Substance Use Disorder (SUD) Community of Practice (CoP) planning session

Date: May 4, 2022

Materials shared: SUD CoP Planning Session PowerPoint

Representation

The **Participant Breakdown by Category** table below reflects the 83 participant categories submitted during polling in the beginning of the meeting. Some participants selected more than one participant category and each submission is counted separately. Non- DHS facilitators (2) and the interpreter (1) are represented in the total number of participants (71) and not included in the representation table below.

Total # of participants: 71

Total # of participant categories submitted: 83

Participant Breakdown by Category

Participant Category	Percentage of Representation
Researcher or member of the academic community	5%
SUD treatment provider	23%
Recovery community organization	6%
Department of Human Services	10%
Department of Health	1%
Department of Correction	0%
County social services agency	10%
Tribal nations or tribal social services providers	1%
Individual who has used SUD treatment services	7%
Family member or support person	3%
Managed care organization not including DHS staff	11%
Other-non-DHS facilitators & interpreter not included	11%
Unknown-no response	12%

Meeting Summary

Welcome and brief introduction

Facilitator: Neerja Singh

Neerja Singh, Behavioral Health Clinical Director of the Community Supports Administration & Interim Director of the Behavioral Health Division, welcomed participants to the first planning session of this new initiative. Feedback and participation will help design the SUD community and field innovations.

What is a community of practice (CoP)?

Facilitator: Regina Acevedo

A CoP is a group of people who share a common goal and interact regularly for ongoing knowledge transfer and learning. The three elements of a CoP include the domain, community, and practice.

1. Domain = what we care about
    - Creates common identity, meaning purpose and value
    - Inspires participation and mutual exploration
2. Community = who cares about it
    - Participants are the community
    - Creates social fabric of learning, fosters mutual respect and trust, willingness to share, ask, listen, be vulnerable and courageous
3. Practice = what and how we do things together about it
    - Creates domain and is based off of knowledge the community develops, shares and maintains, which may include frameworks, tools, ideas, stories, documentation, etc.

SUD CoP Meeting Logistic

Facilitator: Regina Acevedo

Unanimous support to meet monthly for six months to establish the SUD CoP followed by quarterly meetings.

Polling results- How frequently should we meet during the 1st 6 months to establish the SUD CoP?

- **54% = Once monthly**
- 20% = Every 2 months
- 1% = Every 3 months

254B.151 Substance Use Disorder Community of Practice

Facilitator: Regina Acevedo

Subdivision 1. **Establishment; purpose**. The commissioner of human services, in consultation with substance use disorder subject matter experts, shall establish a substance use disorder community of practice. The purposes of the community of practice are to improve treatment outcomes for individuals with substance use disorders and reduce disparities by using evidence-based and best practices through peer-to-peer and person-to-provider sharing. (Minnesota Statutes 2021, Chapter 254B.151)

Participants

Facilitator: Regina Acevedo

Representation for the SUD CoP must include:

1. Researchers or members of the academic community
2. SUD disorder treatment providers
3. Recovery community organizations
4. Department of Human Services
5. Department of Health
6. Department of Corrections
7. County social services agencies
8. Tribal nations or tribal social services providers
9. Individuals who have used substance use disorder treatment services and must highlight the voices and experiences of individuals who are Black, Indigenous, people of color, and people from other communities that are disproportionately impacted by substance use disorders
10. Managed care organizations

Objectives

Facilitator: Regina Acevedo

The domain of the SUD CoP includes the following:

1. Identify gaps in SUD treatment services
2. Enhance collective knowledge of issues related to SUD
3. Understand evidence-based practices, best practices, and promising approaches to address SUD
4. Use knowledge gathered through the community of practice to develop strategic plans to improve outcomes for individuals who participate in SUD treatment and related services in Minnesota
5. Increase knowledge about the challenges and opportunities learned by implementing strategies
6. Develop capacity for community advocacy

Value Cycle Framework

Facilitator: Regina Acevedo

The value cycle framework developed by Wegner, Trayner, and de Laat is a dynamic framework with aspects of value creation to consider as we develop our unique SUD CoP. The use of this framework is flexible and

will be based on community input. As our CoP evolves, this is a tool we may reference to provide further direction.

Contract Vendor Deliverables- DRAFT Deliverables

Facilitator: Regina Acevedo

Contract with a vendor to carry out the following deliverables:

1. Recruit consumers and family members who have used SUD treatment services to highlight the voices and experiences of people who are Black, Indigenous, people of color, and people from other communities that are disproportionately impacted by SUD and co-occurring disorders.

2. Identify challenges faced in implementing ASAM criteria on both a national and state level with a focus on the following and the role these factors play in providing a higher quality of care when provided in combination with SUD treatment services:
    - Support services (supported employment, housing, life-skills, trauma-informed care)
    - Integrated care (receiving other needed health or behavioral health services with SUD treatment)
    - Culturally-specific models (addressing barriers to care due to culture)
    - Person-centered care (focusing on the elements of care, support and treatment that matter most to the patient, their family and their caregivers)
    - Any additional challenges implementing ASAM criteria

3. Develop reports with recommendations/outcomes on objectives after CoP meetings

Contract Vendor Deliverables- Question #1

Facilitator: Regina Acevedo & Neerja Singh

1. Are there any changes we should consider?
    - Separation of 2 conditions – SUD and co-occurring disorders – more than 90% of people with SUD also have mental health concerns; suggest highlighting the co-occurring disorders rather than separating
    - Where do school representatives fit in? Seems like there should be targeted representation.
    - Is provider using EBP evidenced-based manualized treatment curriculum with fidelity to the model?
        - talks on evidence-based programs speaking to fidelity of model; EBP may be used, but because it may be used piecemeal, there is no fidelity to the model
    - SUD as primary diagnosis takes away the uniqueness of each situation
    - Suggestion of using “chemical health and mental health” from a practitioner’s perspective
    - The research suggests that around 80% of people with SUD may have an underlying MH issue however, once a person discontinues use that number drops significantly. We need better research on that.

- I would agree that we are currently not treating the whole person and we should be treating both the MI and SUD at the same time-many times someone has too much "MI" and gets discharged from SUD treatment, yet will have "too much SUD" for a MI treatment center
- Are "co-occurring disorders" limited to Mental Health?
    - There could be other medical issues
    - Neerja acknowledges that physical disabilities could also affect SUD treatment and asks about others to be named
    - Experiencing homelessness
- Under 3A - and maybe this is upcoming, but I would like to see some specific bullets to specify some areas which need reports/recommendations. Specifically I would like to see some research into the gap of funding and how clients are finding their own programs (Direct Access). I am seeing clients struggle to find and navigate the system, referral, getting themselves to a program etc.
    - The areas which need reports/recommendations are the six defined objectives.
- Regina says integrated care mentioning other services recipients may need
- Gambling disorders
- I would hope that the hospitals are involved in this community too.
- Gaps in support once client is done with treatment programming
- Only 10% of people affected by SUD access treatment. Is the initiative only recruiting people who have used treatment? If so, the study is missing the vast majority of people affected by SUD. I'd like to see some effort put into understanding SUD in our communities in a broader context. Many people resolve SUD on their own, don't feel comfortable accessing treatment, or can't access for other reasons. This is an issue broader than treatment - can't we look at more than treatment in their community of practice? What else is happening in our communities that works or is a barrier?
- With the "Community of Practice" are organizations like NAADAC, the ATTC's and MARRCH invited to be involved?
    - Yes
- We lack treatment programs which can accommodate SUD and SPMI/
- Medicare A/B clients who don't qualify for MA or have a spenddown they can't pay.

Contract Vendor Deliverables- Question #2

Facilitator: Regina Acevedo & Neerja Singh

2. What other deliverables would be important for the vendor to carry out?

- Care case coordination and peer recovery specialist
- As mentioned, not everyone can access treatment so it would be good to understand the barriers to doing that and other ways individuals deal with SUD.
- There are disparities in rural areas; not only are there less treatment providers, staffing shortages, transportation can be an issue, child care, treatment to serve women and children-and adolescents
- Peer recovery support specialists are very infrequent in rural settings
- Reaching out to all tribes
- Withdrawal management services in rural areas are difficult to access

Deliverables should include out-reach, education/awareness for communities to help with prevention

Contract Vendor Deliverables- Question #3

Facilitator: Regina Acevedo & Neerja Singh

3. How should we define the minimum required qualifications for prospective vendors?

    - Vendor should have experience with community-based research (Wilder Research is an example).
    - Understanding of Native American culture and traditions
    - Can the vendor not necessarily be from the metro?
    - Culturally responsive - keeping in mind diversity and inclusion
    - Integrated care with strong partnerships with ancillary services and strong communication between all providers to focus on the person as a whole, regular partnerships to staff clients ongoing
    - For profit/non-profit
    - A vendor who can bring people together and manage a large group with potentially different views. Ideally a vendor who is at least somewhat knowledgeable of the SUD field and current research or who can quickly learn.
    - Vendors should have experience working with the communities they serve and must culturally align with the communities they're serving for the work to be culturally competent.

Contract Vendor Deliverables- Question #4

Facilitator: Regina Acevedo & Neerja Singh

4. What should we take into consideration in driving racial equity for SUD treatment services as the group works through required objectives?

    - There is a lack of residential treatment programs for both men and women in rural communities.
    - Reach out to organizations that may not spring to mind – like BIPOC organizations – reaching farther and wider outside the usual box to address racial equity – much talk over the years but needle has not moved
    - LGBTQ+
    - It would be good to see consideration of what would help facilitate participation for individuals from diverse communities as their viewpoints will be critical to include to move forward on equity.
    - I just want to mention veterans are underserved.
    - Seniors as well
    - Yes, SUD in elderly is more common than one thinks.
    - All sizes do not fit-we have very little Hispanic programs in the state too
    - Fathers with children - are there any treatment centers for dads and their kids?
        - Burlington House in Brainerd Has sober living with family
        - RS Eden family is going to have a housing unit for a father or a couple along with output treatment

    - DHS is working to get a pilot program up and running for women with children. We should discuss something on same lines for fathers
- Regarding driving racial equity, I think we need to be open to different concepts of "treatment" and recovery and recognize community-specific assets. Rather than focusing solely on how we can get people into the current system, think about what else works in specific communities.

Contract Vendor Deliverables- Question #5

Facilitator: Regina Acevedo & Neerja Singh

5. What is your vision of the CoP for SUD?

- My vision has outcomes, not just another meeting program which talks about the program but does little for change
- A recovery broad range of recovery-friendly social events, meeting locations, diverse recovery meetings, etc.
- Community of Practice would break the cycle of separate silos in communities
- A place where we can share our experiences, play the situations out - to see where the gaps are and find solutions; I forgot to mention DETOX. We must remember detox (opioid/alcohol) and our lack of detox facilities or those in need today!

De-silo - collaborate for real change that improves outcomes in our communities.