Professional Training/Workforce report out –

1. Lack of training in professional workforce in communities that need it. Like how we take people out of communities for treatment. So we thought building on those community based programs that already do some workforce development and working with those organizations to administrate training for treatment providers or peer recovery specialist. Using a local community resource and seeing what workforce they need in each community. So we aren’t training a bunch of LADC’s where they don’t need LADC’s but they need peer recovery specialists so that is what we train. It is working with the community to identify the need and then training that specific workforce up.

2. Lack of physician in primary care providers that are trained in addiction and chronic pain. Two things we thought about doing
   a. The “One Call” number idea that came from the Minnesota Society of Addiction Medicine, came from child psychiatry that has one number where every pediatrician in the state can call and get a child psychiatrist on the phone. So we talked about all addiction medicine doctors could share in a call line but they would need it to be somehow supported. Having it available at multiple touch points, like providers, nursing homes, schools and mental health agencies.

3. Implementing screening tools within health care. So screening brief intervention and referral to treatment (sbirt) training and reimbursement can be improved upon.

4. Training and holistic management of chronic pain and psychology of pain. In the bill there is a two hour requirement for prescribers. Maybe some sort of create training program for anybody that wanted to do it, but maybe ladc’s and other people that are doing addiction training.

5. Turnover within the profession so lifespan of counselors is two years. There is burnout and reimbursement issues so we didn’t really know what to do with the burnout or reimbursement issue but we did think about a way to increase the supply like job corps programs. Taking people new in recovery, lifting them up and then training to be peer recovery specialists and then training them to be LADC to increase the workforce. We thought turnover was related to reimbursement.

6. Lack of opportunities for people in recovery. We thought incentive employers to hire people in recovery.

7. Lack of funding for addiction medicine fellowship, we thought about state dollars for that.

8. Lack of funding for doctors to find the root cause of chronic pain and needing resources to do deep dive on patients. We talked a little bit about incentives for wellness outcomes in reimbursements and having those conversations.

9. Lack of access to best practices utilized by cultural communities. In the bill there is 2 million dollars for traditional cultural healing which we realize isn’t enough but maybe we could track outcomes.

10. Lack of diversity in the workforce, using community engagement programs to increase the workforce.

11. Underutilization of Medication Assisted treatment, we thought that the “One Call” could help and policy recommendations and regulation of for sober living and treatment programs to accept MAT.

12. Law Enforcement receiving naloxone - working with policy recommendations and working with police unions on educational efforts.
13. Lack of peer recovery specialists in the hospital. Needing people in the hospital to transition people out of the hospital or out of there access/entry point because that is when they are in crisis and walking them to the next step. So people who can do the assessment, get the funding in place. Something like an ACT team for those with severe substance use disorder, someone that can track you in the community.

14. Exploration of the alternative and complimentary medicine to learn more about and what is actually is and isn’t working in the first year of funding.

15. Development of touchpoints, every touchpoint where professionals have with a patient representing the communities served and recognizing the differences there.

16. Retention of trained professionals on every level
   a. Developing resiliency
   b. Avoiding compassion fatigue

Youth and Prevention report out –

1. Disposal sites, we were thinking of a policy recommendation if you dispense you should have a disposal site as well to make disposal more community friendly and common. This would need some incentives for doing this as it costs for pharmacies to dispose of drugs.

2. Schools –
   a. How to Adverse Childhood Experiences (ACES) training or trauma training in schools in schools. Weston talked about how DHS and MMB has 40 school pilot for social emotional learning training for 3,000 students.
   b. Talked about getting addiction treatment into schools. A pilot for getting addiction treatment in school to help with how kids in acceptance issues. This would allow us to bring the treatment to them so they can go to treatment at the same time they are going to school. The treatment would be part of their day to day curriculum while allowing for the kids to be part of the programming allowing them to become leaders within their own communities. They could have a sober group within the high school which would be very powerful.

3. Minnesota Student Survey only done every 3 years, doesn’t track with trends because they change so quickly. The thought is if we could streamline the focus and make it a more regular base survey (every year) that talks only about drug use trends. Sarah asked Increase resiliency through additional prevention education in schools
   a. Lack of understanding of existing curriculum specifically around addiction that might be being done in schools nationally or locally we would begin that process by doing an assessment of the current curriculum in use and outcomes

4. Increase the resiliency in youth and families
   b. Develop resiliency programming for youth and families
      i. Reiterates with needs for a shorter school friendly, funded annual Minnesota Student Survey
      ii. School based setting
      iii. Based on Adverse Childhood Experiences (ACES)
         1. COPE/HOPE inventory measures identified as a resources for outcome/impact
         2. Social emotional learning training

5. Increase of the general public of the risk of opioid prescriptions in homes
a. Institute provider screening questions for opioids in the home and if yes, offer follow up resources for naloxone prescription/access, security storage and safe disposal.
   i. After sharing with larger group it was suggested that the screening be inclusive of additional harmful substances/prescriptions
b. Develop a resources of effective prevention messaging campaigns based on outcomes measures and evidence for consideration in MN
   i. After sharing with the large group Weston shared Weston shared that he has an extensive scan of treatment, prevention and other evidence-based resources from MDH and DHS created by MMB and the impact of the interventions/programming that have been shared below

Reimbursement/Policy report out –
1. We talked about payment reimbursement and thought of some sort of block funding that is ties reimbursement to outcomes.
2. Family programming because that is not well reimbursed.
3. To explore and encourage alternative payment methods. Example, PCODE for Addiction Medicine providers.

Technology report out –
1. Lack of access to broadband and telehealth that would improve the ability to have virtual health visits. Access to telephones that meet criteria of not having access to broadband and opioid use disorder. We could spots within communities that have broadband that they could get to like the library.
2. Interoperability between electronic health records and prescription monitoring program (PMP). The technology is there and we are seeing more and more programs sign on. The question has been who should fund it? Does the private side continue to fund it or should the state fund it? The prescription monitoring program has partnered with Jpal to measure the effectiveness of PMP integration. As the results come in that might further guide us.
3. Look at the functionality of the prescription monitoring program and the electronic health records.

Dana added that we might to consider adding one phone number, an app instead of phone number, locator for naloxone.

Access report out –
1. This was a large category, so we went through the list and tore it up and placed things all around. First thing we talked about was entry points, knowledge of entry points in various communities, especially American Indian and black communities about where do they access help when they need it. Focusing on our knowledge on where they would say they would access help and getting the knowledge out for them to access the structures and systems that are currently in place. Additionally a need to hear from our community members in order to get that right.
2. To increase capacity broadening:
   - Culturally responsive
   - Rural communities
   - Medication Assisted Treatment (List of opioid treatment programs but broadened that to include a variety of treatment options)

3. Then we added discharge planning, meaning that many folks access the system through crisis points like emergency departments, law enforcement, things like that, once they get there what next? Enhancing those discharge planning services through those emergency type interventions in jail, law enforcement, detox.

Naloxone report out –
1. Access to education and kits materials in multiple language we think is pretty low hanging fruit.
2. Access to naloxoxes, also choosing setting where community members might go like visiting in jails, libraries, schools, convenience stores, etc.
3. Deploying to grass roots locations that are out on the streets to use for hot spots.

Pain management add report out:
   - Access especially for those in our disparate population.
   - Financial reimbursement for alternative medicine
   - Physician education

Criminal Justice Add on report out:
Criminal Justice (we decided to rename others to criminal justice because it falls to the bottom of the list of the priorities). In the discussion they had some gap areas so we are making a suggestion to start creating a statute/policy list for this group.

1. Equitable access to those with felony histories
2. Talked about law enforcement changes in education. Example of needles being taken away from law enforcement even when they are part of a naloxone kit if they don’t have a prescription and then being charged with a petty misdemeanor.
3. Transition services out of services, out of drug courts, out of programs, sustainability of recovery environments once they leave the programs. Like they might get daycare while in the drug court but once they transition out they no longer are eligible which creates a challenge that results in them funneling back through the system.
4. Family centered interventions.
5. Community convening where we bring together law enforcement under the criminal justice umbrella all of the law enforcement, providers, courts, and local communities to see what is available, what the gaps are and come up with some local solutions.

Mental Health report out –
1. Increase identification of Mental Illness and Chemical Dependency (MICD) disorders through the use of screens. The screens to be used would be:
   a. GAD
b. PHq-9  
c. PC-PTSD  
So you would get screened and then assessed in order to understand the correlation between substance abuse and co-occurring disorder.

2. Increase access to evidenced-based MH treatments contributing to the substance use disorder (i.e. evidence-based PTSD treatment).

3. Increase access of trained clinicians in varied settings (schools - specific training in the schools), child protection (child and parent), prisons/Jails, hospitals) using evidenced-based treatments for post traumatic stress disorder (PTSD), depression and other co-occurring disorders.

4. Ensure efficacy of program by measuring psychopathology, resiliency, sobriety, recidivism and reunification after completed protocol/follow-up included.

Jolene added that their group discussed trauma informed care. They were thinking about doing something as easy as looking at proposals from organizations to do a trauma informed care curriculum that allows agencies that can’t afford the more formalized trauma informed care training to go to it at a low cost and they can deploy that information at their agencies so more organizations are using a more trauma informed frame. Dana discussed with the opioid prescribing workgroup one of things we acknowledged is that we are trying to change the culture and interactions with patients. In trying to get everyone on the same page with trauma informed care was this idea of having this curriculum and understanding that this is a workforce issue for both sides.

Korey discussed embedding training and education in behavioral health and physical health in the criminal justice system and information sharing to build more partnerships.

Collaboration report out –

1. Peer recovery specialist were the glue in everything related to collaboration to be utilized to be able to provide continuity of care, build up capacity, career laddering, and treatment coordination.

2. Do the “one call” for Medication Assisted Treatment (MAT), specific for all touchpoints in MAT not just providers (like a 1800#, statewide number, touchpoints like someone in crisis, someone in ems, would need to triage so there is someone to call).

Cultural Sensitivity/Humility and Individual Differences Discussion – We didn’t have this conversation as the thought was that we needed to have more people to properly have this discussion with a diverse group. The group decided to have a subgroup around this issue to make sure it is woven in within each of this conversation. John recommended we add Individual Differences so it is inclusive of different groups, religions, cultures, races/ethnicity that we are part of not just cultural, its sexual orientation, its religious groups, its gender and individual differences. Korey added that there is a term that comes from the health care field called “cultural humility” which is really about understanding yourself. You can’t understand all different cultures and individualities but it will give you a better perspective if you can better understand yourself so if you are open to your own biases so that might be incorporated into this as well.

Subgroup will be Korey, Toni, Esther, John. Anne asked if we could open that up to the public or go to stakeholder group – it was agreed to open it up. Willie Pearl asked to locate at least one of the meetings
in the cities because it is more diverse. Dana agreed that the diversity in the group is not sufficient to answer what we are trying to achieve but he is unclear of what we are trying to achieve. Anne said she thought the purpose is to have one or two people from different cultures to have this conversation that we just had about this but not a giant lift. Anab said adding a describer on this is important because opioids is impacting large communities of different cultural groups and showing up in disparities in its outcomes, with culture the beliefs, customs and approach of how we approach the interventions have to match what individuals receive as being helpful and aligned with their culture, community and language so we are just not applying one solution to everyone. She looks at it two-fold:

- What is it about the priority that we are going for that calls out community that are organized by different cultures, where some of those interventions might be shaped by how that intervention would look like in their community.
- In the traditional sense of all the priorities that might be funded what could done to embed culture and culture humility in how we deliver the services. Making services more inconclusive so not leave out as many communities organized differently.

Jolene suggested the Human Project who partnered with the UMN to send out surveys to the hardest hit communities from the opioid epidemic to ask questions of their community members. This could be a good way to get the information, his name is Clarence, and she has his contact information.

Anab said it is important for continuous learning to add that extra time at the meeting to hear from the communities that are hardest hit if we are willing to continue that by inviting them.

John spoke about definition about cultural sensitivity, but back to individual differences like the lgbt, transgender community whose youth are being hit disportionately with opioid use disorder and higher rates of suicide. He wants to make sure when we think of culture that we think it is a part of an individual difference. There is meaning in the words we use so we are really considering that as we move forward. If we are going to be reaching out we need to consider those communities as well. There is also the military culture, the culture up in the Iron Range, the culture in Southern Minnesota so that we have a really defined definition so we get all of these stakeholders.

The group agreed to include the individual differences with culture.

Darren plans to take it to the Dakota Consortium meeting to discuss with them two days before our next meeting. He was going to follow up with Nicole to see if she can input from the Ojibwe tribes as well. The Minnesota Indian Advisory Council, which represents all tribes in Minnesota, are adamant that they have input in addition to Darren and Nicole so they want to facilitate that.