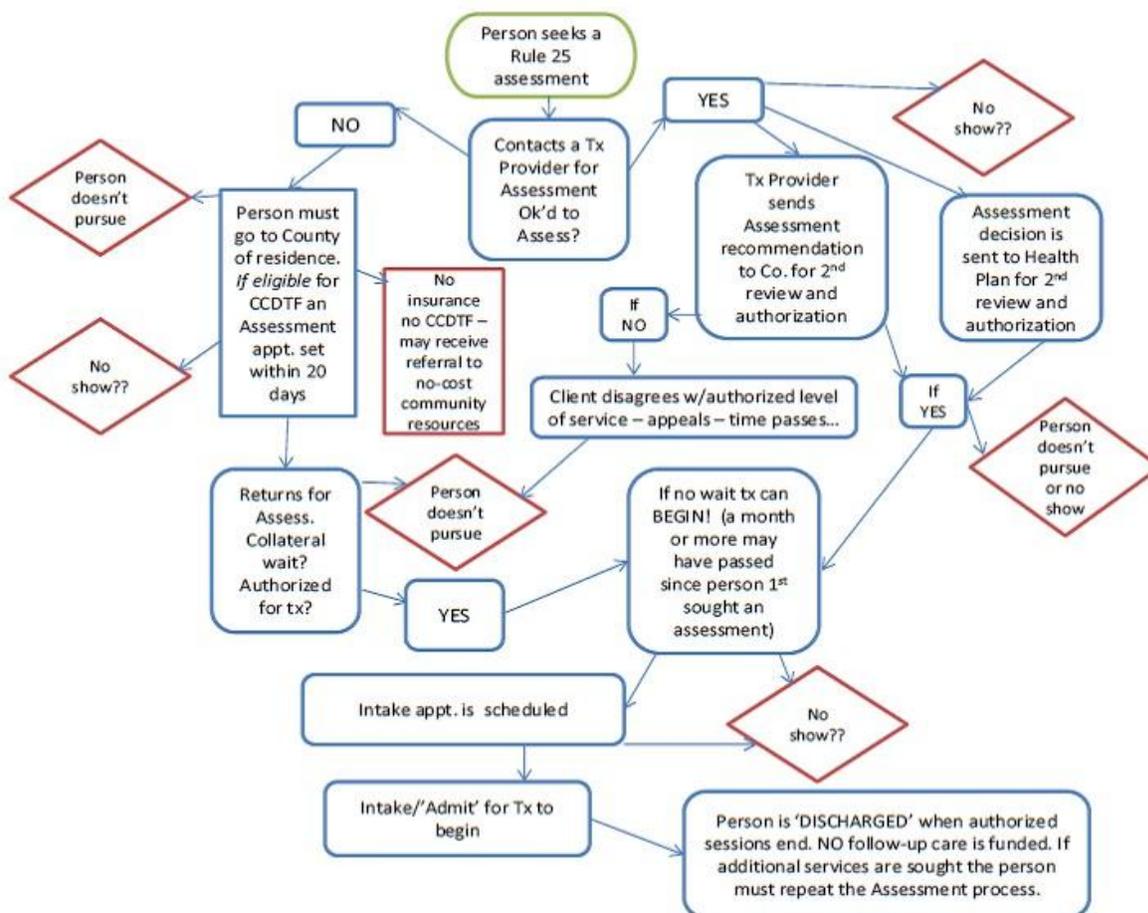
Current qualifications for ‘staff performing assessment’ are outlined in Minnesota Rule 9530.6615, subpart. 2. Some individuals completing Rule 25 assessments are credentialed as Licensed Alcohol and Drug Counselors; however, current rules permit individuals with specified related scopes of practice and (unlicensed) social workers employed by city, county, or state agencies to complete Rule 25 Assessments following the completion of a 30 hours course on assessments, and provided the individual has 2,000 hours qualified work experience in completing assessments or provides assessments under supervision. This has resulted in a varying degree of competence seen in individuals who complete Rule 25 Assessments.

Despite rules, statues and previous efforts to improve the assessment process for publically-funded SUD treatment services, the Assessment/Access Workgroup cited barriers that continue and impede access to SUD services in Minnesota. Listed below are some of the barriers identified during the Assessment Workgroup process that prevent individuals from getting the “right SUD services at the right place and time:”

- A common barrier experienced statewide is that individuals cannot access a Rule 25 Assessment without obtaining prior authorization from a placing authority. Individuals who contact a treatment provider directly and request a Rule 25 Assessment must be re-routed to contact their county, tribe or health plan for approval to get an assessment, who then often re-routes them back to a provider for the actual completion of the assessment. This can cause a delay, which can then result in lack of follow-through by the individual and a missed opportunity for assessment, possible treatment and recovery. Moreover, following the completion of the assessment, the placement authority is required to review the assessor’s diagnosis and service recommendation prior to approval and placement. This can result in more delays, change of assessor recommendations, appeals, etc., any of which can result in lack of follow-through by the individual – and a missed opportunity for treatment and recovery.
- Also important to note is the local practice in some areas of various agencies and entities using different assessment instruments, e.g., Rule 25 Assessment, MN Universal, and DUI/Court/Probation/Tribal assessments. This can result in confusion, duplication of assessments, health disparities, and inequity of access to care due to varying outcomes.
- Finally, although not widespread, the Assessment/Access Workgroup cited the recent enactment of local policies by some placing authorities that are in non-compliance with the applicable Rules, and the result of which are impermissible delay or denial of an individual’s access to a Rule 25 Assessment and treatment services.

Figure 2 helps illustrate several barriers that prevent timely access to an assessment and prevent individuals from getting the right SUD services at the right place and time:

Figure 2:



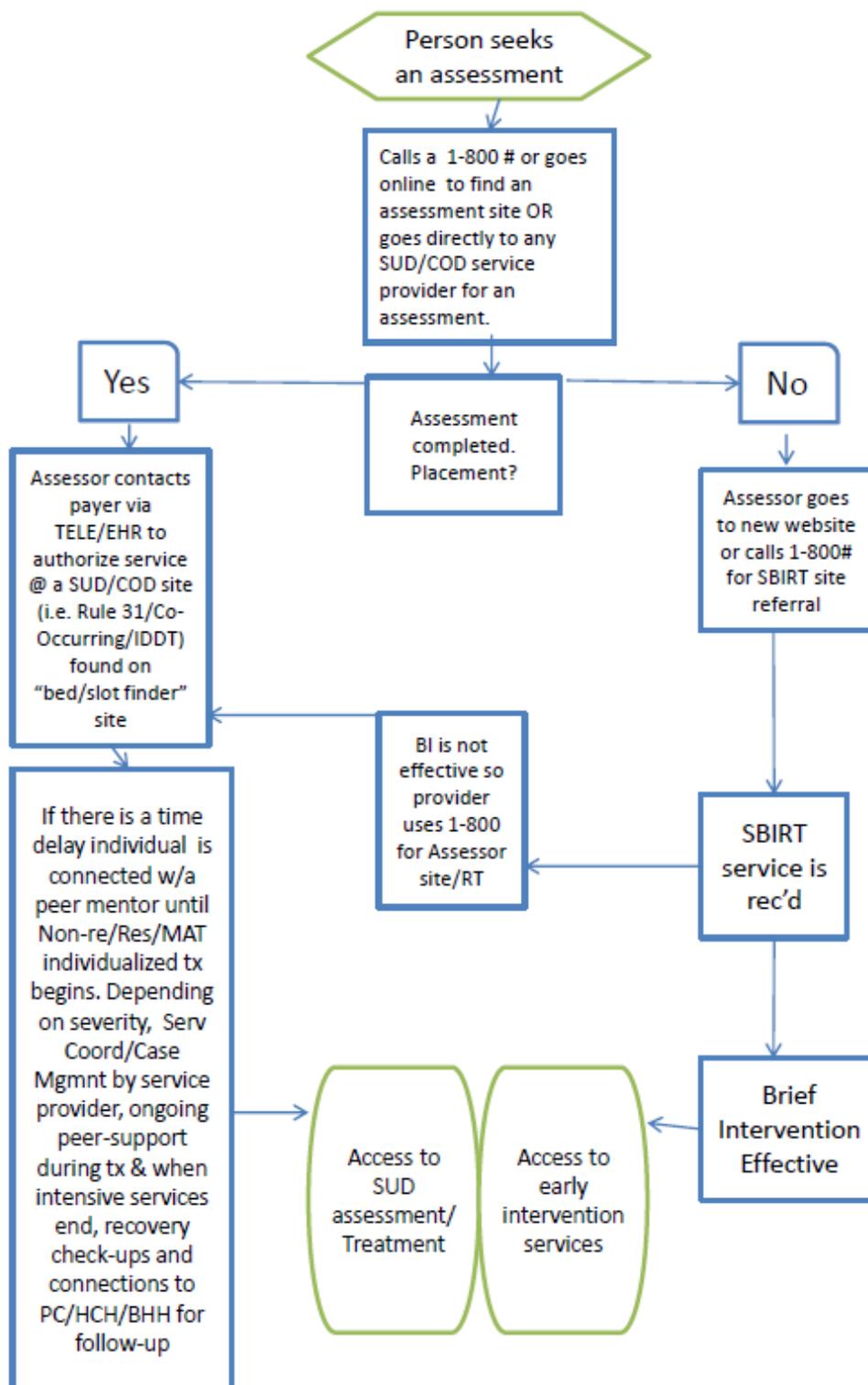
2. A new process for accessing SUD services.

Based on the analysis of the Access/Assessment Workgroup, DHS has identified a need to gather statewide stakeholder input (i.e. Placing Authorities, Department of Corrections, Department of Public Safety, Department of Health, etc.) to develop and support a more efficient system to:

- Identify a statewide uniform assessment instrument.
- Improve assessor qualification and expand assessor capacity to Rule 31/Rule 29, IDDT sites, Behavioral Health Homes/Healthcare Homes, Primary Care Clinics, Hospitals, Detox, EDs, mobile/in-home, etc.
- Allow electronic communication between assessors and payers to streamline the authorization for service.
- Create an infrastructure to reimburse qualified assessors for the assessment service and permit eligibility to confirm and arrange reimbursement for publically-funded treatment services, regardless of whether the payer is Medicaid, CCDTF, etc.
- Have DHS initiate assessor performance measures to support effective/efficient practices.
- Have DHS institute a process to monitor assessment quality and integrity of placement process.
- Integrate SUD treatment placement with other statewide resources (e.g., 211, SAMHSA treatment locator, Minnesota Hospital Association ‘bed finder’ etc.) to improve timely statewide access to the right service at the right place and time.

The result of these steps would be a streamlined access process that eliminates many of the delays and disincentives that currently present roadblocks to SUD treatment. Figure 3 illustrates the simpler revised process.

Figure 3.



C. Increasing the Diversity and Capacity of Minnesota's SUD Workforce

Healthy People 2010 maintains that “increasing the number of minority health professionals is... a partial solution to improving access to care” (DHH, 2000). Paraphrasing one of the key conclusions of the IOM report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* (2004), IOM member stated, “Part of a comprehensive strategy to reduce health disparities is to increase diversity in the health care professions, which will lead to improved access to care, greater patient satisfaction and reduced cultural and linguistic barriers” (Levin, 2004).

One of DHS's highest priorities is to reduce disparities in healthcare access and outcomes based on demographic, cultural, or geographic background. There is ample evidence that a key determinant of treatment success is the quality of the relationship between the person receiving treatment and his or her providers, and that cultural background is an important dimension of this relationship.

The number of licensed Alcohol and Drug Counselors (LADCs) in Minnesota is inadequate to serve *current* needs, with need even more pronounced in Greater Minnesota. (*Sources: Annual statewide Federal Block Grant Independent Peer Review reporting and U.S. Dept. of Health and Human Services Substance Abuse and Mental Health Services Administration Report to Congress http://pfr.samhsa.gov/docs/report_to_congress.pdf*)

It is logical to assume that there will be an even greater need after 2014, when more individuals are insured and substance use disorder (SUD) treatment in part of the ACA's Essential Health Benefits. Healthcare reform will be a driver of future workforce changes in Minnesota, as treatment providers will increasingly rely on partnerships with and payments from insurers.

1. Minnesota's existing SUD workforce.

Workforce knowledge, ability and skill affect client outcomes. Research has found counselor empathy and skill in building a therapeutic relationship with each client is paramount to client change. Building and sustaining a dedicated and skilled SUD treatment workforce in Minnesota, a workforce capable of delivering the most effective treatment services with sensitivity and ability, aligns with the ADAD's mission “to develop and maintain an effective chemical health service system in Minnesota that encourages and supports research-informed practices, expands the use of successful models, and systematically monitors outcomes.”

The 2006 DHS Chemical Health Division/Metro State University Workforce Survey reported the following workforce (Licensed Alcohol and Drug Counselor – LADC) characteristics:

Gender	Percentage
Male	65%
Female	35

Age range	Percentage
20-29	11%
30-39	14
40-49	27
50-59	34
60 and older	15

Education Level	Percentage
Some college/no degree	8%
Chemical Dependency Counseling Certificate/no degree	10
Associate degree	19
Bachelor degree	38
Master's or doctoral level degree	23

LADC's Holding Additional Licensure	Percentage
Nursing	14%
Social Work	8
Psychology	1.7
Other	13.2

The racial makeup of the LADCs in the survey:

Race	Percentage
Caucasian	86%
American Indian	7
African American	5
Latino-Hispanic	1.8
Asian American	1.5

Although the LADC survey was completed in 2006, a comparison with the race/ethnicity of individuals treated for SUD in Minnesota in 2011 (table below) suggests that further study of racial demographics of LADCs is necessary to measure the extent to which the LADC workforce reflects the demographics of the general population in Minnesota and to what extent the workforce resembles the demographics of individuals who access treatment services.

Race of Individuals Treated in 2011	Percentage
Caucasian	73.9%
American Indian	8.3
African American	10.3
Latino-Hispanic	3.8
Asian American	1.1

The majority of individuals in treatment identify as Caucasian. However, the numbers of American Indians and African Americans in treatment are disproportionate to their representation in the general population, and American Indians and African Americans have the highest proportion of SUD treatment readmissions, and Hispanics the lowest (MS 1710-ENG 11/03). To improve treatment outcomes for all populations, one of the Department's priorities is to implement effective strategies to increase SUD workforce diversity to more accurately resemble the populations served.

2. Increasing diversity and capacity of the SUD workforce

The Workforce/Licensing workgroup focused on workforce development and the licensing of addiction counselors in the state and made the following recommendations that align with the strategic direction of moving SUD treatment into Medicare:

- In collaboration with essential boards, associations and licensing agencies (Minnesota Certification Board, Social Work, Nursing, Board Behavioral Health and Therapy (BBHT), Department of Employment and Economic Development, Minnesota Association of Resources for Recovery and Chemical Health (MARRCH), the workgroup recommended that DHS examine disparities in education and the potential to revise licensing requirements to include tiered licensing options.
- In collaboration with stakeholders [treatment providers, Minnesota Certification Board, consumers, Minnesota Coalition of Addiction Studies Education (MN CASE)], increase cultural competence through education and training.
- In collaboration, DHS, other state agencies and stakeholders, improve longitudinal data collection regarding demographics (cultural/ethnicity) of clinical workforce, client population, outcome measures [BBHT, Drug and Alcohol Abuse Normative Evaluation System (DAANES), MARRCH, Minnesota Association of Treatment Directors (MATD)].

- Coordinate efforts with BBHT regarding current legislation to examine a tiered workforce system capable of providing the entire continuum of effective efficient SUD treatment and recovery support services.

3. Steps to increasing the diversity and capacity of the SUD workforce.

There is a presently a lack of data available related to the current SUD workforce capacity in Minnesota and projected future needs. However, anecdotal information indicates the existing number of individuals licensed to provide alcohol and drug counseling services is insufficient to meet the current needs in the state. Moreover, it is predicted that health care reform will result in an increased number of individuals having access to SUD services. Without an increase in the current capacity of the SUD workforce, the expected future increase to access will expand the disparity between the number of individuals in need of services and the number of providers available in the workforce to provide SUD services.

ADAD will work with the BBHT to obtain baseline data as to current capacity, identify the extent to which the demand for services exceeds capacity, develop a projected outlook as to future needs, and identify and implement strategies to obtain and maintain a competent SUD workforce in the future.

ADAD will utilize national resources such as the SAMHSA/Annapolis Coalition *Action Plan for Behavioral health Workforce Development*⁵⁸ and *Workforce Developments* by the ATTC Regional Centers⁵⁹ that outline strategies to address **recruitment, training, development and retention** of the SUD workforce. DHS plans to identify possible Federal, State and community funding resources and partners to collaborate on workforce training and tuition reimbursement, including:

- Affordable Care Act H.R. 3590-508 **Section 756 Mental and Behavioral Health Education and Training Grants** “(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships in...substance abuse prevention and treatment...”
- American Health Education Committee (AHEC) University of Minnesota⁶⁰

⁵⁸ *An Action Plan for Behavioral Health Workforce Development*, 2007. SAMHSA

⁵⁹ <http://www.attcnetwork.org/explore/priorityareas/wfd/overview/surveys.asp>

⁶⁰ <http://www.nationalahec.org/Publications/documents/NRHA%20Brochure%20-%20Jun%202006.pdf>

D. Ensuring Availability and Access to Continuing Care and Recovery Supports

1. The challenge and importance of continuing care and recovery supports.

Individuals with SUD often enter treatment with numerous problems in addition to addiction. Individuals may have co-occurring medical or mental health needs, may be unemployed or be in the midst of problems with their employment. They may be homeless or have other housing issues, and some may have pending criminal matters or past criminal matters that have collateral consequences that impede employment and housing efforts. Many individuals with SUD have experienced damaged relationships with family members and friends, and some individuals may be leaving a violent relationship or need ongoing trauma services and support. Individuals who enter treatment with significant active problems in their life may begin addressing the problems while in treatment, but likely they will find these same problems waiting for them, to some degree, following completion of treatment.

Because addiction affects so many facets of a person's life, a comprehensive continuum of services promotes recovery and enables the individual with SUD to fully integrate into society following treatment. The continuum must have services that support and encourage engagement and motivation, ensure the availability of primary treatment services at the appropriate intensity and level, and include support services that will enable the individual to maintain long-term sobriety while living in the community.

2. Recommendations

Recovery support and continuing care services have been shown to increase treatment engagement and completion, while helping minimize the occurrence or duration of lapses of illness. Individuals with SUD are likely to have better treatment outcomes if other problems in their lives are addressed concurrently with their addiction. Comprehensive Case Management by treatment providers, flexible/periodic professional services as follow-up to primary treatment, face-to-face and telephonic peer recovery support/coaching services that *are now not* currently reimbursed through the CCDTF, would expand Minnesota's service continuum.

The current funding structure for SUD programs does not permit reimbursement for these types of recovery support and continuing care services, nor does it permit a step-down in service intensity absent a client's *discharge* from the current service level, which then necessitates another *admission* to access a new level of care. Rule 31 *requires* service termination⁶¹ and completion of a discharge summary⁶² at the conclusion of each "episode" of treatment. This episodic model of care for a chronic illness is not an effective or efficient process. The inability of individuals with SUD to return for follow-up care or periodic professional services is particularly apparent when contrasted with the management of other chronic health conditions.

Since 2009, ADAD has funded recovery support services through two grant awards. The Minnesota Recovery Connection and the Southern Minnesota Recovery Connection are the operational grant-funded programs. Due to their success and the demand for peer coaching

⁶¹ Minnesota Rules 9530.6465, subpart 3

⁶² Minnesota Rules 9530.6425, subpart 4

services, ADAD has recently funded similar work through grants with the White Earth Reservation, Rainbow Health (LGBT), and Recovery Resource Center. The Minnesota Recovery Connection and the Southern Minnesota Recovery Connection coordinate peer training and access for telephonic peer support and recovery coaches in the metro and southern Minnesota areas. The demand for these effective services far exceeds the availability.

The inclusion of continuing care and recovery supports to Minnesota's current SUD continuum of care could be accomplished by a structure that includes ongoing funding of this level and type of service. In addition, the availability of these services could be increased by widening the SUD continuum of care to include partnerships with primary care providers, healthcare homes, behavioral health homes; added coordination with other community-based providers of resources; and expansion of case management services by treatment providers during and following treatment.

It is recommended that Minnesota identify potential funding streams to ensure the longitudinal availability of continuing care and recovery support services in Minnesota. Some examples of other states that have begun funding peer support services for substance abuse clients include Florida, Kansas, Missouri, New Mexico, New York, Oregon, Pennsylvania, South Carolina and Wyoming. Some states maintain the services in their care continuum as a Medicaid reimbursable services, others reimburse through block grant funds or State general funds. Developing and maintaining a funding structure in Minnesota that permits reimbursement for peer recovery support and flexible continuing care services will ensure that this needed support is an embedded component of the State's SUD continuum of care.

E. Use of Electronic Records by SUD Treatment Providers

1. The challenge and importance of electronic records.

Electronic Health Records are an integral component to the delivery of health care services. Some larger SUD treatment providers have invested in, and benefit from, the adoption of electronic record technology. However, many smaller SUD treatment providers lack access to, and therefore the benefits of, this technology. The implementation of electronic health records for all chemical dependency treatment providers is expected to result in improved information management, increased administrative efficiency, and an improved treatment experience for the client.

2. Recommendations.

Many organizations within Minnesota have invested heavily in recent years in the development, testing and implementation of several electronic health record systems; other substance use disorder treatment programs have only recently begun efforts to implement systems in compliance with the pending requirements. The market for behavioral-health electronic records systems is developed and diverse, and offers a wide range of choices at a variety of price points to existing substance abuse programs.

3. Steps to assuring the use of electronic records by SUD treatment providers.

In Minnesota, laws were passed in 2007 and 2008 to address the federal mandate. The new law states that “all hospitals and health care providers” must have in place by January 1, 2015, an “interoperable electronic health records system,” and gives a process outlined in the “Statewide Plan for Interoperable EHRs” that is very detailed. In addition, it is speculated that in the future some payers may require service providers they contract with to not only submit claims electronically, but are in compliance with the rest of the laws.

The Alcohol and Drug Abuse Division will conduct a survey of Rule 31 providers across the state to determine the collective status of the effort to transform to electronic record management systems. Based on the survey findings, DHS will identify what action is required to ensure a timely and functional completion of the transformation process.

F. Promoting the Use of Telemedicine to Improve Access and Services

1. Opportunities posed by telemedicine.

Telemedicine or telehealth, is the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health care education, public health and health administration. Telehealth utilizes telephones, computers, the internet and interactive video to provide healthcare services for clients.

SUD service providers in rural areas identify the challenge of finding and attracting qualified clinical staff for the provision of SUD services in rural areas. Geographical distance to existing SUD service providers can also be a barrier for individuals living in certain areas of greater Minnesota. In addition, since culturally/population specific services are not located in many areas of the state, individuals who otherwise would not have access to culturally/population specific services could access such programming with telehealth.

Proponents of telehealth promote the use telecommunication to provide counseling and therapy services to address a variety of individual, familial, and social issues. Telehealth has the potential to include screening, assessment, primary treatment and aftercare; to provide more accessible modes of treatment than the traditional ones to those who actively use the recent development of technology; help people access treatment services who traditionally would not seek services because of barriers related to geography, shame and guilt, stigma, or other issues; and be provided as a sole treatment modality, or in combination with other treatment modalities, like traditional or existing treatments.

Even so, while the *potential* of telehealth to provide quality services has been examined extensively, there is little research findings to determine its effectiveness, especially for substance abuse intervention and treatment. It will be important to weigh the benefits of increased access with the cost of the non-verbal elements of communication that are lost when telecommunication methods do not include visual components, or when the visual components of a telecommunication encounter do not effectively transmit the non-verbal cues that could be noted during an in-person interaction.

2. Integration of Telemedicine in Minnesota's SUD provider community

As the use of telehealth for the provision of SUD services continues to evolve in areas around the country, it will have value for Minnesota to explore telecommunication-based service delivery in the future to determine what options the technology might provide to address geographical and other barriers to SUD treatment.

3. Steps to promote telemedicine.

If telehealth services are to be integrated into Minnesota's SUD continuum of care, changes in state and federal law will be required. Current laws do not permit reimbursement for the provision of substance abuse treatment services delivered electronically by licensed alcohol and drug counselors (LADCs).

VI. A Pilot Project

DHS proposes a pilot project that will implement several of the recommendations proposed in this report. This will provide the opportunity to assess the efficacy and efficiency of the measures.

It is recommended that ADAD team with three counties in the State (representing the northern, central and southern regions) to test an assessment and access process that will permit clients to present at the service provider of their choice for a clinical SUD assessment and service recommendations. This process is expected to facilitate quicker access to treatment services, and result in clinically-driven recommendations for service, which will ensure clients have access to the right service, at the right time, in the right amount. Clients will be able to access follow-up care and support, and their progress in recovery will be quantified and measured for future policy-making purposes.

Following the initial SUD assessment, clinically-appropriate treatment, continuing care/case management, and recovery/peer support services will be made available to clients on a longitudinal basis and will be reimbursable to service providers. Clients will not be required to obtain reauthorization or a new assessment each time a client is in need of services of a different intensity or nature. Clients will have access to an updated assessment upon request or if clinically indicated. Service providers will not be required to complete a service termination and a discharge summary will be completed only when clinically appropriate to meet client need.

County participation in the pilot will be incentivized with financial considerations that will be determined prior to a county's agreement to participate. The pilot is expected to yield information related to assessment/access process efficiencies/inefficiencies, which will be used to inform future decisions in modifying the infrastructure of the SUD continuum in Minnesota. The pilot is intended to test the ability of the proposed measures to promote quick access to appropriate and comprehensive services, while avoiding unnecessary, excessive or duplicative expenditures.

The project will begin in July or August 2013, and will operate for three (3) years. Outcome measures will be developed in collaboration with the DHS Performance Measurement and

Quality Improvement Division (PMQI) and will quantifiably and qualitatively measure cost expenditures, services provided and clinical decisions made, client outcomes and satisfaction, impact and strain on providers and the SUD workforce, and what effect the elimination of the gate-keeper function has on reducing delays to accessing treatment.

Appendix A: Legislation

Effective July 1, 2012. Laws of Minnesota 2012, Chapter 247, Article 5, Section 8.

CHEMICAL HEALTH INTEGRATED MODEL OF CARE DEVELOPMENT.

The commissioner of human services, in partnership with the counties, tribes, and stakeholders, shall develop a community-based integrated model of care to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals. The plan shall identify methods to reduce duplication of efforts, promote scientifically supported practices, and improve efficiency. This plan shall consider the potential for geographically or demographically disparate impact on individuals who need chemical dependency services.

The commissioner shall provide the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a report detailing necessary statutory and rule changes and a proposed pilot project to implement the plan no later than March 15, 2013.

Appendix B: Guidance from SAMHSA

SAMHSA's Guiding Principles of Recovery

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery is supported by peers and allies.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality.

SAMHSA's Elements of Recovery Oriented Systems of Care and Services:

[The Steering Committee made a few changes to the characteristics]

- Person-centered
- Inclusive of family and other ally involvement
- Individualized and comprehensive services across the lifespan
- Systems anchored in the community
- Continuity of care
- Partnership-consultant relationships
- Strength-based
- Culturally specific, culturally relevant, and culturally responsive
- Responsiveness to personal belief systems
- Commitment to peer recovery support services
- Inclusion of the voices and experiences of recovering individuals and their families
- Integrated services
- System-wide education and training
- Ongoing monitoring and outreach
- Outcomes driven
- Research based
- Adequately, flexibly, and sustainably financed and structured with rational incentives
- Easily navigated by consumers and providers because it operates in efficient, understandable pathways

SAMHSA's Principles to Guide a Mental Health and Substance Use System:

- Preventing and treating mental and substance use disorders is integral to overall health.
- Services shown to be effective must be available to address current health and behavioral health disparities and be relevant to, and respond to, the diverse cultures and languages of individuals and families.

- A wide range of effective services and supports should be available based on a range of acuity, disability, engagement levels and consumer preferences. The consumer's resilience and recovery goals in their individualized service plan should dictate the services provided.
- The system should use information and science to deliver services. Services should be provided in convenient locations in order to reduce barriers, identify needs as early as possible, and engage individuals in care as early and as easily as possible.
- Wherever possible, the health system should support shared decision making with adult consumers, with youth and with families.
- Effective care management that promotes independence and resilience is key to coordinating health and specialty care.
- Service delivery must achieve high quality standards and results as well as outcomes that are measurable and are measured.
- Technology will be an important tool in delivering services. This includes telehealth, web-based applications and personal digital assistants that assist individuals in their recovery. Increased use of technology will expand access to and coordinate care rather than being limited to location-based service delivery. Services that are proven effective or show promise of success will be funded and should be brought to scale; ineffective services and treatments that have not shown promise will not be funded.