



Co-Occurring Outpatient Treatment Program Policy and Procedure Manual

Prepared By

Document Owner	Organization Role
Jason Vanderscoff	Authorized Agent, MN 245G License Holder

Policy and Procedure Manual Version Control

Version	Date	Author	Change Description
1	06/10/2023	Riko Armstrong	245G July 1, 2022 updates, Updated Drug Screening, Updated Search policy, updated Treatment Services, Updated Job Descriptions, Update Org Chart
2	12/10/2023	Riko Armstrong	245G July 1, 2023 updates, Updated Drug Screening, Updated Search policy, updated Treatment Services, Updated Job Descriptions, Update Org Chart

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 Chanhassen, MN.

NorthStar Regional Policy and Procedure Manual outlines procedure program compliance with Minnesota Rules, 245G and corresponding Minnesota Rules and Statutes, and Federal Regulations governing 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	5
1.1	Program Hours and Population Served (245G.12)	5
1.2	Treatment Structure	5
1.3	Treatment Services (245G.07, subdivision 1)	7
1.4	Additional Services (245G.07, subdivision 2)	9
1.5	Drug Screening.....	10
1.3	Drug Screening	10
	Client Medical Record and Clinical Procedures	11
	Urine Specimen Collection Procedures.....	11
1.6	Specialized Co-Occurring Treatment Services (245G.20)	12
1.5	Assessment and Treatment Planning	13
1.7	Treatment Services Initiation (245G.14)	13
1.8	Intake and Registration	20
1.9	Assessment and Treatment Planning (245G.05, subdivision 1)	22
1.10	Treatment Services Termination (245G.14, subdivision 3, 245G.06 subd. 4)	23
	Staff members Authorized to Terminate Services	23
1.11	Health Monitoring Plan (245G.08, subdivision 1).....	24
1.12	Medication Administration (245G.08, subdivision 5-6)	26
1.13	Drug Control (245G.08, subdivision 6).....	26
1.14	Program Fidelity.....	26
1.15	Plan for Transfer of Care for Clients and Records	27
2	Recordkeeping	29
2.1	Client Records (245G.04, 245G.05, 245G.06)	29
2.2	DAANES Reporting	31
3	Personnel Policies	32
3.1	Personnel.....	32
3.2	New Staff Orientation	32



3.3	Personnel Files	33
3.4	Staff Schedules and Billing Staff Schedules and Billing Procedures	34
3.5	Fraternization	35
	Employees are strictly prohibited for having any sexual or unprofessional relationships with clients and will be terminated if found in violation of this policy. Staff must wait two years prior to engaging in any nonprofessional relationships any client pass or present.	35
	Dating in the workplace	35
	Friendships in the workplace	37
	Openness	37
	Our company’s commitment	38
3.6	Organizational Structure	38
4.6	Job Descriptions	41
4.6.1	NorthStar Regional’s Chief Executive Officer (CEO)	41
4.6.2	Chief of Programs and Services	41
4.6.3	NorthStar Regional’s Chief Operating Officer (COO)	42
4.6.4	NorthStar Regional’s Chief of Marketing	46
4.6.5	NorthStar Regional’s Compliance Officer	47
4.6.6	NorthStar Regional’s Human Resource Director	48
4.6.7	NorthStar Regional’s Program Director	42
4.6.8	Mental Health Clinical Director	43
4.6.9	Mental Health Clinical Supervisor	44
4.6.7	Mental Health Outpatient Therapist	45
4.6.8	Mental Health Practitioner	46
4.6.9	LADC Clinical Supervisor	47
	Licensed Alcohol and Drug Counselor	47
4.6.10	Student Intern (245G.01, Subd. 21)	48
4.6.11	Driver	48
4.6.12	Individuals with a Temporary Permit (ADC-T)	49
4.6.13	Billing and Funding Manager	49
4.6.14	Front Desk Administrator	50
4.6.15	Human Resources Specialist	50
4.6.16	Compliance Officer	51
4.6.18	Marketing Associate	53
4.6.19	NorthStar Regional Medical Laboratory Technician:	53
4.7	Clinical Consultation and Supervision (245G.08, subdivision 4)	54
4.8	Staffing Requirements and Qualifications (245G.11)	55
4.9	Staff Expectations	55
4.10	Staff Alcohol and Drug Use	57
4.11	Staff Development (245G.13, subdivision 2)	58



4.12 Conflict of Interest Policy.....	58
4.13 Severe Weather Policy.....	59
4.14 Service and Emotional Support Animals.....	60
4.15 Personnel Policy for Guests.....	63
4.16 Policy for Vendor Visitation.....	64
4.17 Mileage Reimbursement.....	65
5 Communicable Diseases.....	66
5.1 Communicable Diseases.....	66
Tuberculosis (245G.07, subdivision 1 (2)).....	66
Subdivision 1.Mandatory reporting.....	66
Subd. 2.Voluntary reporting.....	66
Subd. 3.Reportable persons.....	66
Subd. 4.Reporting information.....	67
Subd. 5.Immunity for reporting.....	67
Subd. 6.Falsified reports.....	67
Subd. 7.Waiver of privilege.....	67
Subd. 8.Tuberculosis notification.....	67
5.2 HIV Minimum Standards Compliance (245.A.19, (d), 245G.07, subdivision 2).....	67
5.3 Communicable Diseases Information and Referral Resources.....	71
Communicable Diseases Information and Referral Resources.....	71
6 Client Rights and Responsibilities (245G.15).....	72
6.1 Client Rights.....	72
6.2 Grievances (245G.15, Subdivision 2).....	82
6.3 Photographs of Client (245G.15, subd. 3).....	83
6.4 Client Expectations.....	83
7 Program Safety.....	84
7.1 Program Abuse Prevention Plan (245G.09 subpart 3).....	84
7.2 Emergency Management (245G.16, 245A.04, subdivision 16).....	87
7.3 Maltreatment of Vulnerable Adult Reporting (245A.65, subdivision 1a).....	91
7.4 Maltreatment of Minors Reporting (626.556 and 245A.66).....	92
8 Medication Assisted Treatment Policy and Procedure.....	94
9 1115 Level of Care Requirement Policies.....	96



8.1 Policy and Procedure Review Signature Page 114

APPENDIX A 114

APPENDIX B 134

1 NorthStar Regional’s Treatment Program Services

NorthStar Regional’s Co-Occurring Intensive Outpatient treatment program provides services to adult 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/or co-occurring diagnosis, and their families, during convenient operational hours to meet client needs.

Procedure

1. Services provided will be specifically tailored to adult clients with substance use disorder and/or co-occurring diagnosis and their families.
2. Program operating hours will be Monday through Friday 8am-8pm and will be adjusted appropriately to accommodate client scheduling needs. Groups are organized as follows:
 - a. Tuesday 10am-12pm/6pm-8pm
 - b. Thursday 6pm-8pm
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 through 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.

Program

1. **Comprehensive Assessment:** Clients are provided with an updated comprehensive substance abuse and mental health screening and diagnostic assessment and referral services.
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 psychoeducation and group psychotherapy processes.
 - b. Group census will be appropriate to client needs but will not exceed an average of 16 clients within 30 consecutive calendar days.
 - c. Therapeutic recreation activities are provided by the LADC and/or individuals specifically qualified according to accepted standards of their profession.



- 3. Education** Clients focus on applying skills to avoid pathological substance abuse and manage problems related to substance abuse.
 - 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.
- 4. Transition Services:** Clients are guided to utilize familial and communal resources to assist in the integration of treatment gains to daily life such as ARMHS, Alamo 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.
- 5. 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.
- 6. Mental Health Services:** All clients are screened for mental illness. Clients requiring additional assessment will complete a comprehensive diagnostic assessment update 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 will be provided.
 - 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 co-occurring diagnosis.
- 7. Service Coordination:** Clients are assisted in locating and obtaining professional and community services and resources necessary to establish a healthy lifestyle. Professional referrals are made as appropriate. NorthStar Regional provides continuing documentation of collaboration with continuing care mental health providers, and involvement of those providers in treatment planning meetings.
- 8. Culture-specific Tracks:** Cultural Tracks are developed to address specific cultural issues reflective of client population needs; gender, age, ethnicity, professional status, experience of trauma.
 - a. Individual special and cultural needs specific to each client are documented in the clients' individual treatment plan.
- 9. Drug Screening:** Random drug screening will be used to support client accountability.
- 10. Discharge and Referral:** a requirement that before discharging a client from a residential setting, for not reaching treatment plan goals, the license holder must confer with other interested persons to review the issues involved in the decision. The documentation requirements for a staff-requested service termination must describe why the decision to discharge is warranted, the reasons for the discharge, and the alternatives considered or attempted before discharging the client.
- 11. Aftercare:** Peer-led aftercare groups and activities are provided for all successful program graduates.

ASAM Level 1.0 Outpatient Co-Occurring Program

Clients enrolled in the Low Intensive Outpatient Program reside in sober housing or in the community. Throughout the duration of treatment, clients are required to attend a bi-weekly individual session with their



Primary Counselor and group counseling once a week. During this bi-weekly session, 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 bi-weekly appointment. Clients will also have the opportunity to meet individually with our Mental Health Professional, who will provide them with a Diagnostic Assessment if needed, and weekly individual mental health counseling.

In addition to group and individual meetings, clients are required to attend 1-3 abstinence based sober support group meetings weekly and to maintain a sponsor. While enrolled in the program, clients are able to utilize our membership at the Chaska Community Center, which features an award-winning aquatics area, gymnasiums, racquetball courts, strength equipment, cardio machines, and group fitness classes.

In the Phase III Aftercare 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 Phase III group is on Tuesday. Evening Phase III 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.

Groups

Curriculums include but will not be limited to *Dr. Hal Baumchen's Destinations Workbook* and *cooccurring 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. 1 Primary Group
 - a. Twelve Step facilitation
 - b. Identification of use consequences and support for abstinence motivations Psychoeducational components: substance use disorders-focused
 - I. Addiction, Disease Model
 - c. Relapse prevention
 - i. Identifying and managing relapse triggers a high-risk situation.
 - d. Life management skills
 - i. Financial and home management
 - e. Coping skills Education
 - i. SMART Recovery, Cognitive Behavioral Therapy, relaxation tools
 - ii. Stress and lifestyle management skills
 - iii. Health and nutrition
 - f. Relationship enhancement
 - I. Communication skills, boundaries, interpersonal effectiveness skills, conflict resolution
 - g. Community resource and support building
 - i. Speakers and meeting attendance ii. Community Service
 - h. Spirituality and personal purpose

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/or also co-occurring diagnosis and for their families. Treatment services are provided



by a competent multidisciplinary team of Licensed Alcohol and Drug Counselors and Licensed Mental Health Professionals. Specific treatment tracks are designed to meet clients' individual needs with regard to level of care intensity, age, gender, and other cultural components. 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.
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 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.
 - 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 ARMHS, Alanon 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.
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 cooccurring disorders, the importance of medication compliance, and use of strategic coping skills will be provided.
 - 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 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. **Culture-specific Tracks:** Cultural tracks are developed to address specific cultural issues reflective of client population needs; gender, age, ethnicity, professional status, experience of trauma.
 - 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.
 - 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 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's clinical documentation forms.

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

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

1. **Family Program:** Clients' families and supportive others may participate in the NorthStar Regional's Family Program, where substance use disorders and their interactions are addressed from a family systems perspective. Clients and families are taught healthy communication and relationship skills such as boundaries and assertiveness. The opportunity to participate in relationship/family counseling, facilitated by clinical staff, will identify, and address the impact of clients' substance abuse on others. Support will be provided to strengthen the support structure needed for sustained chemical, mental, and social health. Family members are provided with information regarding community resources, such as case management, crisis management, and education programs. Sessions are scheduled at client request of staff.
2. **Stress Management and Physical Well-being:** 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.
3. **Life Skills:** 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.



- 4. Employment and Educational Services:** 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.
- 5. Social Skills** Clients will participate in group therapy and will be provided with communication skills education and opportunities to practice social skills in a safe environment.
- 6. 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.
- 7. Accountability:** Clients are provided the accountability to maintain sustained abstinence through random drug and alcohol testing.
- 8. Room and Board:** Clients are assisted with the acquisition of housing and economic resources. They will be referred to residential treatment services if appropriate.
- 9. Community Education and Prevention:** Education and prevention services are provided to the community.

Procedures

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 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 COO and CCO to monitor service fidelity and outcomes to ensure that evidence-based practices are consistently used to best serve clients.

1.5 Drug Screening

1.3 Drug Screening

Accountability is an important part of maintain 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 the 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 admit to the program.



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 drug screening through the duration of their programs
2. Clients are provided with the laboratory's HIPAA policies upon orientation
3. Assigned Case Managers, in collaboration with the treatment team, will request and manage appropriate drug screening under supervision of the Program Director
 - a. Client face sheets will be completed upon admission to the program and will remain in designated file
 - b. Client face sheets will be attached to a completed lab requisition form and submitted with completed drug screen or provided for scheduled technician
 - i. When a group drug screen is scheduled, office staff will provide client face sheets to the lab technician upon arrival
 - ii. Copies of the lab requisition forms will be uploaded to client charts
 - c. Copies of the lab requisition forms will be uploaded to client charts
 - i. All results will be uploaded to client charts and documented by the office staff in case management notes
 - Positive screens will be uploaded by office staff and a message indicating the positive screen will be sent to the Case Manager, copying the Program Director. Interventions, consulted and used, should be documented by the Case Manager in the bi-weekly Progress Note.

Urine Specimen Collection Procedures

NorthStar Regional utilizes the direct observed methodology for specimen collection. This 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 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 refusal to test. The collector must stop the collection and report the refusal to test. If the item appears to be inadvertently brought to the collection site, the collector must secure the item and continue the normal collection procedure
3. The collector 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, and secures the restroom to ensure that no one else can enter during the collection process
 - 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. If there is evidence of specimen tampering, the collector is to immediately begin to collect a second specimen using a direct observed collection procedure



1.5 Assessment and Treatment Planning

Pursuant Minnesota Rules 245G.05, subdivision 1, NorthStar Regional's 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 be referred to an appropriate mental health provider. A Comprehensive Assessment Summary will address substance abuse concerns and provide a summary and rationale for assessed 6 Dimensions risk ratings. Treatment planning begins upon service initiation and includes documentation of treatment objectives and interventions related to identified substance use disorder. Individual Treatment Plans and IAPP's are reviewed bi-weekly and revised to address clients' changing needs.

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. Adult participants will be primarily treated separately, except in the case that an adolescent, age 18 or younger, appears to be more appropriately treated in an adult group. 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 intravenous drug users and pregnant persons seeking or recommended for treatment services.

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 and/also
 - b. 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 aftercare.
7. Persons who do not meet program admission criteria, exhibit acute physical 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 accordingly. 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

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 24hour 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 no risk of harm to attributes in the risk description efforts in other dimensions. areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.	0 The placing authority may use the coping skills and presents to support self or others. The client functions in all life areas. client has a mental health diagnosis and is stable. The client functions adequately in significant life areas.
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	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.



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.

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.

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.

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 placing authority must authorize integrated chemical and mental health treatment services provided by a provider licensed under part [9530.6495](#) and 24hour supervision.

4 The placing authority must refer the client for acute psychiatric care with 24hour 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

0 The client is cooperative, motivated, ready to change, admits problems, committed to change, and engaged in treatment as a responsible participant.

TREATMENT PLANNING DECISION

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.

2 The client displays verbal compliance but lacks consistent behaviors; has low motivation for change; and is passively involved in treatment.

3 The client displays inconsistent compliance, minimal awareness of either the client's addiction or mental disorder and is minimally cooperative.

4 The client is:

(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

(B) the client is dangerously oppositional to the extent that the client is a threat of imminent harm to self and others.

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 placing authority must authorize treatment services for the client that include client engagement strategies.

3 The placing authority must authorize treatment services that have specific client engagement and motivational capabilities.

4 The placing authority must authorize treatment services that include:

(A) service coordination and specific engagement or motivational capability; or

(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

0 The client recognizes risk well and is able to manage potential problems.

TREATMENT PLANNING DECISION

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

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.

TREATMENT PLANNING DECISION

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. CEO
- b. COO
- c. Chief Programs & Services
- d. Program Director (or their designee)
- e. Clinical Supervisor
- f. Medical Director
- g. 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. Comprehensive Assessment
 - b. Mental health screening tools
 - i. GAIN-SS (adults)
 - ii. DSM-5 Cross Cutting Screen
 - c. 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. 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 Code of Federal Regulations, title 42, section 2.12(c)(5), and Code of Federal Regulations, title 45, parts 160 to 164.
5. 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’s 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’s 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.** Group Therapy: \$100 per hour
 - c.** Individual and Family/Couple Sessions: \$150 per hour
 - d.** Driving with Care® Level I Program:\$200
 - e.** Driving with Care® Level II Program: \$325
 - f.** Driving with Care® Level II with Therapy Sessions: \$100
 - 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’s Payment Contract prior to session
 - ii.** NorthStar Regional’s 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 an 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.** 2 Releases of Information for collateral
 - ii.** NorthStar Regional’s Notice of Appeals Rights
 - iii.** Tennessen Notice
 - iv.** NorthStar Regional’s Consent for Treatment/HIPAA Acknowledgment
 - v.** NorthStar Regional’s HIPAA Privacy Notice
 - vi.** Client Bill of Rights
 - vii.** Authorization for Release of Information/Vulnerable Adult Form
 - viii.** NorthStar Regional’s Adult/Child Data Form
 - ix.** GAIN-SS (Adults)
 - x.** NorthStar Regional’s Health Questionnaire
 - xi.** Consent for Drug Testing
 - xii.** Release of Information for Third-Party Clinical Laboratory
 - 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 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 minutes early to review paperwork
 - i.** DAANES Notification and Intake form
 - ii.** NorthStar Regional’s Communicable Diseases Policy and Procedure and Resources



- iii. Client Expectations
- iv. NorthStar Regional's Emergency Management Policy and Procedure
- v. NorthStar Regional's Mandated Reporting Policies and Procedures
- vi. NorthStar Regional's Program Abuse Prevention Plan
- vii. NorthStar Regional's Program Structure and Schedule
- b. The Intake Coordinator will give client a facility tour
- c. The Program Director will designate the LADC Case Manager
 - i. The LADC completing Orientation session will enter an intake note in Procentive 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.

4. Treatment Planning Session

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

Pursuant Minnesota Rules, 245G.05, subdivision 1, the NorthStar Regional's 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 be referred to an appropriate mental health provider. A Comprehensive Assessment Summary will address 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 identified 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

Comprehensive Assessment (CA) will be completed within five calendar days on which a treatment session has been provided from the day of service initiation for a client in a non-residential program. It will include determination of a substance use disorder diagnosis in accordance with DSM-5 diagnostic criteria and will include the following documents.

- a. NorthStar Regional's Comprehensive Assessment
 - b. **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 five calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. and will provide a narrative and rationale for assessment using the 6 Dimension Risk ratings.
- 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 10 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 Treatment Plan** All person-centered treatment plans completed within ten (10) 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 client's 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 client 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. Review period will be documented.
 - o 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. CEO
2. Chief Operating Officer
3. Chief of Programs and Services
4. Program Director (or their designee)
5. Clinical 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.
 - 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 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 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



- e. 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 3 consecutive days of programming, will automatically be discharged.
 - iii. See 1.14 Client Expectations for further information on attendance.
 - 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 a 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 Chief of Programs & Services.
- Staff member will complete Critical Incident Report within 24 hours.
 - Clients are provided a list of behaviors in which constitute an At Staff Request (ASR) discharge at time of intake

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 Michelle Tesche, LPCC, LADC, 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.

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

This program will not offer storage, administration, or assistance with self-administration of medications. In compliance with Minnesota Rules 245G.08, 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 is prescribed controlled substances, they will be stored at Sugar Creek.
5. The medication must be verified with a counselor and uploaded into the clients chart.
6. 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.
7. 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.

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 Chief of Programs and Services. 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 Drug and Alcohol Abuse Normative Evaluation System (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 multidisciplinary 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.

Internal Procedures

- 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 are maintained for a period of seven (7) years
- 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;
- File paperwork with DHS to notify them of the program closing
- 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:

Tim Walsh CEO NorthStar Regional

Date

Hal Baumchen, President NorthStar Regional

Date



2 Recordkeeping

Records of treatment provided to clients admitted to NorthStar Regional’s programs will be protected and maintained in compliance with Minnesota Rules 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: 7945 Stone Creek Drive, Suite 30, Chanhassen, MN 55317. 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 will be provided to clients on the day of service initiation.
 - i. Client Rights, Responsibilities and Grievance procedures
 - b. Health and safety information regarding communicable disease safety, tuberculosis, and HIV
 - i. Emergency procedures
 - ii. Program abuse prevention plan
 - iii. Acknowledgement of Mandated Reporting policies
 - c. **Comprehensive Assessment (CA)** will be completed within three calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program.
 - i. **NorthStar Regional’s 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.

d. 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 Comprehensive Assessment Summary will be completed by the LADC within three calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program.

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 ten (10) 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 client's 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 client-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 client's 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 approved by the Commissioner. DHS Licensor reviewed Procentive in February 2018 and will be used for our EHR system.

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 Rules, 245G.13 and associated federal and state rules, statutes and regulations, policies and procedures for personnel associated with NorthStar Regional’s programs are as follows.

3.1 Personnel

Pursuant to Minnesota Rules, 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 Rules, part 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.
 - 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 Rules, 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's Policy and Procedure Manual Location
 - d. NorthStar Regional's 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's Programs
 - i. MN 245G Licensed Intensive Outpatient Treatment
 - ii. Community Education and Prevention
 - iii. NorthStar Regional's Services (MN 245G.07)
 - iv. Program Structure, Schedules, and Curriculum Materials
 - f. Training (Mandatory Reporting, Confidentiality, Boundaries & Fraternalization, and 245G)
 - v. NorthStar Regional's Client Rights Policy
 - vi. NorthStar Regional's Client Records
 - vii. NorthStar Regional's DAANES Reporting Policy and Procedure
 - viii. Client Confidentiality (HIPAA)
 - i. NorthStar Regional's 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.
 - ii. Communicable Diseases and HIV Minimum Standards Policy and Procedure (MN Statutes, section 245A.19). This training will happen immediately upon hire.
 - ix. NorthStar Regional's Emergency Procedures
 - x. Clinical Documentation Procedures (Procentive)
 - xi. Intake Procedures (Procentive)
 - xii. 8/12 hours Co-occurring Disorders Training (within 6 months)
 - § Philosophy, screening, assessment, diagnosis and treatment planning, documentation, programming, medication, collaboration, consultation, and discharge planning
 - f. Payroll, benefits, and Human Relations Information

3.3 Personnel Files

In compliance with Minnesota Rules, 245G.13, subdivision 1, the Program Director will maintain a personnel file for each staff member to demonstrate personnel requirements met under Minnesota Rules, parts 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. Human Resources 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 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.
 - 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 Fraternalization

NSR doesn't want to place undue restrictions on employees dating colleagues, as we acknowledge that freedom of choosing one's partner is an individual's right. But, without rules and guidelines, romantic relationships between colleagues may negatively impact our workplace. This policy will set restrictions to maintain workplace conduct and order.

Friendships forming between employees are also included in this policy. Friendships allow for a more collaborative environment, but they might also occasionally create cliques and fragmentation inside departments.

For the purposes of this policy, "dating" includes consensual romantic relationships and sexual relations. **Non-consensual relationships constitute sexual harassment and we prohibit them explicitly.**

Employees are strictly prohibited for having any sexual or unprofessional relationships with clients and will be terminated if found in violation of this policy. Staff must wait two years prior to engaging in any nonprofessional relationships any client pass or present.

Dating in the workplace

Dating colleagues may cause problems if not handled correctly. Examples of common concerns are:

- Colleagues who date might spend a large portion of their work time talking or meeting with each other instead of completing their duties.
- Interpersonal discord or breakups between couples might affect their ability to collaborate or maintain peace in the workplace.
- So, we advise our employees to:
 - Consider any possible conflict of interest before they enter into a relationship with a coworker.
 - Inform HR and their supervisor when they enter into a romantic or intimate relationship with a colleague.
 - Keep discussions of personal issues out of the workplace.
 - Seek counseling from HR or specialized employees (e.g. psychologist) if needed.
 - Maintain professionalism despite the status of the relationship and seek advice from their supervisor or HR to solve any issues.

When serious problems arise between couples, they can arrange a meeting with HR or their director to find a solution. Example of a possible solution is to consult with and transfer an employee to a different program, without loss of benefits or compensation.

Unacceptable and acceptable behavior

When two employees are in a relationship with one another, they should behave appropriately in the workplace. We define unacceptable behavior as any action that:

- Offends our people.
- Disrupts or hinders our operations.
- Distracts our employees from their duties.



- Decreases our employees' individual performance.

Examples of acceptable behavior for employees are:

- Passing by their partner's office to talk to them for non-work reasons for a short time.
- Displaying affection discreetly and infrequently while on company premises.
- Discussing their plans as a couple during breaks or lunch hours (with or without colleagues.)
- Coming to and leaving from work together.

Examples of unacceptable behavior for employees are:

- Arguing in the workplace during or after working hours.
- Kissing or touching inappropriately in front of colleagues and clients.
- Exchanging an excessive number of text messages, emails, or calls unrelated to their work during working hours.
- Making their colleagues uncomfortable by talking or boasting about the relationship during working hours.

Employees who exhibit unacceptable behavior will face progressive discipline, up to and including termination in cases of repeated violations. HR is responsible for determining appropriate penalties.

Employees are also obliged to behave appropriately towards their colleagues who date each other. We prohibit [victimization](#) and [hostility](#) towards employees for any reason. This includes sexual jokes, gossip, and improper comments. Employees who witness this kind of behavior should report it to HR and their supervisor.

Employees are obliged to follow our [Code of Conduct](#) at all times.

Dating Directors or Officers

To avoid accusations of favoritism, abuse of authority and sexual harassment, we prohibit supervisors from dating employees who report to them. This restriction may extend to every director or officer within two levels above an employee, regardless of team or department to facilitate moving or promoting employees.

Supervisors are strictly forbidden from dating their direct reports. If this occurs, the supervisor may face disciplinary action up to and including termination. This rule may be less strict in cases when directors enter into a consenting relationship with an employee from another program or department. When this happens, they must inform HR as soon as possible. It's to their best interest not to conceal their relationship as they may provoke disciplinary action if and when they are discovered. HR will evaluate the situation and act accordingly (e.g. transfer an employee or prepare a "[love contract](#)") to ensure the relationship is consensual.)

Employees will not face demotion, victimization or loss of benefits if we have to transfer them to another program or department. The supervisor may be reprimanded depending on the circumstances. We may terminate those who repeatedly disregard this restriction.

Couples who are married or in a domestic partnership

Employees who enter in an official relationship with another employee after they're both hired by our company should follow the rules outlined above.

A married employee (or an employee who has a domestic partner) who serves as hiring manager for their team is not allowed to consider hiring their partner for open roles. This might bring about questions of favoritism in the



hiring process. They are allowed to refer their partner for employment to other programs or departments for which they don't have any managerial or hiring authority.

If we discover that a hiring manager hired their partner, HR may move one of them to another team or department where one won't supervise the other. The hiring director will receive a reprimand, as their hiring decision may have compromised our company's commitment to [equal opportunity](#) and avoiding favoritism.

Friendships in the workplace

Employees who work together may naturally form friendships either in or out of their workplace. We encourage this relationship between peers, as it can help employees communicate, collaborate, and preserve harmony while working.

However, we must consider the negative consequences of forming this kind of personal relationship. Employees who are friends might occasionally:

- Enter into disputes over borrowed money.
- Gossip about colleagues and acquaintances.
- Form cliques that exclude certain colleagues and bring discord.
- Prevent one another (whether directly or indirectly) from accepting promotions or relocations for the sake of their friendship.

To mitigate possible issues, we advise our employees to:

- Discuss non-work-related issues outside of the workplace.
- Ask for their director HR's help when they are unable to resolve an issue or conflict of interest.
- Follow our Code of Conduct and act professionally at all times.
- Focus on their work instead of their friendships while at the office.

Friendships with supervisors

Being friends with one's director may have both positive and negative consequences. On one hand, friendship might facilitate honesty, trust and job satisfaction for both parties. Friendship might also make directors and employees confused about how they should treat each other. Questions of favoritism might arise too, and result in negative feelings and loss of morale.

For these reasons, we discourage employees being friends with their directors. We do encourage a harmonious and open relationship, but we think it's to everyone's best interest if supervisors are not involved with their direct reports outside of the workplace.

Openness

The key point of this policy is openness. We can't stop employees from forming relationships with one another and trying to prohibit them from doing so could incite deceit, resentment and gossip.

Employees must let HR and their supervisor know if an incoming employee or a current employee has a close personal friend more or has developed into one so HR/Management can advise and assess whether any rescheduling or site transfer may be in the best interest of the company/clients. Intentionally failing to do so could result in disciplinary action including separation/termination from NSR.



For this reason, we expect our employees to be open about their personal relationships with colleagues. This does not mean that employees should draw attention to their relationship, but keeping work relationships secret may negatively impact all parties involved. HR will be at our employees' disposal to explain our policy, attitude, and course of action in cases of violation.

Our company's commitment

Just like we expect employees to comply with this policy, our company has responsibilities that we are obliged to follow. We will:

- Enforce this policy to HR and senior management as well as employees.
- Treat everyone equally when taking disciplinary action without discriminating against protected characteristics.
- Prohibit victimization, [violence](#) and [retaliation](#) of any kind.
- Examine each situation separately and consider all aspects and perspectives before making decisions.

Our employees should follow our [anti-discrimination policy](#) at all times. For example, HR must not penalize a homosexual couple differently than a heterosexual couple when they both have violated the present policy in the same manner. Likewise, if a team member is discovered to have a relationship with their director, the person who will be transferred or terminated must not be chosen based on their gender.

3.6 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 quarterly with the Program Directors to ensure program fidelity

2. Chief of Programs and Services

- a. Provide leadership and supervision to all facility Program Directors
- b. Work with Program Directors on implementation of program policies and procedures
- c. Assist Directors on utilization and coordination of program financial budget.
- d. Coordination with Program Directors to develop and maintain program curriculum.
- e. Ensuring that all locations are appropriately providing clinical supervision
- f. Addressing programming or performance concerns
- g. Oversee delegation of program management
- h. Work in conjunction with the COO and Chief of Behavioral Health for program compliancy with Minnesota 245G regulation
- i. Staffing ratio
- j. Current Trainings
- k. Proper licensures
- l. Supervision documentation
- m. Chair weekly program staff meetings
- n. Coordination with Department of Human Services for audits or corrections

2. 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 treatment plans review meeting
 - d. Facilitate and manage license-compliant staff training and orientation
 - e. Quarterly Quality Assurance meetings with COO
 - f. Manage program operation and staff
 - i. Staff annual performance reviews
 - ii. Performance Improvement Plans
3. **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 program individual treatment plans
 - c. Attend weekly clinical team consultation and treatment plans review meeting
 - d. Attend required staff trainings
 - e. Direct client services, as needed
 - f. Check staff mailbox and email daily
4. **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
5. **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
6. **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

Procedure

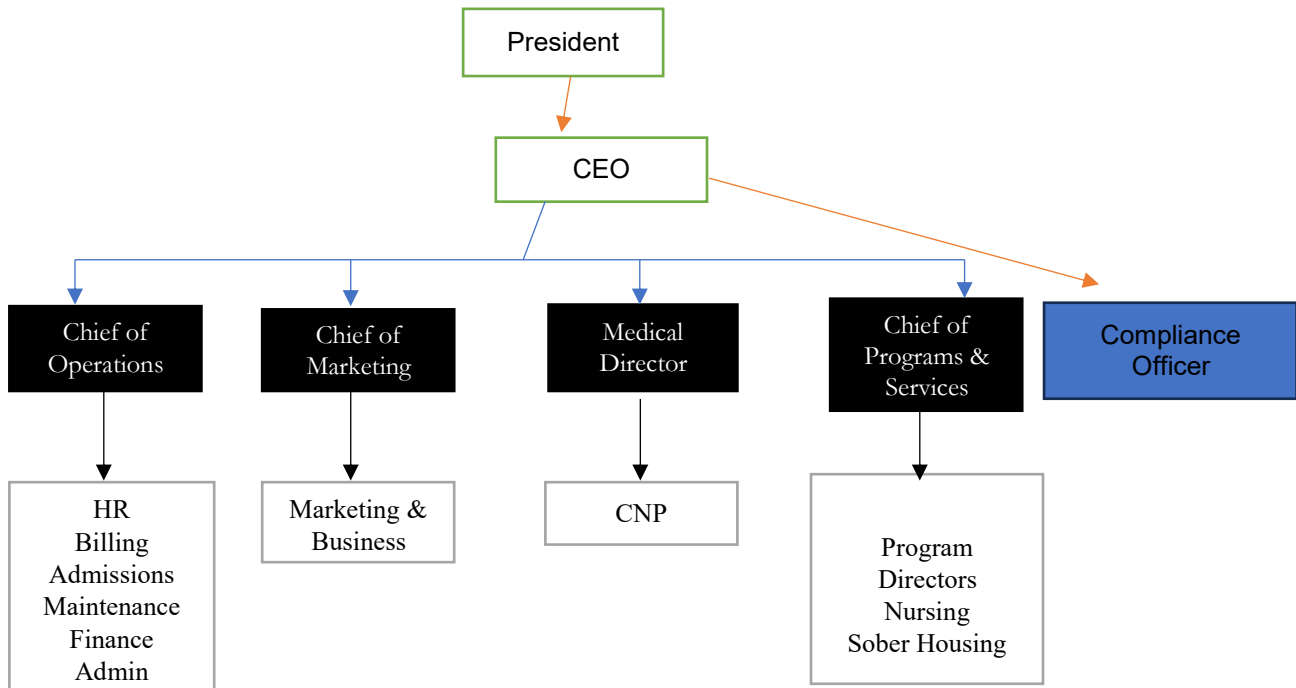
- 1. The Chief of Programs & Services will manage all program operations under management of NorthStar Regional's Chief of Behavioral Health who will assist in evaluation of program fidelity, outcomes, and expansion
- 2. Staff members will adhere to designated lines of authority in addressing all program issues.



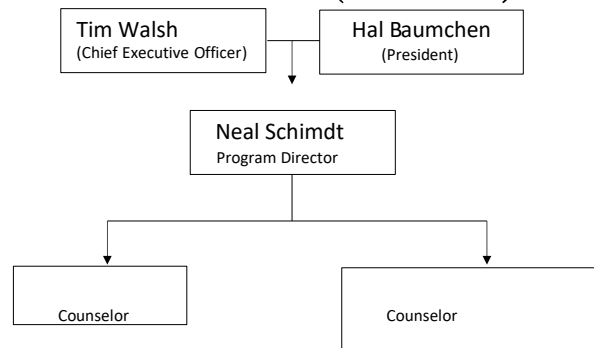
- Staff members will uphold designated responsibilities according to job descriptions.

Organizational Structure

Overall Organization Chart



Chanhassen IOP (Suite 30) Chart





Procedure

1. The Program Director will manage all program operations under management of NorthStar Regional's Chief of Programs & Services 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.

4.6 Job Descriptions

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

4.6.1 NorthStar Regional's Chief Executive Officer (CEO)

Management Report: NorthStar Regional's Owner's

Direct Report: NorthStar Regional's Chief of Behavioral Health

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 service program
3. Designation of NorthStar Regional Program Director position

4.6.2 Chief of Programs and Services

Management Reports: CEO

Direct Reports: Program Directors

Responsibilities

1. Provide leadership and supervision to all facility Program Directors
 - a. Work with Program Directors on implementation of program policies and procedures
 - b. Assist Directors on utilization and coordination of program financial budget
 - c. Coordination with Program Directors to develop and maintain program curriculum
 - d. Ensuring that all locations are appropriately providing clinical supervision
 - e. Addressing programming or performance concerns
2. Oversee delegation of program management
3. Work in conjunction with the CEO for program compliancy with Minnesota 245G regulation
 - a. Staffing ratio
 - b. Current Trainings
 - c. Proper licensures
 - d. Supervision documentation
4. Chair weekly program staff meetings
5. Coordination with Department of Human Services for audits or corrections

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
6. Knowledge and understanding of Minnesota 245G and Minnesota Statutes, chapter 245A (Human Services Licensing Act), and sections Minnesota Statutes, chapter 260E (Maltreatment of Minors Act), 626.557 (Vulnerable Adults Act- VAA), and 626.5572 (VAA Definitions)
7. Must be at least 18 years of age
8. Consent to background check and be cleared by DHS to work within a human services program
9. Freedom from chemical use problems for at least 2 years prior to hire

4.6.2 NorthStar Regional's Chief Operating Officer (COO)

Management Report: NorthStar Regional's CEO

Direct Reports: Admissions Director, HR Director, Finance Director, VP of Operations, Billing & Revenue Director

Responsibilities

1. 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
2. Plan, direct, or coordinate operational activities at the highest level of management with the help of subordinate directors and staff managers.
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. Direct or coordinate an organization's financial or budget activities to fund operations, maximize investments, or increase efficiency.
7. Appoint department heads or managers and assign or delegate responsibilities to them.
8. 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.
9. 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.
10. Prepare budgets for approval, including those for funding or implementation of programs.

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

4.6.3 NorthStar Regional's Program Director

Management Report: NorthStar Regional's Chief of Programs & Services

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
 - 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 Rules, 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

4.6.4 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

4.6.5 Mental Health Clinical Supervisor

Management Report: 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

4.6.6 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)

4.6.7 Mental Health Practitioner

Management Report: 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)



4.6.8 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 Minnesota Statutes, chapter 260E (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 service program
8. Freedom from chemical use problems for at least 2 years.

4.6.9 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

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

Management Report- 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
 - o Correspondence and collaboration with referral source and other involved professionals
 - e. Group psychotherapy and psychoeducation
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

4.6.11 Driver

Management Report- 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

4.6.12 Individuals with a Temporary Permit

Management Report- 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

4.6.13 Billing and Funding Director

Management Reports: COO

Responsibilities

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

4.6.14 Front Desk Administrator

Management Reports: Administrative Supervisor

Responsibilities

1. Answer Phone
 - a. Book Appointments
 - b. Coordinates IOP Admission
2. Data Entry
 - c. Uploads documents
 - d. Client Demographics
 - e. Verifies insurance
 - f. Weekly client census report
3. Greet Visitors
 - Complete first part of Intake procedure on new admissions.
 - 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 years preceding hiring.

4.6.15 Human Resources Specialist

Management Reports: HR Director

Responsibilities

1. Maintain Employee files
 - a. Ensure compliance with USCIS I-9 Employment Verification
 - b. Periodically audit personnel files to confirm compliance
 - c. Ensure compliance with MN State Department of Human Services
 - d. File documents into appropriate employee files



2. Maintain high standards of confidentiality of all employee records and information
3. Assist with the interview and background screening process for new hires
 - a. Phone and in-person interview set-up
 - b. Pre-screening
 - c. Hiring/background submission
4. Respond to reference checks and verifications of employment status
5. Communication of hiring needs for approval
6. Perform HRIS data entry
7. Assist with new employee onboarding
 - a. Preparing onboarding binder
 - b. Collect and track documents & forms
 - c. Set-up needed access for position
 - d. Creation of personnel file & upload of onboarding documents
8. Be available for termination with Directors, HR Specialist, or HR Manager
 - a. Completion of off-boarding checklist
 - b. Appropriate communication of resignation
9. Work in conjunction with management and employees to improve work relationships, morale, and increasing productivity and retention
10. Assist employees and supervisors with basic interpretation of HR policies & procedures
11. Enforce Policies and Procedures and Employee Handbook
12. Performs customer service functions by answering employee requests and questions
13. Maintains and coordinates employee recognition programs.
14. Assists with projects, audits and/or investigations as needed.
15. Able to backup when HR Manager is out of office
16. Ability to work independently, as well as part of a team with flexibility & willingness to learn and take initiative on various tasks and projects.

Qualifications

1. Knowledge of insurance & authorizations
2. Comply with 245G and Program Policies & Procedures
3. Acknowledge understanding of Client Rights, per MN 245G
4. Must be at least 18 years of age
5. Must have High School Diploma or GED equivalent
6. Must complete DHS background check and be cleared to work in human service programs
7. Acknowledge freedom from substance abuse problems for 2 or more years
8. Minimum one (1) year experience in Human Resources
9. Minimum one (1) year experience in customer service
10. Must be able to work in the United States without company sponsorship both now and in the future
11. Bachelor's degree in business administration or human Resources preferred

4.6.16 Compliance Officer

Management Reports: CEO

Direct Reports: None

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 policies 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

4.6.17 Chief Marketing Officer

Management Reports: CEO

Direct Reports: Marketing Associate

Responsibilities

1. Lead marketing and communication activities
 - a. Facilitate effective communication throughout organization
 - i. Develop processes and systems to support internal communications to ensure alignment
 - b. Promote and advertise
 - c. Media relations
2. Monitor market dynamics
 - a. Measures and reports on results of marketing/communications activities. Analyzes complex information to distill impact of marketing programs and conversions
3. Provide timely & responsive changes to marketing and communication plans
4. Coordinate with other departments to implement marketing strategies
5. Work with Leadership and Program Directors to appropriately represent & advertise company & programs
6. Interface daily with various publics and constituents, including but not limited to senior leadership, community and political leaders, and the owners
7. Represent NorthStar Regional positively and consistently
8. Speak on the behalf of the organization, in crisis communication
9. Manage external partners (digital strategy agencies, web development agencies, etc.)
10. Participate in activities that promote ease of access, quality improvement, and patient satisfaction
11. Acts as strategic marketing & communications advisor to system leadership; provides insights and support for system initiatives and priorities.
12. Collaborates with Foundation to develop strategies and plans that support the philanthropic goals of the organization.

Qualifications

1. Comply with 245G and Program Policies & Procedures
2. Must be at least 18 years of age



3. Must have High School Diploma or GED equivalent
4. Must complete DHS background check and be cleared to work in human service programs
5. Acknowledge freedom from substance abuse problems for 2 or more years
6. Master's Degree in Marketing, Communications, or like field
7. Minimum five (5) years' of progressive leadership experience in marketing, corporate communications, and public/media relations

4.6.18 Marketing Associate

Management Reports: Chief Marketing Officer

Responsibilities

1. Represent NorthStar Regional at metro provider meetings
2. Schedule and conduct visit to referral sources
3. Assist with events
 - a. Tradeshows
 - b. Conferences
 - c. Educational/training events
4. Maintain consistency in the overall brand
5. Help maintain website
 - a. Implement layout and design changes
 - b. Make recommendations for improvements
6. Maintain media library of photos and graphics
7. Assist with coordination and design of printed publications
 - a. Supervises the printing and distribution of monthly newsletter
 - b. Assist with the design and development of brochures, booklets, and flyers
 - c. Manage printing and inventory of Journey to Recovery curriculum materials
8. Coordinate emails for constituent groups
9. Update, monitor, and expand social media content
 - a. Facebook
 - b. Twitter
 - c. Instagram
10. Assist with management of Journey to Recovery online store
11. Assist with editing training and Journey to Recovery videos
12. Other electronic/digital duties as needed

Qualifications

1. Comply with 245G and Program Policies & Procedures
2. Must be at least 18 years of age
3. Must have High School Diploma or GED equivalent
4. Must complete DHS background check and be cleared to work in human service programs
5. Acknowledge freedom from substance abuse problems for 1 or more years
6. Bachelor's degree in marketing, journalism, communications, graphic design, or related field
7. Strong proficiency in Microsoft Office and Adobe Creative Suite
8. Basic web design function and knowledge of html

4.6.19 NorthStar Regional Medical Laboratory Technician:

Management Reports: COO

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:

- 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.
- Follow documented policies and procedures to correctly identify the patient and specimen collected.
- Accurately complete all necessary laboratory requisition forms.
- Maintain the clinical laboratory, machines, and equipment in working order per established protocol.
- Operate the Thermo Fischer Indiko Plus machine.
- Monitor procedures and testing for drug levels in specimens collected.
- Perform tests authorized by the clinic lab director, Quality Assurance standards, or Compliance.
- Prepare and maintain supplies to efficiently collect specimens.
- Perform, evaluate and document all quality control activities.
- Other duties as assigned.

Job Requirements:

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

4.7 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 Rules 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. Hal Baumchen, PsyD, LP, LADC
2. Dr. Alonso Morales Medical Director and Addictions Psychiatrist
3. Tim Walsh, MA, LP, DPA, Chief of Behavioral Health
4. Chief of Programs and Services
5. Neal Schmidt, LADC
6. Jacki Kerkow-Dohmen, MSW, LICSW

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.

4.8 Staffing Requirements and Qualifications (245G.11)

NorthStar Regional's Treatment, Education, and Prevention Programs will maintain compliance with Minnesota Rules, 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 Rules, 245G.11. Supportive documentation will be retained by the Program Director in personnel files.

Staffing Requirements

Staffing Requirements

1. Program Director will be employed at all times
2. The LADC Supervisor, qualified according to Minnesota Statute 245G.11 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 Program 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. 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, 260E, 626.557, and 626.5572
5. 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 16 directly supervised clients
6. Group census will not exceed 16 clients
7. All therapeutic staff must have current American Red Cross standard first aid certificate and American Red Cross community or American Heart Association CPR certification
8. All therapeutic staff must have 12 hours of training on co-occurring disorders within 6 months of hire, and 8 hours annually
9. NorthStar Regional Human Resource Specialist 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
 - c. School contracts and/or supervision plans, as well as weekly supervision documentation will be retained by the program

4.9 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 Rules, 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 Rules, 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. Fraternalization
5. 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 o 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 Chief of Programs & Services 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 o 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

4.10 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 well-being
5. The Program Director and/or COO, Chief of Programs & Services 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 or 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 Chief of Programs & Services 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).
2. Program Director or COO will consult with Human Resources
3. 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.

4.11 Staff Development (245G.13, subdivision 2)

The Program Director will ensure that each clinical staff member will be trained in compliance with Minnesota Rules, 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, annually.
 - c. 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.
2. The Program Director will ensure that acknowledgment of training documentation is maintained in staff personnel files.

4.12 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.

4.13 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.

4.14 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 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 perform its duties safely and effectively.
 - 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 wellbeing. 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.

4.15 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 into 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 of Programs & Services.
2. The Program Director, Chief Operations Officer, or the Chief Programs & Services 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.

4.16 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, salesperson, 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 byproduct 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 in to 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 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 technician's 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.

4.17 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.



5 Communicable Diseases

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

5.1 Communicable Diseases

Policies and procedures addressing communicable disease privacy, reporting, and education are in compliance with Minnesota 245G.17 and Minnesota Statutes, section 245A.19, items a through e.

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.

1 144.4804 REPORTING RELATING TO TUBERCULOSIS

Subdivision 1. **Mandatory reporting.**

- 2 A licensed health professional must report to the commissioner or a disease prevention officer within 24 hours of obtaining knowledge of a reportable person as specified in subdivision 3, unless the licensed health professional is aware that the facts causing the person to be a reportable person have previously been reported. Within 72 hours of making a report, excluding Saturdays, Sundays, and legal holidays, the licensed health professional shall submit to the commissioner or to the disease prevention officer a certified copy of the reportable person's medical records relating to the carrier's tuberculosis and status as an endangerment to the public health if the person is reportable under subdivision 3, clause (3), (4), or (5). A reporting facility may designate an infection control practitioner to make reports and to send certified medical records relating to the carrier's tuberculosis and status as an endangerment to the public health under this subdivision.

Subd. 2. **Voluntary reporting.**

- 3 A person other than a licensed health professional may report to the commissioner or a disease prevention officer if the person has knowledge of a reportable person as specified in subdivision 3, or has probable cause to believe that a person should be reported under subdivision 3.

Subd. 3. **Reportable persons.**

- 4 A licensed health professional must report to the commissioner or a disease prevention officer if the licensed health professional has knowledge of:
 - 5 (1) a person who has been diagnosed with active tuberculosis;
 - 6 (2) a person who is clinically suspected of having active tuberculosis;
 - 7 (3) a person who refuses or fails to submit to a diagnostic tuberculosis examination when the person is clinically suspected of having tuberculosis;
 - 8 (4) a carrier who has refused or failed to initiate or complete treatment for tuberculosis, including refusal or failure to take medication for tuberculosis or keep appointments for directly observed therapy or other treatment of tuberculosis; or
 - 9 (5) a person who refuses or fails to follow contagion precautions for tuberculosis after being instructed on the precautions by a licensed health professional or by the commissioner.



Subd. 4. Reporting information.

- 10 The report by a licensed health professional under subdivision 1 or by a person under subdivision 2 must contain the following information, to the extent known:
- 11 (1) the reportable person's name, birth date, address or last known location, and telephone number;
- 12 (2) the date and specific circumstances that cause the person to be a reportable person;
- 13 (3) the reporting person's name, title, address, and telephone number; and
- 14 (4) any other information relevant to the reportable person's case of tuberculosis.

Subd. 5. Immunity for reporting.

- 15 A licensed health professional who is required to report under subdivision 1 or a person who voluntarily reports in good faith under subdivision 2 is immune from liability in a civil, administrative, disciplinary, or criminal action for reporting under this section.

Subd. 6. Falsified reports.

- 16 A person who knowingly or recklessly makes a false report under this section is liable in a civil suit for actual damages suffered by the person or persons reported and for punitive damages.

Subd. 7. Waiver of privilege.

- 17 A person who is the subject of a report under subdivision 1 is deemed to have waived any privilege created in section [595.02, subdivision 1](#), paragraphs (d), (e), (g), (i), (j), and (k), with respect to any information provided under this section.

Subd. 8. Tuberculosis notification

- 18 If an emergency medical services person, as defined in section [144.7401, subdivision 4](#), is exposed to a person with active tuberculosis during the performance of duties, the treatment facility's designated infection control coordinator shall notify the emergency medical services agency's exposure control officer by telephone and by written correspondence. The facility's designated infection control coordinator shall provide the emergency medical services person with information about screening and, if indicated, follow-up.

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, Human Immunodeficiency Virus (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

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

This program will maintain compliance with HIV Minimum Standards to ensure respectful care, education, and comprehensive referrals to address HIV diagnosis and co-occurring complications.

Procedures

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 Training & Resources for Substance Use Disorder Programs

People with substance use disorder (SUD) are disproportionately affected by human immunodeficiency virus (HIV). You should know about the risks of infection. People with SUD may participate in behaviors that increase the risk of acquiring and transmitting HIV, such as sharing injection drug equipment or engaging in sexual behaviors that increase HIV risk. SUD can increase the risk of getting HIV and can negatively impact HIV care, treatment, and related health outcomes.

HIV Basics

While there is no cure for HIV, it can be effectively managed as a chronic illness with antiretroviral therapy (ART). Individuals can take proper steps to help stop the spread of HIV by knowing their own status and remaining safe.

- HIV is a manageable chronic illness.
- HIV continues to have a disproportionate impact on certain populations, particularly racial and

ethnic minorities, transgender women and gay, bisexual, and other men who have sex with men (MSM).

HIV Transmission and Prevention

Understanding how HIV can and cannot be transmitted is at the core of preventing new infections. HIV is a rapidly changing virus, but, it is also preventable.

How is HIV transmitted?

- Unprotected sexual intercourse



- Sharing needles for injection drugs
- Mother to child transmission

What is PrEP and PEP?

- **PrEP (pre-exposure prophylaxis)** is a once-daily pill that people who are HIV negative take to prevent getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.
- **PEP (post-exposure prophylaxis)** means taking medicine to prevent HIV after possible exposure. PEP should be used only in emergency situations and must be started within 72 hours after recent possible exposure to HIV.

Considerations for Substance Use and HIV

Should I test for HIV?

- Testing is the first step in HIV diagnosis and preventing the spread of HIV.
- CDC recommends everyone 13 to 64 years old get tested for HIV at least once as part of their routine care.

What is “Treatment as Prevention”?

- “Treatment as Prevention” refers to a person taking HIV medication to lower their viral load and prevent sexual transmission of HIV.
- People cannot transmit HIV through sexual contact when their viral load is undetectable. (The term “undetectable” means the virus is too low to be measured.)

Substance Use and HIV

Research suggests that substance use, including alcohol, methamphetamine, cocaine, opioids and inhalants, increases sexual behaviors that are associated with increased the likelihood of acquiring HIV (for example, sex without a condom).

How does substance use accelerate the progression of HIV?

- Substances (especially methamphetamine) can activate viral replication, resulting in the increase of viral load in the body.
- People using drugs may decrease their medication adherence (that is, failure to take medicine daily).

Harm Reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social



justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction is shame reduction.

Harm Reduction Resources: Substance Use and Sex

- Building Healthy Online Communities - <https://bhocpartners.org/>
- Testing (in person and at home) - <https://together.takemehome.org>
- Hooking up and meth - <https://tweaker.org/home/>
- Nation Harm Reduction Coalition: Opioid Overdose Basics -

<https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/responding-to-opioid-overdose/>

Considerations for Substance Use and HIV

Opioid Overdose Prevention

Naloxone, brand name “Narcan,” is a non-addictive, harmless and effective medication that can reverse an opiate overdose. Within minutes after Naloxone is administered, this life saving medication can often allow the affected person to breathe again.

Where can I find resources for support with HIV or SUD?

Minnesota Department of Human Services

- HIV/AIDS Programs/Services
- Alcohol, Drug, and Other Addictions Program Overviews

AIDSLine

- AIDSLine Website & HIV Resource Guide
- 612-373-2437 Twin Cities Metro area | 800-248-2437 Statewide
- Text AIDSLine to 839863

Fast-Tracker Minnesota

- Find SUD Treatment Providers

HIV Policy and Procedure Reviewed Annually	Who Reviewed	Date
Yes	Lisette Wright	12/4/18
Yes	Riko Armstrong	06/12/23



5.3 Communicable Diseases Information and Referral Resources

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. Clients are also provided with the Commissioner approved material from MDH titled, “Active TB Disease”.
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.rainbowhealth.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: <https://mnmchs.com>
 - 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/hiv aids>

6 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.

6.1 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 ensure 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 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 another 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 another 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 another 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.

6.2 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, upon 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. Program Director 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 Chief of Programs and Services.
 - c. The Program director will provide an initial response to Compliance Officer and Chief of Programs and services within 72 hours of receiving the grievance.
 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: 335 Randolph Avenue, Suite 290, St. Paul, MN 55102; Phone: 651-201-2756
 - d. Department of Health, Office of Health Facility Complaints: Golden Rule Building, 85 East 7th Place, PO Box 64882, St. Paul, MN. 55164; phone: 651-201-4200
 - e. 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.

6.3 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:

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 client's medical record.

6.4 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 of young adult groups 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
-

7 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.

7.1 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, to include specific measures taken to reduce safety risks within the scope of the treatment services and referrals made to address safety risks outside of the scope of services.

Program Abuse Prevention Plan Physical Plant and Environment

1. Address: 7945 Stone Creek Drive, Suite 30, Chanhassen, MN 55317
 - a. The program is housed in the Stone Creek Office Park. Stone Creek Office Park is in a *cul-de-sac* just south of Hwy 5. The Office Park consists of multiple buildings. NorthStar Regional is in the lower level facing the south and in the center of the Office Park. The building is in excellent condition, meeting all fire and building codes. The program is located near local clinics, restaurants, and shopping and poses minimal safety risk. The condition and design of the building in which the program is housed have no safety concerns for clients. The building is surrounded by areas of shrubbery, sidewalks, and parking lots.
 - i. Clients may be supervised in all treatment areas, including the lobby, group rooms, offices, and any outdoor areas.
 - ii. Clients will be informed of difficult areas to supervise including on the sidewalk outside of the building, back hallways, restrooms, and blind spots around the building. These areas are not supervised by NorthStar Regional's Program staff.
 1. Clients should smoke in designated smoking areas only
 - iii. Clients exhibiting behaviors that could risk the safety of self or others will not be permitted to participate in outdoor activities.



- iv. Clients will be oriented to emergency procedures and the locations of emergency exits upon admission
 - b. 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 consists of a variety of groups, lectures and presentations using an array of curriculum based on the individual needs of the clients. All staff will be oriented to the general operations of the program and clearly prohibits any substance use during work hours and states that staff providing direct client services must have at least 1 year free from active substance abuse problems and 2 years free from active substance abuse problems 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, and they will be moved to different level of care.
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. Low Intensive-Outpatient Program operating hours will be Monday through Friday 8am-10pm 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	Neal Schmidt	

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 and get the client to appropriate level of care.
 - b. Clinical staff will review and update, as applicable, treatment plans bi-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 in the PAPP and any substantiated maltreatment findings since the last review.
 - b. The PAPP will be revised to reflect the review results.
 - c. Reviews will be made available to the commissioner upon request.

7.2 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, 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



- 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. Two Twelve Medical Center | 952-361-2447 |
| | 111 Hundertmark Road |
| | Chaska, MN 55318 |
| 3. Ridgeview Medical Center | 952-442-2191 |
| 500 S. Maple Street | Waconia, MN 55387 |
| 4. NorthStar Regional Office Location | |
| a. Chaska | 952-448-6557 |
| 5. Minnesota Adult Abuse Reporting Center | 844-880-1574 |
| a. Sugar Creek | 952-856-2426 |
| 6. MN Dept 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 | |
| o Adult Division | 612-593-1223 |
| o Child Division | 612-348-2233 |
| e. Ramsey County | |
| f. Adult Division | 651-266-7900 |
| g. Child Division | 651-774-7000 |
| h. Washington County | 651-777-5222 |
| 8. Centerpoint Energy | 1-800-722-9326 |
| 9. Xcel Energy | 1-800-895-1999 |



I approve these policies and procedures

Dr. Alonzo Morales M.D.

Date

7.3 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's 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 at 844-880-1574
 - b. Incidents can be reported internally to the Program Director. If NorthStar Regional's Program Director is involved in the alleged or suspected maltreatment, a report must be made to the Managing Director.
 - i. When an internal report is received the 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 Chief of Programs & Services 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.

7.4 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. Staff members will make an oral report within 24 hours to the appropriate agency.
 - a. 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
 - b. 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
 - c. Other reports of possible violation of minor rights should be reported to the Department of human Services, Licensing Division at 651-431-6500
 - d. Staff members must provide the following information:



8 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.
- Comprehensive 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 residential and IOP with Lodging 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?

- NSR Phrase 3 program does not administer medication.

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

- Safety is maintained in our facilities with observational cameras in appropriate areas, mandated supervising staff during operational hours, 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.

9 1115 Level of Care Requirement Policies

NorthStar Regional Outpatient Program

LEVEL 1.0 CLINICALLY MANAGED LOW INTENSITY OUTPATIENT 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 1.0 clinically managed low-intensity outpatient demonstration provider, NorthStar Regional's Chanhassen Program, is an outpatient 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 Men's Residential Program provides at least:

(1) 8 hours of treatment services per week for adult men and women

a. **Support systems** NorthStar Regional's Chanhassen Program works with Kai Shin for all psychiatric services.

(2) Psychiatric, psychological, laboratory and toxicology services available as appropriate to the severity and urgency of the client's condition

(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, the Medical Director from Kai Shin 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 1.0 CLINICALLY MANAGED OUTPATIENT PROGRAM, 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 Tuesday mornings 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 practitioner for a physical.



(4) Medication assisted treatment. Molly Sommes/Kai Shin is licensed to prescribe Suboxone to clients needing a suboxone taper. She/They 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 stepdown 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 manager 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.

Patient Referral Arrangement Agreements

Level 1.0

Project Turnabout
Nystrom & Associates
Healing Grace LLC

Level 2.1

Project Turnabout
NuWay
Nystrom & Associates



Healing Grace LLC

Level 3.1

Project Turnabout
NuWay

Level 3.3

Vinland National Center


Level 3.5

Project Turnabout
Healing Grace LLC

Level 3.7

Project Turnabout



Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>Northstar Regional</u> and <u>Vinland National Center</u>	
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 <u>256B.0759</u> , 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.	
<input type="checkbox"/> Level 1.0 Outpatient Treatment Services <input type="checkbox"/> Level 2.1 Intensive Outpatient Treatment Services <input type="checkbox"/> Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.2 Clinically Managed Residential Withdrawal Management <input checked="" type="checkbox"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.5 Clinically Managed High-Intensity Residential Treatment Services <input type="checkbox"/> 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: <u>9/10/2020</u>
Referral Provider: 	Date: <u>09/10/2020</u>

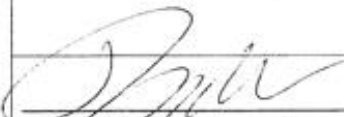
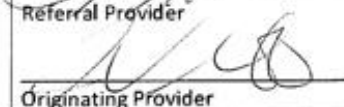


Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>Vinland National Center</u> and <u>Northstar Regional</u>	
This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by <u>VINLAND NATIONAL CENTER</u> as required in MS section <u>2568.0759</u> , 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.	
<input checked="" type="checkbox"/>	Level 1.0 Outpatient Treatment Services
<input checked="" type="checkbox"/>	Level 2.1 Intensive Outpatient Treatment Services
<input type="checkbox"/>	Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services
<input type="checkbox"/>	Level 3.2 Clinically Managed Residential Withdrawal Management
<input type="checkbox"/>	Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services
<input checked="" type="checkbox"/>	Level 3.5 Clinically Managed High-Intensity Residential Treatment Services
<input type="checkbox"/>	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: <u><i>msRoehl</i></u>	Date: <u>09/10/2020</u>
Referral Provider: <u><i>[Signature]</i></u>	Date: <u>9/10/2020</u>



Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>Project Turnabout</u> and <u>NorthStar Regional</u>	
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 <u>256B.0759</u> , 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. <input checked="" type="checkbox"/> Level 1.0 Outpatient Treatment Services <input checked="" type="checkbox"/> Level 2.1 Intensive Outpatient Treatment Services <input type="checkbox"/> Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.2 Clinically Managed Residential Withdrawal Management <input type="checkbox"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services <input checked="" type="checkbox"/> Level 3.5 Clinically Managed High-Intensity Residential Treatment Services <input type="checkbox"/> 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	
 Referral Provider	Date: <u>9-9-2020</u>
 Originating Provider	Date: <u>9-8-20</u>



Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>NorthStar Regional</u> and <u>Project Turnabout</u>	
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 <u>256B.0759</u> , 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. <input checked="" type="checkbox"/> Level 1.0 Outpatient Treatment Services <input checked="" type="checkbox"/> Level 2.1 Intensive Outpatient Treatment Services <input checked="" type="checkbox"/> Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services <input checked="" type="checkbox"/> Level 3.2 Clinically Managed Residential Withdrawal Management <input type="checkbox"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services <input checked="" type="checkbox"/> Level 3.5 Clinically Managed High-Intensity Residential Treatment Services <input checked="" type="checkbox"/> 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	
 _____ Referral Provider	Date: <u>9-8-20</u>
 _____ Originating Provider	Date: <u>9-9-2020</u>



Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>North Star Regional</u> and <u>Nystrom & Associates</u>	
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) <u>North Star</u> as required in MS section <u>256B.0759</u> , 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.	
<input checked="" type="checkbox"/> Level 1.0 Outpatient Treatment Services <input checked="" type="checkbox"/> Level 2.1 Intensive Outpatient Treatment Services <input type="checkbox"/> Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.2 Clinically Managed Residential Withdrawal Management <input type="checkbox"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.5 Clinically Managed High-Intensity Residential Treatment Services <input type="checkbox"/> 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: <u>8/18/20</u>
Referral Provider:	Date: <u>8/18/20</u>



Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>Nystrom & Associates</u> and <u>North Star Regional</u>	
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) <u>NYSTROM & ASSOCIATES</u> as required in MS section <u>256B.0759</u> , 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.	
<input checked="" type="checkbox"/>	Level 1.0 Outpatient Treatment Services
<input checked="" type="checkbox"/>	Level 2.1 Intensive Outpatient Treatment Services
<input type="checkbox"/>	Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services
<input type="checkbox"/>	Level 3.2 Clinically Managed Residential Withdrawal Management
<input type="checkbox"/>	Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services
<input checked="" type="checkbox"/>	Level 3.5 Clinically Managed High-Intensity Residential Treatment Services
<input type="checkbox"/>	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: <u>[Signature]</u>	Date: <u>8/18/20</u>
Referral Provider: <u>[Signature]</u>	Date: <u>8/18/20</u>



DocuSign Envelope ID: 45D2942F-A70D-4857-8E16-8E63F3D4526C

DHS-7309-ENG

Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>NorthStar Regional</u> and <u>NUWAY</u>	
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) <u>NorthStar Regional</u> as required in MS section <u>256B.0759</u> , 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.	
<input type="checkbox"/>	Level 1.0 Outpatient Treatment Services
<input checked="" type="checkbox"/>	Level 2.1 Intensive Outpatient Treatment Services
<input checked="" type="checkbox"/>	Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services
<input type="checkbox"/>	Level 3.2 Clinically Managed Residential Withdrawal Management
<input type="checkbox"/>	Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services
<input type="checkbox"/>	Level 3.5 Clinically Managed High-Intensity Residential Treatment Services
<input type="checkbox"/>	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	
DocuSigned by: Originating Provider: DEBUBBFCAS484C5	Date: <u>7/28/2020</u>
DocuSigned by: Referral Provider: DPA3E8MACE84DC	Date: <u>7/28/2020</u>

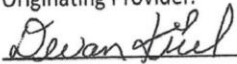



DocuSign Envelope ID: 89D1DCD0-CAF5-48C1-8D9A-03EFB05C66EA

DHS-7309-ENG

Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>NUWAY</u> and <u>NorthStar Regional</u>	
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) <u>NUWAY</u> as required in MS section <u>256B.0759</u> , 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.	
<input checked="" type="checkbox"/>	Level 1.0 Outpatient Treatment Services
<input checked="" type="checkbox"/>	Level 2.1 Intensive Outpatient Treatment Services
<input type="checkbox"/>	Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services
<input type="checkbox"/>	Level 3.2 Clinically Managed Residential Withdrawal Management
<input type="checkbox"/>	Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services
<input checked="" type="checkbox"/>	Level 3.5 Clinically Managed High-Intensity Residential Treatment Services
<input type="checkbox"/>	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	
DocuSigned by: Originating Provider: <u>Ben Roberts</u> DE45E1ADCE840C	Date: <u>7/28/2020</u>
DocuSigned by: Referral Provider: <u>[Signature]</u> DE45E1ADCE840C	Date: <u>7/28/2020</u>



Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>Healing Grace LLC.</u> and <u>Northstar Regional</u>	
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) <u>Healing Grace LLC.</u> as required in MS section <u>256B.0759</u> , 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.	
<input checked="" type="checkbox"/> Level 1.0 Outpatient Treatment Services <input checked="" type="checkbox"/> Level 2.1 Intensive Outpatient Treatment Services <input type="checkbox"/> Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.2 Clinically Managed Residential Withdrawal Management <input type="checkbox"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.5 Clinically Managed High-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.7 Medically Monitored Inpatient Withdrawal Management	
<u>Assurance of Client Choice</u>	
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.	
<u>Term and Termination</u>	
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.	
<u>Privacy and Confidentiality of Consumer Information</u>	
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: <u></u>	Date: <u>06/28/2021</u>
Referral Provider: <u></u>	Date: <u>6/30/21</u>



Patient Referral Arrangement Agreement	
Patient Referral Arrangement Agreement between <u>Northstar Regional</u> and <u>Healing Grace LLC.</u>	
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) _____ as required in MS section <u>256B.0759</u> , 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.	
<input checked="" type="checkbox"/> Level 1.0 Outpatient Treatment Services <input checked="" type="checkbox"/> Level 2.1 Intensive Outpatient Treatment Services <input type="checkbox"/> Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.2 Clinically Managed Residential Withdrawal Management <input type="checkbox"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services <input checked="" type="checkbox"/> Level 3.5 Clinically Managed High-Intensity Residential Treatment Services <input type="checkbox"/> Level 3.7 Medically Monitored Inpatient Withdrawal Management	
<u>Assurance of Client Choice</u>	
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.	
<u>Term and Termination</u>	
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.	
<u>Privacy and Confidentiality of Consumer Information</u>	
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: <u>6/20/21</u>
Referral Provider:	Date: <u>06/28/2021</u>



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
BW0090761 XW0090761	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 1006 (21 USC 824 and 956) 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
BW0090761 XW0090761	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 1006 (21 USC 824 and 956) 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.

Form DEA-223 (06/2016)



NorthStar Regional MAT Procurement Procedure

Obtaining Vivitrol Injection Procedure

- 1) Vivitrol is ordered thru Fairview Specialty Clinic 612-672-5260, if the client has insurance.
- 2) If the client does not have insurance, NorthStar Regional is able use Vivitrol sample once the insurance is active, then we order the next dose through insurance.
- 3) If the insurance needs a prior authorization, nurses process the prior authorization.
- 4) If Vivitrol is a fee for service, NorthStar Regional contacts Midwest Immunology Clinic and follow the form. See form attached.

Obtaining Suboxone

- 1) If client needs help with cravings from Heroin or other Opioids, Nursing consults with Dr. Winegarden to get approval for a Suboxone taper. A Suboxone taper depends on the use history, method of use and how long/amount. If Genoa Pharmacy is able and open NorthStar Regional will use them, if not NorthStar Regional will use Hy-Vee and staff picks up the medication.



Vivitrol Order Form, Outpatient Psychiatric Service

Patient Name: _____

Patient DOB: _____

Patient Phone: _____

Current Address:

Sugar Creek 1055 Stoughton Ave
Chaska MN 55318

Insurance Information:

Insurer Name	_____
Member ID	_____
Group #	_____

Copy of card attached if box is checked

ORDER:

Vivitrol 380mg IM q30 days, quantity #1, with 11 refills

Diagnosis code (please circle): **F10.20** or **F11.20**

- Dr. Thomas Winegarden MD
- Dr. Molly Stommes APRN DNP
- Mr. Michael Keegan APRN CNP

TELEPHONE ORDER READ BACK

Nurse signature: _____ time & date: _____

Nurse Printed Name: _____

Nurse Phone (please circle): **952.208.1112** or **952.297.8655** or **952.297.8648**

Transportation Options:

- MA- Smart Link- 952-496-8341
- Blue Plus- Blue Ride- 952496-8341

Please see additional documentation attached:

- Most recent office visit notes (up to 3)

FAX TO: Midwest Immunology Clinic –Plymouth (f) **763.577.0192**, ATTN: VAL
15700 37th Ave N STE 110, Plymouth, MN 55446 (p) 763.577.0008



8.1 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	
Harold Baumchen	President NorthStar Regional	

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 262 new HIV diagnoses reported in Minnesota in 2022 a decrease of 12% from 2021.
- _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 2022).
- _Foreign-born (non-US born) persons made up nearly 1 in 5 of new HIV infections in 2022, 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 <https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids>

For additional information on HIV, call the MN AIDS Project AIDS line at (612)-373-2437 or 1800-2482437. The AIDS line 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.

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 AIDS Line 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: <https://www.health.state.mn.us/diseases/stds/riskassess/riskguide.pdf>

Quick Connect Services 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, 2022).

About one quarter of HIV-infected persons in the United States are also infected with Hepatitis C virus (HCV). As of May 11, 2023, 9,805 persons in Minnesota are assumed to be living with HIV. Of these people, 2036, (21%) 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, 2022. 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, 2022). The U.S. Public Health Service/Infectious Diseases Society of America guidelines recommend that all HIV-infected persons be screened for HCV infection (CDC, 2022).

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 AIDS Line has a list of HIV support groups in Minnesota. Health care providers may also have some suggestions. Two MAP programs, Rainbow Health, <https://rainbowhealth.org/living-with-hiv/peer-support/positive-link/> , and Gay Cities, <https://minneapolis.gaycities.com/more/225301-youth-aids-projects> , offer social, educational, and activist opportunity to meet people who are involved in HIV advocacy and education. Contact MAP AIDS Line 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 AIDS Line is a resource individuals can call and ask the MAP AIDS Line 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 comorbid 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 Secondary HIV 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 2023, there were 9,805 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. 17

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/syringeexchange.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 result in 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 stepwise 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, cross training 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.uofmmmedicalcenter.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.

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 Clinica

Provides HIV support and counseling for Spanish speaking clients.

<http://www.westsidetchs.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 AIDS Line resource guide webpage. Or contact the AIDS line 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/minnesotahiv-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 612373-2437, 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 Elimination Tuberculosis: 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 xray 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 <https://www.cdc.gov/tb/>