Welcome Everyone

Presenter audio is muted until the presentation begins

If you are using your computer speakers and have trouble hearing the volume during the presentation, we recommend participating with a telephone line.

Attendee microphones are muted upon entry.

Teleconference call information is available in the Event info section
Stakeholder Engagement: Cultural Recommendations
1:30pm-2:30pm

Presenter Today: Amelia Fink, Jeff Hunsberger
Behavioral Health Division

Teleconference call information is available in the Event info section of the WebEx.
How to participate today

• **For technical difficulties** please send your comments to “Jacob Owens” by selecting his name from the drop down menu in the Q&A section.

• **Questions/Comments:** Utilize the Q & A feature

• **Polling:** Polling feature will be used to gather live feedback

• **Questions for today:** [YourOpinionMatters.DHS@state.mn.us](mailto:YourOpinionMatters.DHS@state.mn.us) and put “Stakeholder Engagement” in the subject line.
  
  ➢ Submit questions or comments following the WebEx
  
  ➢ Request a presentation about SUD reform (e.g. regional provider meetings, provider/county meetings, etc.)
  
  ➢ Provide suggestions for future WebEx topics
Today’s Agenda

• 2018 Stakeholder Engagement Overview
• Policy for Cultural Recommendations and Additional policy items and feedback
• Additional time for Q &A
• Wrap-Up
2018 Stakeholder Engagement Overview

- Engage stakeholders for input on policy recommendations from Minnesota’s Plan for the Prevention, Treatment and Recovery of Addiction.

- The report was developed with stakeholder engagement input from a core and fiscal stakeholder workgroup that was convened in 2016. The core workgroup incorporated and built on the recommendations of the 2013 Legislative Report: Minnesota's Model of Care for Substance use Disorder and the input collected in the fall 2015 ADAD listening sessions.

- Several of the policy recommendations were included in legislation that passed as part of SUD reform legislation in 2017 (i.e. care coordination, peer recovery support, comprehensive assessments, direct reimbursement and withdrawal management).
Clinical Participant Engagement Process

• We will be using feedback received from responses gathered from the Guide on Reform Concepts Under Consideration, other documents that DHS has provided with recommendations, and other emails that were sent to youropinionmatters.dhs@state.mn.us.

• We will have an opportunity to take in questions, ideas or concerns for both cultural recommendation and additional topics during this WebEx.

• You can provide additional comments and suggestions after this WebEx by:
  • Emailing YourOpinionMatters.DHS@state.mn.us with “Clinical” or the specific topic, such as “Cultural recommendations”, in the subject line.
2018 Stakeholder Engagement Overview

• WebEx sessions to review the policies that were not passed into law in the 2017 legislative session and other policy recommendations.

• Sub-workgroups will review policies and provide updates.

• The purpose of the clinical sub-group is to gather feedback, ideas and considerations to inform our policy recommendations in the 2019 legislative session and beyond.
Clinical WebEx schedule

• Behavioral Health Division Lead: Amelia Fink-Clinical Services

• WebEx topic meetings, dates and times:

  • Opioids and OTP’s:
    Thursday, August 30th 12:30pm-1:30pm

  • Cultural Recommendations and Additional Topics:
    Tuesday, September 4th 1:30pm-2:30pm

  • 245G Recommendations:
    Wednesday, September 5th, 11:30am-12:30pm
Behavioral Health Division: SUD Team Intros
Cultural Recommendations
Poll- Who is with us today?

Complete the poll and indicate which area best describes who you are representing:

• Tribal substance use disorder program employee
• Tribal social services employee
• 245G program with special populations enhancement rate
• 245G program without a special populations enhancement rate
• Independent provider
• DHS cultural grant recipient
• Other
Some initial feedback was gathered by Don Moore and Brian Zirbes with the American Indian Advisory Council. Items discussed included:

• That Alcohol and Drug Counseling recruitment and retention through UMICAD and other sources be a priority as most current Alcohol and Drug Counselors were aging out.

• Ongoing rule 25 to help in maintaining ability to conduct assessment in light of attrition rates

• Peer support, advocacy for this was emphasized as it was a key factor in providing long-term sobriety. More support in curriculum development and provide more definition and function in the current concept of ‘treatment coordination”.

• Provide leadership to help develop a road map towards certification with UMICAD, curriculum development and scholarships were mentioned as some counselors were unable to pay the $100.00 fee towards initial certification and ongoing recertification.

• There is a need to build a roadmap to allow cultural practices, including healing ceremonies as a billable service. All tribes see value in moving this forward as some states have done so already.
• Research the possibility of bringing back the prevention training with UMICAD. Continued prevention funding with peer support.

• Dire need for sober housing was also discussed.

• Background checks was also discussed Federal vs. State and how people cannot enter into the Substance Use Disorder field because of a past Felony conviction.

• Council members were very interested in giving feedback but in a more structured, focused meeting, giving adequate advanced notice so council members (AIAC) would be able to attend and provide more feedback. 

Occurred Wednesday, August 29th, facilitated by Don Moore.
Clinical: Cultural Recommendations

1. Modify the enhanced rate requirements
2. Stakeholder engagement
3. Funding for culturally specific providers
4. Decrease disparities in outcomes
5. Develop standards with stakeholders
6. Prevention funding for underserved communities
1) Modify the enhanced rate requirements.

• Currently, to qualify as a culturally specific/special populations program, at least 50 percent of treatment staff must be of the culture or special population. We recommend legislation to modify the enhanced rate requirements to allow non-treatment program staff to count toward the 50 percent when providing cultural services. **DHS is no longer in support of this recommendation.**

Mixed level of support
1) Modify the enhanced rate requirements.

**Recommended Changes:**

- “Allow for this only when it is somebody that is regular provider and/or contractor, e.g. a group from MAPS or culturally specific provider that comes in on a weekly basis providing culturally specific services and programming.”

- “Allow for techs and outside tribal members that are enrolled in a tribe to facilitate group/programming that are billable services.”

- “If a program doesn’t have 50% of their staff that is specific to that culture/population, the program should be able to bring in external resources to meet this requirement. External resources can be a great way for patients to gain resources outside of treatment.”
1) Modify the enhanced rate requirements.

**Additional considerations:**

- “The ability to become a culturally specific licensed facility or service provider, even if you are not considered to be providing services to a specific population or identified as a culturally/population specific program in general. Rate increases do not match service cost increases and services provided by each facility and provider sites.”

- “LGBTQ does not currently qualify for an enhanced rate and absolutely should qualify, since the issues related to being a member of the LGBTQ community are specific and require specialized expertise related to therapy and programming.”

- “No rate enhancement. Every professional is held to be culturally competent so there should not be a rate enhancement”

- “There needs to be a clear delineation of who would qualify to provide these services, ideally through company developed specific criteria/ competencies, as well as reasonable DHS specific criteria.”
2) Stakeholder Engagement

• Conduct meaningful stakeholder engagement that is transparent and committed to honestly and persistently working through conflicts and challenges.

All responses were supportive of this

Recommended Changes:

• “I think that DHS needs to be much more transparent in working with the stakeholders and take into consideration what the stakeholders are asking for and/or needing.”

• “Trying to make some of these clients attend 30+ hours of licensed programming is not realistic. Increase the number of licensed programming hours that are made available to the patients to 34 hours per week but do not hold the stakeholder responsible for making the patient attend when they are not mentally or physically capable.”
2) Stakeholder Engagement

• “The state has often introduced initial language prior to consulting stakeholders about issues or concerns. It would be beneficial for the state to bring the concern to the stakeholders where language could be developed collaboratively”

• “Continue seeking feedback from the providers in order to improve how programs deliver care.”

• “Recommend consulting with stakeholders regarding any proposed changes prior to those changes being drafted and introduced, as often times the impact of those changes are not given much consideration and result in laws that are not easy to be in compliance with and that disrupt patient care”
2) Stakeholder Engagement

• “The feel in the past has been that DHS is working against us. DHS should be working with our programs to help us continue to deliver the best possible care to our patients.”

• “Possibly look at ways to incentivize providers for good performance, versus everything being geared toward taking away or punishing providers when there are deficiencies.”

Additional things to consider:

• “Often time general licensing reviews and investigations seem extremely punitive and excessive. It appears from the perspective of the facility that the financial impact of law changes to the programs is not considered.”
2) Stakeholder Engagement

• “Ultimately, having better stakeholder relationships is a necessary prerequisite to good risk management/ process improvement.”

• “Stakeholders are directly impacted by changes made and can offer great insight into how the change affects patient care, financial considerations, realistic implementation, and whether the changes will likely have the impact intended.”

• “Licensing changes often impact the bottom line, rate increases do not keep up with these changes.”
3) Funding for culturally specific providers

• Seek non-Medicaid funding opportunities for culturally specific providers such as traditional healers or other unlicensed individuals who provide cultural services to support a client’s treatment goals.

All who responded were in support of this recommendation

Recommended Changes:

• “Allow for services that are provided by tribal members, LGBTQ population, Ethnically specific (different socio-cultural communities), members of the recovering community to “count” towards licensed programming.”

• “This is a great goal for culturally specific programs. There are unlicensed individuals and groups that can provide very valuable services.”
3) Funding for culturally specific providers

• “Allowing for services that are provided by cultural specific leaders within that specific culture.”

• “Additional adjusted rates for culturally specific services should be able to be requested if being clinically provided at the provider site.”

• “We have a financial impact when bringing in contracted culturally specific individuals. This is a benefit to the services provided to the patients and there should be reimbursement to the facility”

Additional things to consider:

• “The US Department of Health and Human Services strongly supports and encourages culturally competent service provision, and gives guidelines through their National CLAS Standards, which can serve as an excellent resource for this discussion.”
4) Decrease disparities in outcomes

- Support the development of culturally appropriate and effective treatment modalities that decrease disparities in outcomes.

All responses were in support of this recommendation

**Recommended Changes:**

- “Discover a way in which this could somehow be included in DAANEs reporting to ensure improved tracking.”

- “What does that data say? Having culturally specific programming would sure be helpful. Data collection methods that are more focused on Culturally Specific outcomes would be helpful.”

- “Use resources as noted above as best practice guidelines. There are very good clinical resources to help guide the development of culturally appropriate and effective treatment, beyond what the state deems to be best practice.”
4) Decrease disparities in outcomes

Additional things to consider:

• “More awareness related to disparities that correlate to each ethnic/culturally specific group to improve overall services being provided and the continuity of care. How is this being tracked? Or Reported?”

• “Services need to be more oriented to respecting each individual’s cultural needs in a responsive and equitable manner. The workforce should be representative of the particular patient population being served to more adequately meet treatment needs. Continuous quality improvement efforts should focus on collecting more meaningful data than is presently the case.”
5) Develop standards with stakeholders

• Work with stakeholders to consider external standards that could be undertaken to improve the quality and inclusiveness of a program. Explore how culturally competent and inclusive services could also be achieved through staff training requirements and specific attention to clients’ needs and desires.

Very mixed responses received

**Recommended Changes:**

• “Allow stakeholders to devise own competency based criteria to incorporate into policy.”
5) Develop standards with stakeholders

• “Provide for culturally specific training and offer services that are inclusive not segregated by culture”

Additional things to consider:

• “Too much oversight and would complicate being able to provided effective services to patient and discourage new professional from working in the field.”

• “This would discourage programs from engaging in the practice, too much oversight. Rules about the rules about the rules.”
6) Prevention funding for underserved communities

• Seek increased prevention funding to target underserved communities experiencing disparities. Develop prevention efforts with a holistic and tailored focus for different populations

All who responded were still in support of this recommendation

Recommended Changes:

• “More access to these services within the underserved and impoverished neighborhoods.”

• “Prevention is something that is needed and neglected. There are programs funded in the schools however, there is a significant need among the general adult population as well that is being ignored. It requires funding to happen.”
6) Prevention funding for underserved communities

Additional things to consider:

• “This is something that leaders of the LGBTQ community has been requesting for quite some time. There are many opportunities for prevention that could be incorporated into events within the LGBTQ community as well as other ethnic groups.”
Additional feedback

• Please use the next 5 minutes to ask questions, share ideas or express concerns

• We will share feedback and respond to questions with the group today for as long as our time allows. Additional items not addressed today will be incorporated into the final 2018 Stakeholder engagement report.
Additional Topics
Clinical: Additional Topics

1. Insurance plan coverage

2. Rule 25 assessment for individuals with DWI offense.

3. Improvement in the relationships that DHS and its licensors have with the stakeholders.
1) Insurance plan coverage

• Insurance plan coverage for enrolled members who are court ordered or committed. This proposal is modeled after 62Q.535 which requires plans to provide coverage for mental health treatment who are court-ordered or committed. This proposal supports parity.

All who responded were in favor of this recommendation

**Recommended Changes:**

• “Hold the payers responsible for reimbursement”
2) Rule 25 assessment for individuals with DWI offense.

- Rule 25 assessment for individuals with DWI offense. Ten years ago, DHS and DPS met to discuss what type of assessment would be appropriate to require of individuals convicted of DWI. The Rule 25 Assessment was the agreed-upon assessment at that time and this requirement was enacted in 169A.70. To prepare for the upcoming phase-out of the Rule 25 Assessment, this proposal changes the statute to require comprehensive assessment for individuals convicted of DWI instead of the Rule 25 Assessment. DHS, Counties and DPS continue to engage in conversations and will all need to support this change, and this may need to come from DPS agency bill. We do not expect opposition.

All who responded were in favor of this recommendation.
3) Improvement in the relationships that DHS and its licensors have with the stakeholders.

- Improvement in the relationships that DHS and its licensors have with the stakeholders.

Comments included:

- “I think it is critical that DHS become more collaborative in working with the stakeholders. Licensing reviews and investigations should be used as an opportunity to improve our programs as opposed to an opportunity for punitive actions.”

- “DHS should take a closer look at their demands. We make our best efforts to meet them with limited financial resources and workforce shortage however, the response remains punitive.”
3) Improvement in the relationships that DHS and its licensors have with the stakeholders.

- “Begin training with stakeholders monthly on 245G/ expectations of processes.”

- “I read all of the licensing reviews sent out on a regular basis and almost all of the programs are getting multiple citations for the same things. Perhaps DHS needs to look at their expectations and what they are demanding us to do with limited financial resources and workforce shortage.”

- “The only way to really improve the relationship is through demonstrating a true commitment to incorporating feedback that comes through forums like this document and really recognizing the value in the services being delivered to increasingly sicker patients with greater demands for clinical intervention.”
Additional feedback

• Please use the next 5 minutes to ask questions, share ideas or express concerns

• We will share feedback and respond to questions with the group today for as long as our time allows. Additional items not addressed today will be incorporated into the final 2018 Stakeholder engagement report.
Behavioral Health Division Lead: Amelia Fink-Clinical Services

Upcoming Clinical WebEx topic meetings, dates and times:

245G Recommendations: Tomorrow, September 5th, 11:30am-12:30pm
Ways to Stay Informed

• Visit our website to:
  
  • Subscribe for email updates (e-Memo) to receive updates from the Behavioral Health Division on SUD
  
  • Learn more about substance use disorder policies and procedures, initiatives, workgroups, training and conferences, grant announcements, access forms and more

  Look for our “Friday’s Digest” E-memo!

• We want to hear from you about YOUR substance use disorder system. Send input to: YourOpinionMatters.DHS@state.mn.us
Next Stakeholder WebEx: Sept 5th 11:30am-12:30pm
Thank you for joining us
Behavioral Health Division