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1115 Substance Use Disorder System Reform Demonstration Early Adopters Report

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Acronyms

Acronym	Definition
ASAM	American Society of Addiction Medicine
SAMHSA	Substance Abuse and Mental Health Services Administration
PRAA	Patient Referral Arrangement Agreements
SUD/OUD	Substance Use Disorder/Opioid Use Disorder
Great Lakes ATTC	Great Lakes Addiction Technology Transfer Center
UNR-CASAT	University of Nevada – Reno – Center for the Application of Substance Abuse Technologies
Nfar-Tec	National Frontier and Rural Telehealth Education Center
EPL	Enhanced Professional Learning
RFP	Request for Proposal
MARATP	Minnesota Alliance of Rural Addiction Treatment Program
MAT	Medication Assisted Treatment
CCBHC	Certified Community Behavioral Health Clinic
APRN	Advanced Practice Registered Nurse
LADC	Licensed Alcohol and Drug Counselor
LOC	Level of Care

Limitations

This report is based on qualitative discussions between DHS and the Early Adopters. DHS would present prompts or seek feedback on specific components of the LOC Requirements for the 1115 Demonstration. They also submitted quarterly reports to DHS. This report is a summary of Early Adopters opinions and experience implementing the 1115 Demonstration into their programs and ideas on ASAM alignment in Minnesota. Quantitative data was not used in this report.

Introduction

Minnesota's 1115 SUD System Reform Demonstration (the Demonstration) is using nationally recognized and supported criteria to consolidate evidence-based, culturally-responsive, person-centered SUD treatment in Minnesota.[1] As part of the Demonstration, Minnesota has made following commitments to the Center for Medicare and Medicaid Services (CMS):

1. Increasing the use of evidence-based placement criteria to match a client's individual risk with the appropriate American Society of Addiction Medicine's Criteria (ASAM) level of care
2. Expanding Medical Assistance coverage to Institutions for Mental Disease (IMDs), defined as residential facilities with more than 16 beds

Through the 1115 demonstration, Minnesota continues to integrate addiction treatment into primary and mental health care treatment. Minnesota's six goals and objective for the Demonstration are to:

1. Increase rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increase adherence to, and retention in, treatment for OUD and other SUDs;
3. Reduce overdose deaths, particularly those due to opioids;
4. Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment when the utilization is preventable or medically inappropriate, through improved access to more appropriate services available through the continuum of care;
5. Reduce readmissions to the same or higher level of care for readmissions that are preventable or medically inappropriate; and
6. Improve access to care for physical health conditions among beneficiaries with SUD

The ASAM Criteria allows clinicians to assess a client's individual risks, needs, skills, and strengths to create a personalized treatment plan. Utilization of this criteria will help Minnesotans will receive the right level of care (LOC) at the right time. This effort will also move SUD treatment from an episodic model of care towards a long-term chronic disease management model that uses evidence-based treatment methods.

[1] https://mn.gov/dhs/partners-and-providers/policies-procedures/alcohol-drug-other-addictions/1115-sud/

History

Minnesota has moving towards a SUD treatment system aligned with the 1115 Demonstration for 20 years. The 1993-99 study, "The challenges and benefits of chemical dependency treatment," key recommendation was to create an SUD continuum of care consistent with chronic disease management.[2] Similar policy recommendations were made in following reports. Each report reflected the need for an evidence-based system rooted in clients' needs for long-term recovery, reflecting the vision of the 1115 Demonstration.

In 2016, the Minnesota Legislature directed the Department of Human Services to design an SUD system with a full continuum of services available to all Minnesotans (MN Section 254B.15). In 2017, the federal government announced Section 1115(a) Demonstrations to address the opioid crisis; this gave Minnesota the opportunity to implement the recommended changes. Legislation enacted in 2019 provided the Department of Human Services the resources to implement the demonstration (MN Section 256B.0759). On July 22, 2020, the federal Centers for Medicare & Medicaid Services (CMS) approved Minnesota's 1115 Demonstration's Implementation Plan[3], marking the official start of Minnesota's 1115 Demonstration implementation.

Minnesota's 1115 SUD System Reform Demonstration will establish a comprehensive and coordinated network of providers who offer ASAM levels of care to Medical Assistance recipients with SUD. Participating SUD providers have patient referral agreements with programs providing the levels of care they do not offer, allowing recipients access to the services and resources as recommended in their comprehensive assessments. Additionally, residential programs must provide on-site or facilitate off-site medication-assisted treatment (MAT) in accordance with the 1115 Demonstration's MAT Policy.[4]

Early Adopters

A request for proposal (RFP) issued in 2018 yielded the participation of eight different providers (Early Adopters, EA) to partner with the Minnesota Department of Human Services (DHS) in spearheading the Demonstration. They are DHS grantees, receiving the Substance Abuse and Mental Health Services Administration (SAMHSA) State Opioid Response (SOR) awards. This group was able to discuss, provide direction, and feedback to DHS regarding the strengths, barriers, and areas for improvement in the different parts of the Demonstration.

Early Adopters agreed on the following objectives critical to the implementation of the 1115 Demonstration:

- Working to reduce preventable readmissions

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[2] Minnesota Department of Human Services, Performance Measurement & Quality Improvement Health Care Research and Evaluation Division. The challenges and benefits of chemical dependency treatment, 2000.

[3] https://mn.gov/dhs/assets/mn-sud-1115-implementation-plan_tcm1053-431048.pdf

[4] https://mn.gov/dhs/assets/dhs-1115-mat-policy-statement_tcm1053-451090.pdf

- Maintaining and fostering a collaborative relationship with the state
- Participating ASAM trainings (Appendix A)

Early Adopters worked with DHS in following ways:

- Quarterly meetings with DHS
- Development of quarterly reports on status highlighting progress made in achieving key objectives
- Narrative summaries on best practices, lessons learned, challenges and solutions.

Additionally, Early Adopters wrote quarterly reports on their progress in achieving key objectives. Providers were also asked to submit narratives on best practices, success stories, lessons learned, and challenges and solutions. Questions and topics for discussion initially focused on the Demonstration LOC Requirements[5] and later moved into larger SUD system alignment. Participants were encouraged to approach recommendations from a strictly clinical ASAM lens.

1115 Demonstration Focused Components

In identifying trends and commonalities among the information received by the Early Adopters, these 5 areas were frequently discussed:

- Patient Referral Arrangement Agreements (PRAAs)
- Community services.
- Coordination between primary care and mental health professionals.
- ASAM Training
- Implementing ASAM

Outlined below for each area is; a description, successes the Early Adopters experienced, and areas the Early Adopters identified could be improved.

Patient Referral Arrangement Agreements (PRAAs)

In order to be enrolled in the Demonstration, providers are required to have Patient Referral Arrangement Agreements (PRAAs) with other SUD treatment facilities for the ASAM levels of care they do not offer. Providers established PRAAs with lower and higher levels of care, as well as facilities in different parts of the state in order to serve clients regardless of where they were discharging.

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[5] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7326-ENG

Success Stories

Early Adopters did not report any specific gaps in levels of care, and reported success with implementation in the given timeline. Facilities continued to develop new PRAAs and use existing PRAAs to make appropriate referrals.

Overall Early Adopters reported that PRAAs helped in many areas:

- Meeting multiple contract goals and objectives
- Increasing retention in treatment
- Reducing readmissions at the same level or higher levels of care
- Easing the transition between services
- Allowing for better tracking of transitions regardless of where the individual went

Early Adopters said the process of establishing PRAAs taught them more about the services available to clients, and helped them make meaningful connections with other providers. One specific example an Early Adopter gave showed the smooth transition from 3.7 Withdrawal Management locations:

> *[P]atients that are scheduled for admission for ASAM 3.5 level of care needing withdrawal management are able to receive that service at admission instead of multiple transfers between providers*

Areas for Improvement

Early Adopters believe increased participation in the Demonstration would fill most gaps in the continuum. They recommended the following changes:

- Increase participation across the state to improve outcomes
- Ensure contact post-discharge to improve continuity and outcome tracking
- DHS connect with programs not pursuing participation in the 1115 Demonstration and not willing to develop PRAAs

Community Services

In addition to collaborations with other SUD and primary care providers, Early Adopters reported establishing relationships with ancillary and community services outlined below. Many of these relationships are components of the Program Outreach Plan required for participation in the Demonstration. Example of items in the Program Outreach Plan include:

- Increase awareness of early intervention services
- Coordination with CCBHCs
- Plans for client access to Withdrawal Management programs
- Coordination with hospital services
- Collaboration with county and tribal humans service agencies

- Collaboration with primary care and mental health settings

The community relationships Early Adopters established as part of their Program Outreach Plan facilitated a holistic, person centered care along with continuity in treatment. This ensured clients transitioned smoothly out of Early Adopter services. Additionally, these collaborative relationships were able to ensure continuous quality improvement within the program and Demonstration.

Success Stories

Relationships that specifically helped Early Adopters foster collaborative relationships included:

- Legislative members
- DHS staff
- Minnesota Alliance of Rural Addiction Treatment Program (MARATP)
- County provider meetings
- State transition coalition meetings
- Residential crisis settings
- Peer recovery specialists
- Warm hand-off partnerships
- Policies with local detox
- Emergency departments
- Corrections agencies
- Law enforcement

One provider specifically noted:

> *We do presentations to a number of county provider meetings, state transition coalition meetings, CCBHC's, hospitals, emergency departments, outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers. We also coordinate with a number of other providers within the state to assist them with PRAAs.*

Areas for Improvement

An Early Adopter raised an important area for improvement within the referrals and relationships with the Department of Corrections (DOC). While this is not a requirement for participation in the 1115 Demonstration, DHS thought it was valuable to include in this report. While the DOC uses ASAM Criteria within their programs, Early Adopters struggled with referrals and the ability to assess and treat people involved in the criminal justice system.

> *We have had two incidences come up where a client was clearly in need of assessment and treatment, but was referred back to custody because there were no contracts in place to allow for a referral. This was challenging to swallow… but illuminating in how it*

demonstrated to all parties involved that a better system for referrals has to be implemented. We are actively engaging DOC staff to bring this matter to legislation

Physical health providers and services

In order to participate in the Demonstration, providers must document their access to and the availability of medical consultations provided by a licensed practitioner. The time frame for this consultation depends on the ASAM LOC offered. For example, a 2.1 Intensive Outpatient program is required to have access to and document the availability of medical consultation services by phone within 24 hours, where a 3.5 Clinically Managed High-Intensity Residential LOC is required to have telephone or in-person medical consultation available 24 hours a day, 7 days a week.

Success Stories

As a result of the 1115 Demonstration LOC Requirements, Early Adopters changed their staffing and facility administration to meet the physical health needs of clients. This involved hiring additional positions (intake coordinators, nursing), creating memorandums of understanding with local clinics, and physicians. Other notable staffing efforts included referrals from an in-house exercise physiologist to allow for access to facilities where clients can continue their fitness programs.

Early Adopters expressed that these relationships helped in many areas including:

- Improved access to care for physical health conditions among clients with SUD
- Reduction in medically inappropriate readmissions (per facilities admission requirements)
- Preserved a joint continuous quality improvement process
- Establishing primary care providers for clients who previously did not have primary care

The Demonstration also assisted in creating new relationships and partnerships. Those relationships consist between the facilities and:

- Primary health clinics
- Hospital networks
- Emergency rooms
- CCBHC's

Improved documentation initiatives were also reported as a key effort in making sure the physical health needs of clients were being met. All Early Adopters safeguarded the needs of any person continuing MAT. This was done by consulting with a provider on dosing, collaborating with MAT clinics and ensuring any other issues related to MAT were resolved.

Areas for Improvement

Early Adopters recommended continuing efforts to integrate primary care services with SUD treatment through staffing and collaborative agreements.

Co-occurring & Mental Health

In addition to physical health and medical consultation requirements, Demonstration providers are required to have access to psychiatric, psychological and pharmacotherapy services.

Success Stories

Early Adopters added staff and/or worked with a mental health clinic to meet the needs of their clients. Examples of staff added or partnered with include but are not limited to:

- Psychiatric-mental health nurse practitioner
- Psychologists
- Physician assistant
- Licensed mental health professionals
- LADCs with MISUD experience

Early Adopters stated that their mental health staff worked closely with other behavioral health services and local hospitals to help meet the needs of their clients. Based on comments from multiple Early Adopters, the largest area of impact with these collaborative services was seen in outpatient settings. One Adopter highlighted how the mental health referrals work:

> *When a client enters care at any [level of care], they receive mental health screening, which is reviewed by a staff mental health professional. Recommendations and concerns are shared with the client's treatment team... If the determination is made that they are best served by a provider outside our staff… an appointment is secured. There is ongoing communications, collaboration and participation with the treatment team and with the client's primary chemical use counselor.*

Areas for Improvement

Early Adopters did not report any specific areas for improvement with the co-occurring mental health requirements in the Demonstration. They wanted to highlight the changes to facility administration and expanded access to mental health services in this report.

ASAM Training

Early Adopters participated in the ASAM training provided by Great Lakes ATTC, UNR-CASAT, and NFARtec. DHS contracted with the external partners through the RFP process. The Demonstration offered three types of ASAM training: webinar, Enhanced Professional Learning (EPL) series, and ASAM Live. The webinar was as an introduction to ASAM. The EPL series was a 6-week course designed to be a “train the trainer” model available to accepted applicants. DHS and its partners used an application process due to limited space and time required outside of the training. ASAM Live was a question and answer series that allowed providers to have their ASAM questions answered in an immediate format.

Success Stories

Early Adopters provided feedback on the different ASAM Trainings offered. The EPL series was identified as the most helpful. The EPL series included 6 weeks of training that built upon itself, allowing trainees to truly absorb the information they were learning. Some of the training also confirmed their previous knowledge of ASAM, which Early Adopters found encouraging.

Areas for Improvement

While attending ASAM training, Early Adopters were also actively integrating training items into their daily practices. They reported that this was difficult to manage on top of other clinical requirements. They expressed preference to EPL over the ASAM Live because of the varying experiences with ASAM. They believed it was an uneven field of experience, as some attendees had more experience with ASAM than others. Lastly, Early Adopters reported difficulty communicating the nuance of the Minnesota Matrix to the ASAM trainers. Specifically, the Minnesota Matrix is a component of ASAM, however it has been modified to meet the needs of the State. This resulted in confusion between how Minnesota utilized ASAM and what ASAM truly required. They would like to see a train the trainer model (EPL) more widely available to everyone in Minnesota.

Level of Care (LOC) Requirements in Facility Administration

Providers are required to update their policies and procedures to describe how they incorporated the Demonstration requirements into facility administration.

Success Stories

Early Adopters said aligning internal documents and policies with ASAM was critical for enrolling in the 1115 Demonstration. They identified that ASAM integration into their policies, procedures, and practices takes time. It also required routine training of staff, which could be difficult due to staffing patterns, requiring time away from clients and time away from required paperwork. An Early Adopter did note that the changes to nursing services in residential programs resulted in more effective team alignment and support for clients.

They used monthly LADC training to review ASAM Criteria and refresh case managers on the requirements. Other trainings that were identified as helpful were: presentations of the various changes in the Minnesota SUD system referrals (i.e. Rule 25 Assessment); treatment coordination and peer recovery specialist.

Early Adopters reported the 1115 Demonstration:

> *Has provided us an opportunity to better educate our referral sources in order better align the expectations of our referral sources with our individualized treatment model*

One Early Adopter specifically focused on their intakes and referrals for a quarter to help stabilize and align the processes. During this time period, they began looking at gaps in services across their agency. They focused attention on referred clients who may need a 3.2 Clinically Managed Residential Withdrawal Management. Additionally, another Early Adopter noted practicing a “warm handoff approach” with their clients through the intake process, which involved introducing the client to the next staff member they would be working with as

well as an in person check in during the handoff. Another Early Adopter noted they have seen an increase in clients with medical complexity, due partially to being part of the demonstration. As a result, they are beginning to incorporate the ASAM Criteria into their evidence based Modified Therapeutic Community model.

Areas for improvement

Overall, Early Adopters identified facility administration as the area in need for most improvement in implementing ASAM Criteria. Early Adopters discussed the difficulty with implementing and practicing ASAM in an established SUD treatment system that does not align with ASAM. Non-1115 Demonstration referrals continue to be difficult for providers.

For example, ASAM and Rule 25 Assessments do not align entirely, which makes it difficult to challenge decisions of experienced professionals. The primary difference between Rule 25 and ASAM, is that risk scores and assessors discretion determine where and what program the client will be placed. This does not allow much for client choice. Additionally, ASAM allows for more flexibility within its LOC.

Minnesota has implemented Direct Access and currently allows referral and admission to treatment services via Service Agreements (due to sunset on June 30th, 2022) from Rule 25 Assessments and the Direct Access process. One struggles was that facilities on the receiving end of a referral were able to disagree with originating provider's decision for step down care. This impacted the Early Adopters ability to transition clients to an appropriate LOC.

Early Adopters reported that at the time, recommendations from Rule 25 assessments do not meet the clinical treatment rationale, per ASAM standards.

Early Adopters reported that it was challenging to navigate the different expectations while also following the ASAM Criteria. Additionally, providers reported inappropriate referrals (those that did not meet the facilities admission criteria) that took up many of their resources to fulfill. They stated this was challenging, but are proud of the approach they took. It allowed them to see many successes in those referrals when others would not have provided treatment:

> *In fact, we are preparing for a spring graduation where nearly 100 clients will be celebrated for their success in recovery. So many of those clients were inappropriate referrals that we knew no one else would receive for services. Our staff go above and beyond. Our challenge is how to create a business infrastructure around them to support the added efforts*

Providers are seeking guidance on how to handle treatment coordination and placement when there is a disagreement on the best level of care for the client. They requested DHS develop communications to help the counties understand the Comprehensive Assessment, and better support the 1115 Demonstration's efforts. The two other suggestions for improved coordination were better relationships with detoxification and Withdrawal Management providers as well as help with PRAAs. Providers mentioned that obtaining PRAAs can be difficult because people do not understand the Demonstration or purpose of PRAAs. Early Adopters believe expanding participation in the Demonstration will help build with establishing PRAAs.

Early Adopters also said that implementing the Level of Care Requirements and ASAM Criteria took time and training of staff. This is significant concern as staffing for paraprofessionals continues to be an issue. Utilization management and the Kepro portal was another point of discussion with Early Adopters. They identified it has been difficult for staff to keep up with training and workload. One Early Adopter recommended dedicating a specific staff member for 1115 Demonstration requirements to assist with implementation. An Early Adopter noted that the ASAM criteria took time and continuous focus for the admissions infrastructure. They did however recognize that they are seeing improvement:

> *We have started to see an improvement in process, but now see a need to reposition the organization among referral partners and enhance our responsivity to new referral requests. This has been a challenge with new staff as well as ongoing need for new procedures and training, but it is beginning to work*

System Alignment & Improvement

In addition to discussing the Demonstration components and implementation, Early Adopters were asked about aligning the Demonstration with Minnesota's broader SUD system. The goal of these conversations was to better understand provider's perspective and align with clinical best practices. DHS asked providers the following question:

> *In applying the ASAM criteria, what would documentation look like without existing statutes or licensing requirements? Consider this from only the clinical perspective and what would best help you and your staff meet your client's needs.*

Early Adopters focused on three areas: treatment coordination, treatment plan reviews, and residential skilled treatment hours. They described the current challenges with requirements and provided ideas for possible solutions using the ASAM Criteria as a framework.

Treatment Coordination

Current State

Early Adopters expressed concerns with treatment coordination. These concerns fell in three areas; qualifications, definition of treatment coordination, and hiring.

In looking at the education requirements and training necessary for treatment coordination, currently, in order to be eligible to be a treatment coordinator, the individual either needs to be a licensed alcohol and drug counselor or attend a 30 hour treatment coordination certification class. They believe the position and education level don't align. Stating that the most effective treatment coordinators don't always have the required education component. LADC's are typically best suited for treatment coordination because they have standing relationships in communities and with other providers. Early Adopters also believe licensed mental health professionals (LICSW, LPCC, LMFT) met the qualifications without needing additional training.

According to Early Adopters, it is difficult to hire someone for this role because of the importance of working relationships, as well as the requirements for the position. In some cases a candidate would be a strong candidate for the role, but would not meet the educational requirements set by 245G.

Early Adopters also expressed difficulty with treatment coordination for Withdrawal Management. The issues often stem from transfers to and from the Withdrawal Management program back to other level of care programs. Additionally, there is a struggle to understand the abilities and functions of each service level. This can impact transportation, admission wait time and ensuring the proper level of care is received for the client.

Early Adopter Suggestions

Early Adopters suggest examining the treatment coordination education requirements. They believe that human service case management courses in behavioral health and counseling professionals' schools are sufficient for this service. They also expressed interest in the opportunity for nurses to fill this role. Similarly, Peer Recovery specialists could help fill gaps in treatment coordination because they give LADC's more time with clients; however, trainings for Peer Recovery are difficult to access, especially in rural areas.

Documentation & Review

Current State

Minnesota statute uses ASAM's Six Dimensions as the base of the individual treatment plan (MN 245G.05 subdivision 2). However, different intensity throughout the continuum of ASAM LOCs is not taken into consideration for the treatment plan review (MN 245G.05 subdivision 3). According to statute, "a treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent… the review must indicate the span of time covered by the review and each of the six dimensions."

Early Adopters reported that treatment plan review is too frequent for LOCs, and takes clinicians' attention away from client care. The reporting requirements are contributing to workforce burnout and also client burnout. They do not believe it aligns with ASAM's person-centered focus nor do treatment plan requirements allow clinicians to meet the changing needs of their clients. For example, in Minnesota Low Intensity Residential program, which requires clients to attend five service hours per week, clinicians may only see a client one to two times a week. This means a clinician is updating their treatment plan review each time they meet with their client. Early Adopters do not believe this is enough time for significant clinical progress to require an updated treatment plan review. Additionally an Early Adopter raised concerns over writing skills as a barrier for some clinicians. The writing skills required to meet statutory reporting requirements do not always mean higher quality treatment.

Early Adopter Suggestions

Early Adopters believe Minnesota's individual treatment plan review requirements are too stringent and are not proportional to the intensity of different LOCs. Overall, Early Adopters believe the treatment plan reviews requirements are an administrative burden not necessary for evidence-based high-quality clinical care. Early

Adopters would like documentation and treatment plan reviews to mirror the intensity of the ASAM levels of care. They believe this would reduce the administrative and paperwork burden without losing clinically necessary documentation. They believe reducing documentation requirements would allow clinicians to spend more time with clients and allow the system to be agile enough to meet client needs, thus improve quality of care. Table 1 contains Early Adopters suggested frequency of treatment plan reviews for each ASAM LOC offered in the Demonstration.

Table 1 Suggested treatment plan review frequencies. Early Adopters suggested frequencies of treatment plan reviews based on American Society of Addiction Medicine (ASAM) Levels of Care. Treatment plan reviews for 3.2 Clinically Managed Residential Withdrawal Management and 3.7 Medically Monitored Intensive Inpatient Services were not discussed because of the short treatment length.

ASAM Level of Care	Frequency of Treatment Plan Review
1.0 Outpatient	Monthly
2.1 Intensive Outpatient	Biweekly
3.1 Clinically Managed Low-Intensity Residential Services	Biweekly or monthly
3.3 Clinically Managed Population Specific High-Intensity Residential Services	Weekly
3.5 Clinically Managed High-Intensity Residential Services	Weekly

Residential Skilled Treatment Service Hours

Current State

Current Minnesota statutory requirements for residential SUD treatment require providers delivering “high-intensity” residential treatment services to provide 30 hours of clinical services delivered by a qualified professional each week (Minnesota Statute 254B.05). The ASAM Criteria does not identify a specific number of hours of skilled treatment services for levels 3.3 Clinically Managed Population Specific High-Intensity Residential Services and 3.5 Clinically Managed High-Intensity Residential Services. Early Adopters expressed difficulty meeting statutory requirements.

One provider specifically, said:

> *We have a saying that 30 hours a week makes creativity die because of worry of what can count as billable.*

Currently statutory requirements do not allow for flexibility in treatment or creativity by clinicians. Early Adopters also expressed concerns related to the lack of clarity on the requirements for a qualified professional and the additional treatment services qualified professionals are allowed to deliver and bill for.

Early Adopter Suggestions

Early Adopters expressed interest in evaluating existing rules and statutes in Minnesota to create a residential structure more in line with the structures Michigan and Nevada created for their 1115 SUD Demonstration's ASAM residential LOCs (Appendix B and C, respectively). They also expressed concerns related to the lack of clarity on who is a qualified professional and the additional treatment services qualified professionals are allowed to deliver and bill for. Early Adopters believe Michigan's standards and definitions used in their state's 1115 SUD Demonstration created a more flexible foundation for the delivery of ASAM's Skilled Treatment Services and the type of social environment that improves recovery capital in residential settings. Specifically, they cited Michigan's definition of "Core Services" and "Life Skill/Self Care" services (Table 2).

Term	Definition
Core Services	Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling
Life Skills/Self-Care (building recovery capital)	Social activities that promote healthy community integration/ reintegration; development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education

Table 2 – Michigan's definition of Core Services and Life Skills/Self-Care used in the 1115 SUD Demonstration. Michigan's Medicaid Managed Specialty Supports and Services Program FY20 – Treatment Policy #10 is in Appendix B.

Early Adopters cited examples of the types of services their programs provided that were aligned with Michigan's "Life Skill/Self Care" and pointed to the lack of ability for residential providers in Minnesota to count those types of services as billable unless they were delivered by a qualified professional. For example, Early Adopters think the following provide clinical value but cannot count them as billable services:

- Meals
- LADC led trauma-informed yoga
- Fireside community conversation
- Time with a chaplain

Early Adopters pointed to Michigan's "Residential Services Description" table as an example for guidance. They also cited Commission on Accreditation of Rehabilitation Facilities (CARF) definition of level of intensity based on person's level of need. They suggested balancing clarity and flexibility of qualified professionals. Early Adopters

expressed a desire to create a framework using the ASAM Criteria for defining what a skilled treatment service and additional support service should be in Minnesota. They pointed to the required and additional treatment services section of 245G.07 as place to begin comparing the Michigan and Nevada state examples with Minnesota. Early Adopters met with each other to develop an example treatment service grid for residential levels of care that aligns with ASAM (Appendix C)

Conclusion

Minnesota's 1115 SUD System Reform Demonstration (the Demonstration) is using the ASAM Criteria to create a person-centered SUD treatment system for Medical Assistance recipients in the State of Minnesota. Early Adopters, eight programs contracted to implement the demonstration, were a crucial component, as they informed and guided the roll out of the 1115 Demonstration. This group of eight felt the Demonstration components helped them build relationships with other community providers. Creating Patient Referral Arrangement Agreements (PRAAs) taught them about other services available to clients, and will help track client's access to treatment.

One of the main difficulties these Adopters faced was integrating ASAM into a system it does not align with. They were outspoken that true ASAM integration required thoughtful policies, practice and time to train staff. While this was a struggle, the trainings provided within the Demonstration were helpful.

Early Adopters not only provided feedback and suggestions regarding the Demonstration, but additional SUD system reform ideas. These ideas would allow for integration and alignment across the State of Minnesota. They examined staffing roles, utilization management, paperwork requirements, and service expectations. From this they provided recommendations of next steps that could be taken to further improve substance use care and staff satisfaction in all LOCs.

Early Adopters have shown that implementing ASAM in Minnesota is not only feasible but addresses systemic gaps in the state's current SUD framework. The 1115 Demonstration provides the data collection and evaluation infrastructure to fully integrate Minnesota into ASAM continuum of care. Ensuring all Minnesotans will receive the right level of care at the right time based on their individual needs.

Appendix A

Goal (What are the broad intended results you are hoping to accomplish through this project?)	Objective (What are the measurable step(s) you must take to achieve the goal?)
Increase adherence to, and retention in, treatment for OUD and other SUDs	Establish a model for a Program Outreach Plan and formal Patient Referral Arrangement Agreements that meets the standards established for the implementation of the 1115 Levels of

Goal (What are the broad intended results you are hoping to accomplish through this project?)	Objective (What are the measurable step(s) you must take to achieve the goal?)
	Care Requirements under the authority of Minnesota Statutes, section 256B.0759
Fewer readmissions to the same or higher level of care for readmissions that are preventable or medically inappropriate	Establish a model for a Program Outreach Plan and formal Patient Referral Arrangement Agreements that meets the standards established for the implementation of the 1115 Levels of Care Requirements under the authority of Minnesota Statutes, section 256B.0759
Improved access to care for physical health conditions among enrollees with SUDs	Establish a model for a Program Outreach Plan and formal Patient Referral Arrangement Agreements that meets the standards established for the implementation of the 1115 Levels of Care Requirements under the authority of Minnesota Statutes, section 256B.0759
Maintain and foster a collaborative relationship with the STATE, provider partners, and other key stakeholders to ensure continuous Quality Improvement as it relates to OUD/SUD treatment delivery under the 1115 Demonstration	Build smoother transitions through levels of SUD/OUD care through training, consultation and technical assistance on the use of the program outreach model and patient referral arrangement agreement for other providers interested the 1115 Demonstration
Maintain and foster a collaborative relationship with the STATE, provider partners, and other key stakeholders to ensure continuous Quality Improvement as it relates to OUD/SUD treatment delivery under the 1115 Demonstration	Collaboration with STATE to determine best approaches to align the ASAM Criteria with the 1115 Level of Care Requirements, 1115 Assessment and Placement Table and applicable statute and administrative rules related to substance use disorder services
Maintain and foster a collaborative relationship with the STATE, provider partners, and other key stakeholders to ensure continuous Quality Improvement as it relates to OUD/SUD treatment delivery under the 1115 Demonstration	Provide quarterly qualitative summary reports to STATE on implementation of work plan and evaluation plan including: lessons learned, best practices, barriers, success stories, and continuous improvement efforts/recommendations in a format and reporting schedule approved by the STATE

Goal (What are the broad intended results you are hoping to accomplish through this project?)	Objective (What are the measurable step(s) you must take to achieve the goal?)
Maintain and foster a collaborative relationship with the STATE, provider partners, and other key stakeholders to ensure continuous Quality Improvement as it relates to OUD/SUD treatment delivery under the 1115 Demonstration.	Meet quarterly by WebEx with the STATE, other grantees and project partners to discuss lessons learned, best practices and continuous improvement efforts at a date and time determined by the STATE in collaboration with the GRANTEE.

Appendix B

Michigan Medicaid Managed Specialty Supports and Services Program FY20: Treatment Policy #10.

Appendix C

Historically, residential substance use disorder treatment services have been defined by length-of-stay, not by the needs of the client. This definition has resulted in three tiers for residential services in the state of Minnesota: low, medium and high intensity.

The purpose of this document is to align treatment services with ASAM criteria while adjusting service frequency and duration to be more client centered. A secondary goal is to expand the eligible pool of providers to include paraprofessionals.

245G.07 describes the required and optional treatment services that are to be documented in the client record. Statute 254B.05 instructs providers on the amount of service hours to be delivered per tier. ASAM provides guidelines for service frequency and duration for some levels but not others.

The creators of this document relied heavily on examples drawn from residential treatment policies in the state of Michigan. The continuum of services policy was created in Michigan in collaboration with the American Society of Addiction Medicine (ASAM), and offers service hour minimums per level of care (LOC) designations.

For an ASAM 3.3 facility, this proposal offers 12 hours of required treatment services delivered by credentialed staff; with an additional 12 hours of supportive services offered by either credentialed professionals or paraprofessionals. These paraprofessionals remain unidentified by licensing, but are currently providing services to clients in residential settings.

"Paraprofessionals" are defined in 245G.01, as an employee, agent, or independent contractor of the license holder who performs tasks to support treatment services. Currently, the services that paraprofessionals provide are not counted as a treatment service that are captured by the per diem. According to The ASAM Criteria, 3rd Edition, "Habilitation" is defined as the development, for the first time in an individual's life, of an optimum

state of health through medical, psychological, and social interventions. Milieu therapy is a viable intervention that supports autonomy and personal responsibility and could be facilitated by paraprofessionals. It is the belief that these interventions would also enhance the delivery of required medical and psychological services.

One possible area to explore for paraprofessional qualifications would be Adult Rehabilitative Mental Health Services. The following statute is offered as a possible comparable to standards that could be established for 245G residential programs.

256B.0623 Subd. 5 Qualifications of Provider Staff

(4) A mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery from mental illness, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality;

The goal of providing high quality client- centered care is shared by all providers and regulators. This proposal hopes to adjust the current delivery of services to foster a flexible environment for providers, through which they are better able to capture the breadth of such services.

See below for a sample description of treatment services:

Required Treatment Services

Individual Counseling:

Individual Counseling assists the client in identifying and addressing needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder.

Duration: 55 Minutes
Frequency: 1 x weekly
Staffing Requirement: LADC / TREATMENT COORDINATOR / MENTAL HEALTH PROFESSIONAL
Description of Service:
Individual counseling will be provided on site of licensee in 55 minute increments 1x weekly.
General topics will address needs related to substance use according to the treatment plan, including but not limited to;

- Intoxication and withdrawal status,
- Medical complications affecting service delivery,
- Mental health status,

- Motivation for treatment,
- Relapse potential and environmental factors,
- Motivational Interviewing,
- 12 step facilitation,
- Cognitive Behavior Therapy, and
- Community Reinforcement to be deployed to decrease the likelihood of client returning to harmful substance use after discharge.

All modalities to be delivered in a slower paced, repetitive manner to account for cognitive deficits. Individual counseling will address need to obtain the services necessary to support lifestyle change. Inter-agency consultation to Mental Health Professionals, Treatment Coordinators, and Peer Recovery Specialists to be consulted with and referred to on a case by case basis.

Group Counseling:

Group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder:

Duration: 55 Minutes
Frequency: 5 x weekly (Daily)
Staffing Requirement: LADC / MENTAL HEALTH PROFESSIONAL
Description of Service:
Group counseling will be provided on site of licensee in 55 minute increments 5x weekly. General topics will address needs related to substance use according to the treatment plan, including but not limited to;

- Intoxication and withdrawal status,
- Medical complications affecting service delivery,
- Mental health status,
- Motivation for treatment,
- Relapse potential and environmental factors,
- Motivational Interviewing,
- 12 step facilitation,
- Cognitive Behavior Therapy, and
- Community Reinforcement to be deployed to decrease the likelihood of client returning to harmful substance use after discharge.

All modalities to be delivered in a slower paced, repetitive manner to account for cognitive deficits. Group counseling will also guide client to better structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality. Inter-agency consultation with Mental Health Professionals, Treatment Coordinators, and Peer Recovery Specialists regarding referral needs. These needs will be addressed on a case by case basis.

Education Groups:

Client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health.

Duration: 55 Minutes
Frequency: 3 x weekly
Staffing Requirement: LADC / MENTAL HEALTH PROFESSIONAL
Description of Service:
Client education groups will be provided on site of licensee in 55 minute increments 3x weekly. To accommodate clients with cognitive deficits, facilitator will provide education at a slower pace in a concrete, repetitive manner. Education on tuberculosis, HIV, STDs, substance use during pregnancy and hepatitis will be provided along with general topics related to inappropriate substance use and health problems and how to regain and maintain health. Curriculum to be used will be the Substance Use Bridging Initiative.

Integration Groups:

A service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support:

Duration: 55 Minutes
Frequency: 2 x weekly
Staffing Requirement: LADC / COUNSELOR AIDE / MENTAL HEALTH PROFESSIONAL
Description of Service:
Daily Living skills group will be provided on site of licensee in 55 minute increments 2x weekly. Clients to be guided by staff members in the milieu while client completes assigned tasks based on treatment plan goals including but not limited to;

- Tasks associated with activities of daily living
- Laundry
- Meal preparation
- Personal hygiene
- Maintaining personal environment
- Vocational skill building
- Budgeting
- Navigating transportation needs

Mental Health Group:

A service to address issues related to co-occurring disorders.

Duration: 55 Minutes
Frequency: weekly
Staffing Requirement: MENTAL HEALTH PROFESSIONAL
Description of Service:
This group will be provided on site of licensee in 55 minute weekly. General topics will address needs related to mental health diagnosis, symptoms and concerns. Topics will be according to the treatment plan, including but not limited to;

- Diagnostic understanding
- Trauma
- Boundaries
- Conflict management
- CBT/DBT Skills

- Relational support

Treatment Coordination:

Treatment coordination services are provided one-to-one and include assistance in coordination with significant others to help in the treatment planning process whenever possible.

Duration: 55 Minutes
Frequency: 3 x weekly
Staffing Requirement: LADC / TREATMENT COORDINATOR / MENTAL HEALTH PROFESSIONAL
Description of Service:
Assistance in coordination with and follow up for medical services as identified in the treatment plan; facilitation of referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan; facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan; assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs; life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and documentation of the provision of treatment coordination services in the client's file.

Optional Treatment Services

Relationship Counseling:

Relationship counseling to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder.

Duration: 55 Minutes
Frequency: 1 – 2 x weekly
Staffing Requirement: LADC / MENTAL HEALTH PROFESSIONAL
Description of Service:
Relationship counseling sessions will be provided on site of licensee in 55 minute increments 1x weekly in the group setting or individually. Counseling to focus on healthy relationships, conflict mediation, boundaries, anger management, and specialized areas such as trauma, triggers, domestic violence, parenting, and identity concerns. Counseling and clinical monitoring to assist the client with successful initial involvement or re-involvement in regular, productive daily activity and, as indicated, successful reintegration into family living.

Therapeutic Recreation:

Therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals.

Duration: 55 Minutes
Frequency: 1 x Daily, 2 – 5 x weekly
Staffing Requirement: LADC / MENTAL HEALTH PROFESSIONAL/COUNSELOR AIDES/GROUP LIVING WORKERS
Description of Service:

Therapeutic recreation sessions will be provided on site of licensee in 55 minute increments 2x weekly in the group setting or individually. Group sessions of up to 16 clients will meet and be provided with an overview of the therapeutic activity. Activities that clients can participate in include, biking, fishing, canoeing, kayaking, horse shoes, snow shoeing, nature walks, gardening, Frisbee golf, exercise classes, yoga, etc... These activities cover a broad range of rehabilitative physical and mental health goals. Areas of focus include healthy lifestyle and routine, stress and pain management, coping strategies, accessing community resources to reduce isolation and promote independence, social interactions and effective relationship building, emotional processing and regulation, healthy decision making and self- esteem and self -worth. All clients will be presented with the above options as part of the treatment planning process. The individual treatment plan will be updated with the recreation options in either ASAM dimensions 3, 5, or 6.

Stress Management:

Stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being.

Duration: 55 Minutes
Frequency: 1 x Daily
Staffing Requirement: LADC / MENTAL HEALTH PROFESSIONAL/COUNSELOR AIDES / GROUP LIVING WORKERS
Description of Service:
Stress management and physical well-being sessions will be provided on site of licensee in 55 minute increments 5x weekly in the group setting or individually. Clients will work with non-physician addiction specialists to be assessed for appropriate exercise routine. Once plan is established, clients will meet daily to follow established protocols. Members of treatment team will track pre and post data regarding health benchmarks. Mindfulness groups will be delivered in 55 minute increments 1x weekly. Focus of experiential group is to use meditation as a tool to increase wellbeing through awareness of present moment experience. Examples of present moment guided meditations include, Body scans, urge surfing, and awareness of triggers and cues. Interventions are to be included on client's individual treatment plan in dimensions 3, 5, and 6. Service contributes to SUD treatment needs by increasing healthy lifestyle and routines, stress management, increases coping strategies, and improves emotional processing and regulation.

Living Skills Development:

Living skills development to help the client learn basic skills necessary for independent living.

Duration: 55 Minutes
Frequency: 2 – 5 x weekly
Staffing Requirement: LADC / MENTAL HEALTH PROFESSIONAL/COUNSELOR AIDES/GROUP LIVING WORKERS
Description of Service:
Life skills sessions will be provided on site of licensee in 55 minute increments 5x weekly in the group setting or individually. Contingency Management interventions to focus on social activities that promote healthy community integration/reintegration, including the development of community supports, parenting , employment, job readiness, how to navigate transportation issues, personal hygiene, nutrition , laundry, and education. healthy lifestyle and routine, stress management, coping strategies, accessing community resources to reduce isolation and promote independence, social interactions and effective relationship building, emotional processing and regulation, healthy decision making and self- esteem and self -worth.

Employment/Education Services:

Employment or educational services to help the client become financially independent.

Duration: 55 Minutes
Frequency: 1 – 3 x weekly
Staffing Requirement: LADC / TREATMENT COORDINATOR / MENTAL HEALTH PROFESSIONAL
Description of Service:
This service is covered by treatment coordination function.

Socialization Skills:

Socialization skills development to help the client live and interact with others in a positive and productive manner.

Duration: 55 Minutes
Frequency: 1 – 7 x weekly
Staffing Requirement: LADC / LPCC / PRS / TREATMENT COORDINATOR / SUPPORT STAFF/ MENTAL HEALTH PRACTITIONER
Description of Service:
Socialization skills development will be provided on site of licensee in 55 minute increments 5x weekly in the group setting. Contingency Management interventions to focus on therapeutic socialization to generate recovery capital. Goals cognitive function through support, and the sharing of experiences, both successes and challenges. The sharing of peer to peer experiences to foster greater independence to help client transition to lower level of care. Direct activities to include shared meals with peer responsibilities, community meetings to acknowledge wanted behaviors and to offer feedback and guidance for unwanted behaviors.