Minnesota Substance Use Disorder Community of Practice:

December 19, 2023 Meeting Summary

Background

On December 19, 2023, participants attended the fourth Minnesota (MN) Substance Use Disorder (SUD) Community of Practice (CoP). The CoP is composed of people who are engaged in the field of SUD treatment and prevention in any capacity. This includes but is not limited to individuals with lived experience, providers, family members, researchers, recovery peers and advocates. The goal of the MN SUD CoP is to encourage the translation of knowledge into action and provide a framework for information sharing, competence development, rich discussion, and mentoring.

The MN SUD CoP meeting was facilitated by Health Management Associates (HMA) employees, Boyd Brown and Paul Fleissner, with ongoing subject matter expertise from Kamala Greene Genece and Debbi Witham. The CoP meeting was also planned and conducted in partnership with three community consultants, George Lewis, Zhawin Gonzalez, and Yussuf Shafie. While HMA and the community consultants are available to provide a framework for the meetings, the goal of the MN SUD CoP is for participants to actively engage and set priorities for the CoP.

This summary is divided into the following sections:

Contents

Background 1
General Announcements 2
Voices of Experience Panel 2
About Sarah and Recovery Yoga Minnesota 3
ASAM Levels of Care* 3
Level 1 Long-Term Remission Monitoring 4
Level 1.5 Outpatient Therapy 6
Level 1.7 Medically Managed Outpatient Treatment 7
Level 2.1 Intensive Outpatient/High-Intensity Outpatient 8

Sponsored by:
DEPARTMENT OF HUMAN SERVICES

Level 2.5 High-Intensity Outpatient 9
Level 2.7 Medically Managed Intensive Outpatient 10
Level 3.1 Clinically Managed Low-Intensity Residential 11
Level 3.5 Clinically Managed High-Intensity Residential Treatment 12
Level 3.7 Medically Managed Residential Treatment 14
Level 3.7 BIO 15
ASAM Challenges 15
Breakout Room Discussions 16

General Announcements

Boyd Brown, HMA, began the meeting with a few reminders for the CoP participants. These included:

1. **MN SUD CoP Reports**: As part of the MN SUD CoP work, HMA has been tasked with developing reports related to learnings obtained during the CoP meetings. HMA provided the first two reports, the MN SUD CoP Community Advocacy Capacity-Building Strategy Report and the MN SUD CoP Treatment Outcome Gaps Summary, Strategies, & Recommendations Report to participants via email to review and provide feedback prior to finalization on December 31, 2023. Final reports will be available to participants in January 2024.
2. **2024 MN SUD CoP Schedule**: HMA reminded participants that the MN SUD CoP meetings will move to a quarterly cadence in 2024, with workgroups scheduled on topics of interest or for specific groups between full CoP meetings. The meetings and workgroups that are currently scheduled, as well as registration links for each meeting, are provided in the table below.

Meeting	Date/Time	Registration Link
January Workgroup: Full, Participating CoP Members – 2023 CoP Open Feedback Session	January 10, 2024: 12-1 pm CT	https://healthmanagement.zoom.us/meeting/register/tJYodeGtqDgjH9dQvY38n-hyRVLuctbpKUYB
January Workgroup: ASAM Intro Follow-up Session (all members welcome)	January 26, 2024: 3-4 pm CT	https://healthmanagement.zoom.us/meeting/register/tJ0kde-vqjgpGtA9zPqmsQfre_bcpOZIDCKg
Q1 MN SUD CoP Meeting	February 20, 2024: 1-2:30 pm CT	https://healthmanagement.zoom.us/meeting/register/tJYqcuCvqj0qGdUhg06RcX2vpTZr4YsNk49K
Q2 MN SUD CoP Meeting	May 7, 2024: 11 am-12:30 pm CT	https://healthmanagement.zoom.us/meeting/register/tJclfu2ppzsqHdessM7UUG6gO-3MnG01zqzk
Q3 MN SUD CoP Meeting	August 20, 2024: 1-2:30 pm CT	https://healthmanagement.zoom.us/meeting/register/tJ0ldOqpqD4tGtzQfTBGwetIGuqSxssEVLbT
Q4 MN SUD CoP Meeting	October 15, 2024: 1-2:30 pm CT	https://healthmanagement.zoom.us/meeting/register/tJwpd-yhrzktGdAjRiOfyPNDD9wb-h86ocRs

Voices of Experience Panel

Following announcements, participants heard from Sarah Lydeen-Hughes, Founder and Director of Recovery Yoga Minnesota.

About Sarah and Recovery Yoga Minnesota

Sarah Lydeen-Hughes is the founder and owner of Recovery Yoga Minnesota, as well as a certified yoga instructor and a person with lived experience in recovery from addiction. Through Recovery Yoga Minnesota, she is focused on providing a holistic approach to long-term recovery using client-centered yoga and meditation practices, self-awareness, and unification of the mind and body.

Sarah's journey began at an early age, as a child of a family of addiction. Raised in a bi-racial family, she faced struggles with her identity, which was not reflected fully at home or at school. These experiences, in addition to a recent autism diagnosis, contributed to her feeling she did not belong in social situations. Because of this, Sarah began to explore methods of coping with sensory and somatic issues, eventually leading to substance use, which allowed her to self-medicate, feel more at ease in society, and bury physical and mental pain. During her time in active addiction, Sarah dealt with various trauma, assault, and abuse.

In 2018, Sarah entered a recovery phase. Because there were not any facilities in Minnesota that would accept Sarah with her two children, particularly her 15-year-old son, she had to address recovery without treatment facility support. Unfortunately, in 2020, when attempting to assist her brother with his recovery, the father of Sarah's children was killed, causing additional trauma, and leading to a relapse of her SUD.

During her second journey to recovery, Sarah prioritized methods for dealing with emotions and exploring holistic forms of healing. In doing so, she obtained a degree in Integrative Health and Healing and became certified as an SUD recovery yoga instructor. Through Recovery Yoga, Sarah helps those with SUD move from fight or flight mode toward a pathway of exploring and experiencing emotions and challenges head on. For information on Sarah and Recovery Yoga, or inquiries about yoga classes, visit www.recoveryyogamn.com.

Help us continue to highlight Voices of Experience! If you would like to volunteer or have recommendations for continuing to highlight voices of lived experience, please let us know at mnsudcop@healthmanagement.com.

ASAM Levels of Care*

The ASAM criteria is the most widely used and comprehensive set of guidelines for treatment levels of care, placement, continued stay, transfer, or discharge of people with addiction and co-occurring conditions. It is the result of a collaboration that began in the 1980s to define and ensure one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Many states across the country are using the ASAM criteria as the foundation of their efforts to improve the addiction treatment system. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over 5 broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided.

*The following information was obtained via Waller RC, Boyle, MP, Daviss SR, et al, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Volume 1: Adults. 4th ed. Hazelden Publishing: 2023.

The levels of care include:

Level of Care	Description of Service

Level	Services
Level 1: Outpatient Services	• Long-term Remission Monitoring • 1.5 Outpatient Therapy • 1.7 Medically Managed Outpatient Treatment
Level 2: Intensive Outpatient/Partial Hospitalization	• Intensive Outpatient • 2.5 High Intensity Outpatient Treatment • 2.7 Medically Managed Intensive Outpatient Treatment
Level 3: Residential/Inpatient	• 3.1 Clinically Managed Low-Intensity Residential Services • 3.5 Clinically Managed Medium-Intensity Residential Services • 3.7 Medically Monitored High-Intensity Inpatient Services
Level 4: Medically Managed Intensive Inpatient Services	• 4.0 Medically Managed Intensive Inpatient Services

The ASAM criteria is inclusive of the following dimensions:

Dimension	Subdimension
Dimension 1: Intoxication, Withdrawal, and Addiction Medications	• Intoxication and Associated Risks • Withdrawal and Associated Risks • Addiction Medication Needs
Dimension 2: Biomedical Conditions	• Physical Health Concerns • Pregnancy – Related Concerns
Dimension 3: Psychiatric and Cognitive Conditions	• Active Psychiatric Symptoms • Persistent Disability
Dimension 4: Substance Use-Related Risks	• Likelihood of Engaging in Risky Substance Use • Likelihood of Engaging in Risky SUD-Related Behaviors
Dimension 5: Recovery Environment Interactions	• Ability to Function Independently in Current Environment • Safety in Current Environment • Support in Current Environment
Dimension 6: Patient-Centered Considerations	• Barriers to Care • Patient Preferences • Need for Motivational Enhancement

Descriptions of the ASAM levels of care and requirements at each level are provided in the sections below.

Level 1 Long-Term Remission Monitoring

- Services are based on the chronic care model, which treats addition as a chronic health condition with periods of remission and recurrence.
- Services comprised of ongoing check-ins and early reintervention for people in sustained remission.
- Not tied to any specific treatment setting

- Set of services and capabilities that can be provided by a variety of providers and programs in any clinical setting.
- Overarching goal is to maintain ongoing therapeutic alliances and ensure, at a minimum, quarterly recovery management check-ups (RMCs) to support rapid reengagement in treatment for recurrence or danger of recurrence.
- RMCs should include sufficient recovery and remission-focused biopsychosocial screening and assessment to identify current or emerging addiction treatment, biomedical and/or mental health needs that may impact recovery and additional recovery support service (RSS) needs.
- Individualized recovery management plans focusing on services that best support recovery

Topic	Description
Settings	• Any appropriate outpatient or telemedicine-based treatment setting that meets state licensure or certification criteria
Support Systems	• If Level 1 programs do not provide psychotherapeutic services directly, they should be made available through coordinated referral
Staff	• Trained addiction treatment professionals acting within their state-regulated scopes of practice (may also be staffed by allied health staff) • May not provide medical services • If a program is clinically managed, it should have a program director (or responsible clinician in an independent practice) with a minimum of a master's degree in a field related to BH
Services	• Should provide RCMs (including recovery capital assessments; mental health screening; and patient navigation) • Regular follow-ups until the patient is engaged in treatment
Services-Medical	• If medical services not provided directly, they should have established relationships with providers to coordinate access to: - Medication management - Medication adherence monitoring - Infectious disease screening and referral for care as needed; and • - Drug testing and toxicology services
Services-Psychosocial	• Should provide psychosocial services to address emerging issues that may undermine the persons recovery. • If not provided directly, should have formal affiliations with external providers to coordinate access to: - Psychosocial services, including MI and Solution-Focused Therapy (SFT) - Health education for concerns associated with the course of SUD - Family Education
Services-Recovery Support Services	• Level 1.0 programs should provide directly or through referral: - Assessment of RSS needs - Development of individualized recovery and remission management plans
Documentation	• Results from RCMs • Individualized remission management plans

Level 1.5 Outpatient Therapy

- Provides outpatient psychosocial services for people with mild SUD and those in early remission.
- Should include individual counseling, therapy, and psychoeducation
- Can be delivered by a range of staff based on their training, supervision, and scopes of practice.
- Group-based interventions may also be provided.
- Do not typically have medical staff but should be able to refer to an appropriate medical professional and coordinate care as needed,
- Including for initiation and maintenance of addiction medications.
- Beneficial for people who can be safely treated in low-intensity outpatient settings.
- Minimal concerns in Dimensions 1 and 2 and no more than moderate concerns in Dimension 3.
- May be the initial level of care clinically recommended for people who are at low-risk of SUD-related harms, motivated to engage in treatment and able to progress toward recovery goals with available peer and community support and scheduled therapeutic contact.
- May also be appropriate for people transitioning from a more intense level of care.
- Less than 9 structured hours of clinical services per week.

Topic	Description
Settings	• May be offered in any appropriate treatment setting where psychosocial services are provided that meets state licensure or certification criteria: - Office-based practices - Health clinics - Outpatient addiction programs - Behavioral health clinics - Group homes or shelters, and - Telemedicine
Staff	• Trained addiction treatment professionals acting within their state-regulated scopes of practice including clinical staff such as psychologists, clinical social workers, SUD and MH counselors and others trained to assess and treat SUD and co-occurring MH conditions • Typically, do not have a medical director, physicians/advanced practice providers, nursing, and medical support staff • Should have a program director with a minimum of a master's degree in a field related to clinical behavioral health
Assessment	• Level of Care Assessment-includes an addiction focused history conducted/reviewed prior to admission to determine the level of care • Physical Examination-person should be referred to a physician or advanced practice provider for a physical examination (within 1 month ideally)
Treatment Planning	• An individualized treatment plan should be developed within 3 visits. The person-facing treatment plan should include a plan for accessing emergency care 24/7, including when to call 911 or 988.
Reassessment	• Conduct formal reassessment of the treatment plan at least quarterly, with treatment plan updates incorporated as needed
Services-Clinical	• Provide less than 9 hours per week of structured clinical services in an amount, frequency, and intensity appropriate to individual person needs and level of function as determined by multi-dimensional assessment

Level 1.7 Medically Managed Outpatient Treatment

- Provide medically managed outpatient treatment services for people experiencing intoxication, withdrawal, biomedical and/or psychiatric concerns or who require initiation or titration of addiction medications and who can be treated safely and effectively with low-intensity outpatient services.
- Low-intensity ambulatory withdrawal management services
- Initiation or titration of addiction medications
- Biomedical care for persons with comorbid physical health conditions
- Management of common, low-complexity psychiatric conditions
- These programs also provide outpatient psychosocial services consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions.
- Level 1.7 programs should provide all the services of Level 1.5 programs either directly or through formal affiliations with other providers/programs.
- Includes specialty office-based treatment and opioid treatment programs (OTPs).
- Ideally, this level of care should incorporate street medicine strategies to reach people "where they are" and provide low-threshold initiation or titration of addiction medications and treatment engagement.
- Should support same-day access to care, when possible, and low-threshold access to addiction medications.

Topic	Description
Settings	• Level 1.7 services may be offered in any appropriate treatment setting with physician oversight that meets state licensure or certification criteria, such as: - Physicians' offices - Health clinics - Primary care settings - Outpatient addiction programs - Opioid Treatment Programs - Office-based addition treatment programs - Mobile addiction treatment programs
Support Systems	• Encouraged to provide an after-hours telephonic availability through direct connection to on-call services, such as nurse triage lines.
Staff	• Medical director must be a physician with at least two years of documented experience delivering specialty addiction treatment (active care team) • Physicians/advanced practitioners with controlled substance prescribing authority (active care team) • Appropriately trained addiction treatment professionals acting within their state-regulated scopes of practice during program hours • Directly or through formal affiliated providers or programs, by clinical staff such trained to assess and treat SUD and/or co-occurring MH conditions
Assessment	• A physical examination should be conducted by a physician or advanced practice provider within a reasonable time frame of treatment initiation
Treatment Planning	• An individualized treatment plan should be developed within 3 visits (including plan for accessing emergency care 24/7 and when to call 911 or 988)

Services-Medical	• Provide outpatient medical management of acute withdrawal and biomedical and psychiatric conditions including: - Assessment upon admission that includes vitals; history of present illness; baseline evaluation of withdrawal severity and risks and medical history - Addiction-focused physical examination, typically at initial visit - Medication initiation and management for common low complexity psychiatric conditions • Should support outpatient medical monitoring and management of common comorbid biomedical and psychiatric conditions
Services-Clinical	• Provide clinical services in amount, frequency, intensity appropriate to individual needs/level of function as determined by ASAM multi-dimensional assessment
Services-Psychosocial	• Should be individualized based on the person's assessment

Level 2.1 Intensive Outpatient/High-Intensity Outpatient

- Provide intensive outpatient services consisting of counseling, psychoeducation, and psychotherapy regarding management of addiction and co-occurring mental health conditions.
- Provide clinically planned and managed therapeutic milieu facilitated by trained clinical staff that imparts peer support, builds pro-recovery attitudes, and improves coping strategies and behaviors.
- Deliver 9 to 19 hours of structured programming per week.
- Services may be delivered in any appropriate outpatient treatment setting where psychosocial services are provided and meeting state licensure and certification requirements.
- Do not typically provide medical services.
- However, should have policies defining when and how to consult with and refer to addiction specialty physicians, as needed.

Topic	Description
Settings	• Services may be offered in any appropriate outpatient treatment setting where psychosocial services are provided that meets licensure or certification, such as: - Outpatient treatment programs - Behavioral health clinics
Staff	• Interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scopes of practice, including a program and clinical staff. • Typically staffed by allied health professionals who support ongoing engagement in addiction treatment, deliver RSS, and provide warm hand-offs. • Typically, don't provide medical services and do not typically have a medical director/prescriber.
Assessment	• A level of care assessment, including an addiction focused history, conducted, or reviewed prior to admission to determine the recommended level of care • A physical examination should be conducted by a physician/advanced practitioner within 14 days of admission and include assessment for medication needs
Treatment Planning	• Individualized treatment plan should be developed withing 7 days of admission and include a plan for contacting the program after-hours and accessing emergency care 24/7 including when to call 911 or 988.

Reassessment	• Meet at least weekly to discuss the person's progress and adjust the treatment plan as needed. • A weekly progress note should be added to the clinical record that outlines progress, concerns, and any changes to clinical care. • Formal reassessment and treatment plan updates should occur at least monthly and include determination of whether patient is progressing appropriately.
Services-Clinical	• Provide 9 to 19 hours per week of structured clinical services. • Structured services delivered by master's level clinical staff should be provided at least 3 days per week in an amount, frequency, and intensity appropriate to individual needs.

Level 2.5 High-Intensity Outpatient

- Level 2.5 programs provide high-intensity outpatient services for people with SUDs consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring MH conditions.
- Also provide a clinically planned and managed therapeutic milieu facilitated by trained clinical staff that imparts peer support, builds pro-recovery attitudes, and improves coping strategies and behaviors.
- Have a medical director who is responsible for developing program policies, procedures, and protocols for ensuring the appropriateness of admission to this level of care.
- The medical director supports coordination of care for people transitioning from a medically managed level of care and with external medical and psychiatric providers as needed.
- The availability of a medical director enables Level 2.5 programs to provide some integrated biomedical services (varying across programs).
- Provide at least 20 hours of structured clinical services per week.

Topic	Description
Settings	• Services may be offered in any appropriate outpatient treatment setting where psychosocial services are provided that meets licensure or certification, such as: - Outpatient day treatment programs - Partial hospitalization programs
Staff	• Interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scopes of practice, including a medical director, program director, clinical staff, and others trained to assess and treat SUD and/or co-occurring MH conditions. • Typically staffed by allied health professionals who support ongoing engagement in addiction treatment, deliver RSS, and provide warm hand-offs.
Assessment	• A level of care assessment, including an addiction focused history, conducted, or reviewed prior to admission to determine the recommended level of care • A physical examination conducted by a physician/advanced practitioner within 7 days of admission and include assessment for addiction medication needs
Treatment Planning	• Individualized treatment plan should be developed withing 5 treatment days of admission including a plan for contacting the program after-hours and accessing emergency care 24/7 including when to call 911 or 988.

Reassessment	• Meet at least weekly to discuss the person's progress and adjust the treatment plan as needed. • A weekly progress note should be added to the clinical record that outlines progress, concerns, and any changes to clinical care. • Formal reassessment and treatment plan updates should occur at least monthly and include determination of whether the person is progressing appropriately.
Services-Clinical	• Provide at least 20 hours per week of structured clinical services. Structured services delivered by master's level clinical staff should be available at least 5 days per week in an amount, frequency, and intensity appropriate to individual person needs and level of function as determined by the multi-dimensional assessment.

Level 2.7 Medically Managed Intensive Outpatient

- Level 2.7 is an organized outpatient service delivered by medical professionals who provide evaluation and management of intoxication, withdrawal, biomedical concerns, and common low complexity psychiatric concerns.
- Coordinated management of withdrawal and biomedical and psychiatric comorbidities delivered by medical and clinical staff in an intensive outpatient setting.
- Services should be delivered under a defined set of physician-approved policies and physician-managed procedures and medical protocols.
- Provide medically managed intensive outpatient services for people who require access to medical management with extended nurse monitoring but not 24-hour nursing support, overnight medical monitoring, nor residential structure and support.
- Important to have established relationships with Level 3.7 and Level 4 programs to support rapid transition of people requiring continued observation or after-hours nursing care.
- Provide at least 20 hours of clinical services per week, comprised of medical care and psychosocial services.
- Level 2.7 programs should provide all the services of Level 2.5 programs either directly or through formal affiliations with other providers or programs.

Topic	Description
Settings	• Services may be offered in appropriate outpatient treatment setting where psychosocial services are provided that meets state licensure or certification, such as: - Intensive Outpatient Programs - Partial hospitalization programs - OTPs - Office-based specialty addiction treatment practices
Staff	• Interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scopes of practice, including a medical director, physicians/advance practitioners with controlled substance prescribing authority, nurses, program director, clinical staff, and others trained to assess and treat SUD and/or co-occurring MH conditions. • Typically staffed by allied health professionals who support ongoing engagement in addiction treatment, deliver RSS, and provide warm hand-offs to other levels of care.
Assessment	• Within 24 to 48 hours of admission, a physician or advanced practice provider should conduct a history and physical examination on-site and review and approve the admission decision.

Topics	Description
Treatment Planning	• The person-facing treatment plan should include a plan for contacting the program after-hours and accessing emergency care 24/7 including when to call 911 or 988.
Services-Medical	• Intensive outpatient medical management and extended nurse monitoring for stabilization of acute withdrawal and biomedical and psychiatric conditions, including: • Comprehensive medical history and physical examination • Nursing assessment upon admission that includes vitals; history of present illness; baseline evaluation of withdrawal severity and risks; and medical history • Nurse monitoring • Medication management • Prescription services with essential medications on-site • A physician or advanced practitioner should be available in-person or via telemedicine during program hours of operation to initiate or adjust medications based on the results of nursing assessments • Withdrawal management should be available within 1 hour of initial assessment. • Provide outpatient medical monitoring and management of common comorbid biomedical conditions and psychiatric conditions. • Programs should have policies and procedures that define essential medications based on current standards of clinical practice.
Services-Clinical	• Provide at least 20 hours per week of structured clinical services delivered by master's level clinical staff should be available at least 5 days per week in an amount, frequency, and intensity appropriate to individual person needs and level of function as determined by the multi-dimensional assessment.
Services – Psychosocial	• Psychosocial services should be individualized based on the person's assessment selected by master's level clinical staff should be available at least 5 days per week either directly or through formal affiliation.

Level 3.1 Clinically Managed Low-Intensity Residential

- Level 3.1 programs offer clinically managed organized treatment services that feature a planned and structured regimen of care in a 24-hour supervision residential setting.
- The primary clinician responsible for managing the individual's level of care is a clinical addiction profession such as a psychologist, social worker, or counselor.
- Individuals placed in clinically managed levels of care have minimal intoxication, withdrawal, and addiction medication needs and biomedical complications.
- Provides habilitative and rehabilitative services to support the development and consolidation of the recovery skills necessary to avoid the use of substances in a manner that presents a high risk of serious harms or destabilizing loss upon transition to lower level of care.
- People can safely leave the facility without supervision to participate in work, school, or other community activities with appropriate accountability checks.
- Level 3.1 programs provide clinical services 9 to 19 hours per week consisting primarily of counseling, psychoeducation, and psychotherapy to address addiction and co-occurring mental health conditions.

Topics	Description

Settings	• Programs should be offered in any appropriate residential treatment setting with 24-hour staff and integrated clinical services that meets state licensure or certification criteria. • Incorporate space for counseling services, group meetings, therapeutic activities, person's rest and privacy, meals, and hygiene. • Enable adequate supervision and management of people at all times. • The facility should maintain a supportive living environment that provides safety from substances, paraphernalia, and weapons. • Verify and document the whereabouts and wellness of each person who is on-site at least once every hour.
Staff	• Interdisciplinary team of appropriately trained and supervised addiction treatment professionals including a program director, clinical staff, and others trained to assess and treat SUD and/or co-occurring mental health conditions. • Programs should have allied health staff who support ongoing engagement in SUD treatment. • Do not typically provide medical services and do not typically have a medical director and/or nursing and medical support staff.
Assessment	• A Level of Care Assessment, including an addiction-focused history, should be conducted, or reviewed prior to admission to determine the level of care. • A physical examination should be conducted by a physician or advance practice provider within 14 days of admission including assessment for addiction medication needs.
Treatment Planning	• Individualized, with services- including motivational enhancement services -tailored to the person's needs strengths and stage of change in each area developed within 72 hours of admission and including functional deficits.
Reassessment	• The team should meet at least weekly to discuss progress and adjust the treatment plan as needed. • A weekly progress should not be added to the clinical record that outlines progress, concerns, and any planned changes to clinical care.
Services-Clinical	• 9 to 19 hours of clinical services per week, with the type of and intensity of services determined by individual need. • Services include individual, group, and family therapy; medication adherence support and medication education; mental health evaluation and symptom management support; introductory or remedial life skills workshops; coordination and collaboration with external medical and/or mental health providers; and recovery support services such as vocational rehabilitation and job placement. • Interpersonal skills and skills of daily living are promoted through the use of community or house rules, structure, and community meetings of people and staff.

Level 3.5 Clinically Managed High-Intensity Residential Treatment

- Level 3.5 programs provide clinically managed high-intensity services consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring conditions in 24-hour supervision residential settings.
- Also provides a high-intensity, clinically planned and managed therapeutic milieu that encourages development and internalization of prosocial attitudes and behaviors, using community support to reinforce recovery skills.

- Provide services for people needing a safe and stable living environment to develop and practice recovery skills necessary to avoid immediate recurrence of or continuing use in a manner that poses significant risk for serious harm or destabilization.
- Concerns in Dimensions 4 and 5 are sufficiently severe to require this level of treatment.
- Have a medical director who is responsible for developing program policies, procedures, and protocols for ensuring the appropriateness of admission to this level of care.
- Medical director oversees effective care coordination and collaboration with external medical/psychiatric providers.
- Medical director availability enables Level 3.5 programs to provide some integrated biomedical services (varying across programs).
- Have 24-hour on-call medical support to address urgent or emergent issues that may arise.
- Provide at least 20 hours of structured clinical services per week.

Topic	Description
Settings	• Adhere to general residential facility standards that incorporate space for counseling services, group meetings, therapeutic activities, individual rest and privacy, meals, and hygiene. • Supervision and management of people at all times, ensuring that staff can respond to instability in a safe and timely manner. • 24-hour structure and support-staff should verify and document the whereabouts of each person who is on-site at least once every hour. • People should not leave the program premises except under limited circumstances (may be given opportunities to practice skills for community reintegration as they progress).
Staff	• Staffed by an interdisciplinary team of appropriately trained and supervised addiction treatment professionals including a medical director, a program director, clinical staff such psychologists, clinical social workers, SUD, and mental health counselors. • Programs should also have allied health staff.
Assessment	• A Level of Care assessment should be conducted or reviewed prior to admission to determine recommended level of care. • A physical examination should be conducted or reviewed with 72 hours of admission or sooner based on the person's medical presentation.
Treatment Planning	• Initial treatment plan should be developed within 72 hours.
Reassessment	• Interdisciplinary team should meet at least weekly to discuss individual progress and adjust the treatment plan as needed. Formal reassessment and treatment plan updates should occur at least monthly and include determination of whether the person is progressing appropriately.
Services-Clinical	• At least 20 hours of clinical services per week that include individual intervention, psychotherapy, and counseling, as well as structured group sessions for psychoeducation, skill development and practice, and group therapy. • Treatment is focused on habilitative treatment approaches such as clarifying personal values; identifying individual strengths, need and preferences, acquiring hobbies, developing coping skills, recognizing the impact of SUD on the person's life and familial and social relationships, and forming a sense of self-worth.

Services – Support	• Physician or advanced practice provider available on call 24/7 to respond to urgent situations, including evaluating and support management of people who are intoxicated or experiencing withdrawal (including when to engage the on-call physician or call 911/988)
Services-Medical	• Medical director who is responsible for developing, approving, and regularly reviewing program policies, and procedures and protocols for ensuring the appropriateness of admission. • Managed withdrawal management; supervision of self-administered medications for withdrawal in accordance with a prescription from physician or advanced practice provider; and clinical monitoring of withdrawal. • Integrated biomedical services, • 24 hour on-call medical support to address urgent or emergent medical issues and these programs should be able to support people stepping down from Level 3.7 or 4

Level 3.7 Medically Managed Residential Treatment

- An organized service delivered by medical professionals who provide 24-hour evaluation and management of intoxication, withdrawal, biomedical concerns, and common low complexity psychiatric concerns in a permanent residential facility.
- Services delivered under a defined set of physician-approved policies and procedures and medical protocols.
- 24-hour observation, monitoring and treatment are available; however, people admitted to this level of care don't need the full resources of an acute care hospital.
- This level of care is sometimes provided as a step-down service from Level 4.
- Medical director should be board certified in addiction medicine or addiction psychiatry.
- 24/7 nursing is a critical component of Level 3.7 programs.
- Programs that house multiple levels of care should consider delineating which beds may be filled by people at Level 3.7 to ensure that staffing is sufficient.
- Level 3.7 programs should provide all the services of Level 3.5 programs either directly or through formal affiliations with other providers or programs.
- Provide at least 20 hours of clinical services per week comprised of medical care and psychosocial services to address addiction and co-occurring mental health conditions.

Topic	Description
Settings	• Any appropriate residential treatment setting with 24-hour nursing staff and physician oversight that meets state licensure or certification criteria. • Staff should verify and document the whereabouts of each person on-site at least once every hour. (*separate from clinical monitoring)* • Program staff should provide continuous supervision of people when they are off-site
Staff	• Programs are staffed by an interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scope of practice and include a medical director, physicians and advanced practice providers with controlled substance prescribing authority and nurses • Also staffed directly or through formal affiliated providers or programs by a program director, clinical staff, and allied health staff

Assessment and Treatment Planning	• Within 24 hours of admission, a physician or advanced practice provider should conduct a history and physical examination on-site and review/approve the admission.
Services-Medical	• Residential medical management and 24-hour nurse monitoring for stabilization of acute withdrawal and biomedical and psychiatric conditions including: - Comprehensive medical history and physical examination performed within 24 hours of admission - Nursing assessment conducted at admission that includes vitals; history of present illness; baseline evaluation of withdrawal severity and risks; medical history - Hourly nurse monitoring of the person's progress and medication administration as needed; - Medication management; and - Prescription of services with essential medications on-site • A physician or advanced practitioner should be available in-person or via telemedicine 24/7 to initiate or adjust medications based on the results of nursing assessments.
Services-Clinical	• Provide at least 20 hours of structured clinical services per week comprised of both medical and psychosocial services. • Structured psychosocial services selected by master's level clinical staff should be available 7 days per week. • Services should be provided in amount, frequency, and intensity appropriate to individual person needs and level of function as determined by the ASAM Criteria multi-dimensional assessment. • Should be able to provide transportation as needed for clinical services not available on-site.
Services – Psychosocial	• Psychosocial services delivered should be individualized based on the person's assessment

Level 3.7 BIO

- Level 3.7 BIO programs provide residential management of intoxication, withdrawal, biomedical concerns, and common low complexity psychiatric concerns that require IV medications.
- Services delivered under a defined set of physician-approved policies and procedures and medical protocols.
- In addition to the biomedical capabilities of Level 3.7, Level 3.7 BIO programs should have access to the following on-site biomedical capabilities:
- IV medications, including the ability to use and manage an existing PICC line

ASAM Challenges

Challenges with Implementing ASAM, obtained from the 2022 Mid-Point Assessment: Minnesota Substance Use Disorder System Reform Section 1115(a) Demonstration Project performed by NORC at the University of Chicago, included:

- Communication and Training
  - Trainings were not clear
  - Trainings not tailored to their needs
  - Focused on medication assisted treatment (MAT), not ASAM criteria generally
  - ASAM criteria was too general

- Resulting in Current State
    - Providers relying on informal information sharing to prepare themselves
- Reimbursement rates
    - MCOs not already reimbursing providers and/or unaware of the requirement when the provider contacted them
- ASAM Criteria vs. Minnesota Matrix
    - Change in number of hours authorized for treatment under ASAM
- Referral arrangements are burdensome
- Required timelines for follow-up consults due to availability and responsiveness of other providers
    - Don't want to disrupt care to send to someone who can see the person instead of their current provider
- Resulting in Current State
    - Providers reported they had not observed a significant change to their existing referral and care coordination practices
- Workforce
    - Significant loss of staff

Breakout Room Discussions

What do you see as gaps in the current continuum? Are there specific levels of care that are missing? What is missing in delivering services in fidelity with the ASAM criteria in the current state?

- Lack of medium and high intensity residential treatment, largely due to low reimbursement and lack of desire to have patients due to stigma of SUD.
    - Often, patients sent to hospital for high intensity treatment are returned within 2-3 hours, with hospitals noting they do not handle detox from opioid use disorder (OUD). Participants reported speaking with patients who falsely claimed suicidal thoughts to be admitted for withdrawal.
    - There are currently no level fours in Minnesota, so there is a significant gap in where to send these patients
- Lack of willingness to provide evidence-based treatments, such as MAT.
    - Stigma contributes significantly to hospitals not being willing to provide evidence-based care for complex withdrawal patients. There are also significant challenges providing referrals to facilities that can take patients without a delay in care, particularly facilities that provide MAT.
    - There is also MAT stigma in the recovery community, particularly from those who achieved recovery without it. Additional education is needed to help overcome MAT stigma.
- Workforce is also a barrier to meeting SUD care needs, as many in the SUD space are overburdened.
    - Fortunately, there are younger doctors interested in entering the field which may help to lessen the burden.
    - Treatment facilities without prescribers on staff cannot offer MAT or other therapies in a compliant manner.
    - High administrative and paperwork burdens imposed by regulatory agencies have also contributed to workforce burnout.
- It is important that they integrate SUD treatment and primary care and remove silos from the SUD care continuum. Integrating SUD screening into treatment can make tremendous strides toward prevention and early education.
- Lack of culturally adapted care and care that allows families/people with children.
- Low reimbursement levels for SUD services.

- Successful referrals and transitions from one level of care to another is often a struggle for those with SUD.
    - Individuals may be discharged before they feel they are ready to transition, often back into dangerous situations, such as homelessness. Health-related social needs (HRSN) need to be addressed for individuals in recovery.

What are the biggest challenges to implementing the ASAM criteria?

- Technical assistance for providers is lacking.
- Lack of communication between SUD treatment providers/lack of service coordination.
- Lack of awareness of ASAM criteria among providers, including the value for implementing ASAM levels of care.
- Difficulty maintaining changing standards of care, particularly in rural areas or at smaller organizations.
- Additional workforce (including virtual options) is needed.
- Lack of motivation or consequences for treatment centers not complying with regulations. Most centers are only doing the bare minimum to access public funding.
- Challenges implementing 4th edition electronic medical record (EMR) requirements and recommendations, particularly at smaller organizations.

What are some potential solutions?

- Treatment facilities need access to technical assistance beyond occasional trainings.
- Rate increases for SUD services.
- Staffing accommodations to overcome workforce shortages are needed at a state level.
- Additional public awareness campaigns – education related to MAT and other evidence-based therapies.
- Enhanced electronic medical records that allow for seamless data sharing and transitions of care.

The MN SUD CoP will reconvene on February 20, 2023, at 2:00 p.m. CT.
Registration for the February meeting is available via the Zoom registration link.

To obtain the slides presented during the December MN SUD CoP, please email mnsudcop@healthmanagement.com.