Co-Occurring Outpatient Treatment Program Policy and Procedure Manual

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Policy and Procedure Manual Version Control

Version	Date	Author	Change Description
1	10/10/16	Brian Loots	Initial Version for Application Submission
2	12/16/16	Brian Loots	Updated and Rule 31 Approved Version
3	4/24/17	Brian Loots	Updated MICD Version
4	7/10/17	Brian Loots	Updated Job and Group Descriptions
5	1/23/18	Brian Loots	245G Updates
6	6/26/18	Brian Loots	Updated Drug Screening & Job Descriptions
7	10/6/18	Lisette Wright	NorthStar Regional Updates and Licensure Review
8	11/20/18	J.Johnson	Update after DHS Review call
9	3/25/19	Lisette Wright	Updates per DHS Licensor
10	5/31/19	Lisette Wright	Updates
11	8/7/19	Lisette Wright	245G July 1 2019 updates
12	10/10/19	Lisette Wright	Treatment Week Definition
13	1/14/2020	Lisette Wright	Student Intern regulatory reference added; updated Drug Screening Policy
14	2/19/2020	Lisette Wright	Updated Drug Screening to include Unobserved Methodology

15	2/28/2020	Lisette Wright	Inclusion of ESA, Severe Weather, Vendor Visitation, Mileage Policy, Personnel Policy for Guests
16	10/6/2020	Brian Loots	Update to Kirkwood Ct. location, addition of MAT and 1115 Waiver information
17	3/25/2021	Lea Atkinson	Updated 1115 Waiver Policies

Note The content of this manual outlines the NorthStar Regional Co-Occurring Outpatient Treatment Program policies and procedures with which all employees are expected to adhere. This manual will be available to all NorthStar Regional employees in its location at the front desk of the NorthStar Regional facility in Maple Grove, MN .

NorthStar Regional's Policy and Procedure Manual outlines procedure program compliance with Minnesota Statute, 245G and corresponding Minnesota Rules and Statutes, and Federal Regulations governing its Minnesota 245G program license. Policies and procedures will be revised and updated in compliance with governing state and federal rules, statutes, and regulations.

TABLE OF CONTENTS

1 NORTHSTAR REGIONAL'S TREATMENT PROGRAM SERVICES 6

1.1 Program Hours and Population Served *(245G.12)* 6

1.2 Treatment Structure 6

1.3 Treatment Services *(245G.07, subdivision 1)* 9

1.4 Additional Services *(245G.07, subdivision 2)* 11

1.5 Drug Screening 13

1.6 Specialized Co-Occurring Treatment Services *(245G.20)* 16

1.7 Treatment Services Initiation *(245G.14)* 17

1.8 Intake and Registration 25

1.9 Assessment and Treatment Planning *(245G.05, subdivision 1)* 26

1.10 Treatment Services Termination *(245G.14, subdivision 3, 245G.06 subd. 4)* 28

1.11 Health Monitoring Plan (*245G.08, subdivision 1)* 30

1.12 Medication Administration *(245G.08, subdivision 5-6)* 31

1.13 Drug Control *(245G.08, subdivision 6)* 31

1.14 Program Fidelity 31

1.15 Plan for Transfer of Care for Clients and Records 32

2 RECORDKEEPING 33

2.1 Client Records *(245G.04, 245G.05, 245G.06)* 33

2.2 DAANES Reporting 36

3 PERSONNEL POLICIES 36

3.1 Personnel 36

3.2 New Staff Orientation 37

3.3 Personnel Files 38

3.4 Staff Schedules and Billing Procedures 38

3.5 Organizational Structure 39
3.6 Job Descriptions 42
3.6.1 NorthStar Regional's Chief Executive Officer (CEO) 42
3.6.2 NorthStar Regional's Chief Operating Officer (COO) 42
3.6.3 NorthStar Regional's Program Director 42
3.6.4 Mental Health Clinical Director 43
3.6.5 Mental Health Clinical Supervisor 44
3.6.6 Mental Health Outpatient Therapist 45
3.6.7 Mental Health Practitioner 46
3.6.8 LADC Clinical Supervisor 47
3.6.9 Licensed Alcohol and Drug Counselor 48
3.6.10 Student Intern (245G.01, Subd.21) 48
3.6.11 Driver 49
3.6.12 Individuals with a Temporary Permit 49
3.6.13 Billing and Funding Manager 50
3.6.14 Front Desk Administrator 50
3.6.15 Human Resources Specialist 51
3.6.16 Chief Compliance Officer 52
3.6.17 NorthStar Regional Medical Laboratory Technician: 52
3.6.18 Housing Coordinator 53
3.7 Clinical Consultation and Supervision *(245G.08, subdivision 4)* 54
3.8 Staffing Requirements and Qualifications *(245G.11)* 55
3.9 Staff Expectations 56
3.10 Staff Alcohol and Drug Use 57
3.11 Staff Development *(245G.13, subdivision 2)* 58
3.12 Conflict of Interest Policy 59
3.13 Severe Weather Policy 59
3.14 Service and Emotional Support Animals 60
3.15 Personnel Policy for Guests 64
3.16 Policy for Vendor Visitation 65
3.17 Mileage Reimbursement 66

4 COMMUNICABLE DISEASES 67

4.1 Tuberculosis *(245G.07, subdivision 1 (2)* 67

4.2 HIV Minimum Standards Compliance *(245A.19, (d), 245G.07, subdivision 2)* 67

4.3 Communicable Diseases Information and Referral Resources 68

5 CLIENT RIGHTS AND RESPONSIBILITIES *(245G.15)* 70

5.1 Client Rights 70

5.2 Grievances *(245G.15, Subdivision 2)* 81

5.3 Client Expectations 82

5.4 Photographs of client *(245G.15, subd. 3)* 82

6 PROGRAM SAFETY 83

6.1 Program Abuse Prevention Plan *(245G.09 subpart 3)* 83

6.2 Emergency Management *(245G.16, 245A.04, subdivision 16)* 86

6.3 Maltreatment of Vulnerable Adult Reporting *(245A.65, subdivision 1a)* 90

6.4 Maltreatment of Minors Reporting *(626.556 and 245A.66)* 91

7 MEDICATION ASSISTED TREATMENT POLICY AND PROCEDURE 94

8 1115 LEVEL OF CARE REQUIREMENT POLICIES 98

9 POLICY AND PROCEDURE REVIEW SIGNATURE PAGE 122

APPENDIX A 123

APPENDIX B 147

1 NorthStar Regional's Treatment Program Services

NorthStar Regional's Co-Occurring Intensive Outpatient treatment program provides services to adult clients diagnosed as having co-occurring mental health/substance use disorders or substance use disorders, and their families. Additionally, NorthStar Regional provides education and prevention services, such as Driving with Care® to the community.

1.1 Program Hours and Population Served *(245G.12)*

NorthStar Regional's Co-Occurring Intensive Outpatient Program serves adult clients diagnosed with a substance use disorder and co-occurring diagnosis, and their families, during convenient operational hours to meet client needs.

Procedure

1. Services provided will be specifically tailored to adult male and female clients, ages 18-100, with substance use disorder and co-occurring diagnosis, and their families.
2. Treatment service hours will be Monday through Friday 8 AM-4 PM and will be adjusted appropriately to accommodate client scheduling needs.
3. One or more staff members will be present in the office any time a client is present.
4. Treatment Week:
    a. The treatment week starts at 12:00 am Monday though 11:59pm Sunday.

1.2 Treatment Structure

NorthStar Regional's program structure and estimated treatment hours allow the flexibility necessary to meet individual client needs. Clients are admitted to an appropriate level of intensity and will step down throughout completion of treatment. A schedule of weekly groups will be given to clients upon admission and are available at all times.

Program Components

1. **Comprehensive Assessment (CA):** Clients are assessed by a Licensed Alcohol and Drug Counselor (LADC) and referred appropriately
2. **Client Orientation:** Clients will be oriented and admitted to the program and an LADC will begin treatment planning
3. **Groups:** Clients are admitted to a level of intensity appropriate to the acuity of their needs and will then step down through each program focus/intensity in a manner reflective of their stage of change
    a. Group formats will include interactive psycho-education, activities, and therapeutic processes.
4. Group Counseling means a professionally led psychotherapeutic substance use disorder treatment that is delivered in an interactive group setting. Group size will not exceed 16 clients.
5. Client Education means teaching clients strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education can happen in groups at a ratio of 1:48 or one-to-one with a client and qualified staff member.

    Intensive Outpatient Group
    Clients are expected to attend all groups. In addition to group sessions, clients are also required to attend weekly individual sessions with their Primary Counselor. During these weekly sessions, the counselor will review with the client their individual treatment plan, discuss their progress towards discharge, and update their 6 Dimension severity ratings. Clients need to contact their primary counselor to schedule this weekly appointment.

When a client has decreased their severity rating in Dimensions I – VI to a 1, or at staff recommendation, they will complete the primary portion of their program and move on to Continuing Care.

In the Continuing Care group, clients complete a comprehensive Continuing Care Plan, and are required to attend 2 hours of group per week, for a minimum of 12 sessions, before they can complete the entire program. In addition, clients need to be attending regular recovery support meetings, have a sponsor, and be living out the Continuing Care Plan they initially made, that will continue to evolve along with the client. Daytime alumni group is on Wednesday. Evening alumni groups are on Friday. Clients are expected to utilize the group and support systems to address common sober living issues and complete all required assignments.

6. **Individual Therapy and Case Management:** Clients attend weekly individual sessions with their assigned primary counselor. The primary counselor will complete an Individual Treatment Plan and review weekly throughout the duration of treatment. The primary counselor will collaborate and consult with the NorthStar Regional treatment team and other providers, such as county social workers and probation teams.
7. **Drug Screening:** Random weekly drug screening will be used to support client accountability.
8. **Discharge and Referral:** Clients are assessed according to the 6 Dimensions.
9. **Community Outreach:** Space is provided for local support group meetings.

Groups

Curriculums include but will not be limited to *Dr. Hal Baumchen's Destinations Workbook and co-occurring curriculums from Journey to Recovery. We also will use Integrating Dialectical Therapy with the Twelve Steps by Hazelden, DiClemente's Group Treatment for Substance Abuse- Stages of Change Therapy Manual, Gorski's Relapse Prevention Counseling Workbook, Helping Men Recover by Covington, Griffen and Dauer.*

1. **Primary Group: Group Treatment Service**
    - **a.** Cognitive Behavioral Therapy (CBT)
    - **b.** Identification of core beliefs about alcohol and drug use as well as motivational enhancement techniques to create resilience and progression through the stages of change
    - **c.** Psycho-educational components: Substance use disorders-focused
        - **i.** Addiction, Mental Health, and Addiction as a Disease Model
    - **d.** Relapse prevention
        - **i.** Identifying and managing relapse triggers and high-risk situations
    - **e.** Life management skills
        - **i.** Financial, basic activities of daily living, and home management
    - **f.** Coping Skills Education
        - **i.** Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), relaxation tools
        - **ii.** Stress and lifestyle management skills
            - Health and nutrition
    - **g.** Relationship enhancement
        - **i.** Communication skills, boundaries, interpersonal effectiveness skills, conflict resolution, assertiveness
    - **h.** Community resource and support building
        - **i.** Speakers and meeting attendance
        - **ii.** Community service
    - **i.** Spirituality and personal purpose
2. **Coping Skills: Group Treatment Service**

   a. Tracking Urges
   b. Coping with Urges
   c. Setting Boundaries
   d. Being Sober vs. Being in Recovery
3. Co-Occurring Disorders Group: **Group Treatment Service**
   a. Psycho-ed. Components: Mental health and dual disorders-focused
      i. Mood disorders, anxiety and panic disorders, dysthymia, personality disorders, eating disorders, post-traumatic stress disorder and trauma-informed services
      ii. Self-medication, psychiatry, and medication compliance
      iii. Dual disorder cycles
      iv. Preventing symptoms or relapse
   b. Stage-wise
      i. Harm reduction methods
      ii. Motivational Interviewing techniques to move clients into preparation and action stages
         - Identify and strengthen personal values and motivations which are supportive of change
   c. Nutrition and exercise
   d. Community resources and support
4. Primary Skills Group: **Group Treatment Service**
   a. Stage-wise
      i. Identification of use consequences and support for abstinence motivations
   b. Emotional resolution
      i. Distress tolerance
      ii. Anger management
      iii. Self-harm reduction
   c. Coping Skills Education
      i. Cognitive Behavioral Therapy, Dialectical Behavior Therapy, relaxation tools
      ii. Stress and lifestyle management skills
         - Health and nutrition
   d. Relationship enhancement
      i. Communication skills, boundaries, interpersonal effectiveness skills, conflict resolution
   e. Community resource and support building
      i. Speakers and meeting attendance
      ii. Community service
   f. Spirituality and personal purpose
5. Relapse Prevention Group: **Group Treatment Service**
   a. Psycho-ed. Components: Substance use disorders-focused
      i. Abuse, Dependence, Addiction, Disease Model
   b. Relapse prevention
      i. Identifying and managing relapse triggers and high-risk situations
   c. Life management skills
      i. Financial and home management
   d. Sober recreation
   e. Education and occupation planning and skills
   f. Relationship and enhancement
   g. Community resources and support
6. Process Group**: Group Treatment Service**
   a. Group psychotherapy process

   - **b.** Gender, age, culture-specific
   - **c.** Consistent group members and facilitators
   - **d.** Consistent participation throughout treatment
7. Family Week: **Educational Services**
   - **a.** Bi-monthly
   - **b.** Psycho-ed. Components: Co-occurring and family systems-focused
     - **i.** Communication skills, anger management, conflict resolution
     - **ii.** Family roles, rules, and genealogy
     - **iii.** Codependency, enabling, and boundaries
   - **c.** Community resources, support and self-care
   - **d.** Relapse prevention
     - **i.** Relapse triggers and confrontation
   - **e.** Group psychotherapy process
   - **f.** Sober recreation- Graduation Celebration

1.3 Treatment Services *(245G.07, subdivision 1)*

NorthStar Regional's programs provide intensive non-residential treatment services for adult clients with a substance use disorder and/also co-occurring diagnosis and for their families. Treatment services are provided by a competent multidisciplinary team of Licensed Alcohol and Drug Counselors (LADC) and Licensed Mental Health (MH) Professionals. Specific treatment services are designed to meet clients' individual needs with regard to level of care intensity, age, gender, and other cultural components. Treatment programming will holistically address physical, emotional, legal, spiritual, social, family, vocational, and other problems associated with substance abuse and co-occurring disorders. Gender-specific and other culture-specific groups will address specific participant needs. Program fidelity and provision of best client care is imperative and is addressed proactively.

Services

1. **Comprehensive Assessment:** Clients are provided with comprehensive substance abuse and mental health screening and diagnostic assessment and referral services. If symptoms of mental illness are present, clients will complete a comprehensive mental health diagnostic assessment (DA) and will be referred to an appropriate level of care based upon diagnostic results and client needs.
2. **Individual and Group Counseling:** Clients focus on identifying and addressing problems related to substance use and mental health disorders and learn to practice strategic skills to assist with avoidance of continued pathological substance abuse after program discharge
   - **a.** Group facilitation will utilize a combination of interactive psycho-education and group psychotherapy processes.
   - **b.** Group size will not exceed 16 clients.
   - **c.** Therapeutic recreation activities are provided by the LADC and/or individuals specifically qualified according to accepted standards of their profession.
3. **Drug Screening:** Random weekly drug screening will be used to support client accountability.
4. **Education:** Clients learn strategic skills to avoid pathological substance abuse and manage problems related to substance abuse. They will be provided with information and opportunity to participate in physical activities addressing healthful nutrition and exercise that will encourage and support a healthy lifestyle.
   - **a.** In accordance with Minnesota Statutes, section 245A.19, clients will be provided with education concerning risks associated with substance use during pregnancy, sexual health safety, human immunodeficiency virus, tuberculosis, hepatitis, and other communicable diseases.

5. **Transition Services:** Clients are guided to utilize familial and communal resources to assist in the integration of treatment gains to daily life, such as Adult Rehabilitative Mental Health Services (ARMHS), Al-Anon services, medical transportation services, and involvement in local churches or other supportive networks. A supported transition serves to increase clients' independence and reduce unhealthy reliance on program staff
6. **Case Management:** Program staff collaborates with referents and invested parties, such as probation officers, social workers and family members, to assist clients with obtaining resources needed to develop and sustain a healthy lifestyle. The LADC will complete weekly Individual Treatment Plan reviews throughout the duration of their treatment and will collaborate and consult with the NorthStar Regional treatment team.
7. **Mental Health Services:** All clients are screened for mental illness. Clients requiring additional assessment will complete a comprehensive diagnostic assessment within 10 days and be treated onsite or referred elsewhere to a mental health professional.
    a. Education will be provided surrounding symptoms of mental illness and co-occurring disorders, the importance of medication compliance, and use of strategic coping skills.
    b. Reasonable flexibility will be provided for clients who exhibit difficulties adhering to treatment rules, including lapses in abstinence, to support the program's goal of helping clients to successfully complete their treatment program.
    c. Treatment plans will indicate treatment measures recommended and applied and will report mental health symptoms that are present.
    d. Weekly individual counseling by a mental health professional will be available for clients with a co-occurring diagnosis.
8. **Treatment Coordination:** Treatment coordination is provided by an individual who meets staff qualifications in section 245G.11, subd. 7. Treatment coordination services include: assistance in coordination with significant others to help in the treatment planning process wherever possible; assist in coordination with and follow-up with medical services as identified in the treatment plan; facilitate referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan; facilitate referrals to mental health services as identified by a client's comprehensive assessment or treatment plan; and assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs. Treatment coordination allows for a mental health professional who has a scope of practice in SUD treatment to supervise a treatment coordinator. Treatment coordinators require a minimum of monthly supervision, individually or via group supervision.
9. **Peer Recovery Support:** This optional additional service is provided by an individual in recovery. Peer support services include: education, advocacy, mentoring through self-disclosure of personal recovery experiences, attending recovery and other support groups with a client, accompanying to appointments that support recovery, assistance assessing resources to obtain housing, employment, education, and advocacy services, and non-clinical recovery support to assist the transition from treatment into the recovery community.
10. **Continuing Care:** Free peer-led continuing care groups and activities are provided for all successful program graduates.
11. **Culture-specific Tracks:** Cultural tracks are developed to address specific cultural issues reflective of client population needs; gender, age, ethnicity, professional status, and experience of trauma.
    a. Individual special and cultural needs specific to each client are documented in the clients' individual treatment plan.

Procedure

1. The Program Director will designate and manage staff responsibilities.

2. The Program Director will ensure provision of updated and population-relevant curriculum reflective of stage-wise treatment and evidence-based interventions.
3. Designated staff will provide chemical health services according to program schedules.
4. Group facilitators will deliver interactive psycho-education and facilitate group psychotherapy according to program schedules.
    a. Curriculum materials and schedules may be customized to meet group needs upon approval of the Program Director.
5. The Program Director will work with NorthStar Regional's Chief Operating Officer (COO) to monitor service fidelity and outcomes to ensure that evidence-based practices are consistently and appropriately used to best serve clients.
6. All treatment services will address clients' individual treatment plans and will be documented by the clinician providing services, using designated NorthStar Regional clinical documentation forms.

NorthStar Regional IOP Program:

Levels of Treatment Intensity-

1. **Phase I**
    a. Duration: 6 weeks
    b. Group sessions: 4 per week = 72 hours
        - **o** *Co-Occurring Disorders*, *Primary, Relapse Prevention, and Process groups*
    c. Individual sessions: 1 per week = 6 hours
    d. Total hours: Up to 78
2. **Phase II**
    a. Duration: 6 weeks
    b. Group sessions: 3 per week = 54 hours
        - **o** *Primary, Relapse Prevention, and Process groups*
    c. Individual sessions: 1 per week = 6 hours
    d. Total hours: Up to 60
3. **Phase III**
    a. Duration: 6 weeks
    b. Group sessions: 2 per week = 36 hours
        - **o** *Relapse Prevention and Process groups*
    c. Individual sessions: 1 per week = 6 hours
    d. Total hours: Up to 42
4. **Continuing Care**
    a. Duration: 6 weeks
    b. Group sessions: 1 per week = 18 hours
        - **o** *Process groups*
    c. Individual sessions: 1 per week = 6 hours
    d. Total hours: Up to 24

Total program hours: Up to 180 group and 24 individual

1.4 Additional Services *(245G.07, subdivision 2)*

NorthStar Regional's Program may provide or arrange the following additional services, documented in the individual treatment plan, reflective of client needs.

1. **Individual Mental Health Therapy -** Based on a client's acuity level, clients are provided with additional individual mental health therapy. We work with them to provide a specialized co-occurring treatment to educate clients in the understanding of the patterns with life span experiences in relation to mental health and substance use, within the services provided

of life skills, relapse prevention, seeking safety, mental health education. Individuals with underlying issues of PTSD, trauma, neglect, suicidal ideation, history of suicidal attempts, self-harm, abandonment, unhealthy relationships, abuse, co-dependency, emotional deregulation, lack of healthy communication skills, and lack of healthy personal support benefit from these services. Any additional mental health services, above the 25% ratio, are billed separately.

2. **Psychiatric Services** - NorthStar Regional has psychiatric services available to all patients at all levels of care. The level of the patient's acuity is taken into consideration with the provider and the frequency of visits. This service is provided in an effort to support the patient's success in treatment and sobriety. With the interactions of mental health diagnoses such as PTSD, trauma, abandonment, grief, shame, depression, anxiety and ADHD along with the history of substance use, the provider educates the patient and collaborates with them to provide the most effective option for treating them. The psychiatric team is focused collaborating with the patient and the treatment team and provides a very important part of the continuum of services for patients to have a successful treatment experience. Any additional psychiatric services are billed separately, apart from the medical services rate applied to the nursing team.
3. **Stress Management and Physical Well-being: Education Service** Clients are provided with stress management skills education, including guided progressive muscle relaxation, deep breathing, visual imagery, prayer, and meditation, to assist them in reaching and maintaining an acceptable level of overall health and well-being. We provide yoga to our clients as a means to enhance their physical well-being and teach stress management.
4. **Life Skills: Education Service** Education is provided to assist clients in learning and practicing life skills, including schedule management, home upkeep, and basic financial management, to support independent living.
5. **Employment and Educational Services: Education Service** Clients may be provided with education, including resume-writing and interviewing skills, to support completion of high school diploma, GED, college, or employment advancement. Clients will be assisted in locating and obtaining additional services as needed.
6. **Social Skills: Education Service** Clients will participate in group therapy and will be provided with communication skills education and opportunities to practice social skills in a safe environment.
7. **Safe Environment**: Clients are provided with a safe treatment environment. Staff members are present and available at all times that clients are present. Clients are initially and continuously assessed for vulnerability and Individual Abuse Prevention Plans are developed and followed as needed.
8. **Accountability:** Clients are provided the accountability to maintain sustained abstinence through random drug and alcohol testing.
9. **Room and Board:** Clients are assisted with the acquisition of housing and economic resources. They will be referred to residential treatment services if appropriate.
10. **Community Education and Prevention:** Education and prevention services are provided to the community, including Driving with Care® programs serving clients with DUI charges.

Procedure

1. Appropriately licensed staff members will be designated to facilitate and document clinical services in clients' individual treatment plan.
2. Drug screening tools will be obtained and administered by NorthStar Regional staff and/or a contracted laboratory technician.
3. The Program Director will ensure staffing is managed to provide these services in accordance with client needs.
4. The Program Director will ensure availability of curriculum reflective of stage-wise treatment and evidence-based interventions suited to address service needs.

5. The Program Director will work with NorthStar Regional's CEO and Chief Compliance Officer (CCO) to monitor service fidelity and outcomes to ensure that evidence-based practices are consistently used to best serve clients.

1.5 Drug Screening

Accountability is an important part of maintaining successful recovery and quality mental health. As participants in this program, clients are expected to comply with random drug screening as requested by the clinical treatment team. Clients are expected to disclose all prescribed medications and any changes to those medications to their individual therapist/case manager throughout the duration of this program and consent for care coordination with all prescribing physicians. Positive drug screens will be consulted with the treatment team and clinical decisions made with consideration of each individual client. If a client refuses to comply with a requested drug screen, this will be treated as a positive screen and may result in an incomplete discharge from treatment. Drug screening services are intended to provide clients with increased support in reaching a goal of sustained abstinence.

Drug screening services are provided and fees will be processed and managed both through NorthStar Regional Clinical Laboratory billings or independently through a third-party. With client consent, NorthStar Regional's staff will provide the third-party lab with billing information as outlined in an attached release form. NorthStar Regional's staff may offer assistance in obtaining funding resources, but clients are responsible for the cost of all laboratory services. Clients sign a Consent for Clinical Laboratory Services and Billing upon admission to the program.

Clinical Laboratory Urine Collections
Only current, active clients receiving chemical dependency treatment services will be drug screened through the NorthStar Regional Clinical Laboratory and it's third-party confirmation lab. Examples include: client's in Residential, IOP and OP treatment services and clients living in NorthStar Regional sober homes who are currently enrolled in and treatment services.

Quick-Dup Urine Collections
NorthStar Regional utilizes Quick Dips across our system for a variety of purposes. Quick Dips are not allowed to be in the Clinical Laboratory at any time. Additionally, NorthStar Regional owns and operates a number of sober homes in several counties. Individuals living in the sober homes may be current, active clients or may not be. Quick-Dip drug screens may be performed on all sober housing clients, but only current, active clients in treatment programming will have the testing results documented, stored in the current medical record, and billed to third-party payors.

Client Medical Record and Clinical Procedures

1. All clients are informed of NorthStar Regional's collaboration with the laboratories and will be expected to comply with random, observed, drug screening through the duration of their programs.
2. Primary CD Counselors, in collaboration with the treatment team, will request and manage appropriate drug screening under supervision of their Program Director.
    a. Group rosters will be attached to pre-printed labels for the Collectors to identify who gets tested on the designated day.
        i. When a group drug screen is scheduled for a treatment group and at the start of group, Primary CD Counselors and the Collector will confirm who is in attendance and who may be missing for the day.
        ii. Standing Lab Orders are automatically on-file in each client medical record.

b. Completed drug screens will be uploaded into the medical record, marked as positive or negative for the Primary CD Counselor. All positive drug screens will be discussed in case consultation in order to determine an appropriate treatment intervention.

i. All results, from both the in-house lab and the confirmation lab, will be uploaded to client charts and documented by office staff.

- Positive screens will be noted in the medical record. The Primary CD Counselor will discuss these results with the treatment team and/or Program Director to determine next steps in the client's care.

Urine Specimen Collection Procedures

NorthStar Regional utilizes the direct observed methodology for specimen collection under most circumstances. Collections will be randomized and unannounced. Please see the Unobserved Collection Process below for special circumstances. The observed procedure for collection involves an individual who monitors the collection by checking for signs that the donor may be tampering with the specimen. Observers and collectors at NorthStar Regional are the same individual. A direct, observed collection includes the following steps:

1. All clients will confirm their identity with first name, last name, and date of birth for the collector.
2. The labels for the vials are then filled out with: Date, Client Name, DOB, Collection Date, and Signature of Client, and Initial of the Collector. If the donor refuses to complete paperwork, the collector notes the refusal and continues with the collection process.
3. The collector asks the donor to remove any unnecessary outer garments (e.g., coat, jacket) that might conceal items or substances that could be used to adulterate or substitute the urine specimen:
   - **a.** The collector must ensure that all personal belongings (e.g., purse or briefcase) remain with the outer garments; the donor may retain the donor's wallet.
   - **b.** If an item is present that appears to have been brought to the collection site with the intent to adulterate, substitute, or dilute the specimen, this is considered a questionable sample. The collector will continue the collection process as normal then notify the primary CD counselor (if available), the MLT, or the Chief Compliance Officer. The primary CD counselor will be notified, and the medical record will be documented with the observations. If the item appears to be inadvertently brought to the collection site, the collector must secure the item and continue the normal collection procedure.
4. The collector for observed UA's must be the same gender as the donor, unless the collector is a trained medical professional (e.g., nurse, doctor, physician's assistant, technologist or technician) who is licensed or certified to practice where the collection occurs, and:
   - **a.** The collector accompanies the donor into the restroom.
   - **b.** The collector shall instruct the donor to wash and dry the donor's hands prior to urination. After washing the donor's hands, the donor must remain in the presence of the collector and must not have access to any water fountain, faucet, soap dispenser, cleaning agent, or any other materials which could be used to adulterate or substitute the specimen.
   - **c.** If the donor refuses to wash the donor's hands when instructed by the collector, this is considered a "refusal to test." The collector must stop the collection and report the refusal to test.
   - **d.** The collector listens and looks for signs of tampering with the specimen.
   - **e.** After the donor has completed urinating into the collection container: the collector shall receive the container from the donor while they are both in the restroom.
   - **f.** In cases where a donor is unable to produce a sample due to anxiety or previous trauma, the collector will exit the area, communicate with the primary counselor,

and notate the specimen as "Unobserved." See additional step below for Unobserved UA's.

g. Unobserved procedures are as follows:
   i. Ask the donor to turn out their pockets
   ii. Pat down the inner and outer thighs to determine no external objects are being hidden
   iii. Ask the donor to raise their arms and pat down the armpits.
   iv. Ask the donor to turn out or expose their beltline as many people hid objects along the beltline.

5. Integrity, Identity, and Control of a Specimen

a. The collector must inform the donor that, once the collection procedure has begun, the donor must remain at the collection site (i.e., in an area designated by the collector) until the collection process is complete, specimen sealed and verified by the client. Both the donor and the collector must keep the specimen container in view at all times until the collector seals the specimen bottles.

b. After the donor has given the specimen to the collector, whenever practical, the donor shall be allowed to wash the donor's hands and the donor may flush the toilet.

c. When there is any reason to believe that a donor may have adulterated or substituted the specimen, another specimen must be obtained as soon as possible under direct observation.

d. The collector must determine the volume of urine in the specimen container. The collector must never combine urine collected from separate voids to create a specimen.

e. If the donor fails to remain present through the completion of the collection, declines to have a direct observed collection as required, refuses to provide a second specimen as required, or refuses to provide an alternate specimen, the collector stops the collection and reports the refusal to test.

6. Unobserved Collection Process

Under some circumstances, the Primary CD Counselor or Program Director may allow for certain clients to give a urine specimen collected via the Unobserved methodology. Not every circumstance can be delineated in this policy, but some examples include:

a. Client has a known history of trauma;

b. Client's level of anxiety or distress prohibits them from voiding under Observed methodologies

c. There is no gender-specific collector available

The circumstance for administering an unobserved UA must be documented and approved. Unobserved method collectors do not have to be the same gender as the donor. Additionally, the following procedures will take place:

a. Collector will take appropriate measures to decrease the likelihood of tampering during the unobserved collection

b. Do not allow clients to carry personal items with them into the collection area

c. Ensure that potential adulterants, such as soap, ammonia, or bleach are not readily available in the collection area;

d. Provide soap to the client after the specimen is turned over to the collector;

e. Collector will label each vial as "unobserved"

f. Clinical documentation will reflect that the urine specimen was collected as "unobserved"

g. In-house Lab reports will be marked "Unobserved; Confirmation Lab reports are unable to document the methodology of collection

h. Any clinical documentation released to a third-party (ie: probation, courts, etc.) will contain language that "*This report is based on a UA collection that was*

unobserved. Therefore, the authenticity of who the sample belongs to cannot be guaranteed."

7. Specimen Custody Management and Preparation for Testing
    a. All collections are to be split specimen collections: one for NorthStar Regional Clinical Laboratory and one for a confirmation testing by a third-party vendor.
    b. The collector, in the presence of the donor, places the vacuum suction vial into the sample/donation cup to collect the urine from the collection container into two specimen vials.
    c. In the presence of the donor, the collector places the tamper-resistant label/seal over each specimen bottle cap.
    d. The collector places one vial in a bag labels for the In-House lab; the collector places the vial in another bag labeled for the third-party lab.
    e. The collector seals the specimens in a package and, within 24 hours or during the next business day, sends them to the main on-site laboratory that will be testing the urine specimen.
    f. If the specimen is not immediately transported to the laboratory, they must remain under direct control of the collector or be appropriately secured under proper specimen storage conditions until transported.
8. Collectors are not to discuss test results, processes, or other clinical items with patients. Clients with questions are to be referred back to their primary Chemical Dependency (CD) counselor.

1.6 Specialized Co-Occurring Treatment Services *(245G.20)*

In an effort to support clients in successful treatment outcomes, this program insures that clients have access to a medical provider capable of prescribing psychotropic medications and provides appropriate flexibility for clients who may lapse or have difficulties adhering to program rules during their treatment, pursuant to Minnesota 245G.20.

Dr. Thomas Winegarden, MD, is a Board-Certified Addictions Psychiatrist and serves as the Medical Director of NorthStar Regional. He and his psychiatric staff will be available to assist NorthStar Regional clients in psychotropic medication management. Clients will be referred to other medical providers for medication management as appropriate.

Psychiatry Procedures

1. All clients in the NorthStar Regional Co-Occurring IOP who are diagnosed with a mental health disorder that may benefit from medication management will be provided with psycho-education regarding their diagnosis to include psychopharmacological benefits and the importance of proper medication management.
2. Program staff will assist clients in psychiatry referrals and will consult with psychiatry as appropriate.

Flexibility for Lapses and Non-adherence to Treatment Rules Procedures

1. All relapses reported will be discussed with the treatment team to assess for safety and adjustment of treatment plan interventions.
2. Clients must agree to a goal of sustaining abstinence during their involvement in this treatment program; however, if a lapse occurs, the following measures will be taken:
    a. Client's safety will be addressed and a referral to hospital or detoxification services will be made as needed.
    b. Client will process the relapse with his or her individual counselor to increase personal awareness by identifying relapse triggers and readjusting the individual treatment plan to address client needs.

   c. The client will sign an abstinence contract outlining treatment planning adjustments in a Cognitive Behavioral Therapy (CBT) behavior chain analysis format.
   d. The client will be encouraged to share the relapse with group members to receive the benefits of group feedback and support, as appropriate.
3. If a client lapses more than once, the individual counselor will encourage the client to bring in a supportive other to increase environmental support and accountability, in addition to the aforementioned procedures.
4. If a client consistently lapses, the treatment team will consult to address the client needs, safety, treatment interventions, and consider the best level of care of the client.
5. Clients are expected to follow program rules as outlined in the client expectations policy and procedure; however, flexibility will be made as follows:
   a. Clients who are consistently absent and tardy will be contacted by their Case Manager, who will assist them with developing a remedial plan that identifies the importance of attendance and the client's motivations for appropriate participation in treatment. This plan will be signed and documented in the client's treatment plan.
   b. Clients who are disruptive or display inappropriate group behavior will process the behavior with their individual counselor and develop a plan to improve group involvement.
   c. Any behavior that poses risk to other clients will result in a removal from group activities until safety can be expected.

Specialized Co-occurring Treatment Components *(245G.20)*

1. All program curriculums are comprehensive in addressing co-occurring substance use and mental health disorder diagnosis.
2. During Phase I of the program, clients participate in weekly psycho-educational groups focused on understanding mental health conditions, including mood and anxiety disorders, personality disorders and suicidality, attention disorders, psychotic disorders, impulse disorders, experience of trauma and PTSD. These interactive groups provide clients with an increased understanding of mental health conditions and impacting co-occurring components. Additionally, these groups provide an opportunity for clients to process their experiences of such conditions in a safe and supportive therapeutic environment
3. During Phases I and II of this program, clients participate in weekly psycho-educational groups focused on skills training. These groups provide clients with an education of adaptive CBT and Dialectical Behavior Therapy (DBT) skills purposed to assist in managing both mental health symptoms and avoiding maladaptive patterns of substance use. These interactive groups provide clients the opportunity to learn and practice learned skills in a safe and supportive therapeutic environment.
4. NorthStar Regional has a mental health professional available for staff member supervision and consultation.
5. NorthStar Regional follows 245G guidelines to determine group size, structure, and content considering the special needs of a client with a co-occurring disorder.
6. NorthStar Regional continues to document the ongoing collaboration with mental health providers, to include involvement of the providers with treatment planning meetings.
7. NorthStar Regional provides individual psychotherapy and case management throughout treatment service.

1.7 Treatment Services Initiation *(245G.14)*

This program provides non-residential intensive treatment services to adults with substance use disorder diagnosis, and/also mental health diagnosis and to their families. Treatment programming will holistically address physical, emotional, legal, spiritual, social, family, vocational, and other

problems associated with substance use and co-occurring disorders. Gender-specific and other culture-specific groups will address specific participant needs. Participants will be screened for mental health diagnosis upon service initiation. If symptoms of mental illness are present, clients will be referred to complete a comprehensive mental health diagnostic assessment (DA) and will be referred to an appropriate level of care based upon diagnostic results and client needs. Service initiation will be discussed with a multidisciplinary team and authorized by the Program Director. In accordance with the Code of Federal Regulations, title 45, part 96.131, preferential treatment placement will be given to (1) Pregnant injecting drug users; (2) Pregnant substance abusers;(3) Injecting drug users; and (4) All others.

Participants Appropriate for Program Admittance:

1. Participants must meet the following diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5):
    a. Substance Use Disorder Diagnosis,
    b. Co-occurring Axis I Substance Abuse or Dependence diagnosis; and Axis I or II Mental Health Disorder Diagnosis
2. Participants must exhibit willingness to work toward abstinence from all alcohol or drug use during the program duration. Staff members will employ a harm reduction model to allow appropriate flexibility in assisting participants toward a goal of abstinence, considering participant needs and safety.
3. Participants must adhere to program guidelines, including the attendance policy. Staff members will allow appropriate flexibility based upon client needs.
4. Participants must be 18 years or older.
5. Participants will be expected to invite family or significant supportive others to be involved in their treatment.
6. Participants will commit to the entire treatment process, including screening and diagnostic assessment, treatment planning, and Continuing Care.
7. Persons who do not meet program admission criteria, exhibit acute physical, cognitive or mental health needs that exceed the constraints of a non-residential level of care, or pose a physical threat to self or others, will be referred to a medical facility capable of admitting the client. Upon appropriate consultation, assessor will assist such persons with referral for an appropriate level of care to ensure safety and best client care.
8. Predatory offenders convicted of 3rd degree or higher criminal sexual conduct are not accepted.

PLACEMENT CRITERIA *(9530.6622)*

Dimension 1: acute intoxication/withdrawal potential.

The placing authority must use the criteria in Dimension 1 to determine a client's acute intoxication and withdrawal potential.

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client displays full functioning with good ability to tolerate and cope with withdrawal discomfort. No signs or symptoms of intoxication or withdrawal or diminishing signs or symptoms.	0 The client's condition described in the risk description does not impact treatment planning decision.

1 The client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. The client poses minimal risk of severe withdrawal.	1 The placing authority should arrange for or provide needed withdrawal monitoring that includes at least scheduled check-ins as determined by a health care professional.
2 The client has some difficulty tolerating and coping with withdrawal discomfort. The client's intoxication may be severe, but responds to support and treatment such that the client does not immediately endanger self or others. The client displays moderate signs and symptoms with moderate risk of severe withdrawal.	2 The placing authority must arrange for withdrawal monitoring services or pharmacological interventions for the client with on-site monitoring by specially trained staff for less than 24 hours. The placing authority may authorize withdrawal monitoring as a part of or preceding treatment.
3 The client tolerates and copes with withdrawal discomfort poorly. The client has severe intoxication, such that the client endangers self or others, or intoxication has not abated with less intensive services. The client displays severe signs and symptoms; or risk of severe, but manageable withdrawal; or withdrawal worsening despite detoxification at less intensive level.	3 The placing authority must arrange for detoxification services with 24-hour structure for the client. Unless a monitored pharmacological intervention is authorized, the detoxification must be provided in a facility that meets the requirements of parts 245G.01 to 245G.17 or in a hospital as a part of or preceding chemical dependency treatment.
4 The client is incapacitated with severe signs and symptoms. The client displays severe withdrawal and is a danger to self or others.	4 The placing authority must arrange detoxification services for the client with 24-hour medical care and nursing supervision preceding substance abuse treatment.

Dimension 2: biomedical conditions and complications.

The placing authority must use the criteria in Dimension 2 to determine a client's biomedical conditions and complications.

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client displays full functioning with good ability to cope with physical discomfort.	0 The client's risk does not impact treatment planning decisions.

1 The client tolerates and copes with physical discomfort and is able to get the services that the client needs.	1 The placing authority may refer the client for medical services.
2 The client has difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and treatment. The client neglects or does not seek care for serious biomedical problems.	2 Services must include arrangements for appropriate health care services, and monitoring of the client's progress and treatment compliance as part of other chemical dependency services for the client.
3 The client tolerates and copes poorly with physical problems or has poor general health. The client neglects the client's medical problems without active assistance.	3 The placing authority must refer the client for immediate medical assessment services for the client as part of other treatment services for the client. The placing authority must authorize treatment services in a medical setting if indicated by the client's history and presenting problems.
4 The client is unable to participate in chemical dependency treatment and has severe medical problems, a condition that requires immediate intervention, or is incapacitated.	4 The placing authority must refer the client for immediate medical intervention to secure the client's safety and must delay treatment services until the client is able to participate in most treatment activities.

Dimension 3: emotional, behavioral, and cognitive conditions and complications.
The placing authority must use the criteria in Dimension 3 to determine a client's emotional, behavioral, and cognitive conditions and complications.

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client has good impulse control and coping skills and presents no risk of harm to self or others. The client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.	0 The placing authority may use the attributes in the risk description to support efforts in other dimensions.
1 The client has impulse control and coping skills. The client presents a mild to moderate risk of harm to self or others or displays symptoms of emotional, behavioral, or cognitive problems. The client has a mental	1 The placing authority may authorize monitoring and observation of the client's behavior to determine whether the client's stability has improved or declined along with other substance abuse treatment for the client.

health diagnosis and is stable. The client functions adequately in significant life areas.	
2 The client has difficulty with impulse control and lacks coping skills. The client has thoughts of suicide or harm to others without means; however, the thoughts may interfere with participation in some activities. The client has difficulty functioning in significant life areas. The client has moderate symptoms of emotional, behavioral, or cognitive problems. The client is able to participate in most treatment activities.	2 The placing authority must authorize treatment services for clients that include: consultation with and referral to mental health professionals as indicated, monitoring mental health problems and treatment compliance as part of other chemical dependency treatment for the client; and adjustment of the client's services as appropriate.
3 The client has a severe lack of impulse control and coping skills. The client also has frequent thoughts of suicide or harm to others including a plan and the means to carry out the plan. In addition, the client is severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in treatment activities.	3 The placing authority must authorize integrated chemical and mental health treatment services provided by a provider licensed under part 9530.6495 and 24-hour supervision.
4 The client has severe emotional or behavioral symptoms that place the client or others at acute risk of harm. The client also has intrusive thoughts of harming self or others. The client is unable to participate in treatment activities.	4 The placing authority must refer the client for acute psychiatric care with 24-hour supervision and must delay chemical dependency treatment services until the client's risk description has been reduced to number 3 in this dimension or refer the client to a mental health crisis response system.

Dimension 4: readiness for change.

The placing authority must use the criteria in Dimension 4 to determine a client's readiness for change.

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client is cooperative, motivated, ready to change, admits problems, committed to change, and engaged in treatment as a responsible participant.	0 The placing authority may use the attributes in the risk description to support efforts in other dimensions.

1 The client is motivated with active reinforcement, to explore treatment and strategies for change, but ambivalent about illness or need for change.	1 If services are authorized, they must include active support, encouragement, and awareness-raising strategies along with chemical dependency treatment services for the client.
2 The client displays verbal compliance, but lacks consistent behaviors; has low motivation for change; and is passively involved in treatment.	2 The placing authority must authorize treatment services for the client that include client engagement strategies.
3 The client displays inconsistent compliance, minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.	3 The placing authority must authorize treatment services that have specific client engagement and motivational capabilities.
4 The client is:	4 The placing authority must authorize treatment services that include:
(A) noncompliant with treatment and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the client's illness and its implications; or	(A) service coordination and specific engagement or motivational capability; or
(B) the client is dangerously oppositional to the extent that the client is a threat of imminent harm to self and others.	(B) 24-hour supervision and care that meets the requirements of part 9530.6505.

Dimension 5: relapse, continued use, and continued problem potential.
The placing authority must use the criteria in Dimension 5 to determine a client's relapse, continued use, and continued problem potential.

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client recognizes risk well and is able to manage potential problems.	0 The placing authority may facilitate peer support for the client.
1 The client recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.	1 The placing authority may promote peer support and authorize counseling services to reduce risk.

2 (A) The client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems.	2 (A) The placing authority must authorize treatment services for clients that include counseling services to reduce client relapse risk and facilitate client participation in peer support groups.
(B) The client has some coping skills inconsistently applied.	(B) The placing authority must promote peer support and authorize counseling services or service coordination programs that comply with part 9530.6500 or Code of Federal Regulations, title 42, part 8.
3 The client has poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. The client has few coping skills and rarely applies coping skills.	3 The placing authority must authorize treatment services for the client that include counseling services to help the client develop insight and build recovery skills and may include room and board.
4 The client has no coping skills to arrest mental health or addiction illnesses, or prevent relapse. The client has no recognition or understanding of relapse and recidivism issues and displays high vulnerability for further substance use disorder or mental health problems.	4 The placing authority must authorize treatment services that include service coordination and counseling services to help the client develop insight and may include room and board with 24-hour-a-day structure.

Dimension 6: recovery environment.

The placing authority must use the criteria in Dimension 6 to determine a client's recovery environment.

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client is engaged in structured, meaningful activity and has a supportive significant other, family, and living environment.	0 The placing authority may use the client's strengths to address issues in other dimensions.
1 The client has passive social network support or family and significant other are not interested in the client's recovery. The client is engaged in structured meaningful activity.	1 The placing authority may promote peer support and awareness raising for the client's significant other and family.

2 The client is engaged in structured, meaningful activity, but peers, family, significant other, and living environment are unsupportive, or there is criminal justice involvement by the client or among the client's peers, significant other, or in the client's living environment.	2 The placing authority must authorize treatment services for the client that help the client participate in a peer support group, engage the client's significant other or family to support the client's treatment, and help the client develop coping skills or change the client's recovery environment.
3 The client is not engaged in structured, meaningful activity and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.	3 The placing authority must authorize the treatment planning decision described in 2 and service coordination, and help find an appropriate living arrangement and may include room and board.
4 The client has:	4 The placing authority must authorize for the client:
(A) a chronically antagonistic significant other, living environment, family, peer group, or long-term criminal justice involvement that is harmful to recovery or treatment progress; or	(A) the treatment planning decision in 3 and appropriate ancillary services, and room and board within 24-hour structure authorized for the client if an appropriate living arrangement is not readily available; or
(B) the client has an actively antagonistic significant other, family, work, or living environment, with immediate threat to the client's safety and well-being.	(B) tx services that include service coordination and immediate intervention to secure the client's safety. Room and board with 24-hour structure must be authorized for the client if an appropriate living arrangement not readily available.

9. Staff Members Authorized to Initiate Services
- **a.** Chief Operating Officer
- **b.** Program Director (or their designee)
- **c.** LADC Supervisor
- **d.** Medical Director
- **e.** Admissions Coordinator

Procedure

1. The licensed drug and alcohol counselor will complete the following clinical documents and make appropriate treatment recommendations or referrals upon clinical consultation:
- **a.** Minnesota Rule 25 Assessment
- **b.** CA Form
- **c.** Mental health screening tools
  - **i.** GAIN-SS (adults)

ii. DSM-5 Cross Cutting Symptom Measure

d. Admission and recommendation letters will be sent to client and referring agency within 10 days.

2. Service initiation of clients under civil commitment will be managed in compliance with Minnesota Statutes, section 253B.16, subdivision 2.
3. Admission preference will be provided in accordance with the Code of Federal Regulations, title 45, part 96.131. Preferential treatment placement will be given to (1) Pregnant injecting drug users; (2) Pregnant substance abusers;(3) Injecting drug users; and (4) All others.
4. Admission preference will be provided to intravenous drug users and pregnant clients in accordance with the Code of Federal Regulations, title 45, part 96.131.
5. Participants who do not meet program admission criteria are referred based upon acute needs and safety.
   a. Case consultation will take place to support recommendations and referrals made.
   b. Assessor will provide client with written referral and contact information of the referred agency.
   c. If client appears to be intoxicated, experiencing dangerous withdrawal symptoms, suicidal, or posing a substantial likelihood of harm to themselves or others, assessor will call 911 immediately and follow emergency procedures, as needed.
   d. A client who is registered as a sex offender will not be permitted to participate in any programming components involving minors or vulnerable adults.
   e. If the commission of a crime against any staff member or property is involved with denial of initiated services, the assessor will make a report to local law enforcement providing minimal client information, pursuant to Code of Federal Regulations, title 42, section 2.12(c)(5), and Code of Federal Regulations, title 45, parts 160 to 164.
6. Service initiation criteria will be provided for all interested persons upon request.

1.8 Intake and Registration

The following procedure should be followed in addressing prospective clients' interest and inquiries of NorthStar Regional's services and in scheduling and registering new clients.

Procedure

1. NorthStar Regional Program service inquiries will be directed to NorthStar Regional's office staff.
   a. Office staff will share program information with clients and complete the following forms
      i. NorthStar Regional Intake Form
         - Standard private pay fees are available as follows; however, they can be adjusted upon approval of Program Director:
            a. Chemical Health Diagnostic Assessment: $300
            b. Mental Health Diagnostic Assessment: $275 Group Therapy: $100 per hour
            c. Individual and Family/Couple Sessions: $150 per hour
         - Private pay fees will be identified clearly in the client bill of rights.
         - If payment adjustments are warranted, clinician will request approval from the Program Director.
            a. Upon approval, clinician must complete an updated NorthStar Regional Payment Contract prior to session.
      ii. NorthStar Regional Insurance form
         - If a client has MA, staff should direct the client to apply for MN Rule 25 funding through their county of residence and obtain a Release of Information (ROI) in order to coordinate service

funding. Client should schedule an Orientation session with NorthStar Regional's Program Director upon receipt of MN Rule 25 Client Placement Authorization (CPA).

iii. Schedule Comprehensive Assessment with LADC
- Client should arrive 30 minutes early to complete paperwork.

2. Comprehensive Assessment Session (2 hrs.)
   a. The following intake paperwork should be completed:
      i. Minimum of 2 Releases of Information for collateral
      ii. NorthStar Regional Notice of Appeals Rights
      iii. Tennessen Notice
      iv. NorthStar Regional Consent for Treatment/HIPAA Acknowledgment
      v. NorthStar Regional HIPAA Privacy Notice
      vi. Client Bill of Rights
      vii. Authorization for Release of Information/Vulnerable Adult Form
      viii. NorthStar Regional Adult/Child Data Form
      ix. GAIN-SS (Adults)
      x. DSM-5 Cross Cutting Symptom Measure
      xi. NorthStar Regional Health Questionnaire
   b. Clients should schedule an orientation session if the LADC recommends NorthStar Regional's Treatment programming.
   c. If a client does not arrive within 10-15 minutes of his or her scheduled arrival time, office staff will contact him or her to inquire whereabouts and reschedule as appropriate.
   d. Missed appointment letters will be sent to clients who do not call or attend sessions. If two consecutive appointments are missed, clients will be informed that another missed appointment without notice will result in a loss of rescheduling opportunities.
3. Orientation session (60 min)
   a. Client should arrive 20 – 30 minutes early to review paperwork
      i. Drug and Alcohol Abuse Normative Evaluation System (DAANES) Notification and Intake form
      ii. NorthStar Regional's Communicable Diseases Policy and Procedure and Resources
      iii. Client Expectations
      iv. NorthStar Regional Emergency Management Policy and Procedure
      v. NorthStar Regional Mandated Reporting Policies and Procedures
      vi. NorthStar Regional Program Abuse Prevention Plan
      vii. NorthStar Regional Program Structure and Schedule
      viii. Initial Services Plan
      ix. Vulnerable Adult Determination
   b. Orientation Acknowledgment: The Intake Coordinator will give client a facility tour
   c. The Program Director will designate the LADC Manager
      i. The LADC completing Orientation session will enter an intake note in ICANotes in Client Case Management form and return paper chart to "New Clients to Enter" file for office staff to update, documenting the service.
   d. If client endorses symptoms of a mental health disorder, he or she will be referred to an appropriate Mental Health Provider within 10 days of admission.
4. Treatment Planning Session

1.9 Assessment and Treatment Planning *(245G.05, subdivision 1)*

Pursuant Minnesota 245G.05, subdivision 1, the NorthStar Regional assessment and treatment planning processes are comprehensive and include diagnostic assessment of substance use disorders and screening of mental health concerns to best identify client needs. Admitted clients who endorse mental health concerns through the screening process will complete a mental health diagnostic assessment within 10 days and be referred to an appropriate mental health provider. A Comprehensive Assessment Summary will address mental health and substance abuse concerns and provide a summary and rationale for assessed 6 Dimensions risk ratings, as well as determination of whether a client is a vulnerable adult. Treatment planning begins upon service initiation and includes documentation of treatment objectives and interventions related to identify substance use disorders. Clients who are determined to be vulnerable will participate in development of an Individual Abuse Prevention Plan (IAPP) within 24 hours of determination. Individual Treatment Plans and IAPP's are reviewed weekly and revised to address clients' changing needs.

Comprehensive Assessment Procedure

1. **Comprehensive Assessment (CA)** will be completed within three (3) calendar days on which a treatment session has been provided from the day of service initiation. It will include determination of a substance use disorder diagnosis in accordance with DSM-5 diagnostic criteria and will include the following documents
    a. **Minnesota Rule 25 Assessment**
        i. **NorthStar Regional's Minnesota Rule 25 Assessment Update** may be completed in lieu of MN Rule 25 Assessment upon receipt of a Minnesota Rule 25 Assessment completed. The original assessment must be gathered from referring agencies.
    b. **NorthStar Regional's Comprehensive Assessment**
    c. **Mental Health Screening Tool** will be completed and scanned into client charts by office staff.
        i. **GAIN-SS**
        ii. DSM-5 Cross Cutting Symptom Measure

2. **Comprehensive Assessment Summary** will be completed by the LADC within three (3) calendar days on which a treatment session has been provided from the day of service initiation and will provide a narrative and rationale for assessment using the 6 Dimension Risk ratings.
    a. The LADC will send recommendation and/or admittance letters to the client and referral source, with client's permission, and will include client's diagnosis, clear treatment recommendations and appropriate referrals within 7 days of assessment and/or admittance.

Treatment Planning Procedure *(245G.06)*

1. **Initial Services Plan (ISP)** will be completed within 24 hours of admission. If the completion is completed on the second day, the time admission as well as the time of completion of the ISP will be documented. ISP's must be person-centered and client-specific.
2. **Individual Abuse Prevention Plan (IAPP)** will be developed by the LADC within 24 hours of the time of vulnerability determination, in compliance with Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14.
3. **Individual Treatment Plan** All person-centered and client-specific treatment plans will be completed within five (5) calendar days on which a treatment session has been provided from the day of service initiation. All NorthStar Regional treatment plans will be signed by the qualified staff members dated signature, indicate the clients level of participation, and if the

client wishes family or others involved in treatment services, their treatment plan must include how the family or others will be involved in the client's treatment. All treatment plans will be specific and address each identified need in the comprehensive assessment summary, including amount, frequency, and anticipated duration of treatment service. All treatment plans will address the following:

- **a.** Involvement of client's family, and supportive others, in treatment process. Treatment goals are discussed within multidisciplinary clinical consultation. Clear treatment goals are developed addressing problems identified in the 6 Dimensions and mental health symptoms, including active interventions to stabilize mental health symptoms which the client must reach to complete treatment successfully.
- **b.** Specific treatment methods used, appropriate to client's language, reading skills, cultural background, and strengths, including the amount and frequency of treatment components, as well as the expected duration of treatment
- **c.** Documented consultation with treatment providers and referrals made as appropriate
- **d.** Individual treatment plans will be reviewed and revised weekly to address changes in client's condition and effects of treatment interventions.
    - **i.** Client and LADC will sign and date individual treatment plan revisions.

1.10 Treatment Services Termination *(245G.14, subdivision 3, 245G.06 subd. 4)*

It is the goal of this program to assist all clients in successful program completion indicated by completion of mutually developed treatment objectives outlined in the Individual Treatment Plan. Clients are expected to adhere to the designated program structure with the allotment of appropriate accommodations to address individual client needs, as authorized by the Program Director. Clients who exhibit acute physical or mental health needs that exceed the constraints of this program, are unable to adhere to program guidelines, or pose a physical threat to self or others will be discharged and referred to a medical facility capable of admitting clients.

Staff Members Authorized to Terminate Services

1. Chief Operating Officer
2. Program Director (or their designee)
3. LADC Supervisor

Procedure

1. Participants who do not meet program admission criteria are referred based upon acute needs and safety
    - **a.** If the immediate safety of any client is threatened due to intoxication, withdrawal, or any other medical emergency, that client will be referred to the nearest medical facility capable of admitting the individual.
        - **i.** If a client's significant other is present and agrees to transport, this is permissible. If not, staff member will call 911 immediately and follow emergency management protocols or transported by staff in van.
    - **b.** Case consultations will take place to support recommendations and referrals made.
    - **c.** A client registered as a sex offender will not be permitted to participate in any programming components involving minors or vulnerable adults, except the Jail Program.
    - **d.** If the commission of a crime against any staff member or property is involved with denial of initiated services, the assessor will make a report to local law enforcement

providing minimal client information, pursuant to Code of Federal Regulations, title 42, section 2.12(c)(5), and Code of Federal Regulations, title 45, parts 160 to 164.

2. Discharge summaries (DS): The summary must be completed within 5 (five) days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier and include the following:
    - **a.** Client problems, strengths, and needs during treatment
    - **b.** Progress toward achieving each identified individual treatment plan goal
    - **c.** Reason for service termination
    - **d.** Discharge recommendations
    - **e.** Discharge category
3. Discharge recommendation letters will be provided to clients and referring agencies, with client release, within 10 days.
4. Planned discharge notification of a client under civil commitment will be sent by mail, fax or email at least 1 week prior to proposed discharge to the designated referent and client's spouse, adult child, or next of kin prior to discharge and will include the following:
    - **i.** Proposed discharge date;
    - **ii.** Date, time, and place of staff meeting to consult discharge, and
    - **iii.** Indication that the client and next of kin may be present at this meeting
5. Before discharging a client from an outpatient setting for not reaching treatment plan goals, we will first discuss this with the client in the weekly treatment plan review. We will then confer with other interested persons to review issues involved in the decision. We will document and describe to these interested persons the reason why the decision to discharge is warranted, the reason for the discharge, and the alternatives considered or attempted before discharging a client. The following steps will be taken as well:
    - **i.** Proposed staff discharges will be discussed by staff members in a meeting;
    - **ii.** The Program Director will be involved in the decision;
    - **iii.** Staff will call the last known number in the medical record in an attempt to reach the client or emergency contact. We will attempt to contact the affected individuals for 3 consecutive days.
    - **iv.** procedures consistent with Minnesota Statutes, section 253B.16, subdivision 2, that staff must follow when a client admitted under Minnesota Statutes, chapter 253B, is to have services terminated;
6. A copy of the discharge summary must be provided to the client upon the clients request. If the discharge is planned, we will give the client a copy of the discharge summary or offer to mail it to them if they request it.

7. All staff-requested discharges must include:
    - **a.** A description of why the decision to discharge is warranted
    - **b.** The reason for discharge
    - **c.** The alternatives considered or attempted before discharging client
    - **d.** Staff-requested service terminations shall be communicated to the client verbally, we will confer with other interested persons to review issues involved in the decision, and in the case of a client no longer on the premises, the last known phone number in the medical record will be tried in an attempt to communicate with the client.

Categorical Service Termination Procedures

1. **With Staff Approval (WSA):** Client has successfully completed all recommended programming and treatment objectives
2. **Conditional with Staff Approval (CWSA):** Clients who are unable to sustain abstinence or exhibit physical or mental health needs that exceed program provisions

   a. Recommendations should include higher level of care, such as detoxification or hospital based inpatient services
3. **Against Medical Advice (AMA):** Client decides to terminate services against clinical advice
   a. Staff will address client concerns and needs in consultation
   b. Staff will discuss treatment options with the client, but will respect and follow action of the client's decision
   c. Program accommodations and intra-program referrals must be authorized by Program Director
   d. If client poses a danger to self or others, a designated staff member will contact 911 or make an appropriate report in compliance with Maltreatment of Minors and Vulnerable Adults Reporting Duty to Warn policies
4. **At Staff Request (ASR):** Client engages in behaviors that merit discharge
   a. Inability to adhere to program guidelines, including abstinence and attendance guidelines
      i. Staff will attempt to contact clients who fail to attend programming as scheduled and discuss attendance accountability
      ii. Clients not in communication with program staff for a week will be discharged
   b. Disrespectful, disruptive, abusive, or non-participatory behavior that interferes with the treatment of other clients
   c. Physically aggressive behavior that poses a risk to self and/or program-affiliated persons or properties
      i. Crimes threatened or committed by a client, on program premises or against program personnel will be reported to the local police, as follows:
         - Only necessary information regarding the criminal incident description and client involvement, including his/her name, address, and last known whereabouts of the accused client
         - Consultation with the Program Director and NorthStar Regional's Managing Director
         - Staff member will complete Critical Incident Report within 24 hours

1.11 Health Monitoring Plan (*245G.08, subdivision 1)*

HEALTH CARE SERVICES DESCRIPTION: This program provides treatment, education, and prevention services for clients diagnosed with substance abuse disorders. No other health care services—nursing services, dietary services, or emergency physician services—will be provided by this program. The medical needs of clients served will be consistently assessed and staff will provide assistance in obtaining health care services and consultation with other health care professionals, as appropriate. Assessment, referral, and consultation regarding medical needs will be indicated as a part of a clients' individual treatment plan and reviewed as needed.

Consultation services: NorthStar Regional employs Jamie Cox, LPCC, a licensed Mental Health Professional to provide diagnostic assessment and treatment planning assistance.

Procedure

1. Medical interventions outside of the scope of treatment services will result in a referral made by calling 911
2. Staff members will consult with other health care providers as appropriate.
3. Clients will be oriented to the program's emergency management protocol upon admission
4. In the event of a medical emergency, staff members will follow emergency management procedures

1.12 Medication Administration *(245G.08, subdivision 5-6)*

Program services will not include medication administration or assistance with self-administration of medications.

1. Clients will be referred to their prescribing physicians to manage medications
2. Program staff will obtain a release of information from clients to consult with prescribing physicians as appropriate
3. Staff will address medication concerns during clinical consultation
4. In compliance with Minnesota 245G.08, subdivision 5-6, staff will not administer or assist with self-administration of any medication for any client

1.13 Drug Control *(245G.08, subdivision 6)*

This program will not offer storage, administration, or assistance with self-administration of medications. In compliance with Minnesota 245G.08, subdivision 5, program staff will not assist with administration or assistance with self-administration of medications, nor will they store medications or illicit drugs at any time.

Procedure

1. Clients will be referred to their prescribing physician to manage medications
2. Program staff will obtain client release of information and consult with prescribing physicians as appropriate
3. Staff will discuss client medication concerns in consultation
4. If a client attempts to surrender illicit or prescription drugs, staff will refer the client to nearby Carver County medication disposal site located at Carver County Sheriff's Office – Lobby at 606 East 4th Street, Chaska, MN 55318 or 9401 83rd Ave. N, Brooklyn Park, MN 55445 for the Maple Grove location.
5. If any illicit or prescription substance is found by program staff, he or she will bring this to the attention of the Program Director immediately, and contact local law enforcement for disposal instructions
6. If a client attempts to surrender illicit or prescription drugs, or for any discontinued medication, or for outdated or deteriorated medications, the assigned med tech on duty will deliver the medication to Hennepin County medication disposal site located at Hennepin County Sheriff's Office: 9401 83rd Avenue North, Maple Grove, MN 55445.

1.14 Program Fidelity

NorthStar Regional's Outpatient Program operates under NorthStar Regional and is managed by the Program Director who reports to NorthStar Regional's CEO. This program consistently strives to provide to best care for clients served by utilizing evidence-based interventions designed to meet individual and cultural needs. In addition to participation in the drug and alcohol abuse normative evaluation system, it is the policy of this program to regularly evaluate and manage program fidelity and outcome measures.

Procedure

1. The Program Director will assure treatment quality through implementation of program evaluation methods and monitoring treatment outcomes
    a. Directors will meet quarterly to address fidelity and treatment outcome improvements

   b. Clients will be invited to provide program feedback and participate in outcome studies purposed for program improvement
2. Staff members will be trained and experienced to address specific client needs utilizing evidence-based interventions
3. The Program Director will consistently update curriculum to reflect client needs
4. The Program Director will facilitate quarterly program chart audits to assure accurate recordkeeping
5. Staff members will participate in supervision and regular clinical consultation
6. NorthStar Regional will comply with the DAANES and will submit client information to the commissioner in compliance with NorthStar Regional DAANES Reporting procedures
7. Additional information will be submitted to the commissioner upon request

1.15 Plan for Transfer of Care for Clients and Records

NorthStar Regional provides a comprehensive continuum of care, coordinated by a multi-disciplinary team of treatment professionals that includes mental health services and substance use recovery programming. If NorthStar Regional closes, client wellbeing and health information management are top priorities for the organization. This procedure is written to provide for the transfer of client care and access to medical records should the organization close.

An annual review of this specific policy and procedure is required by Minnesota State Law. Reviews and updates shall be kept on file in the Compliance Department.

The following procedures and steps will be taken, or have already taken place:

- Senior leadership will devise a communications plan and timeline;
- Custodian of medical records and service referral contracts will be reviewed and updated as necessary;
    - Custodian for Medical Records: Corporate Northstar Regional
- Notify current clients at least 30-days prior to closure date, by first-class letter, of the organization's intent to close. This will enable clients to locate an alternate healthcare provider and adjust to the transition. The letter will include steps for obtaining medical records and a medical record release authorization form will be included. The letter will state how to obtain medical records and how long the records will be available in accordance with Minnesota Statutes and the Minnesota Department of Health guidelines for record retention. The letter will also discuss continuity of care or transitions of care and where to obtain further treatment;
- Post this same letter prominently on the organizations website;
- Include clients who have received services at the clinic in the last 12 months;
- Scan and retain a copy of the letter in the client records;
- Instruct staff on how to inform and discuss the closure with current clients, the caller on the phone, and other entities that may have questions;
- Maintain a voice-mail system after closure for 1-2 months instructing clients about the closure. Messages will be checked daily and responded to in a timely manner. The message will include the following information: the date office is closed, how clients can find new providers, how to request copies of medical records, and how to obtain emergency treatment.

<u>Internal Procedures</u>

- Identify and inform all stakeholders, vendors and business associates;

- Ensure system of access to medical records is clear and concise;
- Current responsible party for this policy: CEO, President, and/or Compliance Officer
- Current EHR Vendor: Procentive, Hudson, WI
- Scrub the electronic health record of any charts that have been kept beyond the required length of time required by state and federal law;
- Ensure records of minors are maintained for a period of seven (7) years beyond the age of majority;
- Post the closing letter in prominent places throughout the facility and at the front desk;
- Initiate discussion with EHR vendor for transfer of records or data files;
- Distribute talking points to staff and keep communications open about developments in the weekly staff meetings;
- Contact and initiate procedures with Custodian of medical records entity who will assume control, custody, and possession of all the medical records related to the practice of NorthStar Regional and shall retain the records in accordance with applicable Minnesota and federal laws.

On an annual basis, The Transfer of Client Care Upon Closure policy shall be reviewed and updated.

Signatures:

Jason Vanderscoff, CEO NorthStar Regional — Date 3/31/21

Hal Baumchen, President NorthStar Regional — Date 3/31/21

2 Recordkeeping

Records of treatment provided to clients admitted to NorthStar Regional programs will be protected and maintained in compliance with Minnesota 245G.09 subdivision 2, HIPAA, and corresponding state and federal rules, statutes, and regulations.

2.1 Client Records *(245G.04, 245G.05, 245G.06)*

In accordance with Minnesota Statutes, section 254A.09, Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, Code of Federal Regulations, title 45, parts 160 to 164, and Minnesota Statutes, chapter 13, all identifying and clinical client information is protected against loss, tampering, and unauthorized disclosure. Client records are completed in a timely and uniform fashion and are maintained and stored in the location of service provision: 1045 Stoughton Avenue or 102 E 2nd St, Ste 110B, Chaska, MN 55318 and for the Maple Grove location, 12000 Elm Creek Blvd, Suite L70, Maple Grove, MN 55369.Client records contain client orientation information pursuant Minnesota Statutes, section 245A.65, subdivision 2, paragraph (a)(4), initial services plan, CA, assessment summary, individual abuse prevention plan, progress notes, and discharge summary and include dated signatures of providers, supervisors, other staff, clients, and client representatives.

Procedure

1. Non electronic client records will be stored in a locked cabinet in a locked room on the program premises
2. Records of discharged clients will be reviewed for completion and retained for 7 years. In the event that the agency no longer provides services the commissioner will be notified of the location and designee responsible for securely retaining records for 7 years
3. Records of closed facilities shall be kept by the parent company in accordance with Minnesota and Federal laws and regulations.
4. The Program Director will facilitate regular chart audits to ensure documentation compliance
5. Program staff will complete clinical documentation forms designated for NorthStar Regional's programs to ensure uniformity of content and format
    a. Documentation will be signed and dated by service providers, supervisors, clients, and client representatives weekly
    b. Late entries will be clearly labeled as "late entry" and any corrections made will not cause illegibility of original entry
6. Client records will contain the following:
    a. **Orientation Documentation** The following items must be provided and explained to all clients on the day of service initiation.
        i. Client Rights, Responsibilities and Grievance procedures
        ii. Health and safety information regarding communicable disease safety, tuberculosis, and HIV
        iii. Emergency procedures
        iv. Program abuse prevention plan
        v. Acknowledgement of Mandated Reporting policies
    b. **Comprehensive Assessment (CA)** will be completed within three (3) calendar days on which a treatment session has been provided from the day of service initiation.
        i. **Minnesota Rule 25 Assessment**
            - **NorthStar Regional's and NorthStar Regional Minnesota Rule 25 Assessment Update** may be completed in lieu of MN Rule 25 Assessment upon receipt of a Minnesota Rule 25.

        ii. **NorthStar Regional's and NorthStar Regional Comprehensive Assessment** will include the following items:

        (1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education; (2) circumstances of service initiation; (3) previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness; (4) substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date of the most recent use and previous withdrawal symptoms; (5) specific problem behaviors exhibited by the client when under the influence of substances; (6) family status, family history, including history or presence of physical or sexual abuse, level of family support, and substance misuse or substance use disorder of a family member or significant other; (7) physical concerns or diagnoses, the severity of the concerns, and whether the concerns are being addressed by a health care professional.

    c. **Assessment Summary**
        i. Assessment summary includes substance abuse diagnosis based upon DSM-5 criteria, assessment and narrative rationale of the 6 Dimension risk ratings, and other information relevant to treatment planning

ii. The LADC within three (3) calendar days from the date of service initiation.

d. Individual Abuse Prevention Plan (IAPP)

i. Client vulnerability is assessed through a Vulnerable Adult Assessment

ii. Staff will develop an IAPP for clients determined "vulnerable" upon admission and at any time during their treatment, as needed

e. Individual Treatment Plans

i. The LADC will discuss the individual treatment plan in consultation. All person-centered treatment plans will be developed by an alcohol and drug counselor within five (5) calendar days on which a treatment session has been provided from the day of service initiation.

ii. All treatment plans will be signed by the qualified staff members dated signature, indicate the clients level of participation, and if the client wishes family or others involved in treatment services, their treatment plan must include how the family or others will be involved in the client's treatment. All treatment plans will be specific and address each identified need in the comprehensive assessment summary, including amount, frequency, and anticipated duration of treatment service.

f. Treatment Plan Reviews and Documentation of Treatment Services

a) A review of all treatment services must be documented weekly and include a review of:

(1) care coordination activities;
(2) medical and other appointments the client attended;
(3) issues related to medications that are not documented in the medication administration record; and
(4) issues related to attendance for treatment services, including the reason for any client absence from a treatment service.

(b) A note must be entered immediately following any significant event. A significant event is an event that impacts the client's relationship with other clients, staff, the client's family, or the client's treatment plan.

c) A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff member providing the service. The review must indicate the span of time covered by the review and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review must:

(1) indicate the date, type, and amount of each treatment service provided and the client's response to each service;
(2) address each goal in the treatment plan and whether the methods to address the goals are effective;
(3) include monitoring of any physical and mental health problems;
(4) document the participation of others;
(5) document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; and
(6) include a review and evaluation of the individual abuse prevention plan according to section 245A.65.

(d) Each entry in a client's record must be accurate, legible, signed and dated. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.

g. Discharge Summaries (DS)

i. An alcohol and drug counselor must write a discharge summary for each client. The summary must be completed within five days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier. A copy of the discharge

summary must be provided to the client upon the clients request. If the discharge is planned, we will give the client a copy of the discharge summary or offer to mail it to them if they request it.

ii. The service discharge summary must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), and include the following information: the client's issues, strengths, and needs while participating in treatment, including services provided; the client's progress toward achieving each of the goals identified in the individual treatment plan; and a risk description according to section 245G.05;

7. Permission to use Electronic health recordkeeping program, Procentive, has been requested by the Commissioner. Until permission is granted all records will be maintained and protected according to these procedures and in compliance with Minnesota Statutes, section 254A.09, Code of Federal Regulations, title 45, parts 160 to 164, and Minnesota Statutes, chapter 13.

2.2 DAANES Reporting

NorthStar Regional will participate in submission of requested client data to the Drug and Alcohol Abuse Normative Evaluation System (DAANES).

Procedure

1. The LADC will explain DAANES processes and provide the client with the DAANES Notification of Data Collection form and scan a copy into client's chart
2. The LADC will complete the DAANES admission form within 2 days of admission to the program and the discharge form within 2 days of service termination
3. The LADC will send this completed form, along with the Treatment Satisfactory Survey, to the clinical supervisor, who will ensure that the information is entered properly into the online DAANES system within 5 days of the clients' program admission or service termination

3 Personnel Policies

Pursuant to Minnesota 245G.13 and associated federal and state rules, statutes and regulations, policies and procedures for personnel associated with NorthStar Regional programs are as follows.

3.1 Personnel

Pursuant to Minnesota, 245G.13, subdivision 1, new staff members will be oriented to this program and personnel policy according to new staff orientation policy and procedure. Staff members' job retention, promotion, assignment, and pay are not affected by any good faith communication between a staff member and the Department of Health, the Department of Human Services, the ombudsman for mental health and developmental disabilities, law enforcement, or other local agencies for the investigation of complaints regarding a client's rights, health, or safety.

Staff members are provided with a description of organizational structure and clear job descriptions specifying responsibilities, degrees of authority to execute job responsibilities, and qualifications of hire. In compliance with Minnesota 245G.13, subpart 1, Minnesota Statutes, chapter 148A, and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572, behaviors that constitute

grounds for disciplinary action, suspension, or dismissal, such as the existence of active chemical use problems and personal involvement with a client, as well as provision of job performance evaluations, are clearly outlined in the Staff Expectations Policy and Procedure.

NorthStar Regional utilizes speakers and guest instructors in addition to employed staff members. These individuals will be required to comply with the "NorthStar Regional's Personnel Policy for Guests" and will be required to have a background study conducted and confidentiality agreement or HIPAA BAA in place prior to coming on-site.

Procedure

1. Within 24 working hours, new staff members will be oriented according to new staff orientation procedures.
2. All staff members will have access to the program policy and procedure manual and detailed job descriptions and expectations.
3. The Program Director will elicit supervisory feedback to conduct annual performance meetings and written reviews for all staff members based upon standards of job performance and utilized to build upon staff strengths and address improvement goals.
    a. Behaviors that may interfere with provision of treatment and other behaviors that constitute grounds for disciplinary action, suspension, or dismissal are described in the Staff Expectations Policy and will be addressed accordingly.
4. Any guest speakers or instructors must be screened and cleared by both the Human Resources and Compliance Department prior to any 245G client contact of NorthStar Regional.

3.2 New Staff Orientation

In compliance with Minnesota 245G.13, subdivision 1, new staff members will be oriented to program policies and procedures and will have access to the policy and procedure manual within their first 24 working hours. Orientation will include training related to specific job functions, program policy and procedure, client confidentiality, human immunodeficiency virus minimum standards, client needs, and staff expectations.

Procedure

1. The Program Director will facilitate new staff orientation within staff member's first 24 working hours
2. Orientation Agenda is as follows:
    a. Staff Introductions
    b. Office Tour
    c. NorthStar Regional Policy and Procedure Manual Location
    d. NorthStar Regional Personnel Policies
        i. Job Descriptions, Performance Reviews, and Organizational Structure
        ii. NorthStar Regional's Personnel Policy (MN 245G.13 and MN Statute, section 604.20)
        iii. NorthStar Regional's Staff Expectations Policy
        iv. NorthStar Regional's Staff Alcohol and Drug Use Policy (MN Statutes, section 245A.04)
    e. NorthStar Regional Programs
        i. MN 245G Licensed Intensive Outpatient Treatment
        ii. Community Education and Prevention
        iii. NorthStar Regional Services (MN 245G.07)
        iv. Program Structure, Schedules, and Curriculum Materials
    f. Training
        i. NorthStar Regional's/NorthStar Regional Client Rights Policy
        ii. NorthStar Regional's/NorthStar Regional Client Records

iii. NorthStar Regional's DAANES Reporting Policy and Procedure
iv. Client Confidentiality (HIPAA)
v. NorthStar Regional Mandatory Reporting Policy and Procedures (MN Statutes, sections 245A.65, 626.556, 626.5561, 626.5563, 626.557, and 626.5572) This training will happen immediately upon hire.
vi. Communicable Diseases and HIV Minimum Standards Policy and Procedure (MN Statutes, section 245A.19) This training will happen immediately upon hire.
vii. NorthStar Regional's Emergency Procedures
viii. Clinical Documentation Procedures
ix. Intake Procedures
x. 12 hours Co-occurring Disorders Training (within 6 months)
- Philosophy, screening, assessment, diagnosis and treatment planning, documentation, programming, medication, collaboration, consultation, and discharge planning

g. Payroll, benefits, and Human Relations Information

3.3 Personnel Files

In compliance with Minnesota 245G.13, subdivision 1, the Program Director will maintain a personnel file for each staff member to demonstrate personnel requirements met under Minnesota 245G.13. Personnel files will include documentation regarding background study data and clearance to work in a human services program pursuant Minnesota Statutes, chapter 245C. Clinical staff members' files will include documentation of inquiries made to previous employers for the past five years regarding substantiated sexual contact with a client as required by Minnesota Statutes, chapter 604.

Procedure

1. Program Director will maintain a personnel file for all staff members which will include the following items:
   a. Completed employment application containing staff member signature and employment qualifications
   b. Documentation related to the employee's background study data. The submission date and the first date of unsupervised direct contact
   c. Names and addresses of employers under whom the staff member provided clinical services within the past 5 years and documentation of inquiries made regarding substantiated sexual contact with clients
   d. Documentation of completed new staff orientation and trainings
   e. Documentation of current CPR and First Aid certification
   f. Documentation of education and clinical experience and credentialing appropriate to designated employment qualifications and clinical tasks of responsibility
   g. Documentation of tuberculosis screening (annual)
   h. Acknowledgment of Freedom from Substance Abuse Problems
   i. Malpractice Insurance

3.4 Staff Schedules and Billing Procedures

Staff members are encouraged to work as a team, and to engage in an active practice of personal and professional self-care in order to ensure optimal job performance and consistent provision of quality client treatment. Upon hire each staff member is provided with paid time off (PTO). In order to ensure consistent programming, staff members are expected to adhere to this procedure when requesting PTO use and schedule changes. The Program Director will address requests in a timely and fair manner considering both staff and program needs.

Procedure

1. All staff members are provided with determined PTO provided upon hire
2. To request the use of PTO or other schedule changes staff members will submit a completed Schedule Change Request form to the Program Director at least 2 weeks prior to requested changes
    a. If the requested PTO or schedule change interferes with group facilitation, the staff member will address facilitation coverage in this form
3. Program Director will review requests within 3 days and submit approved requests to Administrative Specialist, who will make schedule changes as requested by the Program Director
4. In the case of "late notice" schedule changes, such as illness or emergency, staff member will contact the office and the Program Director as soon as possible
5. The Program Director or designated supervisor will be responsible for making accommodating schedule adjustments to ensure client care is minimally interrupted
6. All staff members are expected to check their schedules and emails daily in case of changes
7. Only designated and trained staff members are authorized to schedule client appointments. If a staff member offers a client appointment outside of his or her regular scheduled hours, he or she must accompany the client to schedule the appointment to ensure appropriate staff coverage
8. All staff members will designate billing diagnosis and place new client charts in the "new clients to enter" file within 72 hours of initial session
9. Billing sheets must be completed with appropriate billing codes daily
10. **Tracking Attendance Policy:**

    Staff will track and record client attendance for each treatment activity and service delivery. Attendance sheets will then be uploaded and stored on the main server of the organization. NorthStar Regional will also track and record client attendance at treatment activities, including the date, duration, and nature of each treatment service provided to the client through the Procentive EHR.

3.5 Organizational Structure

NorthStar Regional's Program operates and is managed by the Program Director who reports to the CEO/Managing Director. Program staff works as a team to support one another with a common goal of providing the utmost care to clients served. Staff members will assist with various program responsibilities as delegated and will not provide services outside of their scope of expertise.

Clinical and Administrative Responsibilities

1. **NorthStar Regional CEO**
    a. Oversee delegation of program management as license holder
    b. Attend Quality Assurance meetings monthly with the Program Director to ensure program fidelity
2. **NorthStar Regional COO**
    a. Determine and formulate policies and provide overall direction of programs within the company within guidelines set up by the CEO and/or board of directors
    b. Plan, direct, or coordinate operational activities at the highest level of management with the help of subordinate directors and staff managers
    c. Implement program policies and procedures
    d. Participate in coordination and execution of marketing and networking initiatives
    e. Develop and maintain program curriculum reflective of population needs
    f. Direct or coordinate an organization's financial or budget activities to fund operations, maximize investments, or increase efficiency

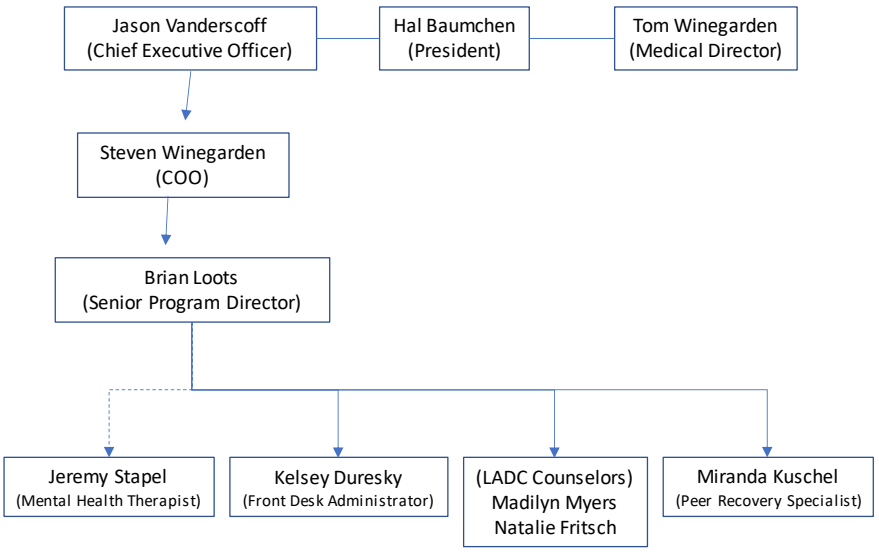
g. Appoint department heads or managers and assign or delegate responsibilities to them
h. Analyze operations to evaluate performance of a company or its staff in meeting objectives or to determine areas of potential cost reduction, program improvement, or policy change
i. Direct, plan, or implement policies, objectives, or activities of organizations or businesses to ensure continuing operations, to maximize returns on investments, or to increase productivity
j. Prepare budgets for approval, including those for funding or implementation of programs

3. **Program Director**
   - **a.** Clinical case load assignment
   - **b.** Supervision
     - **i.** Retain documentation of weekly supervision meetings
     - **ii.** Review and sign all documentation
   - **c.** Facilitate and document weekly clinical team consultation and monthly treatment plans review meeting
   - **d.** Facilitate and manage license-compliant staff training and orientation
   - **e.** Quarterly Quality Assurance meetings with Managing Director/CEO
   - **f.** Manage program operation and staff
     - **i.** Staff annual performance reviews
     - **ii.** Performance Improvement Plans
   - **g.** Manage and facilitate DWC® education and prevention programming
4. **Licensed Mental Health Provider Clinical Supervisor (LMHP Clinical Supervisor)**
   - **a.** Supervision
     - **i.** Submit documentation of weekly supervision meetings to the Program Director
     - **ii.** Review and sign all supervisee clinical documentation
   - **b.** Review and sign program individual treatment plans
   - **c.** Attend weekly clinical team consultation and monthly treatment plans review meeting
   - **d.** Attend required staff trainings
   - **e.** Direct client services, as needed
5. **Licensed Alcohol and Drug Clinical Supervisor (LADC Clinical Supervisor)**
   - **a.** Supervision
     - **i.** Submit documentation of weekly supervision meetings to the Program Director
     - **ii.** Review and sign all supervisee clinical documentation
   - **b.** Review all program individual treatment plans
   - **c.** Attend weekly clinical team consultation and monthly treatment plans review meeting
   - **d.** Attend required staff trainings
   - **e.** Direct client services, as needed
   - **f.** Check staff mailbox and email daily
6. **Licensed Alcohol and Drug Counselor (LADC)**
   - **a.** Comprehensive Assessment and Summary
   - **b.** Client Orientation
   - **c.** Client Discharge
   - **d.** Weekly individual counseling and case management with assigned clients
     - **i.** Correspondence and collaboration with referral source and other involved professionals
   - **e.** Group psychotherapy and psycho-education
   - **f.** Weekly supervision meetings, as required

g. Attend weekly clinical team consultation and monthly treatment plans review meeting
h. Attend required staff trainings
i. Check staff mailbox and email daily

7. **Mental Health Professional (MHP)**
   a. Group psychotherapy and psycho-education
   b. Diagnostic Assessments
   c. Weekly supervision meetings with both the LMHP Clinical Supervisors and the LADC Clinical Supervisor
      i. Task all clinical documentation to designated supervisors within 24 hours of service provided
   d. Attend weekly clinical team consultation and monthly treatment plans review meeting
   e. Attend required staff trainings
   f. Check staff mailbox and email daily

Organizational Structure



Procedure

1. The Program Director will manage all program operations under management of NorthStar Regional's CEO who will assist in evaluation of program fidelity, outcomes, and expansion
2. Staff members will adhere to designated lines of authority in addressing all program issues
3. Staff members will uphold designated responsibilities according to job descriptions

3.6 Job Descriptions

Job Descriptions are inclusive of position responsibilities, authority, and qualifications.

3.6.1 NorthStar Regional's Chief Executive Officer (CEO)

Management Reports: NorthStar Regional's Owners
Direct Reports: NorthStar Regional's COO
Responsibilities

1. Oversee delegation of program management as license holder
2. Attend Quality Assurance meetings quarterly with the Program Director to ensure program fidelity

Qualifications

1. Must be at least 18 years of age
2. Consent to background check and be cleared by DHS to work within a human services program
3. Designation of NorthStar Regional Program Director position

3.6.2 NorthStar Regional's Chief Operating Officer (COO)

Management Reports: NorthStar Regional's CEO
Direct Reports: Chief Compliance Officer, Program Directors, Director of Food and Beverage, Housing Supervisor, Mental Health Director/ NorthStar Regional Program Staff at the Maple Grove location.
Responsibilities

3. Determine and formulate policies and provide overall direction of programs within the company within guidelines set up by the CEO and/or board of directors
4. Plan, direct, or coordinate operational activities at the highest level of management with the help of subordinate directors and staff managers
5. Implement program policies and procedures
6. Participate in coordination and execution of marketing and networking initiatives
7. Develop and maintain program curriculum reflective of population needs
8. Direct or coordinate an organization's financial or budget activities to fund operations, maximize investments, or increase efficiency
9. Appoint department heads or managers and assign or delegate responsibilities to them.
10. Analyze operations to evaluate performance of a company or its staff in meeting objectives or to determine areas of potential cost reduction, program improvement, or policy change
11. Direct, plan, or implement policies, objectives, or activities of organizations or businesses to ensure continuing operations, to maximize returns on investments, or to increase productivity
12. Prepare budgets for approval, including those for funding or implementation of programs

Qualifications

1. Baccalaureate degree or at least 3 years of experience of management or supervision
2. Knowledge and understanding of Minnesota 245G and Minnesota Statutes, chapter 245A (Human Services Licensing Act), and sections 626.556 (Maltreatment of Minors Act), 626.557 (Vulnerable Adults Act - VAA), and 626.5572 (VAA Definitions)
3. Must be at least 18 years of age
4. Consent to background check and be cleared by DHS to work within a human services program
5. Freedom from chemical use problems for at least 2 years prior to hire

3.6.3 NorthStar Regional's Program Director

Management Reports: NorthStar Regional's CEO
Direct Reports: NorthStar Regional's Program Staff

Responsibilities

1. Manage professional operation of the program and staff
2. Maintain program compliancy with Minnesota Rule 245G regulations
3. Implement program policies and procedures
4. Participate in coordination and execution of marketing and networking initiatives
5. Develop and maintain program curriculum reflective of population needs
6. Provide quality assurance through assessment of fidelity and outcome measures and implementations of improvement initiatives
    a. Regular Quality Assurance meetings with CEO and CD/MH Supervisors
    b. Assure documentation compliance through administration of consistent chart audits
7. Provide or delegate clinical supervision appropriately
8. Facilitate and document weekly clinical consultation
9. Chair program staff meetings
10. Coordinate and facilitate staff development trainings in compliance with MN Rule 245G
11. Maintain staffing ratios compliant with co-occurring treatment
12. Clinical case load assignment
13. Coordinate with office staff to manage administrative issues as needed
14. Maintain personnel files in compliance with MN Rule 245G license
15. Delegation of responsibilities as appropriate and within clinical competencies
16. Direct client services, as needed

Qualifications

1. Hold current LADC licensure through Minnesota Board of Behavioral Health and Therapy
2. Baccalaureate degree or at least 3 years of experience of management or supervision within human services
3. 1 or more years of work experience in direct service or management of direct service to individuals with substance abuse problems
    a. If providing clinical supervision the Program Director should have 3 or more years of experience of direct service provision
4. Documentation of 30 hours of classroom instruction, or at least one 3 credit college course focused in adolescent development and 150 hours of supervision providing treatment services to adolescents, if providing services to adolescents
5. Knowledge and understanding of Minnesota 245G and Minnesota Statutes, chapter 245A (Human Services Licensing Act), and sections 626.556 (Maltreatment of Minors Act), 626.557 (Vulnerable Adults Act- VAA), and 626.5572 (VAA Definitions)
6. Must be at least 18 years of age
7. Consent to background check and be cleared by DHS to work within a human services program
8. Freedom from chemical use problems for at least 2 years prior to hire

3.6.4 Mental Health Clinical Director

Management Reports: NorthStar Regional Program Director
Direct Reports: Clinical Supervisor

Responsibilities

1. Member of the Senior Management Team
2. Oversee the mental health program, supervising a team and ensuring that clients receive excellent care that meets licensing and company standards
3. Hiring and orienting clinical staff, in collaboration with Program Director
4. Provide oversight of weekly activities and document compliance in alignment with MN Rule 29 guidelines
    a. The Clinical Director will complete documentation of weekly clinical activities and submit to the Program Director by end of week
    b. The Clinical Director or designated Clinical Supervisor will ensure all clinical documentation completed by supervisees, as well as all clients' initial and updated Individual treatment plan by end of week
5. Review and evaluate all clinical service delivery in the clinic
6. Coordinate with Program Director to complete annual performance reviews
7. Implement and guide clinical staff in adherence to clinic policies and procedures, regulations, compliance and federal/state/local laws
8. Attend required multi-disciplinary staff meetings
9. Direct client services, as needed

Qualifications

1. Current licensure in the field of mental health, as defined by Minnesota Statutes
2. Meet the definition and qualifications of a Clinical Mental Health Supervisor found in Minnesota Statutes, or be a Board-Approved Clinical Supervisor with current credentialing
3. Ability to work with a multidisciplinary team in a positive and cooperative fashion
4. Must be at least 18 years of age
5. Consent to background check and be cleared by DHS to work within a human services program
6. Be competent as demonstrated by experience and graduate-level training in practice and the activities being supervised
7. Have experience and skills that are informed by advanced training, years of experience and mastery of a range of competencies that demonstrate the following:
8. Capacity to provide services that incorporate best practice
9. Ability to recognize and evaluate competencies in supervisees
10. Ability to review assessments and treatment plans for accuracy and appropriateness
11. Ability to give clear direction to mental health staff related to alternative strategies when a recipient is struggling with moving towards recovery
12. Assume duties of the Clinical Mental Health Supervisor as-needed

3.6.5 **Mental Health Clinical Supervisor**

Management Reports: Clinical Director
Direct Reports: Assigned Supervisees and Direct Service Staff

Responsibilities

1. Oversees the clinical service delivery, supervising a team and ensuring that clients receive excellent care that meets licensing and company standards
2. Hiring and orienting program staff, in collaboration with Program and/or Clinical Director
3. Provide weekly clinical supervision of assigned supervisees, documented in compliance with the clinical supervision requirements of MHCP

   a. The Clinical Supervisor will complete documentation of weekly supervision and submit to the Clinical Director by end of week
   b. The Clinical Supervisor will sign all clinical documentation completed by supervisees, as well as all clients' initial and updated Individual treatment plan by end of week
4. Review and evaluate all clinical service delivery in the clinic
5. Coordinate with Clinical Director to complete annual performance reviews for supervisees
6. Implement and guide clinical staff in adherence to clinic policies and procedures, regulations, compliance and federal/state/local laws
7. Attend required multi-disciplinary staff meetings
8. Provide direct client services

Qualifications

1. Current licensure in the field of mental health, as defined by Minnesota Statutes
2. Meet the definition and qualifications of a Clinical Mental Health Supervisor found in Minnesota Statutes, or be a Board-Approved Clinical Supervisor with current credentialing
3. Ability to work with a multidisciplinary team in a positive and cooperative fashion
4. Must be at least 18 years of age
5. Consent to background check and be cleared by DHS to work within a human services program
6. Be competent as demonstrated by experience and graduate-level training in practice and the activities being supervised
7. Not be direct service's blood or legal relative or cohabitant, or someone who has acted as the supervisee's or staff therapist within the past two years
8. Have experience and skills that are informed by advanced training, years of experience and mastery of a range of competencies that demonstrate the following:
   a. Capacity to provide services that incorporate best practice
   b. Ability to recognize and evaluate competencies in supervisees
   c. Ability to review assessments and treatment plans for accuracy and appropriateness
   d. Ability to give clear direction to mental health staff related to alternative strategies when a recipient is struggling with moving towards recovery
   e. Ability to coach, teach and practice skills with supervisees
   f. Accept full professional liability for a supervisee's direction of a recipient's mental health services
   g. Instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with recipients
   h. Review, approve and sign the diagnostic assessment, individual treatment plans and treatment plan reviews of recipients treated by a supervisee
   i. Review and approve the progress notes of recipients treated by the supervisee according to the supervisee's supervision plan
   j. Be employed by or under contract with the same agency as the supervisee
   k. Develop a clinical supervision plan for each supervisee
   l. Ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices
   m. Establish an evaluation process that identifies the performance and competence of each supervisee and document clinical supervision of each supervisee and securely maintain the documentation record

3.6.6 Mental Health Outpatient Therapist

Management Reports: Clinical Supervisor

Direct Reports: None

Responsibilities

1. Provide culturally competent mental health services to individuals, children, adolescents and families who are experiencing varying levels of difficulties due to life situations or mental health concerns
2. Provide high quality, compassionate and ethical outpatient mental health therapy to clients as scheduled
3. Ability to provide group therapy
4. Maintain documentation and billable expectations.
5. Complete all administrative and professional responsibilities
6. Actively participate as a positive member of the multi-disciplinary clinic environment.
7. Utilize system's theory when providing comprehensive integrative services to individuals, children, adolescents and families
8. Perform diagnostic assessments to determine a recipient's eligibility for mental health service
9. Engage clients in actively designing their treatment plans
10. Respond appropriately to crisis situations and rapid screen needs of clients
11. Coordinate services with other programs and providers
12. Maintain case files within electronic health record (EHR)

Qualifications

1. Master's Degree in Psychology, Social Work, or Marriage and Family Therapy
2. Licensed as an LP, LPCC, LICSW or LMFT, or working towards licensure
3. In current good standing with the professional board
4. Oriented and educated in gender, culture and age appropriate care
5. Ability to effectively and efficiently communicate in written and verbal form
6. Computer skills using Microsoft Office products such as Word and Outlook
7. Background in chemical health and DBT (preferred)
8. Knowledge of trauma informed principles (preferred)

3.6.7 Mental Health Practitioner

Management Reports: Clinical Supervisor
Direct Reports: None

Responsibilities

1. Provide culturally competent mental health services to individuals, children, adolescents and families who are experiencing varying levels of difficulties due to life situations or mental health concerns. All services delivery will be clinically supervised under Minnesota Rules
2. Provide high quality, compassionate and ethical outpatient mental health therapy to clients as scheduled
3. Ability to provide group therapy
4. Maintain documentation expectations
5. Complete all administrative and professional responsibilities
6. Actively participate as a positive member of the multi-disciplinary clinic environment
7. Utilize system's theory when providing comprehensive integrative services to individuals, children, adolescents and families
8. Perform diagnostic assessments to determine a recipient's eligibility for mental health service

9. Engage clients in actively designing their treatment plans
10. Coordinate services with other programs and providers
11. Maintain case files within electronic health record (EHR)

Qualifications

1. Master's Degree in Psychology, Social Work, or Marriage and Family Therapy
2. Working towards Licensure as an LP, LPCC, LICSW or LMFT
3. Oriented and educated in gender, culture and age appropriate care
4. Ability to effectively and efficiently communicate in written and verbal form
5. Computer skills using Microsoft Office products such as Word and Outlook
6. Knowledge of trauma informed principles (preferred)

3.6.8 LADC Clinical Supervisor

Management Reports: Program Director
Direct Reports: Designated LADC and Student Interns

Responsibilities

1. Maintain licensure and professional liability insurance and inform the Program Director of changes in status
2. Support professional operation of the program through communication and problem solving of programmatic and staff concerns with Program Director
3. Supports program compliancy with MN 245G regulations and program policies and procedures.
4. Provide weekly clinical supervision for the LADC Counselors and Student Interns as assigned
5. Provide direction for the program staff, as directed
6. Coordinate with Program Director to complete annual performance reviews for supervisees
7. Participate in marketing and networking initiatives
8. Assist in coordination of staff development trainings and clinical consultations, in compliance with MN 245G, to support implementation of effective evidence-based treatment interventions
9. Provide direct clinical services as needed
10. Maintain client records, in accordance with MN 245G regulations and program policies, by assisting with chart audits
11. Regularly participate in coordination and execution of marketing and networking initiatives
12. Assist program director with program operation needs, as appropriate

Qualifications

1. Current LADC licensure through Minnesota Board of Behavioral Health and Therapy
2. Baccalaureate degree within human services fields, such as social work, nursing, sociology, psychology, or nursing
3. 3 or more years of experience providing direct services within a substance abuse treatment program
4. Ability to work with management in a positive and cooperative fashion to effectively supervise and manage staff
5. Knowledge and understanding of Minnesota 245G and corresponding MN Statutes, including Minnesota Statutes, chapter 245A (Human Services Licensing Act), sections 626.556 (Maltreatment of Minors Act), 626.557 [Vulnerable Adults Act (VAA)], and 626.5572 (VAA Definitions)
6. Must be at least 18 years of age

7. Consent to background check and be cleared by DHS to work within a human services program
8. Freedom from chemical use problems for at least 2 years

3.6.9 Licensed Alcohol and Drug Counselor

Management Reports: Program Director, Designated Clinical Supervisors

Responsibilities

1. Maintain licensure and professional liability insurance and inform the Program Director of changes in status
2. Provide direct clinical and case management services, in compliance with MN 245G regulations and program policies and procedures
    a. Clinical assessment (CA)
    b. Client Orientation
    c. Client Discharge
    d. Weekly individual counseling and case management with assigned clients
        i. Correspondence and collaboration with referral source and other involved professionals
    e. Group psychotherapy and psycho-education
3. Attend weekly program meeting/clinical consultation
4. Attend monthly clinical consultation
5. Attend required staff trainings
6. Attend weekly supervision meetings as appropriate
7. Participate in marketing and networking initiatives as directed
8. Complete clinical documentation in compliance with MN 245G and per program policy and procedure
9. Assist with other program duties as needed

Qualifications

1. Current LADC licensure through Minnesota Board of Behavioral Health and Therapy
2. Baccalaureate degree within human services fields, such as social work, nursing, sociology, psychology, or nursing
3. Experience and competencies providing direct services to clients with mental health diagnosis within a substance abuse treatment program
4. Ability to work with a multidisciplinary team in a positive and cooperative fashion
5. Consent to background check and be cleared by DHS to work within a human services program
6. Freedom from chemical use problems for at least 2 years
7. The LADC working with adolescents must provide documentation of 30 hours of classroom instruction, or at least one 3 credit college course focused in adolescent development and 150 hours or more of supervised working experience if providing adolescent services

3.6.10 Student Intern (245G.01, Subd.21)

Management Reports: Program Director, Designated Clinical Supervisors

Responsibilities

1. Acknowledge understanding and maintain compliance with all program policies and procedures
2. Provide direct clinical and case management services under supervision of the LMHP and the LADC clinical supervisors
    a. Clinical Assessment (CA)
    b. Client Orientation
    c. Client Discharge
    d. Weekly individual counseling and case management with assigned clients
        i. Correspondence and collaboration with referral source and other involved professionals
    e. Group psychotherapy and psycho-education
3. Participate in weekly consultation and supervision sessions
4. Assist with clerical duties as assigned

Qualifications

1. Must be at least 18 years of age
2. Must complete DHS background check and be cleared to work in human service programs
3. Freedom from chemical use problems for at least 2 years prior to hire
4. Current enrollment in an approved and accredited higher education program working toward degree completion and appropriate LADC or MHP licensure

3.6.11 **Driver**

Management Reports: Program Director

Responsibilities

1. Use route navigation apps and knowledge of area
2. Complete daily maintenance checks on van and notify manager of any issues
3. Drive in inclement weather, such as light snow
4. Appropriately share personal experiences, wisdom, and knowledge under physical supervision of a LADC
5. Assist with various program duties, as appropriate

Qualifications

1. Must be at least 18 years of age
2. Driver's license with clean driving record
3. Must complete DHS background check and be cleared to work in human service programs
4. Acknowledge freedom from substance abuse problems for 1 or more years

3.6.12 **Individuals with a Temporary Permit**

Management Reports: Program Director, LADC Supervisor

Responsibilities

1. Provide treatment services under appropriate supervision
2. Document clinical supervision weekly
3. Assist with various program duties, as appropriate

Qualifications

1. Must be at least 18 years of age

2. Must complete DHS background check and be cleared to work in human service programs
3. Acknowledge freedom from substance abuse problems for 2 or more years
4. Hold current temporary permit from the Board of Behavioral Health and Therapy

3.6.13 Billing and Funding Manager

Management Reports: CCO, COO, CEO

Responsibilities

1. Billing:
    a. Compile, compute, and record billing, accounting, and other numerical data for billing purposes.
    b. Accounts Receivable Post daily deposits
    c. Process incoming mail concerning billing and invoicing
    d. Communicate with clients about billing discrepancies and questions
    e. Engage management over any AR problems you encounter
    f. Initiate collections on past-due accounts
    g. Maintain accounting ledgers as required
    h. Create and update a log sheet for quality control
    i. Enter in Time module and bill client services
2. Authorizations
    a. MN-ITS
        i. New authorizations
        ii. Expiring authorizations
        iii. Correcting Errors
3. Collections
    a. Initiate collections on past-due accounts
    b. Maintain accounting ledgers as required
4. Supervision
    a. Oversee front desk receptionist
    b. Oversee Residential office manager.

Qualifications

1. Organized, task oriented and self-directed
2. Experience and competencies in billing, authorizations
3. Ability to work with a multidisciplinary team in a positive and cooperative fashion
4. Consent to background check and be cleared by DHS to work within a human services program
5. Freedom from chemical use problems for at least 1 years preceding hiring

3.6.14 Front Desk Administrator

Management Reports: Billing and Funding Manager

Responsibilities

1. Answer Phone
    a. Book Appointments

   b. Coordinates IOP Admission
2. Data Entry
   a. Uploads documents
   b. Client Demographics
   c. Verifies insurance
   d. Weekly client census report
3. Greet Visitors
   a. Complete first part of Intake procedure on new admissions.
   b. Prepares intake packets
4. Clean common areas
5. Orders office supplies
6. Assists clients and staff
7. Coordinates maintenance/repair calls.

Qualifications

1. Organized, task oriented and self-directed
2. Experience and competencies in billing, authorizations
3. Ability to work with a multidisciplinary team in a positive and cooperative fashion
4. Consent to background check and be cleared by DHS to work within a human services program
5. Freedom from chemical use problems for at least 1 year preceding hiring.

3.6.15 Human Resources Specialist

Management Reports: CCO, COO and CEO

The Human Resources Specialist is responsible for providing employees and senior management with objective consultation, recruitment, onboarding processes, performance and retention information. Employee personnel matters, reviews, and compliance issues will also fall under the purview of the Human Resources Specialist. In collaboration with senior leadership, the Human Resources Specialist will provide input on all human resources matters, system policies and procedures, job and legal/regulatory requirements, and employee performance management.

Responsibilities

1. Administration of human resources policies and procedures and activities
2. Recruit and screen candidates for employment, ensure that qualifications and regulatory licensing requirements are met
3. Interviews applicants, create offer letters and prepare new hire packages
4. Conducts staff orientation regarding personnel policies and procedures and benefits
5. Maintain accurate personnel files and the human resources database
6. Compose and place employment ads for open positions
7. Handles all personnel information and issues in a professional manner while maintaining confidentiality
8. Displays a positive supportive and cooperative manner, open and welcome to problem solving
9. Collaboration and assistance with the Compliance Department on mandatory licensing trainings, internal investigations, and personnel matters that may pose risk to the organization
10. Attends all required trainings

Qualifications

1. Required: Bachelor's degree in Human Resources or related field
    a. Preferred: Master's degree
2. Required: Minimum of 2 years of progressive Human Resources experience; excellent communication and interpersonal skills, diplomatic and professional demeanor.

3.6.16 **Chief Compliance Officer**

Management Reports: Chief Operating Officer
Job Title: Clinical Operations & Compliance Officer

Responsibilities

1. Oversees clinical lab and mental health programming and operations
2. Establish and meet state licensure requirements and compliance for the treatment center, mental health clinic and clinical lab
3. Serves as the HIPAA Privacy and Security Officer
4. Creates and implements an effective program aligned around the seven elements described in the Federal Sentencing Guidelines
5. Provides oversight and is responsible for execution of the compliance program
6. Serves as a knowledge base relative to compliance for leadership, employees, consulting with all levels of employees and management regarding that knowledge base, being a reference source of compliance policies and initiatives, laws, regulations, ethical standards, and conflict of interest policies as applicable, working with and through others in a decentralized environment
7. Advocates for compliant business practices and the development of a strong commitment to ethical decision-making
8. Demonstrates familiarity with healthcare laws and regulations, coding and billing requirements
9. Initiates and creates polices as-needed
10. Reviews and updates organizational policies/procedures
11. Support and ensure the development of an active, continuous quality improvement program
12. Promote a safe, health, ethical, and humanistic work environment
13. Contributes to long-term and short-term planning for the organization
14. Initiates, manages, and updates provider contracting and credentialing for the mental health clinic and clinical laboratory
15. Serve as a EHR Champion to leverage and enhance the system functionality for full ROI
16. Onboard, train, and orient all staff and mental health contractors
17. Develop and nurture positive working relationships with all referral sources to the mental health clinic
18. Engage in community outreach and marketing activities including the website for the mental health clinic

3.6.17 **NorthStar Regional Medical Laboratory Technician:**

Management Reports: Chief Compliance Officer
The Medical Laboratory Technician performs waived, moderate or high complexity testing. The (MLT) possesses working knowledge of the clinical laboratory and performs routine clinical laboratory analyses, recognizes problems, identifies basic causes, and makes corrections using established protocols. The MLT correlates data based on knowledge of technical and instrumental conditions affecting test results and performs quality control procedures within established parameters. The MLT works independently under general supervision.

Responsibilities

1. Perform technical and diagnostic laboratory procedures that provide prompt and accurate test results for use in the diagnosis and treatment of clients in the recovery setting
2. Follow documented policies and procedures to correctly identify the patient and specimen collected
3. Accurately complete all necessary laboratory requisition forms
4. Maintain the clinical laboratory, machines, and equipment in working order per established protocol
5. Operate the Thermo Fischer Indiko Plus machine
6. Monitor procedures and testing for drug levels in specimens collected.
7. Perform tests authorized by the clinic lab director, Quality Assurance standards, or Compliance
8. Prepare and maintain supplies to efficiently collect specimens
9. Perform, evaluate and document all quality control activities
10. Other duties as assigned

Qualifications

1. Demonstrate basic knowledge of laboratory procedure and instrumentation
2. Follow federal regulations for quality control, quality assurance, competency, and proficiency testing
3. Adhere to legal, regulatory, and compliance requirements
4. Adherence to NorthStar Regional's confidentiality policy and laboratory policies
5. Work effectively, both in an independent manner and in a team setting
6. Work in a highly detail-oriented environment
7. Demonstrate good customer services skills
8. Assess accuracy of testing in regard to patient test results, quality control and troubleshooting

3.6.18 Housing Coordinator

Responsibilities

1. General:
    a. Facilitate someone to be at new housing client arrival. Greet new housing clients while maintaining a welcoming and hospitable demeanor
    b. Respond to sober house client's housing concerns
    c. Maintain good working relationships with volunteers, staff, board members and visitors
2. Weekly House Meeting:
    a. Maintain individual client housing agreements, behavior contracts and 60 day notices and upload into Procentive
    b. Maintain House Meeting Reports in binder which include
    c. Maintenance, client and staff responsibilities/checks
    d. Facilitate a weekly house meeting and check in with each client that misses the meeting
3. Maintenance and Inspections:
    a. Coordinating repairs and schedule maintenance
    b. Perform monthly housing inspections
    c. Coordinate with outside vendors regarding repairs and appliances
    d. Coordinate preparation of vacant beds for new clients
    e. Discuss with Supervisor team before replacing/purchasing items
4. Sober House Resident Compliance:
    a. Monitor clients for compliance with all rules and policies
    b. Follow up with client notices, behavior contracts
    c. Keep Director apprised of all significant findings

5. Supervise Resident Assistants
    a. Help select, orientate and monitor/communicate with Resident Assistants
    b. Have keys made when necessary
    c. Work with Resident assistant to track key and lock replacement
    d. Keep track of tenant's vehicle's license plates

Qualifications

1. Excellent organizational and communication skills, both written and verbal.
2. Strong commitment to working with people learning to live with mental illness, and substance use disorders.
3. Ability to interact with people of diverse ethnic backgrounds, cultural backgrounds and sexual orientations with respect and dignity.
4. Ability to maintain accurate records/documentation.
5. Working knowledge of Microsoft Word and Excel.
6. Ability to work a flexible schedule with excellent attendance.
7. Comply with MN Rule 31 and program policies and procedures
8. Acknowledge understanding of Client Rights, per MN Rule 245G
9. Must be at least 18 years of age
10. Must complete DHS background check and be cleared to work in human service programs
11. Acknowledge freedom from substance abuse problems for 1 or more years

3.7 Clinical Consultation and Supervision *(245G.08, subdivision 4)*

NorthStar Regional's Treatment, Education and Prevention Programs has a Clinical Supervisor who provides consistent clinical supervision and consultation services to assist in treatment planning and provision of mental health diagnostic assessment and therapeutic care. Clinical consultation and supervision is documented in client charts and retained for program records.

Clinical Staff

In compliance with Minnesota 245G, the following staff members agree to participate in regular clinical consultation and supervision with NorthStar Regional's Treatment, Education and Prevention program staff and provide diagnostic assessment and treatment planning assistance as appropriate.

1. Brian Loots, LADC, Program Director

Procedure

1. The program director will ensure that the LMHP and LADC Clinical Supervisors are staffed and available to support clinical consultation, supervision, and provision of services as needed
2. Designated LADC and LMHP Clinical Supervisors will provide weekly supervision to the LADC and MHP staff and will submit meeting documentation to the Program Director.
3. The LADC Clinical Supervisor will review all initial and updated individual treatment plans weekly
4. The LADC and LMHP Clinical Supervisor will participate in weekly clinical consultation.
5. The LADC's and LMHP will participate in program meetings and trainings, as appropriate
6. The program director will retain documentation of clinical consultation and supervision on site

3.8 Staffing Requirements and Qualifications *(245G.11)*

NorthStar Regional's Treatment, Education, and Prevention Programs will maintain compliance with Minnesota, 245G.11, 5 and vendor eligibility requirements outlined in Minnesota Statutes, section 254B.05, subdivision 5, by meeting staffing requirements, ratios, credentialing, and scheduling as follows. The program has standards for multidisciplinary case review that include a monthly review for each client that , at a minimum includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented.

All staff members employed under NorthStar Regional's Treatment, Education, and Prevention Programs will meet staffing qualifications outlined in job descriptions in compliance with Minnesota 245G.11. Supportive documentation will be retained by the Program Director in personnel files.

Staffing Requirements

1. Treatment Director will be employed at all times
2. The LADC Supervisor, qualified according to Minnesota 245G.11, subdivision 2, will be employed at all times
    a. Currently holds LADC license
    b. 3 or more years of experience providing individual and group counseling to chemically dependent clients
3. A Treatment Director or the LADC Supervisor who is simultaneously employed as an Alcohol and Drug Counselor will be considered .5 full-time equivalent LADC for staffing requirement purposes
4. The LADC providing treatment services to adolescents will have completed the following:
    a. 30 hours of classroom instruction or one three-credit semester college course in adolescent development
    b. 150 hours of supervised experience as an adolescent counselor
5. A designated responsible staff person will be present at all times that clients are present.
    a. Responsible staff person will acknowledge understanding of the implications of Minnesota 245G and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572
6. At least 25% of the LADC's scheduled work hours will be allocated to indirect services, such as clinical documentation, service coordination, program meetings, and other duties
    a. 1 LADC= 30 direct service hours, 10 indirect service hours
    b. .5 LADC= 15 direct service hours, 5 indirect service hours
    c. No LADC will carry a case load of more than 25 directly supervised clients
7. Group census will not exceed 16 clients
8. All therapeutic staff must have current American Red Cross standard first aid certificate and American Red Cross community or American Heart Association CPR certification
9. All therapeutic staff must have 12 hours of training on co-occurring disorders within 6 months of hire, and 8 hours annually
10. NorthStar Regional Treatment Center Program Director will manage personnel files and ensure that staffing ratios are in compliance

Mental Health Staffing Ratios

1. At least 25% of program staff will be mental health professionals, as defined by Minnesota Statutes, section 245.462, subdivision 18, 1-6
    a. No more than 50% of *required* MHP staff will be unlicensed
    b. Unlicensed MHP will be supervised by the LMHP supervisor
        i. School contracts and/or supervision plans, as well as weekly supervision documentation will be retained by the program

3.9 Staff Expectations

It is the policy of this program to provide professional support and accountability to staff members to ensure that program standards are upheld. In compliance with Minnesota 245G.13, subdivision 1, staff members are provided with clear job descriptions, annual performance evaluations, and clearly-described inappropriate behaviors that may result in disciplinary action and potential termination. Staff members are expected to uphold job responsibilities and abide by all program policies and the laws and rules that govern their licenses.

Pursuant to Minnesota 245G.11, subdivision 2, staff members providing direct client care must be free from problematic substance use and must sign acknowledgement of freedom from problematic substance use upon hire. Staff members are prohibited from engaging in personal relationships with clients, in compliance with Minnesota Statutes, chapter 604. Staff members are expected to comply with Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572 prohibiting client abuse of any kind.

Inappropriate Behaviors

1. Active chemical use problems include:
    a. Receiving treatment for chemical use including medication assisted treatment within 1 year for unlicensed staff and within 2 years for licensed staff
    b. Active chemical use that has negatively impacted staff member's job performance
    c. Chemical use that affects the credibility of treatment services with clients, referral sources, or other community members
    d. Symptoms of intoxication or withdrawal during work hours
    e. Enrollment in the Minnesota Health Professionals Services Program (HPSP) with less than two (2) years of continuous abstinence
2. Inappropriate interactions with clients include:
    a. Spending time with clients outside of the program or other professional setting
    b. Sexual contact, discussion, innuendos, or behavior of any kind is not tolerated and is grounds for immediate dismissal
3. Failure to meet job expectations outlined in job descriptions
4. Unprofessional behavior adversely impacting clients or other program staff, including:
    a. Tardiness
    b. Failure to complete assigned tasks
    c. Unmanaged chemical or mental health problems
    d. Ethical problems
    e. Unprofessional interpersonal behavior including, but not limited to, gossiping, inability to work collaboratively with a team, triangulation, and negative attitudes

Procedure

1. Staff members will sign acknowledgement of the following upon hire:
    a. Statement of Freedom from Problematic Substance Use
    b. Personal Client Involvement (Personnel Training Acknowledgment)
    c. Client Abuse Prohibition (Personnel Training Acknowledgment)
2. Job descriptions are clearly outlined and available to staff members in the program policy and procedure manual
    a. All staff members will attend scheduled team meetings, consultations, and supervision meetings
    b. All staff members will check and respond to all correspondence, including email and staff boxes daily
3. The Program Director will conduct annual Performance Evaluations which will include a written annual review, and will be based upon standards of job performance and utilized to build upon staff strengths, as well as address improvement goals
    a. Clinical supervisors will provide feedback for evaluation of supervisees

4. Inappropriate behaviors that interfere with provisions of treatment and program staff functioning will be documented in staff member's personnel file and addressed in the following manner:
    a. Staff will receive a verbal warning upon first infraction
    b. Staff will receive a written warning upon second infraction
    c. The Program Director will develop and implement a Performance Improvement Plan (PIP) third infraction
        i. Failure to satisfactorily meet requirements of PIP may result in termination of employment
5. Staff members are encouraged to resolve interpersonal conflicts directly, and in a professional and productive manner
    a. If staff members are unable to resolve interpersonal conflicts independently, they are expected to seek assistance from their direct report. In order to maintain a positive and productive work environment, gossiping and "third-party" involvement of other staff members will not be tolerated
    b. If a staff member is experiencing a conflict with his or her direct report, a report can be made to the CEO/Managing Director who will address concerns with management as appropriate
    c. All management staff will address interpersonal conflicts and grievances appropriately and professionally, consulting with the management team as needed
        i. Management will not evoke or allow unnecessary and "third-party" involvement of other staff members
6. Inappropriate behavior that poses potential danger to clients or other staff members may result in immediate suspension or termination
7. Active chemical use problems among staff members will be addressed respectfully and discretely; however, the staff member will immediately cease direct client contact until problems are sufficiently resolved
8. Staff members are encouraged not to develop friendships with clients outside of the treatment program for at least 2 years after their last professional interaction

3.10 Staff Alcohol and Drug Use

In compliance with Minnesota Statutes, section 245A.04, subdivision 1, item c, all staff members, including volunteers and interns, are strictly prohibited from the use of illicit drugs or alcohol and abuse of prescription medications or being in any manner under the influence of a chemical that may cause impairment of the individual's ability to provide services or care when directly responsible for persons served by this program. Behavior of this nature is grounds for immediate disciplinary action including prohibition of provision of direct services.

Procedure

1. All staff members will be oriented to this policy and acknowledge training and understanding of Minnesota Statutes, section 245A.04 upon hire
2. Staff abuse of prescription medications and any use of alcohol or illicit drugs during work hours will result in the staff member's immediate removal from all direct client care and is grounds for disciplinary action in accordance with the NorthStar Regional staff expectations policy and procedure
3. Staff should report any concerns regarding personal or staff abuse of substances during provision of client care to the Program Director immediately
4. The Program Director will assess and manage concerns discretely in accordance with client safety and staff wellbeing

5. The Program Director and/or CEO, COO, CCO will identify the following behaviors or incidents as problematic substance use, and will ensure that any staff in violation of such behaviors does not provide direct contact services for the time period listed above.
6. Identify whether behaviors or incidents are problematic substance use, including for those staff who are receiving treatment for substance use within the period specified for the position in the staff qualification requirements, including medication-assisted treatment;
7. Substance use that negatively impacts the staff members job performance;
8. Substance use that affects the credibility of treatment services with a client, referral source, or other members of the community;
9. Identify symptoms of intoxication of withdrawal on the job;
10. And be informed of the circumstances under which an individual who participates in monitoring by the Health Professional Services Program for substance use of mental health disorders is able to provide services to the program's client.

NorthStar Regional will:
1. If the following behaviors are observed, we will notify the Program Director and/or the CEO
Behaviors include the following:

Odors (smell of alcohol, body odor or urine).
Movements (unsteady, fidgety, dizzy).
Eyes (dilated, constricted or watery eyes, or involuntary eye movements).
Face (flushed, sweating, confused or blank look).
Speech (slurred, slow, distracted mid-thought, inability to verbalize thoughts).
Emotions (argumentative, agitated, irritable, drowsy).
Actions (yawning, twitching).
Inactions (sleeping, unconscious, no reaction to questions).
Program Director or CEO will consult with Human Resources
Human Resources will then take appropriate measures to meet with the staff person in question and determine next steps: will ask and assist the employee to leave the premises, and will notify Compliance to begin an internal investigation.

3.11 Staff Development *(245G.13, subdivision 2)*

The Program Director will ensure that each clinical staff member will be trained in compliance with Minnesota part 245G.13, subpart 2. Documentation of training will be retained in staff personnel files.

Procedure

1. The Program Director will ensure that each staff member is trained in the following:
    a. HIPAA Client confidentiality rules and regulations and client ethical boundaries pursuant Minnesota Statutes, section 604.20, bi-annually (every 2 years)
    b. Emergency procedures and client rights as specified in Minnesota Rules and NorthStar Regional policies, bi-annually
    c. Pre-natal exposure to drugs and Human Immunodeficiency Virus (HIV) minimum standards according to Minnesota Statutes, section 245A.19, upon hire and annually
    d. Mandatory Reporting pursuant Minnesota Statutes, sections 245A.65, 626.556, 626.5561, 626.5563, 626.557, and 626.5572, including NorthStar Regional policies concerning obtaining client releases on information, annually
    e. 12 hours of co-occurring mental health and substance use disorder training, within 6 months of hire and 8 hours annually, addressing the following:
        i. Philosophy, screening, assessment, diagnosis, treatment planning, documentation, programming, medication, collaboration, mental health consultation, and discharge planning

2. The Program Director will ensure that acknowledgment of training documentation is maintained in staff personnel files

3.12 Conflict of Interest Policy

In all situations, employees are expected to conduct your activities with integrity, ethically and in accordance with applicable laws and regulations. Employees should not engage in any work activity, practice or conduct which is or appears to be a conflict of interest for the company, its customers, suppliers, contractors, competitors or any person doing or seeking to do business with NorthStar Regional as described below.

You are to act in the best interests of the company, regardless of personal preference, and must not create the perception of personal advantage. An actual or potential conflict of interest occurs when an employee is in a position to influence a decision that may result in a personal gain for that employee or for a relative (related by blood or marriage, or a similar relationship).

The mere existence of a relationship with outside firms does not necessarily create a conflict of interest. However, if you have any influence on transactions involving purchases, contracts or leases, you must disclose the existence of the relationship to your supervisor as soon as possible.

Employees should not solicit or accept a promise of future employment or any gift, loan, gratuity, reward or anything else of monetary value that might appear to influence your judgment or create a conflict in the performance of your job. You may accept occasional unsolicited courtesy gifts or favors (such as business lunches, tickets to sporting events or cultural events, holiday baskets, flowers, etc.) so long as the gifts or favors have a market value under $100, are customary in the industry, and do not influence or appear to influence your judgment or conduct. Contact your supervisor for guidance as needed.

3.13 Severe Weather Policy

Policy Statement:
NorthStar Regional recognizes that on occasion, the weather conditions make for difficult travel to and from the area where treatment services are delivered. This policy sets forth guidelines for severe weather conditions to keep clients and staff safe if severe weather is forecast or occurs. Employees must make decisions about their own safety and use their best judgment about whether they should be driving.
Procedures:
1. Each treatment location has a designated individual as the responsible party to make programmatic decisions. Each location will first consult their Program Director or the Mental Health Clinical Supervisor for NorthStar Regional. In the event that the Program Director or the Mental Health Clinical Supervisor are unavailable, the Chief Operations Officer and/or the Chief Executive Office shall make the determination about the operations during severe weather threats.

2. Internal Severe Weather Alerts have been designated as “Code Purple” in policy and procedure manuals.

3. If staff need to leave their workstation, they are to ensure that computers are locked and all confidential information is secured prior to leaving the area.

4. **In the case of a Tornado, Watch or Warning/Severe Thunderstorm:**
   a. Lightning: Staff and clients are encouraged to stay inside until the weather system passes.

b. Staff will direct clients to safety in an interior room on the lower level of the building, such as the lobby, group room, bathroom, or other interior office.
c. Bring blankets and radio/cell phones for communication.
d. Staff will direct clients to stay close to floor and cover their faces with blankets or available clothing.
e. Program staff will monitor weather conditions and report to the **Program Director or Mental Health Clinical Supervisor** to determine safety measure taken.
f. Staff will wait for an "All clear" before exiting the safe area.
g. If a "watch" is issued, listen to weather radio and keep in contact with Program Director for direction.
h. **Program Director** will work with their staff to determine if there is a need to close the Office/House and communicate it to clients and staff members efficiently.

5. **In the case of Snow, Blizzard Conditions or Extreme Cold:**

a. Staff will monitor the situation by consulting the Minnesota Department of Transportations' 5-1-1 system, or https://hb.511mn.org. The National Weather Service will also be consulted.
b. If the roads are marked as "normal" or "partially covered" regular office hours and programming will be conducted;
c. If the roads are marked as "travel not advised," or "closed" the offices and programming will be canceled or delayed.
d. Staff will monitor the situation, determine the best course of action and consult Program Director or Mental Health Clinical Supervisor. Decisions may be made to close early or not open at all.
e. If severe weather develops during the course of programming, staff may be advised to help notify other people or entities of the "stay in place" decision.

6. Notification of Clients of Inclement Weather Conditions

a. Clients will need an easy way to find out whether or not NorthStar Regional is open for business, or if they are expected to attend regularly scheduled treatment services.
b. Several methods for communication include: an email, phone call, or text message to the affected client, a notice on NorthStar Regional's website, on the homepage of the status of the situation, a post on NorthStar Regionals social media profiles, and/or a recorded message on the telephone system with the date, time, and status of the situation.

7. Staff Notification of Inclement Weather Conditions

a. In the case of program closures, Staff will be notified by their direct-report supervisor. Staff are encouraged to contact their direct report supervisor regarding the status of program delays.

3.14 Service and Emotional Support Animals

Policy

1. NorthStar Regional is a healthcare facility and does not allow Emotional Support Animals in areas where healthcare services are delivered.
2. NorthStar Regional sober homes do comply with the Fair Housing Act and do allow for Emotional Support Animals to be in the homes.
3. NorthStar Regional has two incumbent therapy dogs, Jake and Izzy. No other therapy dogs will be added to the facility.
4. NorthStar Regional complies with the Americans with Disabilities Act in allowing the use of service animals for clients, staff, and visitors. NorthStar Regional complies with the Fair Housing Act in allowing clientele the use of emotional support animals that are approved in

accommodations. This policy applies to all clients, visitors, and workforce members of NorthStar Regional throughout our system.

Definitions

Service Animal:

A service animal as per the ADA is defined as: *"Any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals for the purposes of this definition. The work or tasks performed by a service animal must be directly related to the owner's disability. Examples of work or tasks include, but are not limited to, assisting individuals who are blind or have low vision with navigation and other tasks, alerting individuals who are deaf or hard of hearing to the presence of people or sounds, providing non-violent protection or rescue work, pulling a wheelchair, assisting an individual during a seizure, retrieving items such as medicine or the telephone, providing physical support and assistance with balance and stability to individuals with mobility disabilities, and helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors. The crime deterrent effects of an animal's presence and the provision of emotional support, well-being, comfort, or companionship do not constitute work or tasks for the purposes of this definition."*
(28 CFR 35.104).

Emotional support animals, comfort animals, and therapy dogs are not service animals under Title II and Title III of the ADA.

Emotional Support Animal:

The American Veterinary Medical Association defines Emotional Support Animals as: *"An emotional support animal (ESA) may be an animal of any species, the use of which is supported by a qualified physician, psychiatrist or other mental health professional based upon a disability-related need. An ESA does not have to be trained to perform any particular task. ESAs do not qualify as service animals under the Americans with Disabilities Act (ADA), but they may be permitted as reasonable accommodations for persons with disabilities under the Fair Housing Act."*

Procedures

Requirements for Allowing Service Animals at NorthStar Regional

1. Service Animals are allowed in the healthcare facility of NorthStar Regional, except in designated areas.
2. For an individual to qualify for having a service animal on the property of NorthStar Regional:
   - 2.1. The individual must have a disability as defined by the ADA;
   - 2.2. The accompanying animal must be trained to do specific tasks for the qualified individual; and
   - 2.3. The animal and its owner must get permission from the Chief Operations Officer or the Compliance Department to have the animal on the property.
3. Staff are not allowed to question the individual about their disability. However, staff may ask the following two questions:
   - *3.1. "Is the Service Animal required because of a disability?"*
   - *3.2. "What work or task is the dog trained to perform?"*
4. The Animal Owner:
   - 4.1. Is responsible to attend to and be in full control of the service animal at all times. A service animal shall have a harness, leash, or other tether unless a) the owner is unable to use a harness, leash or tether, or b) using a harness, leash, or tether will interfere with the animal's ability to safely and effectively perform its duties.
   - 4.2. Is responsible for ensuring that the service animal is wearing a leash, harness or cape that identifies the animal as a service animal when on duty anywhere on the property

4.3. Is responsible for the costs of care necessary for a service animal's well-being. The arrangements and responsibilities with the care of a service animal is the sole responsibility of the owner at all times, including regular bathing and grooming, as needed.
4.4. Is responsible for independently removing or arranging for the removal of the service animal's waste. Waste must be disposed in a sealed bag in a designated trash area.
4.5. Is responsible for complying with local and state licensing laws for animal rights and owner responsibilities. Service animals should be current with immunizations and wear a rabies vaccination tag.
4.6. Is responsible for paying for any damage to NorthStar Regional property caused by the animal.

5. NorthStar Regional may prohibit the use of service animals in certain locations due to health and safety restrictions or places where the animal might be in danger. Restricted areas may include but are not limited to: food preparation areas, laboratories, boiler rooms, and other areas prohibited by law.
6. Others Interactions with the Animal: Do not pet or feed a service animal. Do not attempt to separate the animal from the owner. Do not startle or tease a service animal.
7. NorthStar Regional reserves the right to report any service animals who misbehave or any owners (or other individuals) who mistreat their service animals to the Department of Public Safety.

Requirements for Allowing Emotional Support Animals at NorthStar Regional

1. Emotional Support Animals are not allowed in the healthcare facility or wherever healthcare services are delivered.
2. Emotional Support Animals are allowed in our sober homes, in compliance with the Fair Housing Act.
3. The Animal Owner:
   3.1. Must have a letter from a local, qualified mental health professional stating the need for the Emotional Support Animal. The animal owner and the mental health professional must have had an ongoing relationship with the individual.
   3.2. Is responsible to attend to, and be in full control of, the emotional support animal at all times. The emotional support animal shall have a harness, leash, or tether that is no longer than 5 feet long.
   3.3. May allow the animal to stay off-leash in the bedroom area; in common areas the animal must be on a leash, within sight of the owner, or under voice control of the owner at all times.
   3.4. Is the only individual that may "handle" the animal.
   3.5. Will not allow the animal in the kitchen area. The animal must use dishes/bowls that are provided for by the owner and not use house dishes.
   3.6. Is responsible for keeping the animal off of furniture, or, if allowed on furniture, a blanket or towel will be used to reduce allergens.
   3.7. Is responsible for the costs of care necessary for the emotional support animal's well-being. The arrangements and responsibilities for the care of an emotional support animal are the sole responsibility of the owner at all times, including regular bathing and grooming, as needed.
   3.8. Is responsible for not leaving the emotional support animal unattended for an unreasonable length of time.
   3.9. Is responsible for independently removing or arranging for the removal of the emotional support animal's waste. Waste must be disposed in a sealed bag in the designated trash area.
   3.10. If the animal voids on the floor or carpet anywhere inside NorthStar Regional property, the owner is responsible to clean up promptly to the best of their own ability. If necessary, the owner must pay all costs associated with such clean up. Dogs must be housebroken and accidents should be infrequent.

3.11. Is responsible for complying with local and state licensing laws for animal rights and owner responsibilities. Emotional support animals should be current with immunizations and wear a rabies vaccination tag if appropriate.
3.12. In shared living spaces, the emotional support animal should be in an appropriate container if the owner is not in the room with the animal.
3.13. Is responsible for paying for any damage to NorthStar Regional property or pest treatment caused by the animal.
3.14. Animals must leave the sober home with the owner if the owner leaves overnight and during all approved breaks.
3.15. Is responsible and liable if the emotional support animal bites an individual or destroys another resident's property.
3.16. Must abide by all applicable residential policies, including room inspections.

4. NorthStar Regional:
4.1. Will contact potential roommates and suitemates to determine if other residents have any concerns about potentially living with an animal.
4.2. Assist owners and others when questions or concerns arise relating to emotional support animals on the property and seeks legal advice when necessary.
4.3. If other residents raise concerns about the animal and attempts at mediation are unsuccessful, the owner of the emotional support animal will be provided with an alternate living space and expected to move within a reasonable period of time.
4.4. Will report any emotional support animals who misbehave or any owners (or other individuals) who mistreat their emotional support animals to the Department of Public Safety.
4.5. Refrain from charging a fee for the emotional support animal, but may assess usual fees for any damages incurred

NorthStar Regional will make an individualized assessment of each proposed emotional support animal. Dogs must also be completely trained and housebroken. The use of "puppy pads" will not be permitted. For dogs under 12 months old that are not already living with the owner at the time the emotional support animal is requested, NorthStar Regional will ask for a statement that the puppy is housebroken from the breeder, adoption agency, or person providing the animal to the owner. For animals already known to the owner, the owner can self-attest to the housebroken status of the animal.

Important Considerations

A service or emotional support animal can be asked to leave or not allowed participation in housing if:

- The animal is found to be out of control or disruptive and the animal's owner does not take immediate and effective action to control it.
- The animal is not housebroken or kept in a cage where waste can be managed effectively.
- The animal is found to be neglected or mistreated and prompt corrective action is not taken.
- The animal is physically ill.
- The animal is unreasonably dirty.
- A service animal attempts to enter a place on NorthStar Regional property where the presence of an emotional support animal causes danger to the safety of the service animal owner , the service animal, or others.

The process for handling disruptions is as follows:

- The owner will receive a written warning if a complaint(s) is received regarding the animal. Following the first warning, the owner will have the opportunity to rectify the situation and correct the behavior.

- If a second complaint is received, NorthStar Regional will conduct a further assessment of the situation and the extent of impact to the community. At this point, it is possible that the owner with the emotional support animal will be asked to switch rooms or residences if there is availability.
- Following a third complaint or incident, the animal will need to be removed from the property. Owners must identify a person who could come to remove the animal if needed within a reasonable amount of time. This person must be identified during the approval process. The individualized assessment of each incident may lead to escalation of this process, up to and including removal of an animal after a first complaint, depending on the severity of any incident involving any emotional support animal.

3.15 Personnel Policy for Guests

Purpose

NorthStar Regional recognizes the value that certain guests with demonstrated expertise in an area of interest can bring to our client community. These guests could be speakers, certain interns, substitutes for contracted staff, or other individuals who are in training with a NorthStar Regional staff member. NorthStar Regional staff may, from time-to-time, desire to invite a guest speaker who may contribute intellectually, culturally or motivationally to our community. The purpose of this policy is to set forth guidelines for how requests for guests are made by staff and the requirements for bringing guests in to our licensed programs. The goal is to ensure that all individuals interacting with our clients have been approved and screened.

Definitions

Definitions of guests include the following:

1. A guest speaker is anyone who is not directly employed or contracted by NorthStar Regional to provide services to our client population; this guest speaker can be a representative of an organization or an individual.
    a. Examples include: a representative from “Just Us Health Minnesota” who speaks to a group on safe sex practices; a guest speaker who attends a group more than once in a 6-month period; a motivational speaker who comes on a regular basis who is not contracted with NorthStar Regional
2. Interns of certain contracted NorthStar Regional staff.
    a. Examples include: an Art Therapy Intern who is assigned to the Art Therapist because the Art Therapist is a professor at a graduate school
3. The guest speaker is not a “peer in recovery” who is attending a group to tell their story of recovery. These individuals typically come to a group session once. If this individual returns within six months however, they are considered a guest.
4. Substitute teachers, such as for Yoga Class or Art Therapy, when the contracted staff is unavailable.

Procedures for Guests

1. NorthStar Regional staff who would like to bring a guest to NorthStar Regional and whose guest(s) will have interaction with NorthStar Regional clients, must obtain permission at least 2 weeks ahead of the date that the guest would come to NorthStar Regional. Permission may be obtained from the Program Director, Chief Operations Officer, or the Chief Executive Officer.
2. The Program Director, Chief Operations Officer, or the Chief Executive Officer will notify Human Resources and the Compliance Department of the request. Human Resources

and/or the Compliance Department shall determine what type(s) of screening and clearance is required for the guest.
3. Screening of the individual may include any/all of the following: collecting a resume, conducting a DHS Background Study and Clearance, signing a HIPAA Business Associate Agreement and/or other confidentiality or non-disclosure contract, or obtaining documentation from an educational institution validating the individual is a current student. In the case of a licensed healthcare professional coming in as a guest, a verification the license is in good standing with the responsible Minnesota Board of Health Licensing will also be conducted.
4. If approved, clearances are good for a 12-month period of time.
5. An itemized list of individuals who have been screened, whether approved or not, will be kept on file in the Compliance Department.

3.16 Policy for Vendor Visitation

Purpose
Vendor Representatives can play an important role in a client's care and may be present in NorthStar Regional facilities at the request of the medical staff or leadership. This policy serves to establish uniform guidelines for permitting Vendor Representative access to designated areas, including but not limited to, hallways and offices where clients may be present. This is to ensure reasonable control and identification of Vendor Representatives while ensuring safe client care and implementing reasonable safeguards to protect against incidental disclosures of PHI.

Policy Statement
Vendors must follow the requirements established in this policy for access to NorthStar Regional personnel and facilities. Vendor contact is not permitted outside of these guidelines.

Definitions
NorthStar Regional Personnel and Facilities
All personnel, whether employed, contracted or affiliated with NorthStar Regional, including all physicians, health care providers and interns. NorthStar Regional facilities are defined as all facilities and respective campuses, whether owned, leased, rented or controlled by NorthStar Regional.

Vendor Representative(s)
Any representative such as, sales person, manager, liaison, account executive, contact, administrator, company technician, clinical support, nurse clinician, medical/scientific liaison of a manufacturer or company who visits NorthStar Regional in any capacity, including but not limited to, soliciting, marketing or distributing information regarding the use of vendor products or services.

Incidental Uses and Disclosure of PHI
An incidental use or disclosure is a secondary use or disclosure of PHI that cannot reasonably be prevented, is limited in nature, and that occurs as a result of another use or disclosure that is permitted by the HIPAA Privacy Rule. Examples include: overhearing a provider's confidential conversation with another provider or a client, or a glimpse at a patient's information on a sign-in sheet.

HIPAA Privacy Rule
The HIPAA Privacy Rule permits certain incidental uses and disclosures that occur as a by-product of another permissible or required use or disclosure of PHI, as long as the covered entity has

applied *reasonable safeguards* and implemented the minimum necessary standard, where applicable, with respect to the primary use or disclosure. See 45 CFR 164.502(a)(1)(iii). The Privacy Rule mandates that a covered entity (ie: NorthStar Regional) must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule, as well as that limit incidental uses or disclosures of PHI.

Procedures
The following safeguards are put into place by NorthStar Regional to reasonably guard against the incidental use and/or disclosure of PHI while vendor representatives are on the property of NorthStar Regional:
All visitors must sign in/out at NorthStar Regional's front desk in the building where operations or clinical care is being delivered.
Visitors to the 1055 Stoughton Ave Chaska, MN Outpatient Psychiatry Clinic will need to check in at the front desk at 1045 Stoughton and obtain a visitors badge. They will wait in the designated area until the nurse at 1055 Stoughton can escort them to the 1055 building. In lieu of the nurse, front desk personnel may also escort the visitor to the 1055 building. Once in the 1055 building, the visitor may go into the technician office, nursing office, or the office of the medication prescriber only.
Visitors to the 1250 Lincoln Street, Shakopee, MN facility will need to check in at the front desk and obtain a visitors badge. They will wait in the designated area until the desired staff person can escort them to their office.
Visitors to the 320 N Walnut Street, Chaska, MN facility will need to check in at the front desk and obtain a visitors badge. They can wait for the nursing staff in the designated waiting room just outside the technicians office.
Visitors must wear a visitor badge while on NorthStar Regional property.
Depending on who they are/nature of their visit, visitors may be required to sign a HIPAA BAA or a confidentiality agreement.
Depending on who they are/nature of their visit, visitors may be required to have an escort for the duration of their time on-site.
Visitors are not allowed to use any recording device or take photographs while on NorthStar Regional property.
Visitors are not to interact, solicit, or engage with clients or others with whom the visitor has no approved purpose or has no permission to do so. Access is limited to the office or the conference room they have been authorized to visit.
Representatives from external regulatory agencies may access NorthStar Regional without an appointment provided they were their agency ID Badge in a visible location at eye level and they report to the front desk immediately upon arrival.
Visitors from pharmaceutical companies who may be distributing drug samples must only give the drug samples to the designated medical staff and no other staff. All drug samples shall immediately be placed in the locked cabinet for medications.

3.17 Mileage Reimbursement

Policy: Designated NorthStar Regional Staff members traveling on behalf of the organization for business purposes shall be reimbursed at the annual IRS reimbursement rate. An individual's daily commute is not reimbursable. Mileage reimbursement pertains solely to the use of a motor vehicle for company operations and business, using the most direct route between destinations.

Procedures
1. Only pre-approved staff may submit for mileage reimbursement
2. The most direct route between destinations will be taken

3. Mileage will be calculated as follows:
    a. Home to first work destination: Not Reimbursable
    b. Final work destination to home: Not Reimbursable
    c. First work destination, second, or third destination: Reimbursable
4. Mileage logs will be turned in to the Finance Department twice monthly.

4 Communicable Diseases

Policies and procedures addressing communicable disease privacy, reporting, and education are in compliance with Minnesota 245G.07 and Minnesota Statutes, section 245A.19, items a through e.

4.1 Tuberculosis *(245G.07, subdivision 1 (2)*

In compliance with Minnesota 245G.07, subdivision 1 (2), this program provides information about tuberculosis and resources for screening services to all clients and reports known cases of tuberculosis infection according to Minnesota Statutes, section 144.4804.

Procedure

1. All new staff will be oriented to the tuberculosis policy and procedure and will be provided with relevant information upon hire; reviewed annually
2. Clients will be provided with information about tuberculosis, HIV, and other communicable diseases and resources for screening services upon admittance and throughout treatment
3. Staff members will report all known cases of tuberculosis infection to a MN disease prevention officer by calling 651-201-5414 within 24 hours of obtaining knowledge of a reported case

4.2 HIV Minimum Standards Compliance *(245A.19, (d), 245G.07, subdivision 2)*

This program will maintain compliance with Human Immunodeficiency Virus (HIV) Minimum Standards to ensure respectful care, education, and comprehensive referrals to address HIV diagnosis and co-occurring complications. NorthStar Regional will utilize the 2015 DHS Commissioner-Approved HIV Training tool, see Appendix A.

Procedure

1. All staff members will be oriented to this policy within 72 hours of hire, and will participate in an annual in-service training addressing updates to HIV Minimum Standards and NorthStar Regional's policy and procedure; records of training provision and attendance will be maintained in personnel files
2. All clients will be oriented to HIV Minimum Standards Policy and will be provided with a list of HIV testing and treatment resources, updated annually, within 72 hours of admittance
3. Program curriculum will include HIV and communicable disease education to including transmission prevention addressing sexual safety and intravenous drug use, scheduled once per treatment cycle
4. Treatment services will include sensitive and informed support and referral services for clients diagnosed with HIV, including consultation with medical providers

5. Program staff will treat clients respectfully and provide services appropriate to sexual orientation, language, and culture
6. Program staff will apply motivational interviewing skills and use of a harm reduction model when addressing HIV issues
7. This program will maintain strict confidentiality of any clients' HIV diagnosis, except when disclosure is legally mandated
8. NorthStar Regional provides equal access to services for all clinically appropriate clients, despite HIV status
9. Program staff will make all efforts to prevent exposure to avoid occupational HIV transmission; however, in the event of exposure the following procedure should be followed:
    a. Immediate vigorous hand washing with soap and water for 30 or more seconds
    b. Gloves should be worn in the presence of bodily fluids
    c. Surfaces and floors must be disinfected immediately
    d. Center for Disease Control's recommendations for post exposure prophylaxis, located on premises, should be followed

HIV Policy and Procedure Reviewed Annually	Who Reviewed	Date
Yes	Lisette Wright	12/4/18
Yes	Jason Vanderscoff	10/14/2020
Yes	Jason Vanderscoff	3/31/21

4.3 Communicable Diseases Information and Referral Resources

Communicable Diseases can be transmitted through body fluids, including blood, seminal, and vaginal secretions.

1. Tuberculosis
    a. Bacterial disease that affects the lungs
    b. People with weak immune systems, such as substance abusers, are at high risk
    c. Spread through close contact with infected person, such as co-habitation
    d. Symptoms include fever, night sweats, persistent cough, fatigue, and weight loss
    e. Some strains are treatable, but some are resistant to treatment and require long-term hospitalization
    f. We use the CDC TB Elimination General Information Tool, October 2011. A copy of this is in Appendix B.
2. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)
    a. HIV is a virus that attacks the immune system and develops into AIDS which causes severe damage to the immune system making the body susceptible to disease and cancer
    b. Spread through unsafe sexual activity (oral, vaginal, or anal), through IV drug use, and during birth
    c. Symptoms are worsened by alcohol and drug use
3. Human Papillomavirus (HPV)
    a. Venereal warts on genitals
    b. Spread through skin contact, most often during sexual activity (oral, vaginal, or anal) and through birth
    c. Symptoms can be treated through many cryosurgical procedures
    d. If untreated, cancer of the cervix, vulva, penis, or rectum can develop
    e. Prevention through vaccination

4. Syphilis
    a. Bacterial infection
    b. Spread through unsafe sexual activity (oral, vaginal, or anal)
    c. Symptoms include hair loss and sores in and around mouth and genitals
    d. Treated with antibiotics
5. Hepatitis A, B, & C
    a. Viruses that attack the liver, cause cirrhosis of the liver, liver cancer, and death
    b. Spread through unsafe sexual activity (oral, vaginal, or anal), through consumption of contaminated food or drink, and through sharing drinks, pipes, needles, etc.
    c. Symptoms worsened by alcohol and drug use
    d. Symptoms include fever, fatigue, poor appetite, nausea, stomach pain, dark-colored urine and jaundice (a yellowing of the skin and whites of the eyes)
    e. There is no treatment, but with a lot of rest most people's immune systems are able to fight it off
    f. Prevention of Hepatitis A and B through vaccination
6. Herpes
    a. Viral infection that include recurrent outbreaks of symptoms
    b. Spread through sexual activity (oral, vaginal, or anal) even when there is not an outbreak
    c. Symptoms include blister-like lesions on genitals
    d. Symptoms are treatable; disease is not
    e. Symptoms worsened by alcohol and drug use
7. Chlamydia
    a. Most common sexually transmitted disease
    b. Spread through sexual activity (oral, vaginal, or anal) and during birth
    c. Treated with antibiotics
    d. 75% of women and 50% of men have no symptoms; some people experience burning or itching during urination
    e. Untreated this can cause Pelvic Inflammatory Disease (PID), resulting in infertility
8. Gonorrhea
    a. Spread through mucus in throat, penis, vagina, and rectum during sexual activity and during birth
    b. Symptoms Include burning urination and/or yellowish discharge
    c. Treated with antibiotics
    d. Can cause Pelvic Inflammatory Disease (PID) if untreated, resulting in infertility
9. Referrals And Resources
    a. Ask your physician to test you
    b. MN Dept. of Health's STD and HIV Section
        i. 651-201-5414
    c. MN AIDS Project AIDS Line
        i. 612-373-AIDS, 1-800-248-AIDS
        ii. http://www.mnaidsproject.org
    d. Minnesota Department of Health STD and HIV Section
        i. 612-676-5698
        ii. http://www.health.state.mn.us
    e. Minnesota Family Planning and STD Hotline:1-800-738-2287
    f. American Red Cross: http://www.stpaulredcross.org
    g. Rural AIDS Action Network: http://www.raan.org
    h. Minnesota Office of Multicultural and Minority Health: http://www.health.state.mn.us/ommh/index
    i. MN Dept. of Human Services HIV/AIDS Program
        i. PO Box 64972, St. Paul, MN 55164-0972
        ii. 651-431-2414, 1-800-657-3761

iii. http://www.dhs.state.mn.us/hivaids

5 Client Rights and Responsibilities *(245G.15)*

Clients are expected to participate in treatment in a respectful manner in order to provide a positive and productive treatment experience for all program participants.

5.1 Client Rights

In compliance with Minnesota Statutes 254B.02, subdivision 2, 253B.03, 148F.165, and 144.651 the client bill of rights is posted in a prominent office location, such as the NorthStar Regional lobby and provided to clients on the day of service initiation, with reasonable accommodations made for clients with communication impairments or who cannot read or speak English.

Client Bill of Rights

148F.165 CLIENT WELFARE.

Subdivision 1. Explanation of procedures. A client has the right to have, and a counselor has the responsibility to provide, a nontechnical explanation of the nature and purpose of the counseling procedures to be used and the results of tests administered to the client. The counselor shall establish procedures to be followed if the explanation is to be provided by another individual under the direction of the counselor.

Subd. 2. Client bill of rights. The client bill of rights required by section 144.652 shall be prominently displayed on the premises of the professional practice or provided as a handout to each client. The document must state that consumers of alcohol and drug counseling services have the right to:

(1) expect that the provider meets the minimum qualifications of training and experience required by state law;

(2) examine public records maintained by the Board of Behavioral Health and Therapy that contain the credentials of the provider;

(3) report complaints to the Board of Behavioral Health and Therapy;

(4) be informed of the cost of professional services before receiving the services;

(5) privacy as defined and limited by law and rule;

(6) be free from being the object of unlawful discrimination while receiving counseling services;

(7) have access to their records as provided in sections 144.92 and 148F.135, subdivision 1, except as otherwise provided by law;

(8) be free from exploitation for the benefit or advantage of the provider;

(9) terminate services at any time, except as otherwise provided by law or court order;

(10) know the intended recipients of assessment results;

(11) withdraw consent to release assessment results, unless the right is prohibited by law or court order or was waived by prior written agreement;

(12) a nontechnical description of assessment procedures; and

(13) a nontechnical explanation and interpretation of assessment results, unless this right is prohibited by law or court order or was waived by prior written agreement.

Subd. 3. Stereotyping. The provider shall treat the client as an individual and not impose on the client any stereotypes of behavior, values, or roles related to human diversity.

Subd. 4. Misuse of client relationship. The provider shall not misuse the relationship with a client due to a relationship with another individual or entity.

Subd. 5. Exploitation of client. The provider shall not exploit the professional relationship with a client for the provider's emotional, financial, sexual, or personal advantage or benefit. This prohibition extends to former clients who are vulnerable or dependent on the provider.

Subd. 6. Sexual behavior with client. A provider shall not engage in any sexual behavior with a client including:

(1) sexual contact, as defined in section 604.20, subdivision 7; or

(2) any physical, verbal, written, interactive, or electronic communication, conduct, or act that may be reasonably interpreted to be sexually seductive, demeaning, or harassing to the client.

Subd. 7. Sexual behavior with a former client. A provider shall not engage in any sexual behavior as described in subdivision 6 within the two-year period following the date of the last counseling service to a former client. This prohibition applies whether or not the provider has formally terminated the professional relationship. This prohibition extends indefinitely for a former client who is vulnerable or dependent on the provider.

Subd. 8. Preferences and options for treatment. A provider shall disclose to the client the provider's preferences for choice of treatment or outcome and shall present other options for the consideration or choice of the client.

Subd. 9. Referrals. A provider shall make a prompt and appropriate referral of the client to another professional when requested to make a referral by the client.

253B.03 RIGHTS OF PATIENTS.

Subdivision 1. Restraints. (a) A patient has the right to be free from restraints. Restraints shall not be applied to a patient in a treatment facility unless the head of the treatment facility, a member of the medical staff, or a licensed peace officer who has custody of the patient determines that they are necessary for the safety of the patient or others.

(b) Restraints shall not be applied to patients with developmental disabilities except as permitted under section 245.825 and rules of the commissioner of human services. Consent must be obtained from the person or person's guardian except for emergency procedures as permitted under rules of the commissioner adopted under section 245.825.

(c) Each use of a restraint and reason for it shall be made part of the clinical record of the patient under the signature of the head of the treatment facility.

Subd. 2. Correspondence. A patient has the right to correspond freely without censorship. The head of the treatment facility may restrict correspondence if the patient's medical welfare requires this restriction. For patients in regional treatment centers, that determination may be reviewed by the commissioner. Any limitation imposed on the exercise of a patient's correspondence rights and the reason for it shall be made a part of the clinical record of the patient. Any communication which is not delivered to a patient shall be immediately returned to the sender.

Subd. 3. Visitors and phone calls. Subject to the general rules of the treatment facility, a patient has the right to receive visitors and make phone calls. The head of the treatment facility may restrict visits and phone calls on determining that the medical welfare of the patient requires it. Any limitation imposed on the exercise of the patient's visitation and phone call rights and the reason for it shall be made a part of the clinical record of the patient.

Subd. 4. Special visitation; religion. A patient has the right to meet with or call a personal physician, spiritual advisor, and counsel at all reasonable times. The patient has the right to continue the practice of religion.

Subd. 4a. Disclosure of patient's admission. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

Subd. 5. Periodic assessment. A patient has the right to periodic medical assessment, including assessment of the medical necessity of continuing care and, if the treatment facility declines to provide continuing care, the right to receive specific written reasons why continuing care is declined at the time of the assessment. The treatment facility shall assess the physical and mental condition of every patient as frequently as necessary, but not less often than annually. If the patient refuses to be examined, the facility shall document in the patient's chart its attempts to examine the patient. If a person is committed as developmentally disabled for an indeterminate period of time, the three-year judicial review must include the annual reviews for each year as outlined in Minnesota Rules, part 9525.0075, subpart 6.

Subd. 6. Consent for medical procedure. A patient has the right to prior consent to any medical or surgical treatment, other than treatment for chemical dependency or nonintrusive treatment for mental illness.

The following procedures shall be used to obtain consent for any treatment necessary to preserve the life or health of any committed patient:

(a) The written, informed consent of a competent adult patient for the treatment is sufficient.

(b) If the patient is subject to guardianship which includes the provision of medical care, the written, informed consent of the guardian for the treatment is sufficient.

(c) If the head of the treatment facility determines that the patient is not competent to consent to the treatment and the patient has not been adjudicated incompetent, written, informed consent for the surgery or medical treatment shall be obtained from the nearest proper relative. For this

purpose, the following persons are proper relatives, in the order listed: the patient's spouse, parent, adult child, or adult sibling. If the nearest proper relatives cannot be located, refuse to consent to the procedure, or are unable to consent, the head of the treatment facility or an interested person may petition the committing court for approval for the treatment or may petition a court of competent jurisdiction for the appointment of a guardian. The determination that the patient is not competent, and the reasons for the determination, shall be documented in the patient's clinical record.

(d) Consent to treatment of any minor patient shall be secured in accordance with sections 144.341 to 144.346. A minor 16 years of age or older may consent to hospitalization, routine diagnostic evaluation, and emergency or short-term acute care.

(e) In the case of an emergency when the persons ordinarily qualified to give consent cannot be located, the head of the treatment facility may give consent.
No person who consents to treatment pursuant to the provisions of this subdivision shall be civilly or criminally liable for the performance or the manner of performing the treatment. No person shall be liable for performing treatment without consent if written, informed consent was given pursuant to this subdivision. This provision shall not affect any other liability which may result from the manner in which the treatment is performed.

Subd. 6a. Consent for treatment for developmental disability. A patient with a developmental disability, or the patient's guardian, has the right to give or withhold consent before:
(1) the implementation of any aversive or deprivation procedure except for emergency procedures permitted in rules of the commissioner adopted under section 245.825; or
(2) the administration of psychotropic medication.

Subd. 6b. Consent for mental health treatment. A competent person admitted voluntarily to a treatment facility may be subjected to intrusive mental health treatment only with the person's written informed consent. For purposes of this section, "intrusive mental health treatment" means electroshock therapy and neuroleptic medication and does not include treatment for a developmental disability. An incompetent person who has prepared a directive under subdivision 6d regarding treatment with intrusive therapies must be treated in accordance with this section, except in cases of emergencies.

Subd. 6c. Adult mental health treatment.

(a) A competent adult may make a declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include, but are not limited to, consent to or refusal of these treatments.

(b) A declaration may designate a proxy to make decisions about intrusive mental health treatment. A proxy designated to make decisions about intrusive mental health treatments and who agrees to serve as proxy may make decisions on behalf of a declarant consistent with any desires the declarant expresses in the declaration.

(c) A declaration is effective only if it is signed by the declarant and two witnesses. The witnesses must include a statement that they believe the declarant understands the nature and significance of the declaration. A declaration becomes operative when it is delivered to the declarant's physician or other mental health treatment provider. The physician or provider must comply with it to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. The physician or provider shall continue to obtain the declarant's informed consent to all intrusive mental health treatment decisions if the declarant is capable of informed consent. A treatment provider may not require a person to make a declaration under this subdivision as a condition of receiving services.

(d) The physician or other provider shall make the declaration a part of the declarant's medical record. If the physician or other provider is unwilling at any time to comply with the declaration, the physician or provider must promptly notify the declarant and document the notification in the declarant's medical record. If the declarant has been committed as a patient under this chapter, the physician or provider may subject a declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only upon order of the committing court. If the declarant is not a committed patient under this chapter, the physician or provider may subject the declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only if the declarant is committed as mentally ill or mentally ill and dangerous to the public and a court order authorizing the treatment has been issued.

(e) A declaration under this subdivision may be revoked in whole or in part at any time and in any manner by the declarant if the declarant is competent at the time of revocation. A revocation is effective when a competent declarant communicates the revocation to the attending physician or other provider. The attending physician or other provider shall note the revocation as part of the declarant's medical record.

(f) A provider who administers intrusive mental health treatment according to and in good faith reliance upon the validity of a declaration under this subdivision is held harmless from any liability resulting from a subsequent finding of invalidity.

(g) In addition to making a declaration under this subdivision, a competent adult may delegate parental powers under section 524.5-211 or may nominate a guardian under sections 524.5-101 to 524.5-502.

Subd. 7. Program plan. A person receiving services under this chapter has the right to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary. The treatment facility shall devise a written program plan for each person which describes in behavioral terms the case problems, the precise goals, including the expected period of time for treatment, and the specific measures to be employed. Each plan shall be reviewed at least quarterly to determine progress toward the goals, and to modify the program plan as necessary. The program plan shall be devised and reviewed with the designated agency and with the patient. The clinical record shall reflect the program plan review. If the designated agency or the patient does not participate in the planning and review, the clinical record shall include reasons for nonparticipation and the plans for future involvement. The commissioner shall monitor the program plan and review process for regional centers to insure compliance with the provisions of this subdivision.

Subd. 8. Medical records. A patient has the right to access to personal medical records. Notwithstanding the provisions of section 144.292, every person subject to a proceeding or receiving services pursuant to this chapter and the patient's attorney shall have complete access to all medical records relevant to the person's commitment. A provider may require an attorney to provide evidence of representation of the patient or an authorization signed by the patient.

Subd. 9. Notification. All persons admitted or committed to a treatment facility shall be notified in writing of their rights regarding hospitalization and other treatment at the time of admission. This notification must include:

(1) patient rights specified in this section and section 144.651, including nursing home discharge rights;

(2) the right to obtain treatment and services voluntarily under this chapter;

(3) the right to voluntary admission and release under section 253B.04;

(4) rights in case of an emergency admission under section 253B.05, including the right to documentation in support of an emergency hold and the right to a summary hearing before a judge if the patient believes an emergency hold is improper;

(5) the right to request expedited review under section 62M.05 if additional days of inpatient stay are denied;

(6) the right to continuing benefits pending appeal and to an expedited administrative hearing under section 256.045 if the patient is a recipient of medical assistance, general assistance medical care, or MinnesotaCare; and

(7) the right to an external appeal process under section 62Q.73, including the right to a second opinion.

Subd. 10. Proxy. A legally authorized health care proxy, agent, or guardian may exercise the patient's rights on the patient's behalf.

144.651 HEALTH CARE BILL OF RIGHTS.

Subdivision 1. Legislative intent. It is the intent of the legislature and the purpose of this section to promote the interests and well-being of the patients and residents of health care facilities. No health care facility may require a patient or resident to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

Subd. 2. Definitions. For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

Subd. 3. Public policy declaration. It is declared to be the public policy of this state that the interests of each patient and resident be protected by a declaration of a patients' bill of rights which shall include but not be limited to the rights specified in this section.

Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for people who have communication disabilities and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.

Subd. 7. Physician's identity. Patients and residents shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

Subd. 8. Relationship with other health services. Patients and residents who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Residents shall be informed, in writing, of any health care services which are provided to those residents by individuals, corporations, or organizations other than their facility. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

Subd. 9. Information about treatment. Patients and residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients or residents can reasonably be expected to understand. Patients and residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's medical record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative. Individuals have the right to refuse this information.

Every patient or resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

Subd. 10. Participation in planning treatment; notification of family members.

(a) Patients and residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the patient or resident cannot be present, a family member or other representative chosen by the patient or resident may be included in such conferences. A chosen representative may include a doula of the patient's choice.

(b) If a patient or resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the patient as the person to contact in an emergency that the patient or resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the patient or resident has an effective advance directive to the contrary or knows the patient or resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the patient or resident has executed an advance directive relative to the patient or resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the patient or resident;

(2) examining the medical records of the patient or resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the patient or resident has executed an advance directive and whether the patient or resident has a physician to whom the patient or resident normally goes for care; and

(4) inquiring of the physician to whom the patient or resident normally goes for care, if known, whether the patient or resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the patient or resident and the medical records of the patient or resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the patient or resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to

the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

Subd. 11. Continuity of care. Patients and residents shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

Subd. 12. Right to refuse care. Competent patients and residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a patient or resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's or resident's medical record.

Subd. 13. Experimental research. Written, informed consent must be obtained prior to a patient's or resident's participation in experimental research. Patients and residents have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

Subd. 14. Freedom from maltreatment. Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and sections 144.291 to 144.298. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third-party payment contracts, or where otherwise provided by law.

Subd. 17. Disclosure of services available. Patients and residents shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the Medicare or medical assistance program will pay for any or all of the aforementioned services.

Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.

Subd. 19. Personal privacy. Patients and residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable.

Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

Subd. 21. Communication privacy. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Subd. 22. Personal property. Patients and residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients or residents, and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility must either maintain a central locked depository or provide individual locked storage areas in which residents may store their valuables for safekeeping. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

Subd. 23. Services for the facility. Patients and residents shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record.

Subd. 24. Choice of supplier. Residents may purchase or rent goods or services not included in the per diem rate from a supplier of their choice unless otherwise provided by law. The supplier shall ensure that these purchases are sufficient to meet the medical or treatment needs of the residents.

Subd. 25. Financial affairs. Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time.

Subd. 26. Right to associate.

(a) Residents may meet with and receive visitors and participate in activities of commercial, religious, political, as defined in section 203B.11 and community groups without interference at their discretion if the activities do not infringe on the right to privacy of other residents or are not programmatically contraindicated. This includes:

(1) the right to join with other individuals within and outside the facility to work for improvements in long-term care;

(2) the right to visitation by an individual the patient has appointed as the patient's health care agent under chapter 145C;

(3) the right to visitation and health care decision making by an individual designated by the patient under paragraph (c).

(b) Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

(c) Upon admission to a facility, the patient or resident, or the legal guardian or conservator of the patient or resident, must be given the opportunity to designate a person who is not related who will have the status of the patient's next of kin with respect to visitation and making a health care decision. A designation must be included in the patient's health record. With respect to making a health care decision, a health care directive or appointment of a health care agent under chapter 145C prevails over a designation made under this paragraph. The unrelated person may also be identified as such by the patient or by the patient's family.

Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

Subd. 28. Protection and advocacy services. Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.

Procedure

1. Staff will present clients with Client Bill of Rights upon admission
    a. Staff will address client questions and concerns and obtain Client Acknowledgement of Rights
    b. Client refusal to sign this statement must be documented and consulted with Program Director immediately
2. Audio, video, and photographic recordings of treatment services must be approved in writing by involved clients and can be used only for professional enhancement.
3. Client Rights and Responsibilities are posted in the program's lobby
4. Update clinical staff information upon addition of new staff
5. Clients will sign an internal release of information form identifying NorthStar Regional's clinical staff and authorizing communication between staff members regarding the client, upon admission to the program. If a client is uncomfortable with any staff member, this will be addressed by the Program Director in accordance with client rights

5.2 Grievances *(245G.15, Subdivision 2)*

It is the goal of this program that all clients and former clients are provided with quality care including satisfactory acknowledgment of their concerns. Grievances are addressed according to Minnesota 245G.15, subdivision 2, in an appropriate and timely manner with respect to client rights. Client experiences and suggestions are welcomed and concerns will be considered in program improvement initiatives.

Procedure

1. Staff will try to resolve any issue or complaint brought to them immediately. This will be documented and dated in the client record by the staff member should this occur.
2. IF resolution cannot be accommodated: Staff will explain the grievance procedure to clients, former clients and their representative, as applicable, on the day of service initiation
3. Grievance procedures are posted in the program lobby and will be provided to all current and past clients upon request
4. Clients should inform program staff of their need to discuss a grievance as soon as possible. Program staff will assist the client in developing, processing, and submitting a grievance immediately
    a. Staff will respond to the client within 3 days to address client grievance
5. Program staff will discuss client grievances with Program Director within 24 hours and in continued consultation until resolution is made
    a. Program staff will work mutually with client and Program Director toward resolution within 7 days
    b. Clients may discuss a grievance involving the Program Director with the Managing Director
6. If a client is not satisfied with program attempts at resolution, program staff will assist the client in developing, processing, and submitting a grievance with the appropriate board:
    a. Department of Human Services, Licensing Division: PO Box 64242 St. Paul, MN 55164; phone: 651-431-6500

   b. Office of Ombudsman for Developmental Disabilities: 121 7th Place East, Suite 420, St. Paul, MN 55101; phone: 651-757-1800
   c. Minnesota Board of Behavioral Health and Therapy, Alcohol and Drug Licensing Entity: 829 University Ave SE Suite 210, Minneapolis, MN 55414; phone: 612-548-2177
   d. Clients will be protected from retaliation if a report is made
7. Client grievances will be addressed internally in accordance with program policies and procedures and will be considered in program improvement initiatives
8. Documentation directly on the grievance form will contain information about the grievance investigation, discussion, and outcome. This information will be verbally shared and communicated with the client involved.

Participants of this program are expected to adhere to program guidelines in order to ensure the safety of clients and staff and to allow for the provision of effective treatment. It is the goal of this program that clients successfully complete outlined treatment goals. Staff members will provide clients with the support, appropriate flexibility, and accountability needed.

5.3 Client Expectations

1. Participants must exhibit willingness to work toward abstinence from all alcohol or drug use during the program duration. Staff members will employ a harm reduction model to allow appropriate flexibility in assisting participants toward a goal of abstinence, considering participant needs and safety
2. Participants must adhere to program guidelines, including attendance policy. Staff members will allow appropriate flexibility based upon client needs
3. Participants will be continuously assessed to ensure the safety and best care of all participants
4. Participants will be expected to invite family or significant supportive others to be involved in their treatment.
5. There will be no fraternizing among treatment center clients. The formation of exclusive, intimate, sexual, or romantic relationships while in any part of the treatment process will result in discharge.
6. Participants will commit to the entire treatment process, including screening and diagnostic assessment, treatment planning, and Continuing Care
7. Participants will be expected to treat all clients and staff members with respect; this will include maintaining the confidentiality of group members
8. Any behavior that poses a threat to the safety of NorthStar Regional's clients and staff may be grounds for discharge from the program

Procedure

1. Clients will be oriented to this policy upon admission

5.4 Photographs of client *(245G.15, subd. 3)*

A photograph of a client is taken upon admission as part of the provision of treatment service and is considered client records. The photograph is for identification and to assist in staff member supervision. The photograph is only available for use as communications within the program.

Personal Electronics:

1. The use of any personal electronic device including but not limited to cell phone, cameras, note pads that can record, transmit, or make images of another client are forbidden while on the premises. If necessary staff will hold these devices during treatment services. Clients always retain the right to refuse being photographed or recorded. Clients are informed of the Personal Electronics Policy upon Service Initiation. This is documented in the clients medical record.

6 Program Safety

It is the goal of this program to provide clients with a safe and healthy treatment environment. NorthStar Regional's program safety policies and procedures will be updated to continuously reflect client safety needs.

6.1 Program Abuse Prevention Plan *(245G.09 subpart 3)*

This program will enforce the established Program Abuse Prevention Plan in accordance with Minnesota Statutes, section 245A.65, subdivision 2 and Minnesota Statutes, section 626.557, subdivision 14, item a to ensure the safety of clients and staff. Clients will be oriented to the program abuse prevention plan upon admittance and staff members are required to adhere to procedures. Each client determined to be a vulnerable adult, will have an additional Individual Abuse Prevention Plan (IAPP) completed within 24 hours of admission, to include specific measures taken to reduce safety risks within the scope of the treatment services and with referrals made to address safety risks outside of the scope of services.

Program Abuse Prevention Plan

Physical Plant and Environment

1. Maple Grove location: 7384 Kirkwood Court N, Maple Grove, MN 55369
   Maple Grove location:
   The program is housed in Suite 200 of 7384 Kirkwood Court N, Maple Grove, MN 55369, a stand alone brick building located off of I-94 & Hemlock Lane. Suite 200 is a 4,497 square foot space that is part of the bigger 9,181 square foot building. The class B office building was built in 1986 with an addition in 2008. The building currently has 2 tenants, the other being a financial services company, with room for 1 more tenant. The building is on a 1.31 acre lot that offers parking and a large amount of green space. Suite 200 has their own men's and women's bathrooms, entrance, and patio with designated area for clients to smoke. The building is handicap accessible. The program is located near local clinics, restaurants, and Arbor Lakes shopping center and poses minimal safety risk.
   a. Clients may be supervised in all treatment areas, including the lobby, group rooms, offices, and any outdoor areas.
   b. Clients will be informed of difficult areas to supervise including parking lots, building hallways, and restrooms. These areas are not supervised by NorthStar Regional's Program staff.
      i. Clients should smoke in designated smoking areas only

   c. Clients exhibiting behaviors that could risk the safety of self or others will not be permitted to participate in outdoor activities
   d. Clients will be oriented to emergency procedures and the locations of emergency exits upon admission

2. All staff members and volunteers providing direct services to clients must undergo a background check which documents their appropriateness for working in a human services program
   a. For all treatment programming, NorthStar Regional will have a minimum of one staff member present at all times
   b. Internal programming, included in new staff orientation, clearly prohibits any substance use during work hours and states that staff providing direct client services must have at least 1 year free from problematic substance use and 2 years free from problematic substance use for clinical staff members
   c. Staff members will participate in consistent internal training and performance review, facilitated by the Program Director with input from clinical supervisors
   d. NorthStar Regional's management, including the Program Director and clinical supervisors, will work to maintain high employee morale. Clients will work with treatment teams and staffing patterns will be minimally interrupted to ensure constancy and best client care. All available measures will be taken to make staffing transitions as smooth as possible in consideration of clients' best interests
   e. All employees, interns, and/or volunteers of NorthStar Regional will be trained annually on the Maltreatment of Vulnerable Adults, Mandated Reporting and Maltreatment of Minor's regulations and rules governing licensed programs of DHS

Population

1. Age and Gender: This program serves males and females ages 18-100 years
   a. Cultural-specific tracks tend to gender- and age-specific needs and include group psychotherapy and psycho-education
   b. Vulnerable adult clients will never be treated with another client who is registered as a sex offender
   c. Any client who exhibits or threatens violent behavior will be removed from all group interactions until client safety can be assured
2. Range of Mental, Cognitive, and Physical Functioning: This program treats clients with substance use and mental health disorders and associated maladaptive behaviors
   a. Clients admitted to the program shall be mobile and physical health considerations will be assessed, noted, and where needed, accommodated
   b. Clients cognitive functioning will be assessed and noted at admission. Clients with average cognitive functions or above will be admitted
   c. Emotional health will be assessed and noted at admission. Clients admitted to the program will be emotionally stable enough to participate in programming. Clients requiring a higher level of psychiatric care will be referred to a facility capable of admitting them.
   d. Upon admission and throughout the treatment process, a client's history with abuse and trauma will be assessed, noted and included in the individualized treatment plan. Abuse and trauma will be addressed in individual sessions
   e. If a license holder has any knowledge regarding previous abuse involving a client or staff member, information relevant to minimizing risk of abuse for clients is addressed in abuse prevention
   f. Upon service initiation, a client's medical needs are assessed and appropriate referrals are made. Clients are provided with case management services to assist

in referral follow-through and will not be required to participate in any physical activities that may interfere with medical issues

g. Any client who exhibits or threatens violent behavior will be removed from all group interactions until client safety can be assured

h. Any client who reports suicidal ideation will be assessed and referred as appropriate

i. Trauma-informed considerations, including participation in cultural-specific tracks and client interaction with clinical staff, will be taken to accommodate the individual needs of clients diagnosed with post-traumatic stress or related disorders. NorthStar Regional will provide individually-oriented, person-centered and trauma-informed services including but not limited to treatment planning, service delivery, individual sessions, and all assessments.

j. At any time, knowledge may be obtained regarding previous abuse that is relevant to minimizing the risk of abuse for clients. If a client is deemed a vulnerable adult, an IAPP will be developed.

3. Specialized Programs of Care: Programming is tailored for treatment of co-occurring and offers cultural-tracks for clients to address culturally-sensitive issues related to age, gender, ethnicity, sexual orientation, spirituality, trauma, etc. in a safe and accommodating environment with qualified staff

a. Intensive-Outpatient Program operating hours will be Monday through Friday 8am-4pm and will be adjusted appropriately to accommodate client scheduling needs.

b. One or more staff members will be present in the office any time a client is present.

c. Staff will meet staffing requirements for Co-occurring treatment services are, in accordance with both Minnesota Statutes, section 254B.05 as follows:

i. At least 25% of full time counselors are MHP's

- Up to 50% may be composed of graduate or post-graduate students from a behavioral science or related field, under documented weekly supervision by the LADC and the LMHP Clinical Supervisors.

ii. Clinical staff will participate in monthly multi-disciplinary case consultations; documentation of the mental health professional in the case staffing will be made in the medical record

iii. Clinical staff will receive 8 hours of training on co-occurring disorders annually

d. Cultural-specific tracks are governed with significant input from an individual of specified background, in compliance with Minnesota Statutes, section 254B.05, subdivision 5, item 2

i. 150 or more hours of supervised clinical experience

ii. Completion of 30 hours of classroom instruction, or at least one 3 credit college course focused in adolescent development

e. The need for training of staff to meet identified individual needs will be assessed annually and training provided as needed

PAPP Policy and Procedure Reviewed Annually	Who Reviewed	Date
Yes	Lisette Wright	12/4/18
Yes	Brian Loots	10/6/20
Yes	Jason Vanderscoff	3/31/21

Procedure

1. Staff will orient clients and their legal representatives, as applicable, to the Program Abuse Prevention Plan upon admission
2. Clinical staff will assess clients for determination of vulnerable adult status upon admittance and throughout a client's treatment, as needed
    a. If a client is determined to be vulnerable at any time during the treatment process, clinical staff will develop an IAPP within 24 hours
    b. Clinical staff will review and update, as applicable, IAPP's weekly
3. A written copy of the Program Abuse Prevention Plan will be posted in the program's lobby and will available upon request
4. Program Abuse Prevention Plan will be reviewed and updated annually by the Program Director; reflective revisions will be made
    a. Review will include an assessment of factors that encourage or permit measures to minimize abuse can be effectively taken
    b. Reviews will be made available to the commissioner upon request

6.2 Emergency Management *(245G.16, 245A.04, subdivision 16)*

This program recognizes its responsibility for the safety of client and staff members and takes appropriate precautions to provide a safe treatment environment for all clients and staff members. Clinical staff members hold current American Red Cross first aid and CPR certifications and are trained in crisis management and will be available on site at all times clients are present. Staff members will follow the emergency procedures in responding to clients exhibiting behaviors that threaten the safety of the client or others. Inclusive behaviors are as follows:

1. Medical emergencies (i.e. profuse bleeding, seizure, inability to breath or move, loss of consciousness)
2. Intoxication or potentially dangerous withdrawal symptoms
3. Physically aggressive behaviors or threats toward self, others, or property
4. Report of suicidal or homicidal ideation and refusal to commit to a safety contract

Emergency Procedures do not include seclusion or restraint of any client and program staff will avoid physical contact with clients. These procedures are intended to manage acute crises to provide safety for all clients and program staff and will not be used for program convenience, as a treatment intervention, or to enforce program rules.

Procedure

1. Clinical staff members, including the program director, LMHP, LADC, MHP and technicians are authorized to implement emergency procedures, with the assistance of office staff as needed
    a. All clinical and office staff members will use an identified code word, as needed, to discreetly communicate the need for emergency services to be called
    b. Code Words to be used in conjunction with specifying building and exact location:
        i. Code Green: Indicates a client has become violent and/or a threat to the safety of staff or other clients. Action item: Call 911
        ii. Code Blue: Indicates a medical emergency. Action item: Call 911; Be prepared to administer CPR or First Aid
        iii. Code Red: Indicates fire. Action item: Evacuate clients; Call 911
        iv. Code Yellow: Indicates a client has used chemicals or alcohol. Action item: Follow protocol in section 3

v. Code Orange: Possible overdose on opioids. Action item: Bring Narcan; Call 911.
vi. Code Purple: Severe weather warning. Action item: Follow protocol in section 7a.
vii. Code Grey: External Threat Including Bomb Threat and Intruder Action Items: Call 911, Stay on the Phone, Back away. Do not argue/disarm

c. Involved clinical staff members will document emergency and interventions in client chart and complete a Critical Incident Report within 24 hours
   i. If clinical staff was not present, the Program Director will complete a Critical Incident Report with involved office staff
d. All emergencies will be reported to the Program Director and consulted within 24 hours
   i. Staff can contact program director via personal cell phone contact provided, as needed
   ii. Program Director will provide staff support and make off-site counseling referrals as necessary
e. If a client is taken by EMT or police, staff member will inform next of kin (if a release of information form has been completed), as appropriate

2. Medical Emergencies
   a. If a client is experiencing a medical emergency, CPR and First Aid certified clinical and office staff will provide CPR and first aid services, as appropriate.
      i. All staff members will be oriented to the location of the First Aid kit in the office supply closet
      ii. If the client appears medically stabilized by staff members and has a significant other present who is willing to transport the client, staff will direct them to a local hospital
      iii. If the medical emergency is outside of the scope of program staff skills, staff will contact 911 and follow instructions of the emergency medical professionals
3. Intoxication and Withdrawal Emergencies
   a. If a client smells of alcohol, or appears intoxicated or experiencing withdrawal symptoms, clinical staff or clinical laboratory technician will meet with the client and administer a drug screen or breathalyzer to determine impairment
      i. If it is determined that a client is impaired, staff will assess safety risks and make appropriate recommendations
      ii. If client is in need of detoxification services, clinical staff will inform the client of this recommendation and assist in obtaining services
         - If client refuses or is unable to obtain services staff will contact 911
         - If client's supportive other is present and agrees to transport the client to client's primary care physician if appropriate, or staff will direct them to a local hospital or detoxification unit:
            a. Maple Grove location; Unity Hospital, Detoxification Unit: 550 Osborne Road NE, Fridley, MN 55432; phone: 763-236-3655.
      iii. If client does not appear to need detoxification services, clinical staff will assist the client in arranging transportation for the client, informing the client that if he or she attempts to drive away from the premises 911 will be called
         - Staff will not restrain client, but will contact 911 immediately if the client attempts to operate a vehicle

4. Physically Aggressive or Threatened Client Emergencies
    a. Clinical staff will develop and implement Individual Abuse Prevention Plans (IAPP) for clients determined to be vulnerable adults or who pose a threat to the safety of that client or others in accordance with the assessment and treatment planning policy and procedures. IAPP's will address the following:
        i. Interventions for providing a safe environment (i.e. removing dangerous materials from treatment space)
        ii. Implementation of distress tolerance skills, as appropriate (i.e. client exits treatment space and walks, deep breathing, distress tolerance skills, emotional processing under staff supervision)
    b. If a client engages in or threatens physically aggressive behaviors staff will:
        i. Implement IAPP
        ii. Direct client to leave a group setting; if client refuses, staff will direct other group members to vacate group room to ensure safety
            - When co-facilitating one clinician will remain with the group while the other manages client issue. Program Director will assist as needed
        iii. If behaviors cannot be managed by crisis diffusion interventions, program staff will contact the local Police Department by calling 911
5. Suicidal or Homicidal Ideation Emergencies
    a. If a client reports suicidal or homicidal ideation, ask about plan, means and intent. If 2 of those are present, the client is at higher risk of suicide. In that case, clinical staff will sit with client and complete a patient safety plan
    b. Clinical staff will seek consultation with Mental Health Professional immediately. If staff mental health professional is not available, staff will call Suicide Prevention Lifeline Phone at 1-800-273-8255 or call 911, who will route the call to Hennepin County Crisis Center
        i. If client is transported to a higher level of care, such as a mental health hospital, and there is a release on file for an emergency contact, staff will notify the contact and document
6. Reporting a Death in the Program
    a. Within 24 hours of receiving knowledge of the death of an individual served by the program, the Program Director shall notify the commissioner of the death by calling the DHS at 651-431-6500
7. Environmental Emergencies
    a. In the case of threatening weather, fire, terroristic threat, or other emergency clients will be escorted by program staff to a safe place
        i. In the case of a tornado or similarly threatening weather, staff will direct clients to safety in one of the interior group rooms of the building
            - Staff will direct clients to cover their faces with blankets or available clothing
        ii. Office staff will monitor weather conditions and report to program director to determine safety measure taken
        iii. Program Director will work with office staff to determine office closure and communicate this to clients and staff members efficiently
    b. In the case of a fire or terroristic threat, clients and personnel will reassemble in the southwest parking lot in front of the building, and will not re-enter the building until safety is secured
        i. All staff members will be oriented to the location of nearest fire extinguisher, on back wall of behind the front reception desk.
        ii. Clients will be directed to emergency exits located at the front (south side), and rear (northeast side) of the building

   c. Upon awareness of potential environmental emergency, all staff will ensure that computers and paper files containing sensitive client information are secured to ensure client confidentiality

8. De-escalation and Crisis Intervention Procedures
   a. Speak slowly and confidently with a gentle caring tone of voice
   b. Stay calm and take it slow
   c. Avoid nervous behavior
   d. Use non-threatening body-language
   e. No touching, shouting or sudden movements
   f. Reduce distractions
   g. Use clear language
   h. Do not challenge the person
   i. Avoid intense questioning of why questions
   j. Do not laugh, use humor or sarcasm
   k. Announce your movements beforehand
   l. Don't restrict the persons movement
   m. Try to be aware of what may worsen the situation
   n. Paraphrase concerns
   o. Problem solve and offer solutions instead of trying to take control
   p. Ask how you can help
   q. Affirm the persons positive qualities
   r. Offer a face-saving way out
   s. Attempt to get other staff as back-ups
   t. Do a debriefing with the targeted participant(s).
   u. Do a debriefing with the staff involved.
   v. Fill out an incident report.

9. Receipt of Fact Sheet from Law Enforcement
   a. If we are in receipt of a Fact Sheet from law Enforcement notifying us that one of our clients is a predatory offender, with an assigned risk level for that individual, we will
   1. Inform client to whom the report is about.
   2. Discuss options for transfer of client to a more appropriate facility.
   3. As per instructions on Predatory Factsheet inform all clients and staff accordingly

Emergency Contact Information

1.	Emergency	911
2.	Maple Grove Hospital 9875 Hospital Drive	763-581-1000
3.	Maple Grove, MN 55369 Ridgeview Medical Center 500S.MapleStreet Waconia, MN 55387	952-442-2191
4.	NorthStar Regional Office Location	
	a. Chaska	952-448-6557
5.	Minnesota Adult Abuse Reporting Center	844-880-1574
6.	MN Department of Public Safety	
	a. On-duty officer (24 hour)	651-649-5451
	b. Office hours non-emergency	651-201-7400
	c. Hazardous Materials/Poison	651-649-5451
	d. Poison Control Center	800-222-1222 612-871-7676

e. Division of Emergency Management	800-422-0798
f. Homeland Security (24 hour)	651-649-5451
7. Minnesota Department of Human Services Mental Health Crisis	
a. Anoka County	763-755-3801
b. Carver and Scott Counties	952-442-7601
c. Dakota County	952-891-7171
d. Hennepin County	
i. Adult Division	612-593-1223
ii. Child Division	612-348-2233
e. Ramsey County	
i. Adult Division	651-266-7900
ii. Child Division	651-774-7000
f. Washington County	651-777-5222
8. Centerpoint Energy	1-800--22-9326
9. Xcel Energy	1-800-895-1999
	1-800-895-2999

I approve these policies and procedures

Dr. Thomas Winegarden M.D. 3/31/21
Date

6.3 Maltreatment of Vulnerable Adult Reporting *(245A.65, subdivision 1a)*

Program staff members are permitted to make internal and external reports of suspected maltreatment to a vulnerable adult without fear of retaliation and will follow vulnerable adult reporting procedures, in accordance with Minnesota Statutes, section 245A.65, subdivision 1 and Minnesota Statutes, section 626.557, subdivision 4. Staff members are encouraged to discuss reports made with program administration in an effort to improve client treatment.

Procedure

1. Staff members will be oriented to the Maltreatment of Vulnerable Adult Reporting Policy and Procedures within 72 hours of hire and will follow procedures as outlined. The orientation and annual review shall inform the mandated reporters of the reporting requirements and definitions specified under Minnesota Statutes, sections 626.557 and 626.5572, the requirements of Minnesota Statutes, section 245A.65, the license holder's program abuse prevention plan, and all internal policies and procedures related to the prevention and reporting of maltreatment of individuals receiving services. The license holder must document the provision of this training, monitor implementation by staff, and ensure that the policy is readily accessible to staff, as specified under Minnesota Statutes, section 245A.04, subdivision 14
2. Clients will be oriented to the Maltreatment of Vulnerable Adult Reporting Policy and Procedure within 24 hours of program admission
    a. This policy and procedure will be posted in the NorthStar Regional group room and will be available to clients upon request
3. Staff members are required to report maltreatment of a vulnerable adult, as defined in MN Statute 626.5572 and in accordance with any statute revisions available at www.revisor.leg.state.mn.us; the Program Director will assist clinical staff with making reports as appropriate
    a. Reports will be made to the Minnesota Adult Abuse Reporting Center (MAARC) at 844-880-1574

b. Incidents can be reported internally to the Program Director. If NorthStar Regional's/NorthStar Regional Program Director is involved in the alleged or suspected maltreatment, a report must be made to the CEO
   i. When an internal report is received, NorthStar Regional's Program Director is responsible for deciding if the report must be forwarded to the MAARC
   ii. If NorthStar Regional's Program Director is involved in the suspected maltreatment, the Managing Director will assume responsibility for deciding if the report must be forwarded to the MAARC. The report must be forwarded within 24 hours
   iii. If an internal report is made, the reported will receive, within two working days, a written notice that states whether or not the report has been forwarded to the MAARC. The notice will be given in a manner that protects a reporter's identity. It will state that, if the facility's decision on whether or not to report externally is not satisfactory, an individual may still make the external report to the MAARC independently. It will also state a reporter's protection against any retaliation if he or she decides to make a good faith report to the MAARC

4. When the facility has reason to know that an internal or external report of alleged or suspected maltreatment has been made, the facility must complete an internal review within 30 calendar days and take corrective action, if necessary, to protect the health and safety of vulnerable adults. The internal review must include an evaluation of whether:
   a. related policies and procedures were followed;
   b. the policies and procedures were adequate;
   c. there is a need for additional staff training;
   d. the reported event is similar to past events with the vulnerable adults or the services involved; and
   e. There is a need for corrective action by the license holder to protect the health and safety of vulnerable adults

5. The internal review will be completed by the Program Director. If this individual is involved in the alleged or suspected maltreatment, the CEO will be responsible for completing the internal review
   a. The facility must document completion of the internal review and provide documentation of the review to the commissioner upon the commissioner's request
   b. Based on the results of the internal review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by individuals or the license holder, if any

6.4 Maltreatment of Minors Reporting *(626.556 and 245A.66)*

Program staff members are permitted to make internal and external reports of suspected maltreatment of a minor child without fear of retaliation and will follow maltreatment of minors reporting procedures, in accordance with Minnesota Statutes, section 626.556. Mandated reporters are required by law to report maltreatment of minors, including alcohol or drug abuse during pregnancy that poses danger to an unborn child. A mandated reporter who fails to report suspected neglect or physical or sexual abuse of a minor may result in misdemeanor charges and disqualification from provision of direct contact services. The Program Director is available to assist staff members in making reports as needed.

Procedure

1. Staff members will be oriented to the Maltreatment of Minors Reporting Policy and Procedures upon hire and will follow procedures as outlined

2. Clients will be oriented to the Maltreatment of Minors Reporting Policy and Procedures upon admission
3. Staff members will assist clients with making reports as appropriate
4. Maltreatment of Minors Reporting Policy and Procedure will be posted in the program lobby; a written copy will be provided upon request
5. A person who knows or has reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department or county sheriff.
6. Staff members will make an oral report within 24 hours to the appropriate agency
    a. A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the Department of Human Services, which is the agency responsible for licensing the facility. Reports shall be made to Department of Human Services, Licensing Division, Maltreatment Intake line at 651-431-6600
    b. Suspected maltreatment of a minor in a licensed facility should be made to Department of Human Services, Licensing Division, Maltreatment Intake line at 651-431-6600
    c. Suspected abuse or neglect of a minor within the community should be made to the local county social services agency or law enforcement; Carver County Social Services can be reached at 952-361-1600 and for the Maple Grove location contact: Hennepin County Social Services can be reached at 612-348-3552, option 1
    d. Other reports of possible violation of minor rights should be reported to the Department of human Services, Licensing Division at 651-431-6500
    e. If there is any abuse occurring, staff will report to the Minnesota Department of Human Services
    f. Staff members must provide the following information:
        i. Names of maltreated minor and caregiver
        ii. Nature and extent of suspected maltreatment
        iii. Evidence of previous maltreatment
        iv. Name and address of the reporter
        v. Time, date, and location of the reported incident
        vi. Any additional information that may assist in investigation of the reported case
    e. The Program Director will assist staff with making reports as needed, and will do so in a manner that protects the confidentiality of the reporter
        i. If a staff member files a report on behalf of a client, the reporting client will be informed in writing, within 2 days, that the report has been made
7. An internal review will be conducted within 30 calendar days and corrective action taken to protect the health and safety of Minors, if a report of alleged abuse within the program is made. This internal review will include:
    a. Evaluation of compliance with program policies and procedures
    b. Adequacy of policies and procedures
    c. Determination of a need for additional staff training
    d. Assessment of any similarity of past reports involving minors and services involved
    e. Determination of a need for corrective action
        i. If corrective action is required, a corrective action plan will be developed, documented, and implemented to correct current and prevent future lapses in performance of individual staff members or program
8. The Program Director is designated as the primary, and NorthStar Regional's CEO secondary, person responsible to ensure completion of internal reviews when required.

9. Internal reviews will be documented and made available to the commissioner upon request.

7 Medication Assisted Treatment Policy and Procedure

This policy will define the modalities, circumstances, and the procedure of Medication Assisted Treatment for Opioid Use Disorder and Alcohol Use Disorder at NorthStar Regional Facilities.
The use of evidence-based medication for OUD and Alcohol Use Disorder is the most effective option for treating individuals with such diagnoses. This treatment modality is commonly referred to as medication-assisted treatment or MAT.
It is NorthStar Regional's stated policy that the goal of treatment is to be opiate free but still adequately treated with MAT.

FDA-Approved Medications for Opioid Use Disorder (OUD) and Alcohol Use Disorder

There are three U.S. FDA approved medications currently used to treat OUD to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. Methadone, buprenorphine and extended-release injectable naltrexone (XR-NTX/Vivitrol). These MAT medications are safe to use for months, years, or indefinitely.
The most common FDA approved medications currently used to treat Alcohol Use Disorder are acamprosate, disulfiram, naltrexone, and extended-release injectable naltrexone (XR-NTX/Vivitrol). They do not provide a cure for the disorder, but are most effective in people who participate in a MAT program.
Each FDA-approved medication differs pharmacologically and is governed by different regulations:

- Buprenorphine can be prescribed in non-specialty settings if physicians, nurse practitioners and physician assistants obtain a SAMHSA waiver (commonly known as the "x-waiver") by completing requisite training. The Drug Addiction Treatment Act of 2000 (DATA 2000) established that qualified providers can offer buprenorphine for OUD in various settings, including correctional facilities.
- Extended-release injectable naltrexone (XR-NTX/Vivitrol) can be prescribed by any clinician who is licensed to prescribe medication. Unlike methadone and buprenorphine, both opioid agonists, XR-NTX/Vivitrol is an opioid antagonist and not a controlled substance.
- NorthStar Regional facilities will not utilize methadone in the treatment OUD as it requires separate licensure.
- Acamprosate and Disulfiram can be prescribed by any clinician who is licensed to prescribe medication. These medications increase abstinence from alcohol and are not controlled substances.

Opioid Overdose Prevention Medication

Naloxone is used to prevent opioid overdose by reversing the toxic effects of the overdose. According to the World Health Organization (WHO), naloxone is one of a number of medications considered essential to a functioning health care system.

Who is eligible for Medication Assisted Treatment (MAT)?

- Patient must meet DSM 5 criteria for Opiate Use Disorder.
- Thoroughly documented history of opiate use that would likely lead to withdrawal.
- Type of opiate, amount of opiate use, duration of continued use is to be documented.
- Rule 25 Assessment will be included in the history available to the clinician at the time of exam.
- Opiate screening inventory such as the clinical opiate withdrawal scale (COWS) will be administered upon admission and repeated as indicated.

How is MAT initiated?

- Prior to initiating MAT, patient must be free of all opiates for 24 hours in order to avoid inducing abrupt and severe withdrawal.
- Nurse will contact the Medical Director or licensed Suboxone provider to receive Suboxone detox protocol orders.
- The approved MAT medication, dose, and dosing schedule will be determined by the prescribing provider based on collaborating with the patient, completing a thorough review of the patient's history as well as including all of the above.

Where will MAT be used at NSR?

- MAT will be used throughout the facilities that NorthStar Regional owns and operates.
- MAT using Suboxone will primarily, but not limited to, be used in residential treatment facilities. Residential treatment facilities are preferred when utilizing Suboxone as it requires additional staffing resources and precautions which are readily available in the residential setting.

What MAT medications will be used?

- Suboxone is a branded combination of Buprenorphine and Naltrexone the FDA has approved for OUD. The naltrexone element is designed to be deactivated by the enzymes in saliva. Thus, if Suboxone is attempted to be injected or ingested rather than dissolved orally, the naltrexone element will induce withdrawal.
- Acamprosate and disulfiram is FDA approved to treat Alcohol Use Disorder. Oral naltrexone is FDA approved to treat both Alcohol Use Disorder and OUD.
- Extended-release injectable naltrexone (XR-NTX/Vivitrol) FDA approved to treat both Alcohol Use Disorder and OUD.

Storage of MAT medications.

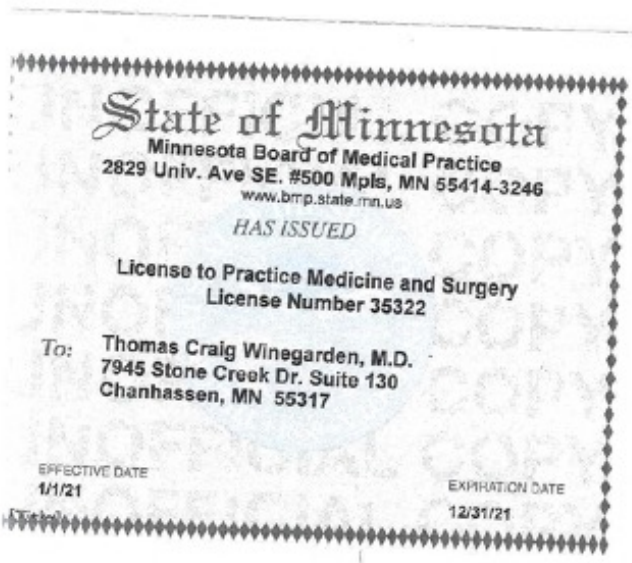
- Buprenorphine is classified by the FDA as a Schedule II controlled substance and requires additional precautions to prevent diversion. Programs licensed as OTPs are additionally subject to the DEA's storage and security regulations. (DEA's Narcotic Treatment Programs Best Practice Guideline)
    - Suboxone will be stored in an approved, affixed, locked cabinet or safe; counted and documented at the time of administration as well as daily by staff.
    - Only staff clinically appropriate and trained to dispense Suboxone will remove medication out of locked storage units and dispense the medication.
    - After completing the MAT protocol, any medication that may not have been administered will be disposed of utilizing defined disposal procedures found in the Medication Administration Policy.
- Acamprosate, disulfiram, naltrexone may be stored in the facility as per the medication administration policy with no extra precautions.
- Extended-release injectable naltrexone (XR-NTX/Vivitrol) is required to be stored in a temperature controlled medical cabinet. Manufacturer's instructions for storage will be followed. It may be stored in the facility as per the medication administration policy with no extra precautions.

How is MAT administered?

- Suboxone will be administered following written orders by Suboxone certified licensed prescribers found in the NSR electronic medication administration record, RTasks.
    - Prior to initiation of MAT using Suboxone, the nurse will verify prescriber's orders found in patient electronic health record Spring Charts.
    - Suboxone dissolvable strips will be dispensed by the nurse or approved staff according to the NSR medication administration policy.
    - Patient will be required to be observed placing the medication in their own mouth under the tongue to ensure that the patient is not attempting to divert or "cheeking" the medication.
- Acamprosate, disulfiram, naltrexone will be administered following written orders by licensed prescribers found in the NSR electronic medication administration record, RTasks.
    - Routinely prescribed for oral administration between one to three times daily, monotherapy or in conjunction with one another.
- Extended-release injectable naltrexone (XR-NTX/Vivitrol) will be administered following written orders by licensed prescribers found in the NSR electronic medication administration record, RTasks.
    - Intramuscular injection to be administered every 30 days per manufacturer's instructions.

The safety of staff and patients as well as confidentiality are priorities of NorthStar Regional.

- Safety is maintained in our residential facilities with observational cameras inappropriate areas, mandated supervising staff 24 hours per day, locked to the outside exterior doors.
- Confidentiality is maintained by utilizing appropriate and approved electronic health record and electronic medication administration record.
    - All patient records are confidential, accessed only by those who are directly involved in their care.
    - All records are kept up to date, are legible and organized in a manner that facilitates access to specific elements of the record and documents individual patient's treatment outcomes.
- As required by HIPAA, patients have a right to access their medical records and other health information.



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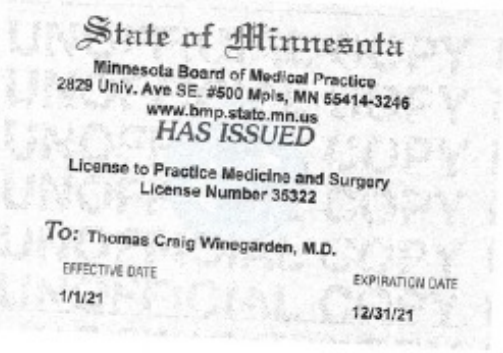
License to Practice Medicine and Surgery
License Number 35322

To: Thomas Craig Winegarden, M.D.
7945 Stone Creek Dr. Suite 130
Chanhassen, MN 55317

EFFECTIVE DATE
1/1/21

EXPIRATION DATE
12/31/21



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8 1115 Level of Care Requirement Policies

NorthStar Regional Residential Program

LEVEL 3.5 CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL REQUIREMENTS

(a) **Applicability** This section establishes the additional standards required for participation in Minnesota's 1115(a) Substance Use Disorder Reform Demonstration Project as outlined in section 256B.0759, subdivisions 2 and 3. NorthStar Regional will participate in the demonstration project, which is subject to all applicable standards governing Substance Use Disorder Treatment Services defined in Chapters 256B, 245G, 254B, 254A, Administrative Rule 9530 or applicable Tribal license.

(b) **Requirements** As a level 3.5 clinically managed high-intensity residential demonstration provider, NorthStar Regional's Residential Program, is a residential setting meeting the provider standard requirements defined in section 256B.0759, subdivision 3, paragraph (b) and meet the following additional requirements:

(1) Be licensed to provide specialized treatment of persons with a substance use disorder and mental health disorder as defined in section 245G.20;

(2) Offer peer recovery support services as defined in 245G.07, subdivision 2, paragraph (8); and

(3) Employ or contract with program staff that meet the staff qualifications of section 245G.11, subdivisions 1-8.

(c) Treatment Services. NorthStar Regional Residential Program provides at least:

(1) 30 hours of treatment services per week for adult women

(d) **Support systems** NorthStar Regional's Residential Program has a medical director, Dr. Thomas Winegarden, a board certified Addiction Psychiatrist, who can do medical consultations with the following support systems:

(1) Telephone or in-person medical consultation available 24 hours a day, 7 days a week.
(2) Psychiatric, psychological, laboratory and toxicology services available as appropriate to the severity and urgency of the client's condition; and
(3) Dr. Thomas Winegarden is a licensed practitioner with a valid and current addiction credential, proof of specialty training in addiction medicine or addiction psychiatry and capable of providing pharmacotherapy. Licensed practitioners meet this requirement through evidence of one or more of the following criteria:

(i) Board Certified by the American Society of Addiction Medicine;
(ii) Board Certified by the American Board of Addiction Medicine;
(iii) Board Certified by the American Academy of Addiction Psychiatry;
(iv) Possess a Drug Addiction Treatment Act of 2000 Waiver from the SAMHSA Center for Substance Abuse Treatment; or

(v) Provide evidence of no less than 8 hours of Continuing Medical Education credits with an addiction medicine focus.

(e) **Assessment and placement**.

(1) Notwithstanding the requirements identified in 245G.05, subdivision 2, for the purposes of the demonstration, assessments used for determining placement must rely on the 1115 Assessment and Placement Table to determine the appropriate level of care. NorthStar Regional utilizes the 1115 Assessment and Placement table to determine the appropriate level of care.

(2) In addition to the comprehensive assessment and assessment summary requirements defined in 245G.05, all NorthStar Regional's comprehensive assessments will include documentation of a licensed practitioner's when there is a risk rating of 3 or higher in dimensions 1 or 2. In the case that the risk rating is above a 3 or higher in Dimension 1 or 2, Dr. Winegarden will be consulted.

(f) Treatment coordination. In addition to the treatment coordination requirements identified in 245G.07, subdivision 1, paragraph (a), clause (5), and paragraph (b), NorthStar Regional will perform treatment coordination activities which will also include documentation of:
(1) Coordination with, and referrals to, step-up and step-down levels of care;
(2) How cultural and socioeconomic factors affecting the patient's access to services are being addressed; and
(3) Follow up on referrals made to services identified in 245G.07, subdivision 1, paragraph (a), clause (5).

(g) **Treatment Planning**

(1) NorthStar Regional will perform documentation of treatment services; treatment plan review. In addition to the treatment service documentation and review requirements defined in 245G.06, subdivision 3, paragraphs (a) and (b), reviews will also include:

(i) A review of biomarkers and toxicology results when such results are available;
(ii) A review of peer recovery support services; and
(iii) A review of the treatment coordination activities that include the additional treatment coordination requirements identified in item 7 (e).

(2) NorthStar Regional will include Service Discharge Summary. In addition to the discharge summary requirements defined in 245G.06, subdivision 4, discharge summaries will also include a process for successful transition to the community or different level of care, considering such factors as proximity to an individual's support network (e.g., family members, employment, counseling and other services near an individual's place of residence)

(3) NorthStar Regional does not work with adolescents.

(h) **Policies and procedures**

In addition to the provider policies and procedures requirements identified in 245G.12, NorthStar Regional's policies and procedures manual is updated to incorporate all applicable level of care requirements defined in number 6, LEVEL 3.5 CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL, items (a) through (h). The provider's policies and procedures must also include the following

(1) 1115 Substance Use Disorder System Reform Enrollment Checklist. A copy of the provider's enrollment checklist must be kept in the policy and procedure manual. The checklist must remain up to date with documentation of the provider's progress on implementing the level of care requirements by the dates identified on the checklist.

(2) Treatment services. A description of treatment services that includes the following:

(i) NorthStar Regional's services incorporates the ASAM therapies for the levels of care offered by the program as defined by the ASAM Criteria Manual;

(ii) NorthStar Regional uses at least three of the following evidence-based practices:

(A) 12-step Facilitation Therapy by providing group and education on the subject;

(B) Brief cognitive behavioral therapy, by utilizing Dr. Hal Baumchen's CBT curriculums;

(C) Motivational interviewing, utilized by counselors and therapists in individual sessions in order to facilitate growth and movement;

(D) Contingency management.

(iii) NorthStar Regional has interdisciplinary treatment plan reviews team meetings on Thursday afternoons that includes the services required in (b) and the support system medical consultations required in item (d).

(3) Physical examinations. NorthStar Regional will transport clients no later than fourteen consecutive calendar days after the day of admission to a local medical practioner for a physical.

(4) Medication assisted treatment. Dr. Winegarden is licensed to prescribe Suboxone to clients needing a suboxone taper. He also prescribes Vivitrol and Naltrexone to patients as needed for assisting with cravings.

(5) Patient Referral Arrangement Agreements. NorthStar Regional signs referrals arrangements with other organizations participating in the 1115 Waiver.

(i) For the purposes of meeting the formal patient referral arrangement requirement as defined in 256B.0759, subdivision 3, NorthStar Regional will maintain the following:

(A) Documentation of formal patient referral arrangements with providers delivering step-up or step-down levels of care.

(B) Patient referral arrangement agreements will be updated immediately upon any change to the referral arrangement agreement.

(ii) NorthStar Regional if unable to admit a client to a level of care offered by the Program, will refer to another program through NorthStar Regional's care coordinator or case mangager to another program that we have a referral arrangement agreement on file

(6) Program Outreach Plan. NorthStar Regional will develop and maintain a program outreach plan that is reviewed and updated annually by the management of the program. The program outreach plan will include additional treatment coordination strategies and processes to ensure seamless transitions across the continuum of care and will include how the NorthStar Regional will:
(i) Increase the awareness of early intervention treatment services, including but not limited to, the services defined in 254A.03, subdivision 3, paragraph (c);

(ii) Coordinate, as necessary, with Certified Community Behavioral Health Clinics when a demonstration provider is located in a geographic region served by a Certified Community Behavioral Health Clinic;

(iii) Partner with 245F Withdrawal Management programs when a demonstration provider is located in a geographic region served by a 245F Withdrawal Management Program. If a 245F Withdrawal Management program is not geographically accessible, the plan must include how the provider will address the client's need for this level of care;

(iv) Coordinate with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers in the area served by the provider to help transition individuals from emergency department or hospital settings and minimize the time between assessment and treatment;

(v) Develop and maintain collaboration with local county and tribal human services agencies; and

(vi) Collaborate with primary care and mental health settings.

DEPARTMENT OF HUMAN SERVICES

Provider Information

This page must be filled out and submitted for each location the provider is seeking to enroll in the demonstration. This form must identify each level of care that will be offered at the location identified and the attached checklist must be filled out and address all of the requirements for each of the levels of care that are identified in the "Level(s) of Care at this Location" box below.

PROVIDER NAME		NPI
NorthStar Regional		1659764587
SERVICE LOCATION ADDRESS		**Level(s) of Care at this Location**
7584 Kirkwood Court North Suite 200		1.0 - OP 2.1 - IOP
CITY	**STATE**	**ZIP CODE**
Maple Grove	MN	55369
CONTACT NAME	**E-mail Address**	**PHONE NUMBER**
Jason Vanderscoff	Jason@northstarregional.com	612-964-4512
AUTHORIZED OFFICER NAME	**AUTHORIZED OFFICER TITLE**	
Jason Vanderscoff	CEO	
AUTHORIZED OFFICER SIGNATURE	**DATE**	
	1/22/21	

Please complete and submit this page for *each* location that the provider organization is seeking to enroll in the demonstration.

2

DEPARTMENT OF HUMAN SERVICES

1115 Substance Use Disorder System Reform Enrollment Checklist

TREATMENT SERVICES, CONSULTATION AND REFERRAL

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(a)Participating demonstration providers must obtain all applicable licensure under chapter 245F, 245G or other applicable standards and must:		
	(1)maintain documentation of a formal patient referral arrangement agreement on a form approved by the commissioner for each of the following levels of care not offered by the enrolled provider:		
	(i) Level 1.0 Outpatient;	NorthStar Regional provides this level of care. There are also Patient Referral Arrangement Agreements for Project Turnabout and Nystrom + Associates.	N/A
	(ii) Level 2.1 Intensive Outpatient	NorthStar Regional provides this level of care. There are also Patient Referral Arrangement Agreements for Project Turnabout, Nystrom + Associates and Nuway.	N/A

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(iii) Level 3.1 Clinically Managed Low-Intensity Residential	There is a Patient Referral Arrangement Agreement in place with Project Turnabout and Nuway.	N/A
	(iv) Level 3.3 Clinically Managed Population-Specific High-Intensity Residential	There is a Patient Referral Arrangement Agreement in place with Pinland Natural Center.	N/A
	(v) Level 3.5 Clinically Managed High-Intensity Residential	NorthStar Regional provides this level of care at their locations. There is also a Patient Referral Agreement in place with Project Turnabout	N/A
	(vi) Level 3.2 Clinically Managed Residential Withdrawal Management; and	There is a Patient Referral Arrangement Agreement in place with Project Turnabout.	N/A
	(vii) Level 3.7 Medically Monitored Inpatient Withdrawal Management	There is a Patient Referral Arrangement Agreement in place with Project Turnabout.	N/A

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(2)have access to and document the availability of a licensed practitioner capable of providing pharmacotherapy that meets one of the following additional requirements: (i) certified in addiction medicine by the American Board of Preventive Medicine; (ii) certified by the American Board of Addiction Medicine; (iii) certified in addiction psychiatry by The American Board of Psychiatry and Neurology; (iv) certified in addiction medicine by the American Osteopathic Association; or (v) possess a Drug Addiction Treatment Act of 2000 Waiver from the SAMHSA Center for Substance Abuse Treatment	Our Medical Director, Dr. Thomas Winegarden, is certified in add. chem psychiatry by The American Board of Psychiatry and Neurology.	N/A
	(b)In addition to the requirements in (a), enrolled demonstration providers licensed under chapter 245G or other applicable standards must: (1) be licensed as specializing in the treatment of persons with co-occurring substance use and mental health disorders according to section 245G.20	NorthStar Regional is currently licensed as a 245G program with co-occurring services.	N/A
	(2) offer peer recovery support services as described in section 245G.07, subdivision 2, (8); and	NorthStar Regional is currently hiring, training and implementing peer recovery support services.	April 1, 2021
	(3) have access to and document the availability of psychiatric, psychological, laboratory and toxicology services available to address the severity and urgency of the client's condition.	Dr. Thomas Winegarden is available 24 hours a day, 7 days per week to address the severity and urgency of a client's condition in regards to psychiatric, psychological, laboratory, and toxicology services.	N/A
	(c)In addition to meeting the requirements defined in paragraphs (a) and (b), enrolled demonstration providers licensed under chapter 245G or other applicable standards offering 1.0 Outpatient or 2.1 Intensive Outpatient levels of care must have access to and document the availability of psychiatric and medical consultation services within 24 hours by telephone.	Dr. Thomas Winegarden is available 24 hours a day, 7 days a week either in person or via phone for psychiatric and medical consultation services	N/A

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(d)In addition to meeting the requirements defined in (a) through (c), enrolled demonstration providers licensed under chapter 245G or other applicable standards offering level 2.1 Intensive Outpatient services must have access to and document the availability of psychiatric and other medical consultation to the client within 72 hours in person.	The client is scheduled during their intake to meet with the provider within 72 hours	N/A
	(e)In addition to meeting the requirements defined in (a) and (b), enrolled demonstration providers licensed under chapter 245G or other applicable standards offering residential levels of care must: (1) have the ability to administer medications or assist with the self-administration of medications according to the requirements of section 245G.08, subdivision 5.		
	(2) Have telephone or in-person medical consultation available 24 hours a day, 7 days a week	Dr. Thomas Winegarden is available 24 hours a day, 7 days a week either in person or via phone for medical consultation.	N/A
	(f)Enrolled demonstration providers offering residential or inpatient levels of care and licensed under 245F, 245G or other applicable standards must support clients to use all types of prescribed medications under the care of their medical provider. For clients without an established medical provider, the enrolled demonstration provider must support the client's preference in seeking medical consultation with a licensed practitioner with prescribing authority to determine the course of treatment. Enrolled demonstration providers offering residential or inpatient levels of care must offer medication assisted treatment at the enrolled location or must facilitate access to medication assisted treatment if it is not offered at the enrolled location.	Dr. Thomas Winegarden meets with the patient and collaborates with them to establish a MAT course of treatment for the patient. NorthStar Regional has a MAT Policy + Procedure. There is also a Patient Referral Arrangement Agreement in place for/with Project Turnabout.	N/A

DEPARTMENT OF HUMAN SERVICES

ASSESSMENT AND PLACEMENT

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	Enrolled demonstration providers licensed under chapter 245F, 245G or other applicable standards must meet the following requirements: (a) Comprehensive assessments must include documentation of: 1) whether or not cultural and socioeconomic factors affect the client's access to services; and	NorthStar Regional is modifying the Comprehensive Assessment to include questions to identify whether or not cultural and socioeconomic factors affect the client's access to services.	April 1, 2021
	(2) a licensed practitioner's review and signature no later than fourteen days from the day of service initiation when there is a risk rating of 3 or higher in dimensions 1 or 2.	Dr. Thomas Winegardner, the Medical Director, reviews comprehensive assessments with a risk rating of 3 or higher in dimensions 1 or 2	n/a
	(b) Assessment summaries must include documentation of whether or not the client's placement is aligned with the level of care recommendation for the client as determined by the Department's 1115 Assessment and Placement Table. The assessment summary must include documentation of the clinical rationale for why a level of care being provided to the client differs from the level of care recommended for the client by the department's 1115 Demonstration Assessment and Placement Table.	NorthStar Regional is modifying the assessment summary to include documentation of the clinical rationale for why the level of care being provided to the client is aligned with the recommendation or if the level of care being provided is different.	April 1, 2021

DEPARTMENT OF HUMAN SERVICES

INDIVIDUAL TREATMENT PLAN

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	Enrolled demonstration providers licensed under chapter 245G or other applicable standards must meet the following additional requirements: (a) The treatment plan must include: (1) a goal for transition planning considering factors such as proximity to an individual's support network including but not limited to, family members, employment, counseling and other services near an individual's place of residence.	The treatment plan will include a goal for transition planning that identify and include factors such as proximity to a client's support network to include: family members, employment, counseling, housing and other factors. NorthStar Regional is modifying the treatment plan and educating staff to be able to accomplish this.	April 1, 2021
	(2) how cultural and socioeconomic factors affecting the patient's access to services are being addressed when needed;	The treatment plan will include how identified cultural and socioeconomic factors affecting the client's access to services are being addressed.	April 1, 2021
	(b) A treatment plan for an adolescent client must include maintenance strategy goals and methods that address relapse prevention and strengthening of protective factors.	We do not offer treatment services for adolescent clients.	

DEPARTMENT OF HUMAN SERVICES

TREATMENT COORDINATION

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	Enrolled demonstration providers licensed under chapter 245G or other applicable standards must include documentation of the following additional treatment coordination activities: (a) Facilitation of referrals to other levels of care established through the license holder's formal patient referral arrangements required in item IV(a)(1);	NorthStar Regional has completed multiple Patient Referral Arrangement Agreements. If NorthStar Regional is unable to admit a client to a level of care we provide, we will refer the client to another program that we have a Patient Referral Agreement.	N/A
	(b) Ongoing coordination between the demonstration provider and the provider of services the client was referred to that includes: (1) Referrals to other levels of care as identified in (a)	NorthStar Regional will maintain Patient Referral Arrangement Agreements for each level of care not offered through our programs.	N/A
	(2) Treatment coordination services described in section 245G.07, subdivision 1, paragraph (a), clause (5); and	Treatment coordination services will be documented in the client's file. The coordination of services are but not limited to: involving client's support network in treatment planning; coordinate follow-up services, referrals for other care, referrals to services/care that assist with client needs as well as referrals to long-term services and support.	N/A
	(3) Consultation, referral, and treatment services defined in item IV	NorthStar Regional provides co-occurring services, provide peer recovery services, 24/7 access to the Medical Director, access to client's file for documentation of all services provided. Staff on site are trained in medication administration and/or monitoring with access 24/7 via phone or in-person medical consultation. The client is provided with the appropriate level of care for co-occurring treatment services. The client and the Medical Director will collaborate and determine an appropriate course of treatment.	N/A

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(b) Follow up on the services the client was referred to in (b).	Treatment planning and services will include in documentation of treatment plan or services the cultural differences and special needs of a client that have been identified. The identified cultural differences and special needs will be documented in the client's individual treatment plan.	N/A

DOCUMENTATION OF TREATMENT SERVICES; TREATMENT PLAN REVIEW

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	The review of all treatment services performed by enrolled demonstration providers licensed under chapter or other applicable standards must also document reviews of the following: (a) Services offered to the client's family or significant others	Services offered to the client's family or significant other as part of treatment coordination and treatment planning is documented in the individual treatment plan	N/A
	(b) Biomarkers and toxicology results when such results are available;	Biomarkers and toxicology results are reviewed, discussed and documented when results are available in a one to one session. The information is documented in the individual treatment plan	N/A

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(c)Peer recovery support services;	Peer recovery support services will be implemented into the treatment services. These services will be documented in the client's file.	April 1, 2021
	(d)Treatment coordination activities that include the additional treatment coordination requirements defined in item VII;	Treatment coordination involves all staff involved in the client's treatment. It will include referrals as well as ongoing coordination of services and the facilitation of the identified services. This will be documented in the client's file as well as in the individual treatment plan.	N/A
	(e)Interdisciplinary treatment recommendations that include the following: (1)Consultation, referral, and treatment services required in item IV; and (2)Collaboration with continuing care mental health providers as required in section 245G.20.	NorthStar Regional has an interdisciplinary team that consults, refers, identifies treatment services, and collaborates with continuing care providers. The interdisciplinary team meets weekly and includes: medical director, mental health provider, primary counselor, director, LPNs, RNs and others.	N/A
	(f)Progress made on transition planning goals;	The client's individual treatment plan is utilized to document the progress made on transition planning goals. It will include how cultural and socio-economic factors are being addressed as well as considering factors such as proximity to support network, employment, counseling, residence and other factors	April 1, 2021
	(g)Adolescent treatment plan reviews must include ongoing assessment of: (1)Parent or legal guardian supervision when available; (2)School and peer relationships; and (3)Warning signs of recurrence of affective disorders	NorthStar Regional does not provide treatment services to adolescents.	

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(h)The treatment plan review requirements defined in 245G.06, subdivision 3(c) must include the additional treatment services defined in this section.	NorthStar Regional will provide documentation of treatment services; treatment plan review. In addition to the treatment ~~plan review~~ service documentation and review requirements defined in 245G.06, subdivision 3(c) will also include a review of the biomarkers, and toxicology results when the results are available, a review of peer recovery support services and a review of treatment coordination activities that include additional treatment coordination requirements in item 7(c).	April 1, 2021

DEPARTMENT OF HUMAN SERVICES

POLICIES AND PROCEDURES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	Enrolled demonstration providers licensed under chapters 245F, 245G or other applicable standards must develop written program policies and procedures describing how the requirements in items through IV through VIII will be met.	NorthStar Regional has developed written program policies and procedures describing how the requirements will be met. These policies will be included in the program's policy and procedures.	April 1, 2021
	(a)1115 Substance Use Disorder System Reform Enrollment Checklist. Enrolled demonstration providers licensed under chapters 245F, 245G or other applicable standards must maintain a copy of their approved enrollment checklist in the program's policy and procedure manual. Providers must implement the additional requirements identified on the enrollment checklist by the date identified in, "Date the requirement will be implemented" column of the checklist.	The 1115 Substance Use Disorder System Reform Enrollment Checklist will have an approved copy placed in the program's policy and procedure manual with the "Date the requirement will be implemented" by the identified date.	April 1, 2021
	(b)Description of Treatment Services. Enrolled demonstration providers licensed under chapters 245F, 245G or other applicable standards must develop a policy and procedure containing a description of treatment services which includes the following items where applicable; (1)How interdisciplinary treatment recommendations from treatment services, consultations and referrals provided to a client as required in item IV will be incorporated into the documentation of treatment services and treatment plan reviews required in item VIII.	NorthStar Regional have an interdisciplinary treatment meeting once per week. The recommendations from the interdisciplinary team are documented and incorporated into the documentation of treatment services and the individual treatment plan.	April 1, 2021
	(2)How the enrolled provider will deliver the required amount of treatment services for each level of care offered and defined in item X including how the license holder will deliver the services according to each client's specific treatment schedule as directed by the individual treatment plan.	In the level of care requirements; NorthStar Regional staff reviews the client's comprehensive assessment, meet with the client to review the assessment and to develop a treatment plan and create treatment goals identified in their treatment plan to create a treatment schedule that meets or exceeds the requirements.	April 1, 2021

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(3)How the enrolled provider's methods used to achieve desired client outcomes will incorporate at least three of the following evidence-based practices: (i)12-step facilitation therapy; (ii)Brief cognitive behavioral therapy; (iii)Motivational interviewing; (iv)Contingency management.	NorthStar Regional utilizes at least three of the identified evidence-based practices in the treatment program through groups and in individual sessions/treatment services.	N/A
	(4)A description of the treatment coordination activities designed to support the use of the enrolled provider's formal patient referral arrangements required in IV(a)(1); and	If NorthStar Regional is unable to admit a client to a level of care offered by us, we will refer to another program through NorthStar Regional's care coordinator or case manager to another program that we have a Patient Referral Arrangement Agreement on file.	N/A
	(4)Referral procedures that a provider will implement when the program is unable to admit a client to a level of care offered by the program.	If NorthStar Regional is unable to admit a client to a level of care offered by the program, we will refer to another program through NorthStar Regional's care coordinator or case manager to another program that we have a Patient Referral Arrangement Agreement on file	N/A
	(c)Program Outreach Plan. Enrolled demonstration providers licensed under chapters 245F, 245G or other applicable standards must develop and maintain a program outreach plan. The treatment director must review and update the plan annually. The program outreach plan must include additional treatment coordination strategies and processes to ensure seamless transitions across the continuum of care and must include how the provider will:		
	(1) Increase the awareness of early intervention treatment services, including but not limited to, the services defined in section 254A.03, subdivision 3, paragraph (c);	The outreach plan will include additional treatment coordination strategies and processes to ensure seamless transitions across the continuum of care to increase awareness of early intervention treatment services.	April 1, 2021

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(2)Coordinate, as necessary, with Certified Community Behavioral Health Clinics when a demonstration provider is located in a geographic region served by a Certified Community Behavioral Health Clinic;	We will coordinate care with certified community Behavioral Health Clinics when the geographic location is in an acceptable proximity for the client.	April 1, 2021
	(3)Establish a referral arrangement agreement with a Withdrawal Management program licensed under chapter 245F when a demonstration provider is located in a geographic region served by a Withdrawal Management program licensed under chapter 245F. If a Withdrawal Management program licensed under chapter 245F is not geographically accessible, the plan must include how the provider will address the client's need for this level of care;	NorthStar Regional has a Patient Referral Arrangement Agreement with Project Turnabout.	N/A
	(4)Coordinate with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers in the area served by the provider to help transition individuals from emergency department or hospital settings and minimize the time between assessment and treatment;	NorthStar Regional coordinates with these providers to minimize the time between assessment and treatment.	N/A
	(5)Develop and maintain collaboration with local county and tribal human services agencies; and	NorthStar Regional has an ongoing collaboration with local county and tribal human services agencies.	N/A
	(6)Collaborate with primary care and mental health settings.	NorthStar Regional collaborates with primary care providers and mental health settings/ providers.	N/A

DEPARTMENT OF HUMAN SERVICES

LEVEL OF CARE REQUIREMENTS

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	Enrolled demonstration providers licensed under chapter 245G or other applicable standards must be able to provide the following amounts of treatment services per week according to each client's specific treatment schedule as directed by the individual treatment plan:		
	(a)Up to 8 hours of skilled treatment services for adults and up to 6 hours of skilled treatment services for adolescents in a Level 1.0 Outpatient program.	NorthStar Regional provides 8 hours of skilled treatment services for adults in Level 1.0 Outpatient programming	N/A
	(b)Between 9 and 19 hours of skilled treatment services for adults and between 6 and 19 hours of skilled treatment services for adolescents in a Level 2.1 Intensive Outpatient program.	NorthStar Regional provides between 9 and 19 hours of skilled treatment services for adults in a level 2.1 Intensive Outpatient program.	N/A
	(c)At least 5 hours in a Level 3.1 Clinically Managed Low-Intensity Residential program. Treatment service hours must consist of a combination of skilled treatment services, peer recovery services and treatment coordination.		

DEPARTMENT OF HUMAN SERVICES

	1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement. If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented. (N/A if requirement is already met)
	(d)At least 30 hours in a Level 3.3 Clinically Managed Population-Specific High-Intensity Residential program. Treatment service hours must consist of a combination of skilled treatment services, peer recovery services and treatment coordination. Level 3.3 Clinically Managed Population-Specific High-Intensity Residential license holders must be enrolled as a culturally specific program as described in section 254B.05, subdivision 5, paragraph (c), clause (2) and must specialize in serving persons with a traumatic brain injury or a cognitive impairment so significant, and the resulting level of impairment so great, that outpatient or other levels of residential care would not be feasible or effective.		
	(e)At least 30 hours in a Level 3.5 Clinically Managed High-Intensity Residential program. Treatment service hours must consist of a combination of skilled treatment services, peer recovery services and treatment coordination.		

Patient Referral Arrangement Agreement

Level 1.0:

Project Turnabout

Nystrom & Associates

Level 2.1:

Project Turnabout

NuWay

Nystrom & Associates

Level 3.1:

Project Turnabout

NuWay

Level 3.3:

Vinland National Center

Level 3.5:

Project Turnabout

Level 3.7:

Project Turnabout

Patient Referral Arrangement Agreement

Patient Referral Arrangement Agreement between **Northstar Regional** and **Vinland National Center**

This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by **Northstar Regional** as required in MS section 256B.0759, subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)

We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.

_____ **Level 1.0 Outpatient Treatment Services**

_____ **Level 2.1 Intensive Outpatient Treatment Services**

_____ **Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services**

_____ **Level 3.2 Clinically Managed Residential Withdrawal Management**

__X__ **Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services**

_____ **Level 3.5 Clinically Managed High-Intensity Residential Treatment Services**

_____ **Level 3.7 Medically Monitored Inpatient Withdrawal Management**

Assurance of Client Choice

Each party acknowledges that all clients have the freedom to choose (request) a provider and level of care up to and including the level of care recommended. Neither party has received an inducement nor other consideration in exchange for entering this agreement, nothing within this agreement requires or is intended to require payment, each party remains separate and independent.

Term and Termination

This agreement may be terminated at any point, by either party, by giving notice to the other entity. Termination of the agreement will require the originating provider to secure a new agreement with a provider that will offer the level(s) of care not provided by the originating provider.

Privacy and Confidentiality of Consumer Information

Care will be coordinated in a manner that complies with privacy and confidentiality requirements. Each party will request consumers consent for disclosure of their health information, in accordance with state and federal law. Each party will follow consumer preferences for shared protected health information. This section shall survive termination of this agreement.

Signatures

Originating Provider: _____ Date: 9/10/2020

Referral Provider: MS Rouse Date: 09/10/2020

Patient Referral Arrangement Agreement

Patient Referral Arrangement Agreement between Vinland National Center and Northstar Regional

This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by VINLAND NATIONAL CENTER as required in MS section 2568.0759, subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)

We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.

- X **Level 1.0 Outpatient Treatment Services**
- X **Level 2.1 Intensive Outpatient Treatment Services**
- ____ **Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services**
- ____ **Level 3.2 Clinically Managed Residential Withdrawal Management**
- ____ **Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services**
- X **Level 3.5 Clinically Managed High-Intensity Residential Treatment Services**
- ____ **Level 3.7 Medically Monitored Inpatient Withdrawal Management**

Assurance of Client Choice

Each party acknowledges that all clients have the freedom to choose (request) a provider and level of care up to and including the level of care recommended. Neither party has received an inducement nor other consideration in exchange for entering this agreement, nothing within this agreement requires or is intended to require payment, each party remains separate and independent.

Term and Termination

This agreement may be terminated at any point, by either party, by giving notice to the other entity. Termination of the agreement will require the originating provider to secure a new agreement with a provider that will offer the level(s) of care not provided by the originating provider.

Privacy and Confidentiality of Consumer Information

Care will be coordinated in a manner that complies with privacy and confidentiality requirements. Each party will request consumers consent for disclosure of their health information, in accordance with state and federal law. Each party will follow consumer preferences for shared protected health information. This section shall survive termination of this agreement.

Signatures

Originating Provider: MSRachl Date: 09/10/2020

Referral Provider: [signature] Date: 9/10/2020

Patient Referral Arrangement Agreement

Patient Referral Arrangement Agreement between Project Turnabout and NorthStar Regional

This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by (Project Turnabout) as required in MS section 256B.0759, subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)

We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.

__X___ Level 1.0 Outpatient Treatment Services
__X___ Level 2.1 Intensive Outpatient Treatment Services
_____ Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services
_____ Level 3.2 Clinically Managed Residential Withdrawal Management
_____ Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services
__X___ Level 3.5 Clinically Managed High-Intensity Residential Treatment Services
_____ Level 3.7 Medically Monitored Inpatient Withdrawal Management

Assurance of Client Choice

Each party acknowledges that all clients have the freedom to choose (request) a provider and level of care up to and including the level of care recommended. Neither party has received an inducement nor other consideration in exchange for entering this agreement, nothing within this agreement required or is intended to require payment, the level(s) of care not provided by the originating provider.

Term and Termination

This agreement may be terminated at any point, by either party, by giving notice to the other entity. Termination of the agreement will require the originating provider to secure a new agreement with a provider that will offer the level(s) of care not provided by the originating provider.

Privacy and Confidentiality of Consumer Information

Care will be coordinated in a manner that complies with privacy and confidentiality requirements. Each party will request consumers consent for disclosure of their health information, in accordance with state and federal law. Each party will follow consumer preferences for shared protected health information. This section shall survive termination of this agreement.

Signatures

_____ Date: 9-9-2020
Referral Provider

_____ Date: 9-8-20
Originating Provider

Patient Referral Arrangement Agreement

Patient Referral Arrangement Agreement between NorthStar Regional and Project Turnabout

This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by (NorthStar Regional) as required in MS section 256B.0759, subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)

We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.

__X___ **Level 1.0 Outpatient Treatment Services**
__X___ **Level 2.1 Intensive Outpatient Treatment Services**
__X___ **Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services**
__X___ **Level 3.2 Clinically Managed Residential Withdrawal Management**
_____ **Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services**
__X___ **Level 3.5 Clinically Managed High-Intensity Residential Treatment Services**
__X___ **Level 3.7 Medically Monitored Inpatient Withdrawal Management**

Assurance of Client Choice

Each party acknowledges that all clients have the freedom to choose (request) a provider and level of care up to and including the level of care recommended. Neither party has received an inducement nor other consideration in exchange for entering this agreement, nothing within this agreement required or is intended to require payment, the level(s) of care not provided by the originating provider.

Term and Termination

This agreement may be terminated at any point, by either party, by giving notice to the other entity. Termination of the agreement will require the originating provider to secure a new agreement with a provider that will offer the level(s) of care not provided by the originating provider.

Privacy and Confidentiality of Consumer Information

Care will be coordinated in a manner that complies with privacy and confidentiality requirements. Each party will request consumers consent for disclosure of their health information, in accordance with state and federal law. Each party will follow consumer preferences for shared protected health information. This section shall survive termination of this agreement.

Signatures

_____ Date: 9-8-20
Referral Provider

_____ Date: 9-9-2020
Originating Provider

Patient Referral Arrangement Agreement

Patient Referral Arrangement Agreement between North Star Regional and Nystrom & Associates

This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by (enter name of originating provider) North Star as required in MS section 256B.0759, subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)

We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.

X **Level 1.0 Outpatient Treatment Services**

X **Level 2.1 Intensive Outpatient Treatment Services**

____ **Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services**

____ **Level 3.2 Clinically Managed Residential Withdrawal Management**

____ **Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services**

____ **Level 3.5 Clinically Managed High-Intensity Residential Treatment Services**

____ **Level 3.7 Medically Monitored Inpatient Withdrawal Management**

Assurance of Client Choice

Each party acknowledges that all clients have the freedom to choose (request) a provider and level of care up to and including the level of care recommended. Neither party has received an inducement nor other consideration in exchange for entering this agreement, nothing within this agreement requires or is intended to require payment, each party remains separate and independent.

Term and Termination

This agreement may be terminated at any point, by either party, by giving notice to the other entity. Termination of the agreement will require the originating provider to secure a new agreement with a provider that will offer the level(s) of care not provided by the originating provider.

Privacy and Confidentiality of Consumer Information

Care will be coordinated in a manner that complies with privacy and confidentiality requirements. Each party will request consumers consent for disclosure of their health information, in accordance with state and federal law. Each party will follow consumer preferences for shared protected health information. This section shall survive termination of this agreement.

Signatures

Originating Provider: [signature] Date: 8/18/20

Referral Provider: Kevin J. Evenson Date: 8/18/20

Patient Referral Arrangement Agreement

Patient Referral Arrangement Agreement between Nystrom & Associates and North Star Regional

This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by (enter name of originating provider) Nystrom & Associates as required in MS section 256B.0759, subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)

We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.

- X Level 1.0 Outpatient Treatment Services
- X Level 2.1 Intensive Outpatient Treatment Services
- _____ Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services
- _____ Level 3.2 Clinically Managed Residential Withdrawal Management
- _____ Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services
- X Level 3.5 Clinically Managed High-Intensity Residential Treatment Services
- _____ Level 3.7 Medically Monitored Inpatient Withdrawal Management

Assurance of Client Choice

Each party acknowledges that all clients have the freedom to choose (request) a provider and level of care up to and including the level of care recommended. Neither party has received an inducement nor other consideration in exchange for entering this agreement, nothing within this agreement requires or is intended to require payment, each party remains separate and independent.

Term and Termination

This agreement may be terminated at any point, by either party, by giving notice to the other entity. Termination of the agreement will require the originating provider to secure a new agreement with a provider that will offer the level(s) of care not provided by the originating provider.

Privacy and Confidentiality of Consumer Information

Care will be coordinated in a manner that complies with privacy and confidentiality requirements. Each party will request consumers consent for disclosure of their health information, in accordance with state and federal law. Each party will follow consumer preferences for shared protected health information. This section shall survive termination of this agreement.

Signatures

Originating Provider: Kelsey Swenson Date: 8/18/20

Referral Provider: _____ Date: 8/18/20

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DHS-7309-ENG

Patient Referral Arrangement Agreement

Patient Referral Arrangement Agreement between NorthStar Regional and NUWAY

This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by (enter name of originating provider) NorthStar Regional as required in MS section 2568.0759, subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)

We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.

- [ ] **Level 1.0 Outpatient Treatment Services**
- [x] **Level 2.1 Intensive Outpatient Treatment Services**
- [x] **Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services**
- [ ] **Level 3.2 Clinically Managed Residential Withdrawal Management**
- [ ] **Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services**
- [ ] **Level 3.5 Clinically Managed High-Intensity Residential Treatment Services**
- [ ] **Level 3.7 Medically Monitored Inpatient Withdrawal Management**

Assurance of Client Choice

Each party acknowledges that all clients have the freedom to choose (request) a provider and level of care up to and including the level of care recommended. Neither party has received an inducement nor other consideration in exchange for entering this agreement, nothing within this agreement requires or is intended to require payment, each party remains separate and independent.

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Privacy and Confidentiality of Consumer Information

Care will be coordinated in a manner that complies with privacy and confidentiality requirements. Each party will request consumers consent for disclosure of their health information, in accordance with state and federal law. Each party will follow consumer preferences for shared protected health information. This section shall survive termination of this agreement.

Signatures

DocuSigned by:

Originating Provider: [signature] Date: 7/28/2020

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DocuSigned by:

Referral Provider: Erin Roberts Date: 7/28/2020

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DocuSign Envelope ID: 89D1DCD0-CAF5-48C1-BD9A-03EFB05C66EA

DHS-7309-ENG

Patient Referral Arrangement Agreement

Patient Referral Arrangement Agreement between NUWAY and NorthStar Regional

This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by (enter name of originating provider) NUWAY as required in MS section 256B.0759, subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)

We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.

- [x] **Level 1.0 Outpatient Treatment Services**
- [x] **Level 2.1 Intensive Outpatient Treatment Services**
- [ ] **Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services**
- [ ] **Level 3.2 Clinically Managed Residential Withdrawal Management**
- [ ] **Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services**
- [x] **Level 3.5 Clinically Managed High-Intensity Residential Treatment Services**
- [ ] **Level 3.7 Medically Monitored Inpatient Withdrawal Management**

Assurance of Client Choice

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Signatures

DocuSigned by:

Originating Provider: Erin Roberts Date: 7/28/2020

DocuSigned by:

Referral Provider: Date: 7/28/2020

What levels of care does NorthStar Regional Provide and where?

Level 1.0:

1045 – Sugar Creek

Maple Grove

Level 2.1:

1045 – Sugar Creek

1055 – Sugar Creek

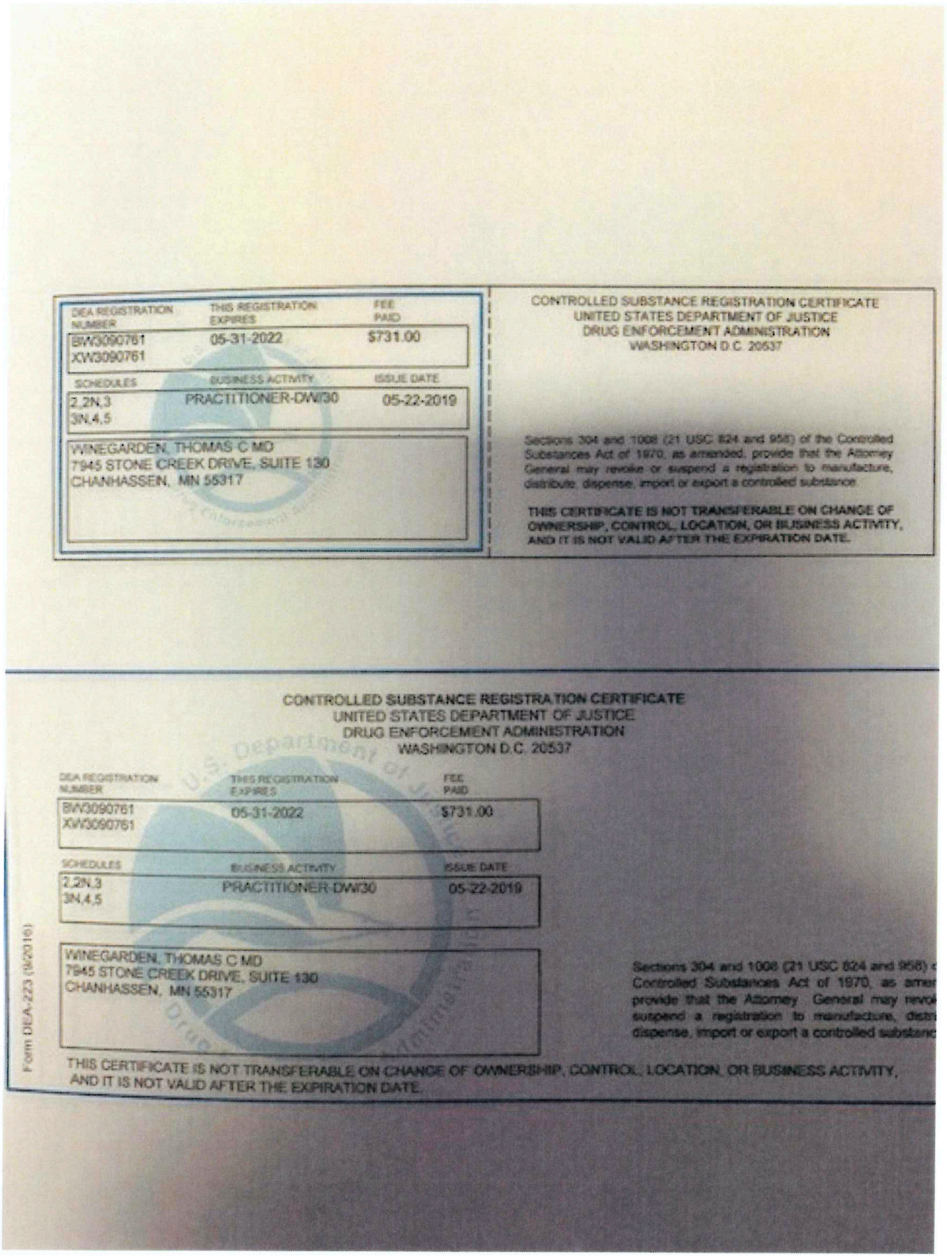
7945 - Chanhassen

Maple Grove

Level 3.5:

MRTC

WRTC



CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BW3090761 XW3090761	05-31-2022	$731.00

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,3 3N,4,5	PRACTITIONER-DW/30	05-22-2019

WINEGARDEN, THOMAS C MD
7945 STONE CREEK DRIVE, SUITE 130
CHANHASSEN, MN 55317

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BW3090761 XW3090761	05-31-2022	$731.00

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,3 3N,4,5	PRACTITIONER-DW/30	05-22-2019

WINEGARDEN, THOMAS C MD
7945 STONE CREEK DRIVE, SUITE 130
CHANHASSEN, MN 55317

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

9 Policy and Procedure Review Signature Page

This Policy and Procedure Manual will be reviewed annually. The signatures below indicate this manual has been reviewed and approved by the following personnel of NorthStar Regional Corporation.

Name	Title	Signature and Date
Jason Vanderscoff	CEO NorthStar Regional	3/31/21
Harold Baumchen	President NorthStar Regional	3/31/21

APPENDIX A

HIV TRAINING IN CHEMICAL DEPENDENCY TREATMENT PROGRAMS, 2015 edition
as required in Minnesota Statute 245A.19
This publication is a joint venture between the Alcohol and Drug Abuse Division, DHS and the Minnesota AIDS Project.

Chapter 1-Introduction to HIV/AIDS Basic HIV information Available in MN
HIV Basics

Many significant changes have occurred in recent years in the treatment of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). This impacts substance abuse treatment practices in complex ways. HIV is a community issue and one that still generates a great deal of misunderstanding and stigma. Each individual can take proper steps in knowing their own status and remaining safe to help stop the spread of HIV.
Common misconceptions and fears are huge roadblocks in the fight against this disease so prevention and education is critical. Because substance abuse and the HIV/AIDS pandemic are so interrelated, substance abuse treatment can play an important role in helping substance abusers reduce risk-taking behavior, thus helping to reduce the incidence of HIV/AIDS. (TIP 37; SAMHSA, 2008).

What is HIV?
Human – because the virus can only infect human beings. Although similar diseases exist in other animals, such as monkeys and cats, those viruses cannot infect humans nor can HIV infect other animals.
Immunodeficiency – because the virus creates a deficiency with the body's immune system, causing it to fail to work properly.
Virus – because the organism is a virus which is incapable of reproducing by itself; it must use a human cell to reproduce.
HIV (Human Immunodeficiency Virus) is a virus that affects certain white blood cells—CD4 T cells—that manage human immune system responses. When these blood cells are damaged, it becomes difficult for people to fight off infections or diseases.

What does AIDS stand for?
Acquired – because HIV is not a condition passed on genetically; a person has to become infected with it.
Immune – because the immune system's ability to fight off viruses and bacteria becomes much less effective.
Deficiency – because the immune system fails to work properly.
Syndrome – because there are a wide range of diseases and infections a person may experience. When HIV disease was first recognized in the early 1980s, it was called AIDS. Today, the term "HIV disease" is a more accurate description of the condition. However, AIDS is still used, primarily for the purpose of counting infections and as a description for advanced–stages of HIV disease. AIDS refers to individuals who have particular "AIDS–defining" conditions such as a very low CD4 white blood cell count or specific illnesses.

How does HIV cause illnesses?
HIV reproduces continuously in the body from the first day of infection. A person may experience severe flu-like symptoms during this initial stage of infection which can last 2-4 weeks. A person's immune system attacks HIV soon after infection and at first is able to clear a large amount of virus from the body every 24 hours. However, for each virus particle cleared, at least one new one is created. The body's initial, vigorous anti–HIV response creates a temporary equilibrium between immune cells and the virus that may last for months or even years. After the initial infection, a person typically will show no outward signs of illness for a number of years. Over time, however, the virus gains the upper hand. The amount of HIV in the body (viral load) increases and the CD4 T cell count declines. The immune system cannot work properly under constant attack from HIV. Eventually, the virus overwhelms the defenses of the immune system, which then can no longer ward off other illness–causing infections, some of which can be life threatening. There are now many medications a person living with

HIV can take to slow the progression of the disease. When taken as prescribed, these medications can keep a person's health stable for a very long time. When taken as prescribed these medications can also greatly reduce the ability to pass on the virus to others. These medical therapies will be discussed further in chapter 2.

HIV Transmission
Understanding how HIV can and cannot be transmitted is at the core of preventing new infections. HIV is a rapidly changing virus but, thankfully, it is also entirely preventable. In this section, you can learn more about how HIV is transmitted and how to reduce your, or others', risk of being infected. Below are several key points to understand with HIV transmission.

HIV Must Be Present
Infection may only occur if one of the people involved in an exposure situation is infected with HIV. Some people assume that certain behaviors or exposure situations can cause HIV disease, even if the virus is not present. This is not true. **There Needs to Be Enough Virus**
The concentration of HIV determines whether infection will occur. In blood, for example, the virus is very concentrated. A small amount of blood is enough to infect someone. The concentration of virus in blood, semen vaginal fluid or breast milk can change, in the same person, over time. Persons who take HIV medications as prescribed can have very low quantities of HIV present in bodily fluids, greatly reducing the risk of transmitting HIV to their partners or their infants. It is important to note that HIV is a very fragile virus which will die quickly when exposed to light and air. Exposure to small amounts of dried blood or other infectious fluids is not a realistic risk for HIV transmission.

HIV Must Get Into the Bloodstream
It is not enough to be in contact with an infected fluid for HIV to be transmitted. Healthy, intact skin does not allow HIV to get into the body. HIV can enter through an open cut or sore, or through contact with mucous membranes. Transmission risk is very high when HIV comes in contact with the more porous mucous membranes in the genitals, the anus, and the rectum which are inefficient barriers to HIV. Although very rare, transmission is also possible through oral sex because body fluids can enter the bloodstream through cuts in the mouth. Infectious Fluids – HIV can be transmitted from an infected person to another through:

- _Blood
- _Semen (including pre–seminal fluid)
- _Vaginal secretions
- _HIV can also be transmitted through breast milk expressed through feeding, in limited circumstances, where there is exposure to large quantities.

HIV Transmission Routes
HIV can enter the body through open cuts or sores and by directly infecting cells in mucous membranes. HIV cannot cross healthy, unbroken skin. Unprotected sexual intercourse (vaginal, and anal), sharing needles for injection drug use and mother to child transmission (in utero, during delivery, and breastfeeding) are the main transmission routes for the HIV virus.

Sexual Transmission
Sexual activity is the most common way for HIV to be transmitted. HIV can be transmitted through sexual intercourse, both vaginal and anal. HIV can easily pass through the mucus membranes in the vagina and the anus, or may pass through cuts and sores. Although very

rare, HIV can also be transmitted through oral sex. Conditions such as bleeding gums and poor oral health increase the risk of transmission through oral sex.

Anal Sex
Anal sex without a condom is the riskiest activity for HIV transmission. The receptive partner is at the greatest risk because anal tissue is easily bruised or torn during sex which then provides easy access to the bloodstream for HIV carried in semen. The insertive partner is also at some risk because the membranes inside the urethra can provide entry for HIV into the bloodstream. The presence of other sexually transmitted infections can increase the risk of HIV transmission during anal sex.

Vaginal Sex
Unprotected vaginal sex is also considered risky for HIV transmission. The female is at the greatest risk because the lining of the vagina is a mucous membrane which can provide easy access to the bloodstream for HIV carried in semen. The male is also at some risk because the membranes inside the urethra can provide an entry for HIV into the bloodstream. The presence of other sexually transmitted infections can increase the risk of HIV transmission during vaginal sex.

Oral Sex with a Man
The risk of HIV transmission through oral sex with a man is very low because the mouth is an unfriendly environment for HIV. Saliva contains enzymes that break down the virus and the mucous membranes in the mouth are more protective than anal or vaginal tissue. There are a few documented cases where it appears that HIV was transmitted orally and those cases are attributed to ejaculation into the mouth. The minimal risk of transmission from oral sex with a man is only for the person performing the oral sex. Open cuts and abrasions in the mouth or bleeding gums can create an entry point for HIV and increase the risk of transmission. A person receiving oral sex is generally not at risk because that person is coming into contact only with saliva, which does not transmit HIV. The presence of other sexually transmitted infections can increase the risk of HIV transmission during oral sex.

Oral Sex with a Woman
The risk of transmission through oral sex with a woman is very low because the mouth is an unfriendly environment for HIV. Saliva breaks down the virus and the mucous membranes in the mouth are more protective than anal or vaginal tissue. The minimal risk of transmission from oral sex with a woman is only for the person performing the oral sex as their mouth is in contact with vaginal fluid. However, there is little data documenting HIV transmission via oral sex from an infected woman to an uninfected person. However, performing oral sex on a woman who is menstruating increases the risk because blood has more HIV than vaginal fluid. A person receiving oral sex is generally not at risk because that person is coming into contact only with saliva, which does not transmit HIV. The presence of other sexually transmitted infections can increase the risk of HIV transmission during oral sex.

Oral to Anal Sex
Oral to anal contact (rimming) poses minimal risk for HIV transmission. However, rimming is a risk for transmission of hepatitis, parasites, and many other sexually transmitted infections.

Non–sexual Transmission
HIV can be transmitted by contact between infectious fluids and bleeding cuts or open sores in the skin. However, healthy intact skin does not allow HIV to enter the body and provides an excellent barrier against the virus. Non-sexual transmission is rare. The rare circumstances

where non-sexual transmission has occurred typically involve medical settings or accident scenes where there is a very large volume of blood exposure or a needle stick.

Injection Drug Use
Sharing syringes [including needles and works] poses a very high risk for HIV transmission. Sharing a syringe is the most efficient way to transmit the virus as it passes blood directly from one person's blood stream to another's. Sharing syringes is also a very efficient way to transmit other blood borne viruses such as Hepatitis B and Hepatitis C.

Tattoos and Piercings
There have been no documented cases of transmission of HIV by piercing or tattooing. However, there are documented cases of Hepatitis B transmission. Since Hepatitis B and HIV are transmitted by the same activities, there is a theoretical risk of HIV transmission through tattoos and piercing.

Mother to Infant Transmission
It is possible for a mother who has HIV to pass the virus to her baby by exposure to blood and vaginal fluids during birth or through breast milk during feeding. The risk of transmission from mother to child during pregnancy or birth can be greatly reduced by taking certain HIV medications as prescribed.(Re-used with permission from The Minnesota AIDS Project website).

HIV Incidence in Minnesota
The current trend in the national HIV/AIDS pandemic shows that a disproportionate number of minorities who live in inner cities are affected by or at risk for contracting HIV. This population is low income, hard to reach through traditional public health methods, and in need of a wide range of health and human services (TIP 37; SAMHSA, 2008). Although a low incidence state, Minnesota shows similar trends.

Minnesota HIV Summary:

- _There were 301 new HIV diagnoses reported in Minnesota in 2013, a decrease of 4% from 2012.
- _Great disparities in HIV diagnoses persist among populations of color and American Indians living in Minnesota.
- _Male-to-male sex remains the leading risk factor for acquiring HIV/AIDS in Minnesota.
- _New HIV diagnoses remain concentrated in the Twin Cities seven-county metro area (82% of new diagnoses in 2013).
- _Foreign-born (non-US born) persons made up nearly 1 in 5 of new HIV infections in 2013, and progress from HIV to AIDS more quickly than U.S. born persons living with HIV in Minnesota.

Additional Statistical and epidemiological HIV data for the state of Minnesota and is available from the Minnesota Department of Health at (651)- 201-5414 or online at http://www.health.state.mn.us/divs/idepc/diseases/hiv/stats/index.html
For additional information on HIV, call the MN AIDS Project AIDSline at (612)-373-2437 or 1800-248-2437. The AIDSline will supply information on HIV/AIDS and recommend organizations to contact for more information.

Chapter 2-Medical Assessment and Treatment-
HIV Testing

Getting an HIV test is the first step in a client finding out their HIV status. It's also a vital part of preventing the spread of HIV. Regardless of the result, getting an HIV test can empower clients to make decisions that are right for them and to take the necessary steps to live a healthy life. Testing for HIV is a crucial first step in engaging the HIV-infected substance abuser.

A low threshold for testing should exist when one assesses the client's level of risk for HIV. This can be determined by the following: if the client has engaged in risky behaviors; if the client has ever had a sexually transmitted disease (STD); if the client has a history of sharing drug injection equipment; or if the client is presenting with any of a number of symptoms that might indicate recent infection with HIV or early symptomatic infection.(TIP 37; SAMHSA, 2008).

Rapid HIV Tests

There are several tests currently approved by the FDA that provide results in 10 to 40 minutes. All rapid tests look for the presence of HIV antibodies. Results of rapid tests are either negative or reactive. A negative test means that no HIV antibodies were detected by the test. If the test result is negative and the individual testing has had three or more months without an HIV risk exposure, the person is considered to be negative. If the test result is negative and the individual testing has had a risk in the last three months, the person should be tested again once a full three months has passed to get a conclusive result. If the test result is reactive, meaning that HIV antibodies have been detected, a confirmatory test is required before a diagnosis of HIV infection can be given. A Western Blot test is generally used as the confirmatory test. This is done through a blood draw and processed at a medical lab. Results of this test are generally available in one to two weeks.

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Anonymous VS Confidential Testing

Changes in HIV testing funding have eliminated the option for anonymous testing at most sites. In Minnesota, anonymous testing is no longer offered due to reporting requirements. However, confidential testing continues to be available. This means a testing client's information is only used if a test is reactive, and then only to facilitate the process of linking clients to care. As noted above if a client's test result is negative, nothing further will happen with the information provided by the client. It will be kept in a secure location at the testing site. However, if a client receives a reactive test result, Minnesota's reporting law requires testing sites to pass along all identifying information about the client to the Minnesota Department of Health (MDH). This is to ensure the client receives proper medical care. Getting clients into care soon after they test HIV-positive will greatly improve their health and decrease their chance of spreading the virus. The information released to MDH is maintained confidentially and specific information about the individual is not released for public use. MDH has established very rigid protocols to protect this data and there has never been a breach of this data.

For information about out HIV testing sites, their hours and specific details about HIV testing contact the AIDSLine at 612-373-2437.

Medical Treatment Considerations

Treating HIV/AIDS is extremely complex. It is important that the medical care team have experience working with substance-abusing clients because the combination of substance abuse and HIV/AIDS poses special challenges. Integrated care is the best treatment option, and medical practitioners who work with substance abuse treatment centers should be experienced in treating HIV/AIDS patients.

Primary care staff serving HIV-infected patients with substance abuse disorders should understand and be responsive to patients' needs, potential for relapse, and cultural variations. Primary care models that are incorporated as part of substance abuse treatment programs should be evaluated to identify how they can be modified and expanded to address the special needs of the HIV-infected substance abuse disorder population.

Ideally, all treatment programs should be capable of conducting HIV risk assessments and providing basic HIV/AIDS education and counseling to clients. In addition, all programs should provide access to HIV testing and pre- and post-test counseling. If such services cannot be provided, linkages should be established with other agencies that can provide these services, (TIP 37; SAMHSA 2008).

A risk assessment tool is available on The Minnesota AIDS Project website: http://www.mnaidsproject.org/quiz/quiz.php?q=1

Quick ConnectServices in Minnesota
Quick Connect is a service of the Minnesota AIDS Project that assists HIV-positive persons in accessing such resources as transportation, insurance, emergency financial aid, and emotionally supportive services. Quick Connect can also work with individuals who are newly diagnosed, who have been out of medical care, or who are new to Minnesota to link them to on-going medical care. Quick Connect staff helps individuals by answering questions about living with HIV, assisting them in choosing an HIV clinic and making an appointment, as well as making referrals to Medical Case Management programs at both clinic and community-based Case Management programs.

For a Quick Connect appointment, contact the AIDS line at 612-373-2437.

Antiretroviral Therapy
If a client is diagnosed as HIV positive, a thorough medical history is an important step to help the clinician proceed to clinical evaluation and formulate a treatment plan. Before starting antiretroviral therapy in any patient, laboratory studies should be done and may include HIV ribonucleic acid (RNA) (or viral load), CD4+ T cell counts, blood counts, screening chemistries, syphilis, toxoplasmosis, purified protein derivative (PPD), hepatitis A, B, and C viruses, and chest x-ray. In 2015 the general medical consensus for HIV Antiretroviral treatment is to test and begin treatment as soon as possible. There are clear benefits to viral suppression. The decision to begin antiretroviral therapy in the asymptomatic patient who is also using substances is complicated. The factors that must be considered include patient willingness to begin therapy and remain adherent, the degree of immunodeficiency, the risk of disease progression as determined by plasma HIV RNA, the risks of side effects, the ongoing treatment of other medical conditions, and barriers to care, such as lack of insurance and unstable housing.

Adherence to antiretroviral treatment means that the client must follow a prescribed and Sometimes complicated treatment regimen. Adherence should be maintained because non-adherence can lead to the rapid development of drug resistance. One means to encourage adherence is to educate clients and their significant others about HIV/AIDS treatment (TIP 37; SAMHSA, 2008).

HIV and Hepatitis C Co-infection-

Hepatitis C Virus (HCV) was detected in 1989 and now there is evidence of twin epidemics emerging in the U.S. including HIV/HCV co-infected individuals. About 350,000 Americans are estimated to be co-infected. The risk factors for acquiring HCV are similar to those for HIV and include:

- _Transfusion prior to 1991
- _Injecting drug use
- _Tattooing or body piercing
- _Long term hemodialysis
- _High risk sexual contact
- _Occupational exposures to blood or blood products
- _Receiving an organ or tissue transplant from someone infected with HCV
- _Transmission from HCV-infected mother to infant.

The most common route for transmission is injecting drug use. Although sexual transmission is low for HCV, it is increased when there is concurrent HIV infection. Co-infected women are three to four times more likely to transmit HCV to their unborn children than women with HCV only. Transmission of HCV from breast feeding has not been definitively demonstrated. (MDH, 2012).

About one quarter of HIV-infected persons in the United States are also infected with Hepatitis C virus (HCV). As of December 31, 2013, 7,723 persons in Minnesota are assumed to be living with HIV. Of these people, 893, (12%) are co-infected with either Hepatitis C or B. HCV is a bloodborne virus transmitted through direct contact with the blood of an infected person. Thus, co-infection with HIV and HCV is common (50%–90%) among HIV-infected injection drug users (CDC, 2014). Progression of liver disease is accelerated among co-infected individuals, especially those with compromised immune systems from HIV infection. In co-infected persons, age at time of HCV infection, immune cell (CD4) count and level of alcohol consumption are associated with a higher rate of liver fibrosis. Without successful treatment for HCV, co-infection usually leads to an earlier death. At present, liver disease accounts for 50% of deaths among those with HIV, (MDH, 2012).The U.S. Public Health Service/Infectious Diseases Society of America guidelines recommend that all HIV-infected persons be screened for HCV infection (CDC, 2014).

HIV, Substance Use and Pain Management

Managing acute and chronic pain in HIV infected patients with substance abuse disorders can be a challenging clinical problem. As with all patients in pain, the provider's primary goal is to maximize comfort while minimizing side effects. The treatment plan and the reason for using narcotics for pain control must be clear to both provider and patient. It is important not only that the patient knows that his or her pain is taken seriously but also that narcotic use will not be extended beyond a limited period required for analgesia.

Because HIV/AIDS patients often have pain problems similar to those of cancer patients, the World Health Organization's (WHO's) "cancer pain analgesic ladder," http://www.who.int/cancer/palliative/painladder/en/, is useful as a starting point for managing pain in HIV infected persons. Setting clear limits and devising a consistent treatment plan can help to reduce the risk of medication abuse by patients (TIP 37; SAMHSA, 2008).

Alternative HIV Treatment Therapies

Care providers must be aware that HIV infected patients may be using alternative or complementary therapies; for example, acupuncture, meditation, and vitamin and herbal dietary supplements. Patients need not be discouraged from trying a therapy unless it is known to be harmful. Clinicians have a responsibility to discover, in a nonjudgmental manner, what alternative or unapproved therapies patients are using and then to obtain as much information as possible about these therapies (TIP 37; SAMHSA, 2008)

Chapter 3-Mental Health Treatment-
Coping with an HIV Diagnosis-
An HIV diagnosis is a life–altering event that will require a number of changes in order to maintain health. However, with the appropriate support and access to care, it is possible to continue living well. HIV is a challenge but one that can be met. Minnesota has a wide variety of support options to assist people living with HIV and multiple AIDS Services Organizations that serve as resources to help determine the best possible options to achieve the best possible outcomes. Along with identifying a medical health care provider, clients may want to develop the social, emotional or spiritual resources that will help them deal with tough times and make the most of the good times.

MAP AIDSLine has a list of HIV support groups in Minnesota. Health care providers may also have some suggestions. Two MAP programs, Positive Link, http://www.positivelink.org/, and PrideAlive, http://www.pridealive.org/, offer social, educational and activist opportunity to meet people who are involved in HIV advocacy and education. Contact MAP AIDSLine for additional support group suggestions and more information. (Re-used with permission from The Minnesota AIDS Project website).

Disclosing HIV Status-
A person who tests HIV positive may have a responsibility to let past and current needle–sharing and/or sexual partners know that they were exposed to HIV as soon as possible so they can be tested. It is important to note, however, that disclosure of an HIV positive person's status can put him or her at risk for bodily harm. Safety considerations should always come into play when considering how and when to disclose. A person's HIV status is private medical information and there are many factors that need to be considered when a person decides when and to whom they should disclose. Some examples to be discussed are family, friends, employers, property managers etc.

For many people, telling partners, friends and family is hard. Sometimes an HIV diagnosis brings secrets about sexual partners, sexual activity or chemical dependency out into the open. In this situation, an individual might have someone a trusted friend, relative or counselor weigh the pros and cons of disclosure with them or to practice what they want to say and how to answer questions.

Isolation and loneliness can have a negative effect on overall health and well–being. Taking the risk to tell people can be helpful in the long run. The MAP AIDSLine is a resource individuals can call and ask the MAP AIDSLine health educators questions about HIV disclosure. . **(**Re-used with permission from the Minnesota AIDS Project website).

More information related to legal aspects of disclosure can be found in Chapter 9, Legal Issues.

Substance Abuse and Mental Health- Treatment Considerations-

Individuals with substance abuse disorders, whether or not they are HIV infected, are subject to higher rates of mental health disorders than the rest of the population. Counselors working with HIV-infected substance abusers should be aware of the variety of both HIV- and substance-induced psychiatric symptoms. It is also important to recognize that psychiatric symptoms may be caused by substance abuse, HIV/AIDS, or the medications used to treat HIV/AIDS, as well as by pre-existing psychiatric disorders. Treatment programs that do not have the resources to adequately assess and treat mental illness should be closely linked to mental health services to which clients can be referred. Open lines of communication will enable personnel in both locations to be informed about a client's treatment program. Treatment staff should maintain contact with the client and continue treatment during and after the psychiatric referral.

Assessment and diagnosis of mental illness in HIV-infected substance-abusing clients is a challenge because of these clients' complex problems. Therefore, it is important to evaluate clients' behavior in context (e.g., acute depression is common in people who have just learned they are HIV positive).

Communication between medical and counseling staffs is important to ensure that cognitively impaired clients are not perceived as deceitful or manipulative. Care providers must keep in mind that cognitively impaired clients' non-adherence to treatment may be a result of the impairment and not caused by denial, resistance, or unwillingness to accept care. It is essential to set realistic treatment goals that correspond to the client's functional capacities.

Counseling is an important part of treatment for all substance abusers, including those with co-morbid psychiatric disorders. The goal of counseling is to help the HIV-infected substance abuser maintain health, achieve recovery from the substance abuse, and attain the best possible level of psychological functioning, (TIP 37; SAMHSA, 2008).

Pharmacological Treatment-
Standard pharmacologic approaches may be used to treat psychiatric disorders in HIV infected substance abusers, with some specific considerations. With highly active antiretroviral therapy, (HAART), the physician must be aware of potential drug interactions that can increase the toxicity of medications or reduce their levels in the patient's blood, resulting in decreased effectiveness and/or the development of resistance. The mental health counselor should be familiar with the symptoms that could indicate that a client is experiencing a drug interaction. When prescribing, clinicians should attempt to use the lowest effective dose to minimize side effects. With clients symptomatic with HIV/AIDS, it may be wise to begin with very low doses, of the magnitude generally associated with geriatric patients. (TIP 37; SAMHSA, 2008).

Suicidality-
Substance abusers are at increased risk of suicide. HIV-infected individuals may also be at risk of suicide, especially if they are suffering from a mood disorder. Medication should be dispensed in small amounts until a client's level of responsibility can be fully assessed. Suicide risk assessments should be completed on an ongoing basis during the treatment stay. If a client is not acutely suicidal but wants to talk about suicide, the counselor should maintain interest, allow the client to discuss his feelings, assess the severity of the client's suicidality, and obtain help if needed. The counselor should not minimize the client's experiences because talking openly about suicide decreases isolation, fear, and tension. (TIP 37; SAMHSA, 2008).

Cultural Considerations-

Therapeutic interventions must be sensitive to the culture and ethnicity of the client population. Whenever possible, therapists and support group leaders should share the culture of their clients and should speak the same language. Cultural compatibility between therapists and clients is important in creating an atmosphere of trust where sensitive issues, such as family support and group mores, can be addressed, (TIP 37; SAMHSA, 2008).

Chapter 4-Primary and SecondaryHIV Prevention and HIV Risk Reduction
HIV is like many other social and public health issues involving behavior, such as smoking, eating health foods, seatbelt use and speeding; people need to be continually reminded. HIV prevention education doesn't always reach those who need the information and for many young people they may only receive the information once while in high school. Later in life they may have many questions and that's why information about HIV prevention should be a part of on-going public health information campaigns. HIV has impacted certain communities disproportionately due to ongoing stigma and fear. Focused prevention efforts can help to engage these communities to slow the spread of HIV.

As of the end of 2013, there were 7,7 23 people known to be living with HIV in Minnesota. There are several thousand others who are also HIV-positive, but have not been tested and thus don't know their status. Advances in treatment have allowed people with HIV to live longer, healthier lives. That also means that there is a growing percentage of the population that is living with HIV. This trend will continue as long as there is not a viable vaccine for HIV.

HIV is a preventable disease but to achieve this everyone needs complete, accurate information in order to reduce their risk surrounding HIV. Ongoing age-appropriate education is necessary to raise awareness in the public and reduce new infections.

HIV Risk Reduction

Sexual Transmission Risk Reduction
Sexual activity is the most common way for HIV to be transmitted. People have varying ideas of what they think of as sexual activity. When determining risk for HIV and ways to reduce that risk, consider the range of sexual activities clients engage in. It is important to understand that the risk of HIV transmission from various sexual activities falls along a continuum. Once understanding of where certain sexual activities are on this continuum, steps to take to lower individual risk can be determined. The goal of traditional safer sex practices is to avoid getting the blood, semen or vaginal fluid of sexual partners who are HIV–positive or whose HIV status is unknown in your body. It also means to avoid having your blood, semen or vaginal fluid enter your partner if an individual is HIV–positive or their HIV status is unknown.

Antiretroviral Advances/PrEP and HIV Risk
Medical treatment is also now an important part of HIV risk reduction. If a person living with HIV is treated with anti-retroviral medications so that the amount of virus in their blood is undetectable it is much less likely for HIV to be transmitted. This is true even if there is contact with the blood, semen or vaginal fluid of the positive person. For an HIV-negative person, there is also an anti-viral medication that can be prescribed which is referred to as PrEP (Pre-Exposure Prophylaxis). When taken as prescribed, PrEP greatly reduces the risk of being infected when an HIV-negative person is exposed to HIV. When the medical treatments described above are paired with condom use, the risk of HIV transmission can be nearly zero.

What is PrEP?

PrEP is an acronym for Pre-Exposure Prophylaxis, which describes the taking of the HIV medication Truvada, with the purpose of not contracting HIV. Medical providers have been familiar with PEP, or post-exposure prophylaxis, for quite some time. Now, anyone who meets specific behavioral criteria can get a prescription for PrEP, and protect themselves from HIV. PrEP is a once-daily pill regimen that can reduce risk of HIV infection by 92-99% if adhered to daily by individuals who engage in high risk sexual or injection drug use behaviors. The Centers for Disease Control and Prevention endorsed the use of PrEP for HIV Prevention in May 2014.

Who should take PrEP?
PrEP is approved for those individuals at high risk of contracting HIV. Individuals at high risk of contracting HIV include, but are not limited to: injection drug users, people in relationships with HIV+ folks and individuals who exclusively bareback or intermittently use condoms.

Some questions to ask when considering PrEP:

- _Is your main sexual partner HIV-positive? In other words, are you part of a mixed-status couple?
- _Has a man – especially an HIV-positive man, or a man whose status you're not sure about penetrated you during anal sex ("topped" you) without a condom recently?
- _Have you been treated recently for a sexually transmitted disease in your butt, such as rectal gonorrhea?
- _Have you used PEP more than once in the past year?
- _Have you or your partner(s) been in prison?
  _Do you use alcohol and/or drugs heavily; or, does your sex partner(s)?
- _Do you exchange sex for money, housing or other needs; or, does your sex partner(s)?
- _Has your partner threatened you with violence or physically harmed you recently?

If you answer "yes" to any of these then you should consider discussing PrEP with your doctor.

Where can I get PrEP in Minnesota?
The Red Door Clinic's Health Interventions for Men (HIM) in Minneapolis accepts clients both with and without insurance, and can work with you to help with access to medication assistance. The HIM Program can be reached at 612-348-9100. More about the HIM program.

Red Door Clinic's HIM Program 525 Portland Ave, 4th floor Minneapolis MN 55415
HCMC in Minneapolis can also start individuals on PrEP. For more inquiries and more information please contact the HCMC PrEP voicemail at 612-873-9988.

How Effective is PReP?
For full effectiveness, PrEP needs to be taken every day, and prescribed individuals need regular check-ups with a medical professional. When combined with latex, polyurethane or polyisoprene condoms, one study of gay/bisexual men and transgender women reported over 99% effectiveness in preventing HIV transmission when taken every day. The Red Door's HIM Program and HCMC's Seventh Street PrEP Clinic are dedicated to providing the supportive services necessary to make PrEP work for eligible individuals.Continue reading below to learn

more about HIV risk factors and risk reduction methods for specific scenarios. (Re-used with permission from The Minnesota AIDS Project website).

Anal Sex
To reduce your risk, use a latex, polyurethane or polyisoprene condom when engaging in anal sex. Some people prefer to use "bottom condoms" which can be inserted into the rectum before engaging in anal sex. No matter which type of condom you prefer, be sure to use plenty of water–based lubricant when you have anal sex. Don't use oil–based lubricants, such as petroleum jelly or hand lotion, because oil destroys the condom and causes it to break.

Vaginal Sex
To reduce your risk, use a latex, polyurethane or polyisoprene condom when engaging in vaginal sex. Some people prefer to use female condoms which can be inserted into the vagina before engaging in sexual activity. Use plenty of water–based lubricant when you have vaginal sex. Don't use oil–based lubricants, such as petroleum jelly or hand lotion, because oil destroys the condom and causes it to break.

Oral Sex with a Man
To reduce your risk of HIV transmission completely, use a latex, polyurethane or polyisoprene condom when performing oral sex on a man. If you do not use a condom you can also reduce your risk by not having your partner ejaculate in your mouth. Talk to your partner about their sexual health and do not perform oral sex on someone who has an active sexually transmitted infection. Do not perform oral sex if you have other oral health conditions which have significantly compromised the tissue in your mouth.

Oral Sex with a Woman
There is little data documenting HIV transmission through performing oral sex on a woman. To completely eliminate HIV risk, use a barrier such as a dental dam or plastic wrap. If you do not use a barrier you can reduce your risk by not performing oral sex on a woman who is menstruating. Talk to your partner about their sexual health and do not perform oral sex on someone who has an active sexually transmitted infection. Do not perform oral sex if you have other oral health conditions which have significantly compromised the tissue in your mouth.

Oral to Anal Sex
There is little data documenting HIV transmission through oral to anal sex. When engaging in oral to anal sex you can significantly reduce the HIV risk by using a barrier such as a dental dam or plastic wrap.

Non–Sexual Transmission Risk Reduction
Injection Drug Use
One way to reduce the risk of HIV infection is to abstain from injecting drugs. Current users or those who may be at risk for substance abuse may choose to find support from treatment programs or other sources. Another way to reduce risk is to use a new syringe each time you inject and use it only once. If a person does reuse, only their own equipment should be used. Sharing injection drug equipment is always a risk form transmission of blood borne infections like HIV and Hepatitis B and C. In Minnesota, it is legal to possess ten or fewer clean syringes. Some Minnesota pharmacies sell syringes in "ten packs" to any individual (Re-used with permission from The Minnesota AIDS Project website).

Please visit the Minnesota Department of Health website for more information and a list of participating pharmacies.

http://www.health.state.mn.us/divs/idepc/dtopics/stds/mnpharmacy.html

Syringe Exchange Programs-
Needle and syringe exchange programs are a type of harm reduction program that provide clean equipment to people who inject drugs. World Health Organization (WHO) studies report that Syringe Exchange Programs significantly and cost effectively reduce the number of HIV infections without evidence that the programs exacerbate injection drug use at either an individual or societal level. In December 2011 the United States Congress reinstated a federal ban on funding for syringe exchange programs. This has further marginalized the program participants and increased barriers for implementation and optimum management of such initiatives, (AVERT.org, 2014). You can exchange your used syringes at the following locations in Minnesota:

Minnesota AIDS Project's Mainline Syringe Exchange Program
1400 Park Avenue South Minneapolis, MN 55404
http://www.mnaidsproject.org/services/prevention-testing/syringe-exchange.php

Rural AIDS Action Network Syringe Services Program-Duluth
114 1st Ave W
Duluth, MN 55802
http://www.raan.org/

Minnesota Transgender Health Coalition- The Shot Clinic
3405 Chicago Avenue South
Minneapolis, MN 55407
http://www.mntranshealth.org/index.php?option=com_content&task=view&id=65&Itemid=68

Valhalla Place- Woodbury
6043 Hudson Drive Suite 220
Woodbury, MN 55125
Phone: 651-925-8200

Valhalla Place- Brooklyn Park
2807 Brookdale Drive N.
Brooklyn Park, MN 55444
Phone: 763-237-9898

Tattoos and Piercings
There have been no documented cases of transmission of HIV by piercing or tattooing. However, there is a theoretical risk for transmission of HIV and other blood borne viruses. To eliminate your risk only use licensed tattoo and piercing services that comply with universal precautions.

Reducing Risk from Mother to Infant During Pregnancy, Childbirth and Breastfeeding
In the United States, reducing the risk of transmitting HIV from mother to child during pregnancy or childbirth has been a success story. With the use of antiviral therapy during pregnancy, the rate of transmission for HIV–positive women to their infants has decreased overall from 25 percent to less than two percent. It is recommended that all pregnant women who do not know their HIV status have an HIV test as early as possible in the pregnancy. If this test does not show the woman is HIV–positive, but she is engaged in high–risk activities,

the test should be repeated during the pregnancy, preferably three months after the last known high–risk activity. Knowing your status allows you to make the best decisions to protect your health and the health of your baby. If a woman is HIV–positive, receiving antiviral treatment for HIV will reduce the risk of transmission to two percent or less. Treatment will include anti–retroviral medication during the pregnancy, labor and delivery. In some cases a physician may decide that a cesarean section will further reduce the transmission risk, but this is not always necessary. After birth, additional steps are taken to reduce the risk of HIV infection for the infant. Antiviral therapy is given to the infant for four to six weeks. Breast milk contains HIV and it is possible for an HIV–positive woman to transmit HIV to her baby through breast feeding. Talk to your physician to determine the best alternative to breast feeding to eliminate this risk. Determining the HIV status of an infant takes time and requires repeat testing. Standard HIV tests look for the presence of HIV antibodies. Because infants of HIV–positive mothers have the mother's HIV antibodies, they will automatically test "positive" after birth. It can take up to 18 months for an infant to clear these antibodies and receive an accurate HIV antibody test. Because of this issue, physicians recommend using a testing method that looks for the presence of the actual HIV virus and can give a definitive resultin within a few months of birth.

Reducing Risk in Occupational and Controlled Exposure Settings
The best way to reduce risk in occupational settings is to use universal precautions. However, accidents can occur which involve a potential exposure putting a person at risk of infection. Post–Exposure Prophylaxis (PEP) treatment used immediately following a serious exposure that poses a demonstrated risk for HIV infection can significantly reduce the likelihood of the exposure resulting in an infection. The idea behind PEP treatment is to attack the virus with HIV antiviral drugs; this prevents the virus from starting its replication process in the body. PEP treatment is routinely used in occupational settings, particularly in healthcare settings to prevent infection from work–related exposures. In some circumstances, physicians will prescribe PEP treatment for individuals who have experienced a recent non–occupational exposure such as a sexual or injecting drug use exposure. PEP treatments typically include a combination of HIV antiretroviral drugs and will last for one month. The combination may vary depending upon the seriousness of the exposure. PEP treatments needs to start as soon as possible after an exposure and no more than 72 hours after the exposure.

Prevention Considerations in Substance Abuse Treatment-
For HIV-infected clients in substance abuse treatment, there must be a comprehensive approach to treatment that includes three goals: living substance free and sober, slowing or halting the progression of HIV/AIDS, and reducing HIV risk taking behavior.
Counselors should address the full range of potential risk behaviors in their history taking, including both syringe sharing and unsafe sex. They must take into account a wide range of sexual orientations, including those of homosexual, bisexual, heterosexual, and transgender clients. As outlined in previous sections, condom use and safer sex practices education must be a special focus of the assessment.

HIV sexual risk reduction programs should be integrated into substance abuse treatment programs. Sexual risk reduction programs should provide clients with basic information about safer sex practices, as well as an array of alternative strategies and choices that are client controlled. Counselors need to know what the client believes about HIV/AIDS, including any information the client received from other treatment professionals.

In promoting risk reduction, the alcohol and drug counselor should help the client understand the need for change, provide psychological support for behavior change, and assist the client

in developing the appropriate skills to sustain the behavior change. Discussion of risk behaviors should take place in language that is culturally appropriate, clear, and understandable.

IDU risk reduction is best approached in a step-wise fashion; for example, abstinence is the best step, no syringe use is the second best step, not sharing syringes is the third best step, using only clean syringes is the fourth best step, and so on. (TIP 37; SAMHSA, 2008).

Exposure Control in Substance Abuse Treatment Settings-
The HIV/AIDS pandemic poses a number of challenges for infection control policy and practice in substance abuse treatment programs. Treatment programs should apply the same universal precautions that exist in hospitals and other health care facilities.

The most important approach to reducing the risk of occupational HIV transmission is to prevent exposure. However, in the event of occupational exposure, substance abuse treatment programs should follow the CDC's recommendations for post-exposure prophylaxis. (See the previous section: Reducing Risk in Occupational and Controlled Exposure Settings). (TIP 37; SAMHSA, 2008).

Chapter 5-Integrating Treatment Services-
Treatment for substance abuse and HIV/AIDS should reflect the interconnected relationship they share and be coordinated as much as possible to maximize care for persons with both HIV/AIDS and substance abuse disorders. Substance abuse treatment counselors and HIV/AIDS service providers should continue to develop their skills in establishing and maintaining treatment plans that support the "total" person.

In any effort to develop integrated treatment for substance abuse and HIV/AIDS treatment, either within a single agency or through individual care plans, the following are essential: having a strong case management model, including social services as a core part of the treatment plan, crosstraining all providers in the requirements of the other treatment centers, and facilitating eligibility determinations.

Many HIV-infected substance abusers are unable to maintain total discontinuation of substance use. In dealing with clients' ongoing substance abuse, treatment programs must find a balance between abstinence-oriented approaches, where clients must immediately stop substance use, or public health–oriented approaches, where clients who cannot abruptly abstain are encouraged to reduce substance use gradually.
Counselors who work with HIV-positive substance abusers should familiarize themselves with the local AIDS Service Organizations (ASOs) and substance abuse treatment services. When establishing a network of care coordination, the provider must consider the issue of confidentiality. Providers must be aware of State and Federal laws and professional ethical codes, along with agency and community policies and agreements. The provider should understand the difference between "consent" and "informed consent." (TIP 37; SAMHSA, 2008).

Minnesota Chemical Dependency Rules and Statutes-
Statutes related to chemical dependency treatment in Minnesota can be found on the Minnesota Department of Human Services Chemical Health webpage:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_054366

Minnesota statutes specifically related to HIV and Chemical Dependency can be found on the Office of the Revisor of Statutes webpage: https://www.revisor.mn.gov/statutes/?id=245A.19

AIDS Service Organizations in Minnesota-

African American AIDS Task Force-
Provides culturally specific prevention, education and case management services for people of African descent that are living with or at risk for HIV/AIDS.
http://www.aaatf.org/

The Aliveness Project- A community center located in South Minneapolis that provides nutrition, complementary therapies and case management services to the HIV/AIDS community.
http://www.aliveness.org/

Clare Housing-
Clare Housing provides a continuum of affordable and supportive housing options that create healing communities and optimize the health of people living with HIV/AIDS.
http://www.clarehousing.org/

Delaware Street Clinic - Research, education and family services at the HIV primary care clinic for the University of Minnesota in Minneapolis.
http://www.uofmmedicalcenter.org/Clinics/InfectiousDiseaseHIVClinicDelawareStClinic

Hennepin County Public Health/ Red Door Clinic- Minnesota's largest HIV and STD testing site.
http://www.reddoorclinic.org/

Hope House- Provides housing and assisted care to individuals living with HIV who can no longer live independently.
http://www.hopehousescv.org/

Indigenous People's Task Force- HIV/AIDS education, prevention, case management and support services to the Native American community.
http://indigenouspeoplestf.org/

Minnesota AIDS Project- Harm reduction services, legal services, benefit counseling, case management, transportation, chemical health and peer support services with other persons living with HIV and advocacy for the gay and lesbian community.

http://www.mnaidsproject.org/
One Heartland- Camping and support for kids and teens with HIV/AIDS.
http://www.oneheartland.org/
Open Arms of Minnesota- Prepares and delivers meals to people living with HIV/AIDS and other chronic illnesses.\
http://www.openarmsmn.org/
Positive Care Center at Hennepin County Medical Center- Provides education, Case Management and serves as a community and family resource, and contributes extensively to the advancement of HIV-related knowledge.
http://www.hcmc.org/clinics/HCMC_CONDITIONS_80
Rural AIDS Action Network **-** Locates rural primary health care providers, HIV testing, outreach and case management.
http://www.raan.org/
Sub-Saharan African Youth and Family Services in Minnesota- Provides HIV education and materials appropriate to African-born persons throughout Minnesota, with focus on the Ethiopian and Oromo communities.
http://www.sayfsm.org/
Tubman/Chrysalis-
Provides health and human service programs to women, children and families.
http://tubman.org/
Turning Point, Inc.- Provides social services and public health programs to the African-American community in the Twin Cities metro area, including housing and HIV/AIDS case management.
http://www.ourturningpoint.org/
Westside Community Support Services, La Clinic
Provides HIV support and counseling for Spanish speaking clients.
http://www.westsidechs.org/programs.php?clinic=4
Youth and AIDS Projects- Prevention programs, counseling and testing services, financial assistance, case management, mental health services and advocacy services.
http://www.yapmn.com/
See chapter 6 for additional resources for people living with HIV available in Minnesota.

Chapter 6-Accessing and Obtaining Services-
A case management approach recognizes that satisfying such basic needs as general health and adequate housing and food when an individual is actively abusing substances can be overwhelming and that substance abusing behavior will impair a person's ability to gain access to a formalized system of services. For best outcomes, case management should be utilized in dealing with the multiple problems presented by HIV/AIDS in combination with substance abuse. Case management promotes teamwork among the various care providers. For example, linkages among the client's primary care provider, Medical/HIV case manager, mental health provider, and substance abuse treatment provider can greatly benefit the client and improve care.

It is sometimes difficult for the HIV-infected substance abuser to find and fund needed services. The case manager can play an important role in helping find specific services and navigate the plethora of public and private funding options. The counselor should be familiar with funding options for services such as substance abuse treatment, mental health treatment, medical and dental care, and HIV/AIDS drug therapy.
Counselors should be knowledgeable about the eligibility criteria, duration of service, and amount of assistance for basic financial assistance programs, including welfare, unemployment insurance, disability income, food stamps, and vocational rehabilitation. For

specific information on economic assistance available in Minnesota visit the Department of Human Services website: http://mn.gov/dhs/.

In response to implementation of the Affordable Care Act, Minnesota's health care exchange, MNSURE has partnered with six health insurance agencies across the state to offer free, in-person enrollment assistance. Certified agents and navigators will be available to answer questions, recommend plan selection and work to help you complete your enrollment. Whether you seek a competitively priced private health insurance plan, or qualify for a public program like Medical Assistance or MinnesotaCare, you can contact a lead agency listed below to schedule an appointment or request walk-in hours. For more information please visit the MNSURE webpage at https://www.mnsure.org/, or contact MNSURE by phone at 1-855-366-7873.

The Ryan White Care Act provides additional coverage for those living with HIV that may be uninsured or under-insured. More information regarding Ryan White programs can be found in Chapter 10., Funding and Policy Considerations. For information about Ryan White Programs in Minnesota please visit the Minnesota Department of Human Services webpage: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=HA_01

For a comprehensive guide to HIV related resources in Minnesota please visit the Minnesota AIDS Projects AIDSLine resource guide webpage. Or contact the AIDSline at 612-373-2437 http://www.mnaidsproject.org/resource-guide/

Chapter 7-Counseling Clients-
Before conducting any screening, assessment, or treatment planning, counselors should reassess their personal attitudes and experiences toward working with HIV infected substance-abusing 25 clients. It is important for a provider to reassess comfort level with each client because clients vary in demographic and cultural background.

Providers should identify other programs and agencies with which to network in order to provide care for their clients. At a minimum, client services should include the following in order of priority: substance abuse treatment, medical care, housing, mental health care, nutritional care, dental care, ancillary services, and support systems.

Providers must take precautions when notifying clients of HIV test results, complying with regulations to ensure that their confidentiality is preserved. Treatment providers and counselors must examine two essential factors when working with linguistically, culturally, racially, or ethnically different populations: the socioeconomic status of the client or group and the client's degree of acculturation. A distinction may need to be made between a population as a whole and a particular segment of that population.

Providers must work to develop culturally competent systems of care. One component of this involves making services accessible to and highly usable by the target risk populations. Effective systems also recognize the importance of culture, cross-cultural relationships, cultural differences, and the ability to meet culturally unique needs.

Clients facing progressive illness and disability need a variety of supportive services. The counseling of ill and dying clients should be supportive and non-confrontational, addressing issues relevant to the client's illness at a pace determined by the client. Providers should increase their proficiency at counseling clients who are at the end stages of AIDS by examining

their own beliefs about death and dying. Providers should discuss end-of-life health care options with clients, such as making a living will, appointing a health care proxy, and so on, and they should do this before clients become ill. In preparing their children for the loss of parents, clients should be practically assisted in the following areas: legal guardianship, standby guardianship, leaving a legacy of living memories, and dealing with survivor guilt. (SAMHSA, 2008).

At Risk Clients and Substance Abuse Treatment-
As previously discussed, in Minnesota HIV is disproportionately represented in specific populations. Some of these include but are not limited to men who have sex with men and transgender individuals, people who live in the Twin Cities Metro, people of African American, Latino and American Indian descent, and foreign born individuals. It is vital that treatment staff complete training to be competent in working with diverse populations and the unique issues that are relevant to at risk populations.

Chapter 8-Ethical Issues
Because providers routinely encounter emotionally charged issues when treating substance abusers, they should possess the tools to explore ethical dilemmas objectively. By doing so, and by examining their own reactions to the situation, providers can proceed with the most ethical course of action. All programs should have a consistent process for dealing with ethical concerns. While ethical issues are usually complex enough to require a case-by-case evaluation, agency practices should include a routine process for approaching an ethical issue, (TIP 37; SAMHSA, 2008).

The Need for Staff Training-
Issues relating to ethics rarely are covered in orientation sessions or continuing education activities within agencies. Perhaps this is because these issues can be so personal and there are no clear right or wrong answers in many of the case examples. Yet, the intense nature of the job and the problem solving required in the daily work of a substance abuse treatment professional require that further training about ethics be provided. This section can be a starting point for ongoing discussions among those treating persons with HIV in substance abuse treatment programs (TIP 37; SAMHSA, 2008).

The Ethics of HIV/AIDS-
Taking the most ethical course of action becomes even more complex when HIV/AIDS is thrown into the mix of concerns that the client may present. HIV/AIDS has its own unique ethical issues. Because HIV can be transmitted through sexual activity and by sharing drug equipment, it evokes significant personal feelings and judgments in the general public, as well as in health and social service providers.

Advocates for persons with HIV have fought for years to maintain confidentiality, avoid mandatory reporting, and ensure access to care for those with the disease. Because of the labels “drug abuser” or “homosexual” and the fear of a backlash toward people with HIV, advocates have been working to eliminate stigma and discrimination. This has led to creating safeguards to protect these individuals from discrimination in health care, employment, housing, and other services.

Minnesota AIDS Project launched its “HIV Stigma Stops with Me” initiative in June of 2013 with a splash of community awareness activities at the Twin Cities Pride festival. The campaign raised awareness through education and by encouraging people to sign a personal and/or organizational pledge to fight stigma. More than 700 people signed the pledge, either online

or at events in 2013 and 2014. For more information on this Campaign and other Minnesota initiatives please visit the Minnesota AIDS Project web page: http://www.mnaidsproject.org/community/hiv-stigma.php

The duty to treat, from an ethical perspective, is especially relevant when working with disenfranchised populations. A clinician involved with homeless, chronic alcohol dependent individuals may find it difficult to access services for a client with HIV. Substance abuse treatment professionals may have to take on an advocacy role within their community to educate and campaign for care. At the same time, it is important that the counselor and the counselor's agency appear accessible to all and that there are no restrictions that could impede the care of one client just because the client is different in some way. Adding restrictions to a population that is already disenfranchised will require more creativity, patience, and determination on the part of the clinician who is trying to advocate for a client, (TIP 37; SAMHSA, 2008).

Reporting HIV-
Ethical and legal HIV reporting obligations for individuals and clinicians vary from state to state. For specific information related to disclosure, reporting and legal implications visit the MN Department of Health's webpage on Reporting Human Immunodeficiency Virus (HIV), Including Acquired Immunodeficiency Syndrome (AIDS) (lab-confirmed cases). http://www.health.state.mn.us/divs/idepc/dtopics/reportable/hiv.html#who

See chapter 9 for additional legal information related to HIV/AIDS.

Chapter 9-Legal Issues
Substance abuse treatment providers may encounter discrimination against their clients as they try to connect them with services. Counselors should be familiar with Federal and State laws that protect people with disabilities and how these laws apply to HIV-infected substance abusers. Although the Federal law protecting information about clients in substance abuse treatment and State laws protecting HIV/AIDS-related information both permit a client to consent to a disclosure, the consent requirements are likely to differ. Therefore, when a provider contemplates making a disclosure of information about a client in substance abuse treatment who is living with HIV/AIDS, he or she must consider both Federal and State laws.

The rules regarding confidentiality in the provision of substance abuse treatment to persons with HIV/AIDS are very specific. Generally, no more than two sets of laws will apply in any given situation. If only substance abuse treatment information will be disclosed, a program is generally safe following the Federal rules. If HIV/AIDS– treatment-related information will be disclosed, and the disclosure will reveal that the client is in substance abuse treatment, the program must comply with both sets of laws (Federal and State). When in doubt, the best practice is to follow the more restrictive rules.

Any counselor or program considering informing someone of a client's HIV/AIDS status without the client's consent should carefully analyze whether there is, in fact, a duty to warn. It may be possible to persuade the client to communicate this information him or herself or consent to the program staff doing so. For information about criminal charges that may result after HIV transmission, as well as criminal charges that can result in a person being required to take an HIV test, please visit the Minnesota AIDS Project HIV Statutes page: http://www.mnaidsproject.org/public-policy/minnesota-hiv-statutes/criminal.php

As noted in Chapter 8, Ethical Issues, providers in Minnesota should refer to reporting and disclosure guidelines specific to the Minnesota Department of Health. http://www.health.state.mn.us/divs/idepc/dtopics/reportable/hiv.html#who

For additional legal inquiries clients and providers in Minnesota can also contact the AIDSline at 612-373-2437, or consult with the Minnesota AIDS project's legal department. Legal staff are available to assist with a variety of legal services related to HIV including confidentiality, estate planning, debt counseling, discrimination and accessibility, and benefits assistance. Please use the link below for additional information.

http://www.mnaidsproject.org/services/support-services/legal-services.php

Chapter 10-Funding and Policy Considerations
State and Federal Policy Shifts-
Dramatic changes in clinical management of HIV/AIDS have resulted in a shift from regarding AIDS as a fatal disease to a chronic one, and as a result funding urgency and need has diminished in the eyes of both policymakers and some segments of the public. Questions have been raised about why AIDS support has been so great given that other disease conditions such as cancer and heart disease kill many more people. Organizations advocating for these conditions have begun to lobby intensively for increased funding, thereby increasing competition for dollars that were allocated to HIV/AIDS.

National HIV Strategy-
In 2010, President Barack Obama committed to developing a National HIV/AIDS Strategy with three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

This strategy focuses on effective treatment as prevention. More must be done to ensure that new prevention methods are identified and that prevention resources are more strategically concentrated in specific communities at high risk for HIV infection. People who are aware of their HIV status and who are effectively engaged in antiretroviral treatment are much less likely to transmit the virus to others. For more information related to The National HIV Strategy please visit the White House's Office of National AIDS Policy: http://www.whitehouse.gov/administration/eop/onap/nhas

Mainstreaming HIV Services-
AIDS-related comprehensive treatment planning groups are increasingly recommending the mainstreaming of some services to help address fragmentation of services and funding. In some instances, this takes the form of awarding services under competitive bid processes to private or public organizations that historically have not been identified as HIV/AIDS service organizations.

Examples of mainstreaming include:

_Awarding Housing Opportunities for Persons With AIDS (HOPWA) contracts to private housing brokers who maintain lists and links of available housing units, manage vendor payments, and provide home management skills training to residents.

_Awarding home-based meal services to meal delivery organizations such as Meals on Wheels.

_Providing transportation by private bus companies and taxi-jitney services.

_Providing contracts to private providers for mental health services and spiritual counseling.

_Awarding dollars for return-to-work initiatives to work placement companies such as Goodwill Industries and Manpower Development Services.

There are several advantages to mainstreaming:

- _Increased familiarity with scopes of work for specific services.
- _Less time and effort spent in program startup Industry-wide standards of care, service, and quality are often already in place

Those considering mainstreaming services may have to address the following challenges:

- _Refragmentation of services
- _Increase in the size and complexity of multidisciplinary teams.
- _Reluctance of private sector providers to attend multidisciplinary team meetings without identifying meeting attendance as billable services.
- _Difficulties in establishing linked entries in Uniform Reporting System from private providers.
- _Possible harm to people with HIV/AIDS from providers not trained in cultural competency, HIV/AIDS, or substance abuse treatment

Ryan White HIV/AIDS Program-

The Ryan White HIV/AIDS Program works with cities, states, and local community-based organizations to provide services to an estimated 536,000 people each year who do not have sufficient health care coverage or financial resources to cope with HIV disease. The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and the development of innovative models of care.

The Ryan White HIV/AIDS Program, first authorized in 1990, is funded at $2.32 billion in fiscal year 2014. The Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). (HRSA, 2014).

Program and enrollment information on Minnesota's Ryan White assistance program, Program HH, can be found on the Minnesota Department of Human Services website: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=HA_01

For more information on current initiatives and recent information on HIV related funding and services can be located on the Health Services and Resources Administration HIV/AIDS programs webpage http://hab.hrsa.gov/.

HIV/AIDS Policy Recommendations for Minnesota- Investments in HIV Prevention and Services is Smart Public Policy-

In 2012, Minnesota experienced an 8 percent overall increase in new HIV infections, followed by a 4% reduction in 2013. Government has a responsibility to the state's public health, and HIV is a public health issue. Investment in HIV prevention and services is smart public policy and saves taxpayers in the long run ensuring that people living with HIV receive necessary medical treatment and support, assisting them with living their lives to the fullest potential, and help prevent new HIV infections.

HIV Prevention Programs Can Save Taxpayer Dollars
Minnesota currently provides approximately $1.4 million for HIV prevention programming to targeted communities. In a cost–benefit analysis of HIV prevention programs, researchers found that the lifetime costs of caring for a person living with HIV are far greater than the funding needed to reach that same individual with prevention messages. The study found that even a greatly expanded HIV prevention program in the U.S. could pay for itself through savings in averted medical care costs.

Treatment and Services for People Living with HIV are Essential
Minnesota currently provides approximately $1.2 million per fiscal year for insurance premiums and case management program support. While HIV prevention programs are a public health priority, we must also commit to ensuring that people living with HIV receive the medical care and services they need. State resources currently fund important services for people living with HIV. This includes subsidized insurance premiums for low income, or uninsured individuals. Case management programs rely on state funds to help people living with HIV manage the disease and access services necessary for their health and well being. When HIV positive individuals learn their status, receive education about HIV and how it is transmitted, and begin to receive necessary medical care and support services, they are less likely to transmit the virus to others.

Take Action
Minnesota funds targeted HIV prevention programming and services for people living with HIV with state resources from the General Fund. These resources are vital to preventing new HIV infections and helping people living with HIV to do so with respect and dignity. In these difficult financial times, it is all the more important to invest in these vital programs. Please protect state resources for HIV prevention and services.

APPENDIX B

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Division of Tuberculosis Elimination
TB EliminationTuberculosis: General Information

What is TB?
Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

What are the Symptoms of TB?
The general symptoms of TB disease include feelings of sickness or weakness, weight loss, fever, and night sweats. The symptoms of TB disease of the lungs also include coughing, chest pain, and the coughing up of blood. Symptoms of TB disease in other parts of the body depend on the area affected.

How is TB Spread?
TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection.

What is the Difference Between Latent TB Infection and TB Disease?
People with latent TB infection have TB germs in their bodies, but they are not sick because the germs are not active. These people do not have symptoms of TB disease, and they cannot spread the germs to others. However, they may develop TB disease in the future. They are often prescribed treatment to prevent them from developing
TB disease. People with TB disease are sick from TB germs that are active, meaning that they are multiplying and destroying tissue in their body. They usually have symptoms of TB disease. People with TB disease of the lungs or throat are capable of spreading germs to others. They are prescribed drugs that can treat TB disease.

What Should I Do If I Have Spent Time with Someone with Latent TB Infection?
A person with latent TB infection cannot spread germs to other people. You do not need to be tested if you have spent time with someone with latent TB infection. However, if you have spent time with someone with TB disease or someone with symptoms of TB, you should be tested.

What Should I Do if I Have Been Exposed to Someone with TB Disease?
People with TB disease are most likely to spread the germs to people they spend time with every day, such as family members or coworkers. If you have been around someone who has TB disease, you should go to your doctor or your local health department for tests.

How Do You Get Tested for TB?
There are tests that can be used to help detect TB infection: a skin test or TB blood tests. The Mantoux tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm. A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm. The TB blood tests measures how the patient's immune system reacts to the germs that cause TB.

What Does a Positive Test for TB Infection Mean?
A positive test for TB infection only tells that a person has been infected with TB germs. It does not tell whether or not the person has progressed to TB disease. Other tests, such as a chest x-ray and a sample of sputum, are needed to see whether the person has TB disease.

What is Bacille Calmette–Guèrin (BCG)?
BCG is a vaccine for TB disease. BCG is used in many countries, but it is not generally recommended in the United States. BCG vaccination does not completely prevent people from getting TB. It may also cause a false positive tuberculin skin test. However, persons who have been vaccinated with BCG can be given a tuberculin skin test or TB blood test.

Why is Latent TB Infection Treated?
If you have latent TB infection but not TB disease, your doctor may want you to take a drug to kill the TB germs and prevent you from developing TB disease. The decision about taking treatment for latent infection will be based on your chances of developing TB disease. Some people are more likely than others to develop TB disease once they have TB infection. This includes people with HIV infection, people who were recently exposed to someone with TB disease, and people with certain medical conditions.

How is TB Disease Treated?
TB disease can be treated by taking several drugs for 6 to 12 months. It is very important that people who have TB disease finish the medicine, and take the drugs exactly as prescribed. If they stop taking the drugs too soon, they can become sick again; if they do not take the drugs correctly, the germs that are still alive may become resistant to those drugs. TB that is resistant to drugs is harder and more expensive to treat. In some situations, staff of the local health department meet regularly with patients who have TB to watch them take their medications. This is called directly observed therapy (DOT). DOT helps the patient complete treatment in the least amount of time.

Additional Information
CDC. Questions and Answers About TB
http://www.cdc.gov/tb/publications/faqs/default.htm
http://www.cdc.gov/tbOctober 2011