Minnesota Substance Use Disorder Community of Practice:

February 20, 2024 Meeting Summary

Background

On February 20, 2024, participants attended the fifth Minnesota (MN) Substance Use Disorder (SUD) Community of Practice (CoP). The CoP is composed of people engaged in SUD treatment and prevention in any capacity. This includes 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, Jill Kemper, Boyd Brown, and Paul Fleissner, with ongoing subject matter expertise from Debbi Witham and other HMA colleagues. 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.

General Announcements

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

1. January and February Workgroups: HMA conducted three workgroups in January and February. The first was to obtain feedback on the CoP structure from full CoP members, The second and third meetings were dedicated to obtaining feedback on implementation of the American Society of Addiction Medicine (ASAM) 4th edition criteria in Minnesota (see below). HMA thanked participants for their attendance in the 2024 workgroups thus far.
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 and available on the MN SUD CoP webpage.

Meeting	Date/Time	Registration Link
Culturally Specific Care Workgroup #1	Friday, March 29, 2024: 12:00-1:00 pm CT	https://healthmanagement.zoom.us/meeting/register/tJEkc-6qqT0jHNfygRptsOjDZGsPBx1dMw_w
Culturally Specific Care Workgroup #2	Tuesday, April 16, 2024: 2:00-3:00 pm CT	https://healthmanagement.zoom.us/meeting/register/tJEsd-CtrjsiG9Cv4ZUT7UyA5j-jzLfNcE9W
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

3. Upcoming CoP Agenda Items: During the 2023 CoPs, participants and Voices of Experience presenters shared significant gaps in culturally competent SUD care in Minnesota. For the next several months, this will be the topic of focus for workgroups and CoPs.
    - March and April 2024: Workgroups dedicated to culturally competent SUD care
    - May 2024: Full MN SUD CoP dedicated to culturally competent SUD care
    - June 2024: Developing a report on delivering culturally competent care

    While this is the main focus for the next several months, culturally competent SUD care will continue to be a focus throughout the MN SUD CoP.

ASAM Levels of Care Workgroups

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, including Minnesota, are using the ASAM criteria as the foundation of their efforts to improve the addiction treatment system. To develop a Roadmap on how to implement the ASAM 4th Edition Levels of Care in Minnesota as mentioned above, HMA conducted two, 1-hour workgroups in January and February. For each level of care, participants were asked:

- Is this service available in your community?
- Can you deliver at this level to these standards?
- What are the barriers to providing this level of care?

The responses provided by participants are summarized below. For those unable to attend the workgroup, HMA also developed an optional survey for participants to provide feedback on the ASAM levels of care available in Minnesota, provided via email after the meeting.

General Feedback Across All Levels:

Low reimbursement rates	Non-SUD barriers (housing, incarceration, insurance, transportation, etc.)	General workforce/ staffing challenges	Lack of access in rural communities	Lack of education/understanding of new ASAM criteria

Level of Care Specific Feedback:

Level of Care	What are barriers to delivery?
1.0 Long-term Remission Monitoring	• Limited number of available RCOs and grant dollars • No central hub • Lack of transportation for rural programs • Length of time they are required to keep patients
1.5 Outpatient Therapy	• Low internet bandwidth in rural areas for telehealth • Programs unfamiliar with ASAM/need additional training • Programs not meeting language/interpreter requirements
1.7 Medically Managed Outpatient Treatment	• Low reimbursement for increased services at this level • Low capacity for recruiting and retaining medical staff (LPNs specifically)
2.1 Intensive Outpatient	• Significant distance between services in rural areas • Waitlists • Challenges with the Direct Access model • Denial of payments for individuals with DUI charges
2.5 High-Intensity Outpatient Treatment	• Lack of housing/legal concerns with offering housing • Ability to recruit and retain medical directors
2.7 Medically Managed Intensive Outpatient Treatment	• Lack of access to medication
3.1 Clinically Managed Low-Intensity Residential Services	• Lack of staffing • Lack of information/resources available to providers • Transition to ASAM from outpatient with lodging model
3.5 Clinically Managed Medium-Intensity Residential Services	• Requirement to staff 7 days per week (difficulty recruiting medical professionals to work weekends) • Lack of reporting among programs that are closing
3.7 Medically Monitored High-Intensity Inpatient Services	• Misunderstandings between WM and detox centers • Reimbursement rates are low • Challenges placing individuals who are severely mentally ill • Difficulty recruiting medical staff
3.7 BIO	• Fear of delivering services to individuals who require additional care • Overall infrastructure challenges (access to care, meds, etc.)

Voices of Experience Panel

Following announcements, participants heard from LaTricia Tate, CEO and Co-Founder of Twin Cities Recovery Project, Inc.

About LaTricia and Twin Cities Recovery Project

LaTricia Tate is the CEO and Co-Founder of Twin Cities Recovery Project, Inc. (TCRP). She earned her degree and worked in human services for over 20 years. Some of her many roles and accomplishments in the field include participation and contribution in the Project for Pride and Living (PPL), the Franklin Avenue Safety Team, PPL's Diversity, Equity, and Inclusion (DEI) work, and the PPL Rebuilding Our Community Piece by Peace Initiative. Her work also includes membership in the 1st Step Housing Consulting, the Governor's Advisory Council on Opioids, Substance Use, and Addiction, and the MARCO Board.

TCRP was also founded by President, CEO, and Peer Recovery Specialist, Marc L. Johnigan (1969-2021). LaTricia shared that the mission of TCRP is, "to offer assistance and support to those suffering from substance use disorder in their transition toward lifestyles of health and productivity, by offering a drug-free environment, as well as resources to develop holistic recovery. This will enable them to build healthy and positive relationships, and to become productive members of society." While TCRP started as a social club in 2016, it has evolved into an exemplary recovery organization in Minnesota and provides services such as:

- Peer Recovery Support
- Grief Support Programs
- HIV Testing and Education
- Re-Entry and Anti-Recidivism Support
- Vocational and Occupational Support
- Community Outreach
- Recovery Advocacy
- Substance-Free Social Events
- Men's Support Groups
- Young People in Recovery
- Minnesota Addiction Recovery Initiative Safe Station (SUD services available at local Minneapolis Fire Station #14)

Additional information on the Twin Cities Recovery Project is available on this webpage here.

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.

Presentation and Discussion: Delivering Culturally Competent SUD Care to Black Americans

Presented by George Lewis, Founder and CEO of Motivational Consulting, Inc.

To begin the presentation, George shared the historical background that contributes to how Black Americans experience care, including:

- **Who Are Black Americans?:** Historically, Blacks in America are Americans of African Ancestry descended from Africans who were stolen from Africa and forced into slavery.
- **The Impact of Ignorance:** "One doesn't have to operate with great malice to do great harm. The absence of empathy and understanding are sufficient." - Charles M. Blow
- **What is Racism?:** "Racism is a total system structure that functions in all areas of activity: economics, education, entertainment, labor, law, politics, religion, sex, and war, for the ultimate

purpose of maintaining the power structure of white power over non-whites to produce non-white powerlessness." - Neely Fuller Jr.

- **Systemic Racism and SUD Treatment:** "Systemic racism is the ongoing institutionalization of inequality. Blacks seeking SUD treatment receive programming that is socially and culturally White. Such racism is subtle, sometimes overt, and often unrecognized, even by the people who perpetuate it. But to its victims, the results are clear." - *The Continuation of Historical Trauma*

George then shared insight into how historical and present trauma affects SDU and mental health.

- **Barriers To SUD/Mental Health Services:** A history of atrocities against Black Americans contributes to ongoing suspicion and paranoia regarding physical and mental health services. Lack of diversity among service staff delivering services can also be problematic.
- **SUD and Historical Trauma:** Historical trauma is cumulative – Its emotional and psychological impact manifests differently in many different cultural groups. SUD has the universal impact of destruction which crosses all cultural, social, and economic barriers. The impact seems to increase in its devastation based on the historical background of the ethnic group being affected.
- **Black Americans & Historical Trauma:** Black Americans have been exposed to generations of discrimination, racism, race-based segregation, and the resulting poverty. They have also been exposed to micro-aggressions—the almost daily incidents of bias and racism, and the daily hassles aimed at individuals from minority racial and ethnic groups.
- **Symptoms of Historical Trauma and Its Effect on Treatment**: Including discomfort around White people, anxiety, isolation, sleep loss, shame, violence, suicide, substance use, loss of concentration, fear, distrust, anger, and depression. These symptoms affect the success of people of color as they attempt to navigate traditional treatment.
- **The Social Trauma of Black Skin:** Blacks are not able to assimilate into American society as other immigrant groups have done. The color of black skin is a constant reminder of historical trauma.
- **Psychoeducation from the Bami Soro Workbook, written by George Lewis, "Trauma and Violence In The Black Community"**: Ever wonder why your Black clients are hesitant to express their feelings? Americans of African descent who come from the culture of the streets when they enter your program, continue to live by that code either knowingly or unknowingly. This behavior's origin connects directly to slavery. Silence was the only power a slave had, never let your antagonist see your pain"

Finally, George shared differences in how SUD care delivery may differ between Black and White clients, and how to improve care for Black Americans in SUD treatment.

- **White Privilege:** White privilege is an invisible package of unearned assets that White people can count on cashing in every day. White people are taught not to recognize it. The country's Constitution supports this concept "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." People of color acknowledge that the Constitution only implies that all men are created equal, but in everyday American life that implication is not factual. Especially in the delivery of SUD services.
- George asked participants to consider the following questions to understand the concept of **White privilege**:
    - Are you around your race most of the time?
    - Do you have to spend time with people you mistrust or who make you uncomfortable?

- If you can afford it, can you move into the neighborhood and housing you want and expect your neighbors to be civil toward you?
- Do history books show the accomplishments of people who look like you?
- Do TV and magazines mostly feature people who look like you?
- Do most hair salons style your type of hair?
- Do you teach your children how to survive police contact?
- Do you worry about being shot for a traffic violation?
- Do you have to teach your children about systematic racism?
- When you need health care and mental health services, are you confident that you can find providers who look like you?
- In other words, are people who look like you the norm?

- Treatment Don't Look Like Me: Black Americans are *forced* to enter treatment with the knowledge that treatment will look like the society that has caused most of his/her social trauma, yet they have no other option. Even though Blacks don't automatically see the world through the White perspective, they are forced to learn to assimilate the white view, to receive SUD services. Often the assessment is the beginning of the trauma of treatment. I have heard from many people of color not just Blacks that the assessor tells them how they feel the moment the client disagrees with the assessor's view of the client's condition.
- Help Me Recover
  - Establish Respect. By the time you come in contact with many of your Black clients, they have come through social or justice systems that have not offered them any respect. This is the time to establish a willingness to listen and learn.
  - Encourage Questions at any time during sessions
  - Establish Confidentiality and Security with No Judgement
  - Go to great lengths to ask open-ended questions
  - The goal is to restore the client's self-worth by relinquishing some control of the process back to them
  - Client participation is key, so it's important to assess:
    - Verbal, social, and written skills
    - Positive or negative experiences with group activities/discussions
    - Get "non-clinical."
  - Most programs focus on the program plan, program model, or clinical descriptions of the effects of addiction. Black and Brown people will see this approach as impersonal, or "not applying to ME" when they have no input or if the information is offered in a way that a client can't relate.
  - Actively listen and validate the individuals' experiences and emotions
  - Remain curious, asking questions about family/community histories
  - Stay aware of the obstacles faced by Black Americans
  - Speak WITH, not AT or DOWN TO your client.
  - Recognize that language/expression is not a measure of intelligence.
  - Trust that the individual can do the work necessary to recover.
  - Challenge excuses—not the individual—when meeting with resistance.

The MN SUD CoP will reconvene on May 7, 2024.

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