



**SUD Stakeholder Advisory Committee
Meeting Minutes
April 25, 2016
DRAFT UNTIL APPROVED**

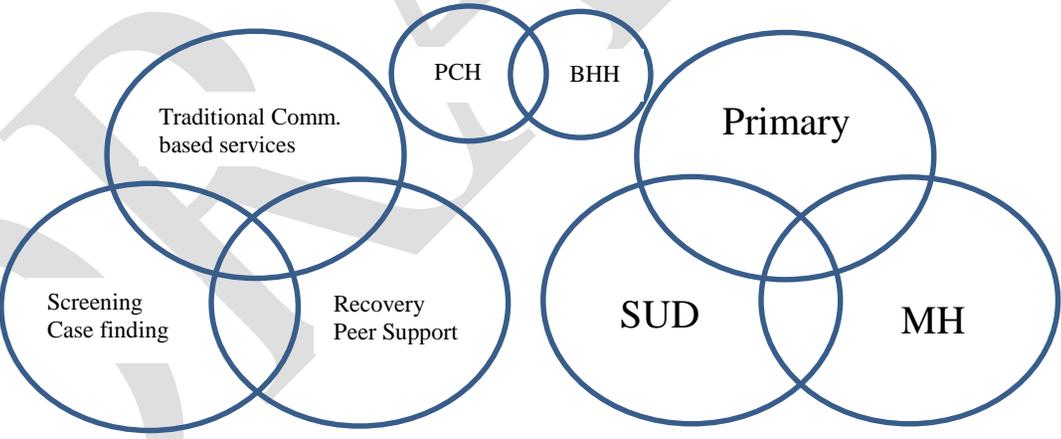
Participants in attendance: Devarshi Bajpai, Jeff Blackford, Gary Cobb, Deborah Friedman, Johnnie Gage (phone), Tim Hartnett (phone), Tonya Huff (phone), Jackie Mercer, Marie McDaniel-Bellisario, Mary Monnat (phone) Cheryl Ramirez, Tim Murphy, Sheila North, Caroline Cruz (phone) **OHA Staff Present:** Karol Dixon, Karen Wheeler, Nicole Corbin, Michael Morris, David Simmitt, Dana Peterson, Janna Starr and Michelle Meuwissen

Topic	Name	Discussion	Action
Welcome & Introductions	All	Karen welcomed participants and began the meeting. Participants provided introductions.	
Old Business	All	<ul style="list-style-type: none">• The group reviewed the notes from the last meeting together.• Participants approved the March 28th meeting by consensus.	
Concept Paper	Dana Peterson	<ul style="list-style-type: none">• Dana described the drafted concept paper. The template is structured similarly to what California has recently sent for their amendments. Discussed the flow of information and asked for review of the work product as being developed by the group.	Cheryl will send out action paper to Janna

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		<ul style="list-style-type: none"> • Described some work HSD will do independently, regarding budget neutrality, regarding public notice and public comment process, etc. • Karen added tribal consultations, sharing the information with other advisory groups such as AMHPAC, etc. This will be built into plan/timeline to conduct public comment and ensure is clear and structured (expectations, timelines) to complete vetting needed. • Group discussed data, the quality measures involved in the paper. <p>The group reviewed and discussed the high level areas, to ensure involving all needing to include, and to identify areas to connect with other areas of work directly related (such as CCBHC- need more concrete ideas about that area of work in particular).</p> <ul style="list-style-type: none"> • Standards of care, EBP Benefit design – areas directly related to the CMS letter. Don't directly line up with our timelines. Will work in towards presenting a concept, and into quality measures. • Discussed subtopics needed (equity, robust service network for all people). Karen asked to be sure to gather input from the tribes. • Karen asked for members to email staff with additional feedback as people further review the template. 	
		<p>Dana described drafted language the areas, such as the Network development concept.</p> <ul style="list-style-type: none"> • Dana asked the group to provide feedback. <ul style="list-style-type: none"> ○ Network is affected by workforce challenges. 	<p>Dana will add looking at rates, with GF savings, to the benefit</p>

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		<ul style="list-style-type: none"> • The group brainstormed to conceptualize how they want the SUD system to become. <ul style="list-style-type: none"> ○ Solutions needed by both services in the community and support needed built in at the state level (for what is out of their scope). ○ Already have enough problem statements in the paper, now need to develop and describe the solutions. ○ We have well identified gaps and now opportunity to conceptualize where we want the system to move forward. ○ Discussed opportunities to access additional resources with the CCBHC, however extenuating factor is demo is not ensured. Karen suggested could still bring out some of the concepts from CCBHC, with/without the demo granted to the state. ○ Moving towards CCBHC with/without grant, and can take about CCBHC concepts without labeling it as CCBHC (which is essentially advance BH homes, high level health homes). ○ Q/A: What CCBHC resources are there, referring to funding? Cheryl- yes, with the grant there will be funding related resources. Will CCBHC include workforce development? Cheryl- the issues being discussed in CCBHC related committees and is parallel between CCBHC and SUD Committees regarding workforce development needs, etc. • Discussed workforce needs and capacity for SUD. What is needed right now? <ul style="list-style-type: none"> ○ Second sentence in 3.3, discussed services and capacity mixed in workforce needs. Overall more capacity is needed: 	<p>management section.</p> <p>Karen will inquire with Nicole Corbin to gather ATR Grant information, run reports to send out if able.</p>

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		<ul style="list-style-type: none"> • More in early intervention (means more experts, better education and identification in patients for appropriate level of care needed). Wraparound services to capture people in different settings, hopefully earlier as onset, for those needing the services. Better provider connect and capacity as those in need reach services. • Increase mental health capacity, working with dual diagnosis is what is needed right now. Some of these needs being discussed might take more time: 1, 5, 10 years <ul style="list-style-type: none"> ○ Currently not attracting and developing the workforce we need. Larger systems issue. ○ We need a system that is culturally competent (cultural competence needs to overlay the entire system, not just in ‘pockets’) • Larger scope: Need to improve the institutions of learning. To be integrated, all workforce must be adequately trained, cross training needed. Need more cross training within education: such as master’s degree programs need to be training MH technicians on criminality, MAT, etc. Building that capacity is agreeably a larger scope beyond SUD. <ul style="list-style-type: none"> ○ LNPs need to be talking about substance use treatment and addictionology. The further trainings are needed to obtain the desired system and workforce. Need to cross train MH clinicians to get CDACs, etc. 	

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		<ul style="list-style-type: none"> ○ Issue is when it is not happening in the institutions, then gets tasked at the local level to provide the training overtime (MH clinicians to get CADCs for example) as building workforce needed. ○ Discussed requirements for alcohol and drug counselor certification ○ Medicaid rules may need to change to be able to diagnosis mental health conditions if a LP is able to sign off (allowing an LNP, a licensed QMHP or MD, to sign off) would help achieve true integration. ○ Although the education and training needs are part of a larger scope, those improvements are still needed. 	

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		<ul style="list-style-type: none"> • Conceptualized thinking of things as being person-centered: What is most critically needed by the person? (the person that is a client, that isn't a client yet but needs to be, the person that just needs ensured access to the information if becomes needed, how to access and navigate the resources to ensure connecting services to people. <ul style="list-style-type: none"> ○ #1: a Peer is needed ○ CDAC expansion throughout the state ○ Discussed access points and issues involved (primary care settings to channel to other services). ○ Need to duplicate the warm hand off and peer work with lived experience, with THW – this workforce exists, and is not to scale. Needs to be to the capacity it should be (and needs to become statewide). Discussed building into the paper, to be able to build this workforce. ○ Discussed outreach worker referral examples allows connection with statewide resources (not just limited to County, is able to use tx facility throughout Oregon). <ul style="list-style-type: none"> • This is needed for whole community (not just within DHS/child welfare as it is currently) • Discussed how to improve workforce, with more certified recovery mentors. <ul style="list-style-type: none"> ○ Idea to create better incentives to pay for becoming a certified recovery mentor (burden/barrier to enter/ education level needed is fairly low) would help develop the workforce needed ○ Needs to be built into the payment structure 	

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		<ul style="list-style-type: none"> ○ The group is highly interested to address Peer Support. Discussed need for incentives to build the capacity for recovery support positions. Discussed need to build in affordability (into the payment structure, and suggested analysis of that work within the paper). ○ How? The entire network needs to become more robust, at every point of entry; Catch people earlier (reach in, less residential); more level 2 needed; more intensive outpatient (expand what we have). Footnote: Adequate rates are needed as part of keeping the network healthy. Dana offered to add looking at rates, with GF savings, to the benefit management section. <p>The group discussed what is needed for people to stay in their communities programs as disappearing from outpatient.</p> <ul style="list-style-type: none"> ● Assertive case management, training (for office-base clinicians), ● Need more outreach with peer recovery mentors and peer mentor Specialists (some doing well now, some aren't). ● Tim suggested a good model used by Bridgeway mentors, in which combines a CDAC 1 level education and training with the activism/lived experience of a peer. ● Case management training with housing support trainings. ● Discussed peer employment. Traditional healing peer supports. Discussed workforce pay as a barrier. ● Footnote: Include model programs, regarding employment & housing (note: building housing into core waiver side). 	

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		<ul style="list-style-type: none"> • The group discussed tools to capture statewide disparities, in order to identify gaps. Jonnie mentioned current work with CCOs regarding a Health Share tool specific to peers (required and funded now through Health Share, and meant to inform the entire system). • Peer intake forms need to capture more (and it needs to become part of the conversation). • Family Member support is lacking (possible in Medicaid program?) • Family therapy, if Medicaid pays for family therapy for A&D. Also need support for a Medicaid individual not yet in treatment. The group conceptualized family therapy as part of a treatment plan. Are those consultations billable? Or perhaps GF could build another service for families (re: consultations, etc.). • MH side brings in client and bills them. There is a huge need for this in gambling. If we can't use Medicaid, need to look at maybe can use GF. • Discussed benefits of home-based services. • Care coordination needs to be integrated care (coordinating with a delivery system that isn't integrated causes barriers). • Supported employment, is essential and currently not coded. The prioritized list of cods as only one for SUD. Need to question if we are funding correctly. Group discussed out-of-facility codes and referenced the CMS letter/1915i. • Pet therapy, pet supports- huge, could be built on. 	

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		<ul style="list-style-type: none"> • “We have some supports out there, we can help someone get clean; but, what we need is a system that will maintain that wellness” ~ Gary Cobb • The group discussed the budgetary impact on the fee for service side, anything would need to have budget neutrality. Discussed CCO Global Budget. • Participants discussed the ATR grant, asked what is being done and what outcome tied to? There is data involved, may not be statewide. Karen offered to inquire with Nicole Corbin to gather information, run reports to send out if able. • Discussed issues to provide services during transitions (such as benefits being suspended while incarcerated). • The group discussed that based on the letter, CMS may want a more narrow approach, and group to be careful not getting too broad. • The group discussed the importance to address what CMS is directing on and could go beyond (and at least consider intended direction for the longer, larger scope) and ultimately approach through lens of how are we meeting people where they are at as individuals and then assess what is needed around (to support) that individual’s needs. • Discussed pay for outcomes and monitoring needs. • Alumni people and groups to connect and coordinate with people after their treatment (is a built in follow-up, built into rate structure). CCC alumni (community called for it). Barriers to 	

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		<p>follow-up without phone, address, etc. Footnote: Staff to ID what programs are doing this.</p>	
		<p>Brainstorming activity: Community integration encompasses:</p> <ul style="list-style-type: none"> • Housing • Education • Recreation • Employment • Health • Valued social roles (marriage, gender, etc.) • Spirituality • Peer Support <p>Discussed community integration and home and community-based settings. Members suggested adding a 1915i staff representative to this committee. Staff will follow up.</p> <ul style="list-style-type: none"> • Participants conceptualized a ‘road map’ to recovery. <div style="text-align: center;"> <pre> graph LR A[Comm. Integ.] --> B[Presence/ Participation] A --> C[Recovery Well-being] C --> B B --> C </pre> </div> <ul style="list-style-type: none"> • Members questioned what does a TX or recovery plan ever even ‘close out’ (system built on acute care model). Regulatory prohibits/ issues to address with this concept? Would also have to increase current staff, major case loads. Staff offered to check on this in-between meetings. • Members discussed adult BH rule on Medicaid, need to determine what is guiding? 	

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		<ul style="list-style-type: none"> • Members suggested state Medicaid rule needs to be re-written. <ul style="list-style-type: none"> ○ Discussed what value those rules are bringing, and idea to keep the value if it exists, while open to be flexible (maybe based on if is a billable service, based on medical need). Suggestion to gather input from Pacific Source. • Regarding the continuum we don't have respite, we don't have out-patient detox, we need both. • Dana explained that scope would be discussed at the next meeting. Dana asked for any volunteers to write this discussion to collaborate on the concept (use to go out to groups/committees for feedback). Dana will follow-up by email. 	
Public Comment and Wrap Up	All	<ul style="list-style-type: none"> • No public comment received. • Meeting adjourned. 	
Next Meeting		<p>May 23, 2016 2:30 – 4:30 pm Location: Human Services Building 500 Summer Street NE, Salem Conference Room 352</p>	

For questions or further information please contact: Dana Peterson