Women's Residential 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

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Note: The content of this manual outlines the NorthStar Regional Women's Residential 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 Chaska, MN.

NorthStar Regional's Policy and Procedure Manual outlines procedure program compliance with Minnesota 245G 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.

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1 NorthStar Regional Residential Treatment Program Services

NorthStar Regional's high intensity residential treatment and education programs for adult women provide services to female clients diagnosed as having co-occurring mental health/substance abuse disorders or substance abuse disorders and their families.

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

NorthStar Regional's Residential program serves adult female clients with a substance use disorder and/also co-occurring diagnosis, and their families, during convenient operational hours to meet client needs. NorthStar Regional's Co-Occurring Residential and Outpatient treatment program provides services to adult females, ages 18-100, diagnosed as having co-occurring mental health/substance use disorders or substance use disorders and their families.

Procedure

1. Residential services provided will be specifically tailored to adult female clients with substance use disorder and their families. Residential will be specifically tailored to adult female clients with substance use disorder and/or co-occurring disorders.
2. Staff will be present onsite at the residential program 24/7/365
3. Treatment service hours will be Monday through Sunday 8am-10pm and will be adjusted appropriately to accommodate client scheduling needs
4. One or more staff members will be present in the office any time a client is present

1.2 Treatment Structure

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

Program Components

1. **Comprehensive Assessment (CA):** Clients are assessed by a Licensed Alcohol and Drug Counselor (LADC) and referred appropriately
2. **Client Orientation:** Clients will be oriented and admitted to the program and LADC will begin treatment planning
3. **Groups:** Clients are admitted to a level of intensity appropriate to the acuity of their needs and will then step down through each program focus/intensity in a manner reflective of their stage of change
    a. Group formats will include interactive psychoeducation, activities, and therapeutic processes
    b. Culture-specific treatment components are expanded to accommodate client needs; gender, age, ethnicity, professional/social background, trauma history, sexual orientation, spirituality, physical disability, parenting and pregnant mothers
    c. Group Counseling means a professionally led psychotherapeutic substance use disorder treatment that is delivered in an interactive group setting. Group size will not exceed 16 clients.
4. **Individual Therapy and Case Management:** Clients attend weekly individual sessions with their assigned primary counselor. The primary counselor will complete an Individual Treatment Plan and review weekly throughout the duration of treatment. The primary counselor will collaborate and consult

with the NorthStar Regional's treatment team and other providers, such as county social workers and probation teams

5. **Drug Screening:** Random weekly drug screening will be used to support client accountability
6. **Discharge and Referral:** Clients are assessed according to the 6 Dimensions
7. **Continuing Care:** Continuing Care groups and activities are provided for all successful program graduates
8. **Community Outreach**
    a. Prevention education directed toward schools and community youth and recovery support programs
    b. Space is provided for local support group meetings; a staff member will be present during meetings (not for the public at the Women's Residential Treatment Center).

Levels of Treatment Intensity: Residential Program

Treatment at NorthStar Regional Residential Treatment Program is individualized and includes ongoing assessment in each of the six dimensions according to 245G.05 Subp.2(c) ((1-6)). Duration listed below is only an average. Actual duration will depend upon the client's 6-dimension severity ratings.

Program

a. Duration: 4-6 weeks
b. Group sessions: 19 per week = 33.5 hours
    i. Primary (12.5 hrs.), Mental Health Recovery Group (7.5 hrs.), Lecture: Topics (1.5 hr.), Daily Meditation (5 hrs.), Community Meeting (1 hr.), Health & Wellness (50 min.) Life in Balance (1 hr.), and Helping Women Recover (2 hr.), and Tactile Skills Group (2 hr.).
c. Individual sessions: 2.15 hr per week = 1- LADC, 1- MH, and 15 min Peer Recovery
d. Total program hours: 31 hours of group, 1-3 hours of individual per week
e. A schedule of weekly groups will be given to residents at admission and available at all times

Levels of Intensity: High Intensity Residential

Clients are expected to attend all groups. During the daytime, each group meets for 3 hours on 3 separate days per week. In addition to group sessions, clients are also required to attend a weekly individual session with their Primary Counselor and weekly Mental Health counselor. During these weekly sessions, the counselor will review with the client their individual treatment plan, discuss their progress towards discharge, and update their 6 Dimension severity ratings. Clients need to contact their primary counselor to schedule this weekly appointment. When a client has decreased their severity rating in Dimensions I - VI to a 1, or at staff recommendation, they will complete the primary portion of their program and move on to Continuing Care.

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

Groups

Curriculums include but are not limited to Dr. Hal Baumchen's Destinations Workbook and co-occurring curriculums from Journey to Recovery. We also will use integrating Helping Women Recover by Covington, Seeking Safety, and Living in Balance from Hazelden.

1. **Primary Group: Group Treatment Service** *(Group Counseling)*
    a. *This group occurs 12.5 hours per week with a Licensed Alcohol and Drug Counselor. The group may consist of:*

i. Twelve Step facilitation
ii. Cognitive Behavioral Therapy
iii. Motivational Enhancement Therapy
iv. Identification of use consequences and support for abstinence motivations Psycho-educational components: substance use disorders-focused
v. Addiction, Disease Model
vi. Relapse prevention
    - Identifying and managing relapse triggers and high-risk situations
vii. Utilizing Coping Skills
    - SMART Recovery, relaxation tools
    - Stress and lifestyle management skills
    - Health and nutrition
viii. Relationship enhancement
    - Communication skills, boundaries, interpersonal effectiveness skills, conflict resolution
ix. Spirituality and personal purpose

2. **Meditation Group:** *(Client Education, Living Skills, Group Counseling)*
    a. This group is done first thing in the morning for the duration of 5 hours per week and is facilitated by a Qualified Professional. It helps clients integrate gains made during treatment into daily living, and to reduce reliance on staff for support. This group consists of:
        i. Meditation & feedback
        ii. Feelings inventory
        iii. Daily goal sheet
        iv. Positive Affirmations
3. **Mental Health Recovery Group:** *(Co-Occurring Disorders)*
    a. (Duration 7.5 hours per week facilitated by an onsite qualified Mental Health Provider: Hour 1.5: Client Education, Hour 2: Group Counseling)
    b. Emotional resolution
        i. Distress tolerance
        ii. Anger management
        iii. Self-harm reduction
    c. Dialectical Behavior Therapy
    d. Group psychotherapy process
    e. Relationship and enhancement
    f. Symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder.
4. **Community Meeting: Group Treatment Service** *(Client Education)*
    a. Staff and clients get together to practice assertive confrontation, problem identification, and using support system for solutions.
    b. This group occurs 1 hour per week by a qualified professional.
5. **Family Education Group: Group Treatment Service** *(Client Education)*
    a. Not currently provided
    b. Weekly participation with clients and their families for 2 hours per week facilitated by a qualified professional.
    c. Psycho-educational components: Co-occurring and family systems-focused
        i. Communication skills, anger management, conflict resolution
        ii. Family roles, rules, and genealogy
        iii. Codependency, enabling, and boundaries
    d. Community resources, support, and self-care
    e. Education for sober recreation
6. **Helping Women Recover Group (Group Counseling)**
    a. This group is facilitated by a qualified professional offered once per week for the duration of one hour.

b. This group utilizes the curriculum from 'Helping Women Recover' and is trauma informed treatment program. The goal is to allow the clients to process in a safe environment that include group sessions, summaries of information presented by the facilitatory and reflection and activities to assist in gaining insight. There are four modules:
   i. Self
   ii. Relationships
   iii. Sexuality
   iv. Spirituality

c. This group will help clients continue to develop interpersonal relationships while maintaining their sobriety and focusing on recovery.

7. Life in Balance (Group Treatment Service, Co-Occurring Disorders, Client Education):

a. Utilizing the Living in Balance Curriculum by Hazelden Betty Ford, this group covers topics such as Triggers and Cravings, moving toward a life in recovery, and relapse prevention. This group takes on the approach of hands-on learning and client centered care. This group occurs once weekly for 2 hours and is facilitated by a Qualified Professional.

8. Stages of Change Group Treatment Service (Outpatient program only)

a. Stages of Change Group is facilitated by a licensed professional once per week for the duration of one hour.

b. The group consists of:
   i. Introduction
   ii. Decisional Balance
   iii. SOCRARTES 19-item Readiness to Change Questionnaire
      - Ambivalence
      - Recognition
      - Taking Steps
      - Roadblocks

c. The facilitator runs the group to help education the clients on the stages of change, how to identify where they are at and what they need to do to either maintain or grow.

9. Coping Skills Group (Outpatient Program Only)

a. This group is facilitated by a licensed professional once per week for the duration of two hours.

b. The group identifies:
   i. Tracking urges
   ii. Coping with urges
   iii. Setting boundaries
   iv. Being sober vs Being in recovery

c. This group is an education group that helps build off of the Relapse Prevention information and integrate it.

10. Foundations (Outpatient Program Only)

a. This group is facilitated by a licensed professional weekly for the duration of one hour

b. The group is focused on education of addiction and models of addiction. Some items covered but are not limited to:
   i. Models of Addiction
   ii. My Name is Bill W
   iii. Twelve Steps and Twelve Traditions
   iv. Active listening and constructive feedback
   v. Pleasure Unwoven

c. This group is to provide the client with further education on addiction, continue to develop communication skills as well as look at alternative modalities to offer support in sobriety

11. Family Topics Group (Outpatient Program Only)

a. This group is offered once per week for the duration of one hour and is facilitated by a licensed professional.

b. The goal of the group is to identify family roles, family education, support, and resources for the clients to gain insight into how they have impacted their family as well as how to begin to rebuild the relationship with family.

c. There will be discussions on communication and how to communicate effectively, healthy relationships, coping skills, and boundaries.

12. Tactile Skills Group Treatment Service

a. Art therapy is the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma, or challenges in living, and by people who seek personal development

b. Through creating art and reflecting on the art products and processes, clients can increase awareness of self and others, cope with symptoms, stress, and traumatic experiences; enhance cognitive abilities; and enjoy the life-affirming pleasures of making art

13. Recovery Topics Group Treatment Service

a. A group for clients to work on, share, and process treatment plan assignments from the treatment plans.

14. Health and Wellness

a. This group is facilitated by a licensed alcohol and drug counselor or qualified mental health professional, for 1-2 hours, as needed, per client's treatment plan.

b. Health and Wellness offers a unique type of support to assist in strengthening sober support connections, increasing self-esteem, improving mental health symptoms, expanding communication skills, and inspiring clients to participate in sober activities.

c. This group session may include, but is not limited to, playing a recovery related game (such as, Recovery Jenga, Recovery Jeopardy, or Recovery BINGO), creative writing or journaling, and music therapy.

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

NorthStar Regional's Women's Residential program provides residential treatment services for adult female clients with a substance use disorder and/also co-occurring diagnosis and for their families. Treatment services are provided by a competent multidisciplinary team of Licensed Alcohol and Drug Counselors and Licensed Mental Health Professionals. Specific treatment services 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 psychoeducation 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.
    - **d.** All clients will be required to sign into each treatment service that they attend on the Group Sign-in Sheet. This sheet identifies the date, time, duration, and qualified professional leading the group.
        i. The Primary Counselor will utilize these sheets to ensure the client is participating in the minimum 30 hours of programming as required by DHS. Any client that is at risk for not meeting the minimum 30 hours will meet with their Primary Counselor or another qualified professional to ensure the 30 hours of programming have been met.
3. **Drug Screening:** Random drug screening will be used to support client accountability and any legal obligations.
4. **Education:** Clients learn strategic skills to avoid pathological substance abuse and manage problems related to substance abuse. They will be provided with information addressing healthful nutrition and exercise that

will encourage and support a healthy lifestyle. Client's will receive the above information in one of three ways: During the intake process, during Health and Wellness group, or in a 1:1 session with clinical staff.

   a. In accordance with Minnesota Statutes, section 245A.19, clients will be provided with education concerning risks associated with substance use during pregnancy, sexual health safety, human immunodeficiency virus, tuberculosis, hepatitis, and other communicable diseases

5. **Transition Services:** Clients are guided to utilize familial and communal resources to assist in the integration of treatment gains to daily life such as Minnesota Department of Human Services (DHS) Adult Rehabilitative Mental Health Services (ARMHS), Al-Anon services, medical transportation services, and involvement in local churches or other supportive networks. A supported transition serves to increase clients' independence and reduce unhealthy reliance on program staff.
6. **Mental Health Services:** All clients are screened for mental illness. Clients requiring additional assessment will complete a comprehensive diagnostic assessment and be treated onsite by a mental health professional. For those in the outpatient program, clients requiring additional assessment will complete a comprehensive diagnostic assessment within 10 days and be treated onsite or referred elsewhere to a mental health professional.
   a. Education will be provided surrounding symptoms of mental illness and co-occurring disorders, the importance of medication compliance, and use of strategic coping skills 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. **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, life skills advocacy and assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs as well as support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed. Documentation of treatment coordination services will be included in the client's file.
8. **Peer Recovery Support:** This service is provided by an individual in recovery. Peer support services are provided 1:1 and 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. The duration of the 1:1 session will be determined in the client's individual treatment plan
   a. All peer recovery services are on-site for residential clients.
   b. Peer recovery services for outpatient clients may be off-site.
9. **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.

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 psychoeducation and facilitate group psychotherapy according to program schedules.
    a. Curriculum materials and schedules may be customized to meet group needs upon approval of the Program Director.
5. The Program Director will work with NorthStar Regional's COO and the Chief of Programs and Services 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. **Individual Mental Health Therapy -** Based on a client's acuity level, clients are provided with additional individual mental health therapy. We work with them to provide a specialized co-occurring treatment to educate clients in the understanding of the patterns with life span experiences in relation to mental health and substance use, within the services provided of life skills, relapse prevention, seeking safety, mental health education. Individuals with underlying issues of PTSD, trauma, neglect, suicidal ideation, history of suicidal attempts, self-harm, abandonment, unhealthy relationships, abuse, co-dependency, emotional deregulation, lack of healthy communication skills, and lack of healthy personal support benefit from these services. Any additional mental health services, above the 25% ratio, are billed separately. The services billed separately include but are not limited to: Individual mental health sessions and individual psychiatric sessions.
2. **Family Issues Group:** 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
3. **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. This service is provided individually, as needed. We provide yoga to our clients to enhance their physical well-being and teach stress management.
4. **Life Skills: Education Service -** Education is provided as a group service once weekly for one hour to assist clients in learning and practicing life skills, including schedule management, home upkeep, and basic financial management, to support independent living and life in recovery.
5. **Employment and Educational Services: Education Service -** Clients may be provided with education including resume-writing and interviewing skills, to support completion of high school diploma, GED, college, or employment advancement. Clients will be assisted in locating and obtaining additional services as needed individually with a licensed alcohol and drug counselor, qualified mental health professional, or certified peer recovery specialist.
6. **Social Skills: Education Service -** Clients will be provided with communication skills education and opportunities to practice social skills in a safe environment during group sessions or individually, as needed. This service may be provided in place of a regularly scheduled group for one hour.
7. **Prevention Plans** are developed and followed as needed. Overnight staff are awake (Residential Program)
8. **Safe Environment:** Clients are provided with a safe treatment environment. Staff members are always present and available when clients are present. Outpatient clients are initially and continuously assessed for vulnerability and Individual Abuse Prevention Plans are developed and followed as needed
9. **Residential Room and Board:** Clients are assisted with the acquisition of housing and economic resources in preparation for discharge from the residential program

10. **Accountability:** Clients are provided the accountability to maintain sustained abstinence through random drug and alcohol testing

Procedure

1. Appropriately licensed staff members will be designated to facilitate and document clinical services in clients' individual treatment plan
2. Drug screening tools will be obtained and administered by NorthStar Regional staff and/or 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 Chief Programs & Service to monitor service fidelity and outcomes to ensure that evidence-based practices are consistently used to best serve clients

1.5 Drug Screening

Accountability is an important part of 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. Ensure the Standing Order for labs is uploaded into the client's file.
4. Ensure UA screening form in upload into the client's file for medical necessity
5. Assigned LADC, 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. Completed drug screens will be documented in a case management note in client charts, and all positive drug screens will be discussed in case consultation in order to determine an appropriate treatment intervention.
        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 LADC & MH, copying the Program Director. Interventions, consulted and used, should be documented by the primary counselor in the 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 client may be tampering with the specimen. Observers and collectors at NorthStar Regional are the same individual. A direct, observed collection includes the following steps:

1. All clients will confirm their identity with first name, last name, and date of birth for the collector.
2. The labels for the vials are then filled out with: Date, Client Name, DOB, Collection Date, and Signature of Client, and Initial of the Collector. If the client refuses to complete paperwork, the collector notes the refusal and continues with the collection process.
3. The collector asks the client 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 client may retain the client'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.
4. The collector must be the same gender as the client, 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 client 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 client to wash and dry the client's hands prior to urination. After washing the client's hands, the client 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 client refuses to wash the client'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.
    f. After the client has completed urinating into the collection container: the collector shall receive the container from the client while they are both in the restroom.
    g. In cases where a client is unable to produce a sample due to anxiety or previous trauma, the collector will exit the area, communicate with the primary counselor, and notate the specimen as "Unobserved".
5. Integrity, Identity, and Control of a Specimen
    a. The collector must inform the client that, once the collection procedure has begun, the client must remain at the collection site (*i.e.,* in an area designated by the collector) until the collection process is complete, specimen sealed and verified by the client. Both the client and the collector must always keep the specimen container in view until the collector seals the specimen bottles.
    b. After the client has given the specimen to the collector, whenever practical, the client shall be allowed to wash the client's hands and the client may flush the toilet.
    c. When there is any reason to believe that a client may have adulterated or substituted the specimen, another specimen must be obtained as soon as possible under direct observation.
    d. The collector must determine the volume of urine in the specimen container. The collector must never combine urine collected from separate voids to create a specimen.
    e. If the client fails to remain present through the completion of the collection, the collector stops the collection and reports the refusal to test.

6. Specimen Custody Management and Preparation for Testing
    a. All collections are to be split specimen collections: one for NorthStar Regional Clinical Laboratory and one for a confirmation testing by a third-party vendor.
    b. The collector, in the presence of the client, pours the urine from the collection container into two specimen bottles.
    c. In the presence of the client, the collector places a tamper-resistant label/seal from the requisition form over each specimen bottle cap. The collector records the date of the collection on the tamper-resistant labels/seals.
    d. The collector instructs the client to initial the tamper-resistant labels/seals on each specimen bottle. If the client refuses to initial the bottles, the collector notes the refusal and continues with the collection process.
    e. The collector asks the client to read and sign a statement certifying that the specimens identified were collected from the client. If the client refuses to sign the certification statement, the collector notes the refusal and continues with the collection process.
    f. The collector seals the specimens in a package and, within 24 hours or during the next business day, sends them to the laboratory that will be testing the urine specimen.
    g. If the specimen is not immediately transported to the laboratory, they must remain under direct control of the collector or be appropriately secured under proper specimen storage conditions until transported.
7. Collectors are not to discuss test results, processes, or other clinical items with patients. Clients with questions are to be referred to their primary Chemical Dependency (CD) counselor.

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

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

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

Psychiatry Procedure

1. All clients in the NorthStar Women's Regional Residential program who are diagnosed with a mental health disorder that may benefit from medication management will be provided with psychoeducation regarding their diagnosis to include psychopharmacological benefits and the importance of proper medication management.
2. Program staff will assist clients in psychiatry referrals and will consult with psychiatry as appropriate

Flexibility for Lapses and Non-adherence to Treatment Rules Procedures

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

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

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

1. All program curriculums are comprehensive in addressing co-occurring substance use and mental health disorder diagnosis.
2. Throughout the program clients participate in weekly psycho-educational groups focused on understanding mental health conditions, including mood and anxiety disorders, personality disorders and suicidality, attention disorders, psychotic disorders, impulse disorders, experience of trauma and Post-traumatic stress disorder (PTSD). These interactive groups provide clients with an increased understanding of mental health conditions and impacting co-occurring components. Additionally, these groups provide an opportunity for clients to process their experiences of such conditions in a safe and supportive therapeutic environment.
3. Throughout the program, clients participate in weekly psycho-educational groups focused on skills training. These groups provide clients with an education of adaptive CBT and DBT skills purposed to assist in managing both mental health symptoms and avoiding maladaptive patterns of substance use. These interactive groups provide clients the opportunity to learn, and practice learned skills in a safe and supportive therapeutic environment.

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

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

Participants Appropriate for Program Admittance-

1. Participants must meet the following diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5):

   a. Substance Use Disorder Diagnosis, 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. Clients must be willing to participate in appropriate daily structured activity
7. Participants will commit to the entire treatment process, including screening and diagnostic assessment, treatment planning, and Continuing Care
8. Persons who do not meet program admission criteria, exhibit acute physical or mental health needs that exceed the constraints of a residential level of care, or pose a physical threat to self or others, will be referred to a medical facility capable of admitting the client. Upon appropriate consultation, assessor will assist such persons with referral for an appropriate level of care to ensure safety and best client care
9. 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 24-hour medical care and nursing supervision preceding substance abuse treatment.

Dimension 2: biomedical conditions and complications.

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

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client displays full functioning with good ability to cope with physical discomfort.	0 The client's risk does not impact treatment planning decisions.
1 The client tolerates and copes with physical discomfort and is able to get the services that the client needs.	1 The placing authority may refer the client for medical services.
2 The client has difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and treatment. The client neglects or does not seek care for serious biomedical problems.	2 Services must include arrangements for appropriate health care services, and monitoring of the client's progress and treatment compliance as part of other chemical dependency services for the client.
3 The client tolerates and copes poorly with physical problems or has poor general health. The client neglects the client's medical problems without active assistance.	3 The placing authority must refer the client for immediate medical assessment services for the client as part of other treatment services for the client. The placing authority must authorize treatment services in a medical setting if indicated by the client's history and presenting problems.
4 The client is unable to participate in chemical dependency treatment and has severe medical	4 The placing authority must refer the client for immediate medical intervention to secure the client's safety and must

problems, a condition that requires immediate intervention, or is incapacitated.

delay treatment services until the client is able to participate in most treatment activities.

Dimension 3: emotional, behavioral, and cognitive conditions and complications.

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

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client has good impulse control and coping skills and presents no risk of harm to self or others. The client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.	0 The placing authority may use the attributes in the risk description to support efforts in other dimensions.
1 The client has impulse control and coping skills. The client presents a mild to moderate risk of harm to self or others or displays symptoms of emotional, behavioral, or cognitive problems. The client has a mental health diagnosis and is stable. The client functions adequately in significant life areas.	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.	2 The placing authority must authorize treatment services for clients that include: consultation with and referral to mental health professionals as indicated, monitoring mental health problems and treatment compliance as part of other chemical dependency treatment for the client; and adjustment of the client's services as appropriate.
3 The client has a severe lack of impulse control and coping skills. The client also has frequent thoughts of suicide or harm to others including a plan and the means to carry out the plan. In addition, the client is severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in treatment activities.	3 The placing authority must authorize integrated chemical and mental health treatment services provided by a provider licensed under part 9530.6495 and 24-hour supervision.
4 The client has severe emotional or behavioral symptoms that place the client or others at acute risk of harm. The client also has intrusive thoughts of harming self or others. The client is unable to participate in treatment activities.	4 The placing authority must refer the client for acute psychiatric care with 24-hour supervision and must delay chemical dependency treatment services until the client's risk description has been reduced to number 3 in this dimension or refer

	the client to a mental health crisis response system.

Dimension 4: readiness for change.

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

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client is cooperative, motivated, ready to change, admits problems, committed to change, and engaged in treatment as a responsible participant.	0 The placing authority may use the attributes in the risk description to support efforts in other dimensions.
1 The client is motivated with active reinforcement, to explore treatment and strategies for change, but ambivalent about illness or need for change.	1 If services are authorized, they must include active support, encouragement, and awareness-raising strategies along with chemical dependency treatment services for the client.
2 The client displays verbal compliance but lacks consistent behaviors; has low motivation for change; and is passively involved in treatment.	2 The placing authority must authorize treatment services for the client that include client engagement strategies.
3 The client displays inconsistent compliance, minimal awareness of either the client's addiction or mental disorder and is minimally cooperative.	3 The placing authority must authorize treatment services that have specific client engagement and motivational capabilities.
4 The client is:	4 The placing authority must authorize treatment services that include:
(A) noncompliant with treatment and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the client's illness and its implications; or	(A) service coordination and specific engagement or motivational capability; or
(B) the client is dangerously oppositional to the extent that the client is a threat of imminent harm to self and others.	(B) 24-hour supervision and care that meets the requirements of part 9530.6505.

Dimension 5: relapse, continued use, and continued problem potential.

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

RISK DESCRIPTION	TREATMENT PLANNING DECISION
0 The client recognizes risk well and is able to manage potential problems.	0 The placing authority may facilitate peer support for the client.
1 The client recognizes relapse issues and prevention strategies but displays some vulnerability for further substance use or mental health problems.	1 The placing authority may promote peer support and authorize counseling services to reduce risk.
2 (A) The client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems.	2 (A) The placing authority must authorize treatment services for clients that include counseling services to reduce client relapse risk and facilitate client participation in peer support groups.
(B) The client has some coping skills inconsistently applied.	(B) The placing authority must promote peer support and authorize counseling services or service coordination programs that comply with part 245G or Code of Federal Regulations, title 42, part 8.
3 The client has poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. The client has few coping skills and rarely applies coping skills.	3 The placing authority must authorize treatment services for the client that include counseling services to help the client develop insight and build recovery skills and may include room and board.
4 The client has no coping skills to arrest mental health or addiction illnesses or prevent relapse. The client has no recognition or understanding of relapse and recidivism issues and displays high vulnerability for further substance use disorder or mental health problems.	4 The placing authority must authorize treatment services that include service coordination and counseling services to help the client develop insight and may include room and board with 24-hour-a-day structure.

Dimension 6: recovery environment.

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

RISK DESCRIPTION	TREATMENT PLANNING DECISION

0 The client is engaged in structured, meaningful activity and has a supportive significant other, family, and living environment.	0 The placing authority may use the client's strengths to address issues in other dimensions.
1 The client has passive social network support or family and significant other are not interested in the client's recovery. The client is engaged in structured meaningful activity.	1 The placing authority may promote peer support and awareness raising for the client's significant other and family.
2 The client is engaged in structured, meaningful activity, but peers, family, significant other, and living environment are unsupportive, or there is criminal justice involvement by the client or among the client's peers, significant other, or in the client's living environment.	2 The placing authority must authorize treatment services for the client that help the client participate in a peer support group, engage the client's significant other or family to support the client's treatment, and help the client develop coping skills or change the client's recovery environment.
3 The client is not engaged in structured, meaningful activity and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.	3 The placing authority must authorize the treatment planning decision described in 2 and service coordination and help find an appropriate living arrangement and may include room and board.
4 The client has:	4 The placing authority must authorize for the client:
(A) a chronically antagonistic significant other, living environment, family, peer group, or long-term criminal justice involvement that is harmful to recovery or treatment progress; or	(A) the treatment planning decision in 3 and appropriate ancillary services, and room and board within 24-hour structure authorized for the client if an appropriate living arrangement is not readily available; or
(B) the client has an actively antagonistic significant other, family, work, or living environment, with immediate threat to the client's safety and well-being.	(B) tx services that include service coordination and immediate intervention to secure the client's safety. Room and board with 24-hour structure must be authorized for the client if an appropriate living arrangement not readily available.

10. Staff Members Authorized to Initiate Services

- CEO
- Chief of Programs & Services
- Chief Operating Officer
- Program Director (or their designee)
- Clinical Supervisor
- Medical Director

- Admissions Coordinator

Procedure

1. The licensed drug and alcohol counselor will complete the following clinical documents and make appropriate treatment recommendations or referrals upon clinical consultation.
    a. Minnesota Comprehensive Assessment
    b. Clinical Assessment (CA) Form
    c. Mental health screening tools
        i. GAIN-SS (Adults)
        ii. DSM-5 Cross Cutting Symptom Measure
    d. Admission and recommendation letters will be sent to client and referring agency within 10 days
2. Service initiation of clients under civil commitment will be managed in compliance with Minnesota Statutes, section 253B.16, subdivision 2
3. Admission preference will be provided in accordance with the Code of Federal Regulations, title 45, part 96.131. Preferential treatment placement will be given to (1) Pregnant injecting drug users; (2) Pregnant substance abusers;(3) Injecting drug users; and (4) All others.
4. 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 the Chief Executive Officer (CEO)
                a. Chemical Health Diagnostic Assessment: $300
                b. Per diem Rate: $475
            - 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 Medical Assistance (MA), staff should direct the client to apply for MN Rule 25 funding through their county of residence and obtain a Release of Information (ROI) in order to coordinate service funding. Client should schedule an Orientation session with NorthStar Regional's Program Director upon receipt of MN Rule 25 Client Placement Authorization (CPA)

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

2. Comprehensive Assessment Session (2 hrs.)
   a. The following intake paperwork should be completed:
      i. 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. NorthStar Regional's Consent for Laboratory Testing
      vii. Client Bill of Rights
      viii. Authorization for Release of Information/Vulnerable Adult Form
      ix. NorthStar Regional's Adult/Child Data Form
      x. GAIN-SS (Adults)
      xi. DSM-5 Cross Cutting Symptom Measure
      xii. NorthStar Regional's Health Questionnaire
   b. Clients should schedule an orientation session if the LADC recommends NorthStar Regional's Treatment programming
   c. If a client does not arrive within 10 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. Client Expectations
      iii. NorthStar Regional's Emergency Management Policy and Procedure
      iv. NorthStar Regional's Communicable Diseases Policy and Procedure and Resources
      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 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 Statutes 245G.05, 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

1. **Comprehensive Assessment (CA)** will be completed by the LADC within five calendar days from the day of service initiation for a residential program or within three calendar days on which a treatment session has provided from the day of service initiation for outpatient programs and will include determination of substance use disorder and diagnosis in accordance with DSM-5 diagnostic criteria and will include the following documents
    - i. **Mental Health Screening Tool** will be completed and scanned into client charts by office staff
        - **i. GAIN-SS -** completed by client during intake
        - **ii. DSM-5 Cross-Cutting Measures Screen -** completed by client during intake
    - ii. **Comprehensive Assessment Supplement and Summary** will be completed by the LADC within five calendar days from the day of service initiation for a residential program or within three calendar days on which a treatment session has provided from the day of service initiation for outpatient programs and will provide a narrative and rationale for assessment using the 6 Dimension Risk ratings.
        - **i.** 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 5 days of assessment and/or admittance.
        - **ii.** A diagnosis of a substance use disorder or a finding that the client does not meet the criteria for substance use disorder
        - **iii.** A determination of whether the individual screens positive for co-occurring mental health disorders using a screening tool approved by the commissioner pursuant to section 245.4863.
        - **iv.** A risk rating and summary to support the risk ratings within each dimension listed in section 254B.19 sub 1.
        - **v.** Recommendations for the ASAM level of care identified in section 254B.19 sub 1
        - **vi.** If the client is assessed for opioid use disorder, the program must provide educational material to the client within 24 hours of service initiation on opioid use disorder and dependence (treatment options, medication, risk & recognition of overdose

Treatment Planning Procedure *(245G.06)*

1. **Initial Services Plan (ISP)** must be completed within 24 hours of admission. If the Initial Service Plan is completed on the second day, NorthStar Regional will note time of admission as well as time of completion of the ISP. All Initial Service Plans at NorthStar Regional will be person-centered and client-specific, address the immediate health and safety concerns, and identify the treatment needs of the client to be addressed during the time between the day of service initiation and development of the individual treatment plan.

2. **Individual Abuse Prevention Plan (IAPP)** will be developed by the LADC within 24 hours of the time of vulnerability determination, in compliance with Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14
3. **Individual Treatment Plans** All person-centered treatment plans will be completed within ten (10) days from the day of service initiation for Residential Programs. 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 specific and address each identified need in the comprehensive assessment summary, including amount, frequency, and anticipated duration of treatment service. All treatment plans will be completed and signed by the client, the qualified staff member, and the licensed mental health professional 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 every 14 days to address changes in client's condition and effects of treatment interventions
        i. Client and LADC will sign and date individual treatment plan revisions

1.10 Treatment Services Termination *(245G.14 subd. 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

- Chief of Behavioral Health
- Chief of Programs & Services
- Chief Operating Officer
- Program Director (or their designee)
- 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, except the Jail Program.
d. If the commission of a crime against any staff member or property is involved with denial of initiated services, the assessor will make a report to local law enforcement providing minimal client information, pursuant 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) must be completed within 5 days of the client's service termination and include the following:
   a. Client problems, strengths, and needs during treatment
   b. Progress toward achieving each identified individual treatment plan goal
   c. Reason for service termination
   d. Discharge recommendations
   e. Discharge category
      i. If staff is 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
      ii. The reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the program's policies on staff-initiated client discharge. If a client is discharged at staff request, the program must give the client crisis and other referrals appropriate for the client's needs and offer assistance to the client to access the services
3. Discharge recommendations will be communicated to clients and referring agencies, with client release, within 5 days of discharge.
4. Planned discharge notification of a client under civil commitment will be sent by mail, fax or email at least 1 week prior to proposed discharge to the designated referent and client's spouse, adult child, or next of kin prior to discharge and will include the following:
      i. Proposed discharge date;
      ii. Date, time, and place of staff meeting to consult discharge, and
      iii. Indication that the client and next of kin may be present at this meeting
5. Before discharging a client from a residential setting for not reaching treatment plan goals, we will first discuss this with the client in the weekly treatment plan review. We will then confer with other interested persons to review issues involved in the decision. We will document and describe to these interested persons the reason why the decision to discharge is warranted, the reason for the discharge, and the alternatives considered or attempted before discharging a client. The following steps will be taken as well:

      i. Proposed staff discharges will be discussed by staff members in a meeting;
      ii. The Program Director will be involved in the decision;
      iii. Staff will call the last known number in the medical record in an attempt to reach the client or emergency contact. We will attempt to contact the affected individuals for 3 consecutive days.
      iv. procedures consistent with Minnesota Statutes, section 253B.16, subdivision 2, that staff must follow when a client admitted under
      Minnesota Statutes, chapter 253B, is to have services terminated;

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

Categorical Service Termination Procedures

1. **With Staff Approval (WSA):** Client has successfully completed all recommended programming and treatment objectives.
2. **Against Staff Approval (ASA):** Clients who are unable to sustain abstinence or exhibit physical or mental health needs that exceed program provisions.
3. **Against Medical Advice (AMA):** Client decides to terminate services against clinical advice.
    a. Staff will address client concerns and needs in consultation.
    b. Staff will discuss treatment options with the client but will respect and follow action of the client's decision.
    c. Recommendations should include higher level of care, such as detoxification or hospital based inpatient services.
    d. Program accommodations and intra-program referrals must be authorized by Program Director.
    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.

1.11 Health Monitoring Plan (*245G.08, subdivision 1; 245G.21 Subp 7)*

HEALTH CARE SERVICES DESCRIPTION: NorthStar Regional's Women's Residential program provides treatment, education, medical services, and prevention services for clients diagnosed with Substance Use and Co-Occurring Disorders. Mental Health and Nursing 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.

Residential Medical Services

NorthStar Regional offers Medical Services to clients in our program. The following policies and procedures will be followed, in accordance with MN Statute 254B.05:

1. Documentation of the nature and provision of medical services by the MD, RN, APRN, LPN or other appropriately credentialed healthcare staff in an amount equal to two hours per client per week will be completed weekly.
2. In addition to this policy and procedure manual, a separate "Medication and Mental Health Services at NorthStar regional" Manual is also used and followed.

Procedures and Responsibility: Staff members on duty are responsible for collecting client health information at admission and throughout treatment as follows:

1. Staff will make visual observations of client's health status at intake and throughout the treatment episode, noting client's behavior and appearance. The information gathered and documented in the medical record will be reviewed by the RN or LPN on duty. Visual observation may include the following areas:
    a. Coordination
    b. Speech
    c. Breath
    d. Face
    e. Pupils
    f. Attitude
2. Staff will review medication orders and procedures with the client and document medications in the EMAR (Electronic Medication Administration Record)
3. Staff will review past treatment, mental health and/or medical documents received from other agencies
4. Staff will obtain information on client's current health complaints and relevant medical history
5. Dietary information, including food allergies will be collected by the cook at intake. Food will be prepared according to special dietary needs
6. Toxicology tests [urine analysis (UA) and/or breathalyzer] will be done at intake and randomly thereafter
7. The staff in the residential programs will make rounds every 60-90 minutes to confirm the safety of all clients. Overnight staff will send a nightly report documenting client presence and any unusual, non-emergency, events
8. In the case of emergencies, staff will respond by following emergency procedures in the NorthStar Regional Policy and Procedure Manual
9. Health information will be recorded in client's chart

Health Assessment: The nurse will review the health-related information to assess for:

1. Additional information necessary for medications to be administered
2. Ability to self-medicate
3. Potential for emergency situations
4. Identification of safety concerns
5. Need for referral
6. Need for education to client or staff

Standardized Health Assessment Tool: In addition to items documented in Dimension 2 and the above-listed Health Assessment items, the program will use the standardized patient health Information sheet. This tool will be given by the RN or LPN upon admission, or as needed, and documented in the medical record for review by the RN or LPN.

Whenever indicated the nurse will develop a plan with instructions for the staff on monitoring for specific health care needs on an individual basis.

Approval: The health monitoring plan has been approved by a registered nurse.

_____ _____

Registered Nurse Signature Date

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; 245G.21 Subp 8)*

Residential Procedures

1. Delegations of administration of medication are limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical
2. Each client's file must include documentation indicating whether staff will be administering medication, or the client will be doing self-administration or a combination of both
3. A client may carry emergency medication such as nitroglycerin as instructed by their physician
4. Medication will be packaged and prepared for self-administered when a client is scheduled not to be at the facility
5. If medication is to be self-administered at a time when the client is present in the facility, medication will be self-administered under observation of a trained staff person
6. Paraprofessional/Tech staff will record the client's use or refusal of medication client's use of medication in the EMAR (Electronic Medication Administration Record), including staff signatures with date and time
7. Paraprofessional/Tech staff will inform a registered nurse of problems with self-administration including failure to administer, client refusal of a medication, adverse reactions, or errors. Staff will fill out medication error form, upload it to medical record and then email the registered nurse a notification upon discovery
8. Only one assigned technician per shift is permitted to have access to the keys to the locked drug compartments
9. No legend drug supply for one client will be given to another client

10. Additional Procedures are located in the NSR Medication Procedures Manual including the policy and procedure for administering Narcan.

Residential Procedures for acceptance, documentation, and implementation of prescriptions

1. Written physician orders will be obtained for all prescription medication
2. Medications may be ordered by a physician, dentist, or other health professional licensed to prescribe
3. Written physician orders will be located in the individuals' record and documented in the electronic medical record. A legible pharmacy label on a medication container may be used as a written physician's order and will be verified with the pharmacy.
4. Administer medication according to the physician's orders and established procedures.
5. Client will be given medication one at a time
6. Staff will document in the EMAR immediately after the medication is given. Staff will electronically sign along with date/time stamp this documentation

I am a registered nurse and approve these policies and procedures,

_____ _____

NSR Registered Nurse Date

OUTPATIENT MEDICATION ADMINISTRATION

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

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

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

Medication will be stored in compliance with Minnesota 245G.08, subdivision 6.

Procedure

1. All drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart
2. All drugs will be accounted for each shift. Schedule II drugs will be documented in the Controlled Medication Log each shift.
3. Clients will be referred to their prescribing physician to manage medications
4. Program staff will obtain client release of information and consult with prescribing physicians as appropriate
5. Staff will discuss client medication concerns in consultation
6. If a client attempts to surrender illicit or prescription drugs, or for any discontinued medication, or for outdated or deteriorated medications, the assigned med tech on duty will deliver the medication to 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.

To destroy a discontinued, deteriorated, damaged or expired medication, staff will:

1. Place medication in the "dead med drawer" in the med cart
2. Staff will destroy them by dumping them into the drug buster at the next available time

To destroy a narcotic or illicit drug medication, staff will:

1. Place medication in the illicit drug disposal container inside the locked narcotic safe
2. Nurse and a second staff member will fill out Medication Destruction Form documenting the medication destroyed, amount, date, and signed by Nurse

I approve these policies and procedures,

_____ _____

NSR Registered Nurse Date

1.14 Program Fidelity

NorthStar Regional's Residential Program operates under NorthStar Regional and is managed by the Program Director who reports to NorthStar Regional's Chief Programs & 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 prove 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 of minors are maintained for a period of seven (7) years beyond the age of majority;
- Post the closing letter in prominent places throughout the facility and at the front desk;
- Initiate discussion with EHR vendor for transfer of records or data files;
- Distribute talking points to staff and keep communications open about developments in the weekly staff meetings;
- Contact and initiate procedures with Custodian of medical records entity who will assume control, custody, and possession of all the medical records related to the practice of NorthStar Regional and shall retain the records in accordance with applicable Minnesota and federal laws.

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

_____

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 Statutes 245G.09 (subd. 1-3) HIPAA, and corresponding state and federal rules, statutes, and regulations.

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: 1055 Stoughton Avenue Chaska, MN 55318. 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, in compliance with Minnesota 245G.05, subd1.

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 upon service initiation.
        i. Client rights, responsibilities, and grievance procedures
        ii. Personal electronics device policy
    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
            1. Obtain a release of information from the client upon intake to give NorthStar Regional permission to report to MAARC. It is their right to refuse to provide NorthStar with a release.
    c. **Comprehensive Assessment (CA) for the Residential Program** will be completed by an LADC within three calendar days after service initiation. The **Comprehensive Assessment (CA) for the Outpatient Program** will be completed by the LADC the day of service initiation.
    d. **The Comprehensive Assessment for both Residential and Outpatient Programs consist of:** Minnesota Rule 25 Assessment, and the Comprehensive Assessment Supplement and Summary**:**

        i. **Comprehensive Assessment Supplement and Summary includes:**
            1. Assessment summary includes substance use diagnosis based upon DSM-5 criteria, assessment and narrative rationale of the 6 Dimension risk ratings, and

other information relevant to treatment planning; must be completed within 5 days.

2. (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.

e. Individual Abuse Prevention Plan (IAPP)

i. Residential Program Staff will develop an IAPP for all clients within the first 24 hours

f. Outpatient Program: Client vulnerability is assessed through a Vulnerable Adult Assessment

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

g. Individual Treatment Plans

i. Residential Program: The LADC will discuss the individual treatment plan in consultation and will complete the person-centered individual treatment plan within ten days from the day of service initiation (Residential Program). The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. This must be completed within 10 days.

ii. Outpatient Program: The LADC will discuss the individual treatment plan in consultation and will be developed by an alcohol and drug counselor will complete the person-centered individual treatment plan **within ten calendar days** on which a treatment session has been provided from the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. **Treatment plan reviews must be completed every 30 days.**

iii. The LADC and the client will review and sign all initial and updated individual treatment plans within 10 days.

h. 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, including a LADC and a Mental Health Professional at a minimum;
(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.

i. 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.

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; the client's living arrangements at service termination; and continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and service termination diagnosis.

iii. A copy of the client's service discharge summary must be provided to the client upon the client's request.

7. Permission to use electronic health recordkeeping program, Procentive, has been requested by the Commissioner. Until permission is granted all records will be maintained and protected according to these procedures and in compliance with Minnesota Statutes, section 254A.09, Code of Federal Regulations, title 45, parts 160 to 164, and Minnesota Statutes, chapter 13. DHS Licensor reviewed Procentive in February 2018.

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 (245G.11, 245G.13)

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

Staff members are provided with a description of organizational structure and clear job descriptions specifying responsibilities, degrees of authority to execute job responsibilities, and qualifications of hire. In compliance with Minnesota 245G.13, Minnesota Statutes, chapter 148A, and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572, behaviors that constitute grounds for disciplinary action, suspension, or dismissal, such as the existence of active chemical use problems and personal involvement with a client, as well as provision of job performance evaluations, are clearly outlined in the Staff Expectations Policy and Procedure.
NorthStar Regional utilizes speakers and guest instructors in addition to employed staff members.
These individuals will be required to comply with the "NorthStar Regional's Personnel Policy for Guests" and will be required to have a background study conducted and confidentiality agreement or HIPAA BAA in place prior to coming on-site.

Procedure

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

3.2 New Staff Orientation

In compliance with Minnesota 245G.13, 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 and/or the HR Specialist 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.07, 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 Residential Treatment
        ii. NorthStar Regional's Services (MN 245G.07)
        iii. Program Structure, Schedules, and Curriculum Materials
    f. Training
        i. NorthStar Regional's Client Rights Policy
        ii. NorthStar Regional's Client Records
        iii. NorthStar Regional's DAANES reporting Policy and Procedure
        iv. Client Confidentiality (HIPAA)
        v. 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.
        vi. Communicable Diseases and HIV Minimum Standards Policy and Procedure (MN Statutes, section 245A.19). This training will happen immediately upon hire.
        vii. NorthStar Regional's Emergency Procedures
        viii. Clinical Documentation Procedures (Procentive)
        ix. Intake Procedures (Procentive)
        x. 12 hours Co-occurring Disorders Training (within 6 mo.)
            § Philosophy, screening, assessment, diagnosis and treatment planning, documentation, programming, medication, collaboration, consultation, and discharge planning
    g. Payroll, benefits, and Human Relations Information

3.3 Personnel Files

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

Procedure

1. 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. Acknowledgment of Freedom from Substance Abuse Problems
    h. Malpractice Insurance

3.4 Staff Schedules and Billing Procedures

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

Procedure

1. All staff members are provided with determined PTO provided upon hire
2. To request the use of PTO or other schedule changes staff members will submit a PTO Request in Insperity to the Program Director at least 2 weeks prior to requested changes
    a. If the requested PTO or schedule change interferes with group facilitation, the staff member will address facilitation coverage in this form
3. Program Director will review requests within 3 days and submit approved requests to Administrative Specialist, who will make schedule changes as requested by the Program Director
4. In the case of "late notice" schedule changes, such as illness or emergency, staff member will contact the office and the Program Director as soon as possible
5. The Program Director or designated supervisor will be responsible for making accommodating schedule adjustments to ensure client care is minimally interrupted
6. All staff members are expected to check their schedules and emails daily in case of changes
7. Only designated and trained staff members are authorized to schedule client appointments. If a staff member offers a client appointment outside of his or her regular scheduled hours, he or she must accompany the client to schedule the appointment to ensure appropriate staff coverage
8. All staff members will designate billing diagnosis and place new client charts in the "new clients to enter" file within 72 hours of initial session
9. Billing sheets must be completed with appropriate billing codes daily
10. **Tracking Attendance Policy:**
    Staff will track and record client attendance for each treatment activity and service delivery. Attendance sheets, which are completing for all group sessions, will then be uploaded and stored on the main server of the organization. If a client arrives to group late or leaves early, it is noted on the attendance sheet and reflected in the group note through Procentive EHR. 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 by way of group notes and in the client's weekly progress note

where staff will locate in client's EHR chart. If a client is short hours; the client will work with the primary counselor to schedule a time throughout the week to make up those hours and will review topics in which the client missed in regular programming. This will be documented in a case management note. Staff also complete an excel spreadsheet weekly, where all client hours are tracked including all groups and individual sessions.

3.5 Fraternization

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.

3.5.1 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.

3.5.2 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.

3.5.3 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.

3.5.4 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.

3.5.5 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.

3.5.6 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.

3.5.7 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 many 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.

3.5.8 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 Chief of Programs and Services and CEO. 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 CEO 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

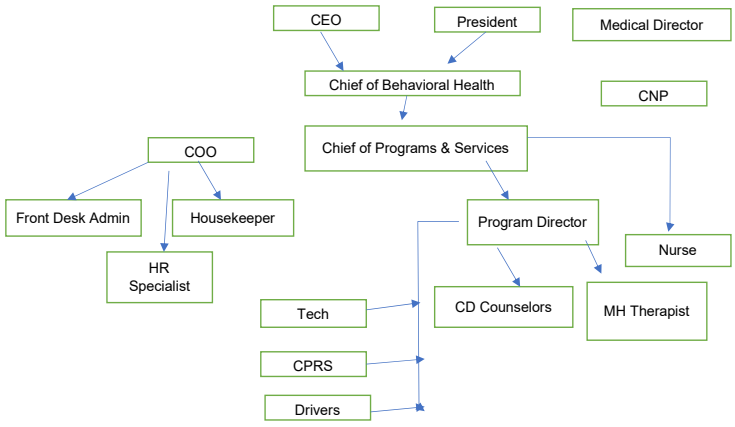
6. **Mental Health Professional (MHP)**
   - **a.** Group psychotherapy and psycho-education
   - **b.** Diagnostic Assessments
   - **c.** Weekly supervision meetings with both the LMHP Clinical Supervisors and the LADC Clinical Supervisor
     - **i.** Task all clinical documentation to designated 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.
3. Staff members will uphold designated responsibilities according to job descriptions.

RTC W – C Chart



3.7 Job Descriptions

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

3.7.1 Chief Executive Officer (CEO)

Direct Reports: NorthStar Regional's Chief of Behavioral Health Strategies & Solutions

Responsibilities

1. Oversee delegation of program management as license holder
2. Attend Quality Assurance meetings monthly 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

3.7.2 Chief of Programs and Services

Management Reports: CEO

Direct Reports: Program Directors and Nursing Director

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

3.7.3 Program Director

Management Reports: NorthStar Regional's Chief of Programs and 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 Statue 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 (must because licensed within a year or hire)
2. Baccalaureate degree or at least 3 years of experience of management or supervision within human services
3. 1 or more years of work experience in direct service or management of direct service to individuals with substance abuse problems
    a. If providing clinical supervision, the Program Director should have 3 or more years of experience of direct service provision
4. Documentation of 30 hours of classroom instruction, or at least one 3 credit college course focused in adolescent development and 150 hours of supervision providing treatment services to adolescents, if providing services to adolescents
5. Knowledge and understanding of Minnesota 245G and Minnesota Statutes, chapter 245A (Human Services Licensing Act), and sections 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 services program
8. Freedom from chemical use problems for at least 2 years prior to hire

3.7.4 Licensed Mental Health Provider Clinical Supervisor

Management Reports: Program Director
Direct Reports: Assigned Supervisees

Responsibilities

1. Maintain licensure and professional liability insurance and inform the Program Director of changes in status
2. Provide weekly clinical supervision of assigned supervisees, documented in compliance with MHCP clinical supervision guidelines

   a. The LMHP will complete documentation of weekly supervision and submit to the Program Director by end of week
   b. The LMHP will sign all clinical documentation completed by supervisees, as well as all clients' initial and updated Individual treatment plan by end of week
3. Coordinate with Program Director to complete annual performance reviews for supervisees
4. Attend weekly clinical consultation and monthly treatment plans review meetings
5. Attend required staff development trainings
   a. Participate in facilitation as needed
6. Participate in marketing and networking initiatives
7. Direct client services, as needed
   a. Mental Health Diagnostic Assessments, group, individual, and family therapy

Qualifications

1. Current licensure in the field of mental health, as defined by Minnesota Statutes, section 245.462, subd. 18, clauses 1-6
   a. Licensed Clinical Social Worker (LICSW)
   b. Licensed Psychologist (LP)
   c. Licensed Psychiatrist (MD)
   d. Licensed Marriage and Family Therapist (LMFT)
   e. Licensed Professional Clinical Counselor (LPCC)
   f. Registered Nurse (RN), who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatry or mental health nursing and has a master's degree in nursing or a related behavioral science, with 4,000 or more hours of post-master's supervised experience in direct mental health services
2. Ability to work with a multidisciplinary team in a positive and cooperative fashion
3. Must be at least 18 years of age
4. Consent to background check and be cleared by DHS to work within a human services program
5. Freedom from chemical use problems for at least 2 years

3.7.5 Mental Health Residential and Outpatient Therapist

Management Reports: Licensed Mental Health Provider Clinical Supervisor
Direct Reports: None

Responsibilities

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

Qualifications

1. Master's Degree in Psychology, Social Work, or Marriage and Family Therapy
2. Licensed as an LP, LPCC, LICSW or LMFT, or working towards licensure
3. In current good standing with the professional board

4. Oriented and educated in gender, culture and age appropriate care
5. Ability to effectively and efficiently communicate in written and verbal form
6. Computer skills using Microsoft Office products such as Word and Outlook
7. Background in chemical health and DBT (preferred)
8. Knowledge of trauma informed principles (preferred)

3.7.6 Mental Health Practitioner

Management Reports: Mental Health Clinical Supervisor & Chief of Programs and Services
Direct Reports: None

Responsibilities

1. Provide culturally competent mental health services to individuals in the Outpatient and Residential programs
2. All services delivery will be clinically supervised under Minnesota Rules
3. Provide high quality, compassionate and ethical outpatient mental health therapy to clients as scheduled
4. Ability to provide group therapy
5. Maintain documentation expectations
6. Complete all administrative and professional responsibilities
7. Actively participate as a positive member of the multi-disciplinary clinic environment
8. Utilize system's theory when providing comprehensive integrative services to individuals, children, adolescents and families
9. Perform diagnostic assessments to determine a recipient's eligibility for mental health service
10. Engage clients in actively designing their treatment plans
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. Working towards Licensure as an LP, LPCC, LICSW or LMFT
3. Oriented and educated in gender, culture and age appropriate care
4. Ability to effectively and efficiently communicate in written and verbal form
5. Computer skills using Microsoft Office products such as Word and Outlook
6. Knowledge of trauma informed principles (preferred)

3.7.7 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 services program
8. Freedom from chemical use problems for at least 2 years.

3.7.8 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

3.7.9 Certified Peer Recovery Specialist

Management Reports: Program Director

Responsibilities

1. Meet with clients on a regularly basis to discuss routine recovery issues from a peer perspective

2. Provide direct assistance in the form of transportation, making phone calls, filling out forms, and accompanying clients to appointments and/or court
3. Transporting and staying with client at crisis appointments
4. Assist in finding necessary community programs to meet basic needs
5. Outreach with lodging participants
    a. Help with acclimation to their new surroundings
    b. Explore recovery resources in the area
6. Provide education about self-help groups, obtaining sponsorship, and recovery support meetings that accommodate their schedules
7. Role model behavior that is consistent with and supportive to the population in recovery from a chemical use disorder such as, but not limited to:
    a. Reliable attendance
    b. Upholding ethical standards
    c. Self-accountability
8. Assist with tasks associated with clients arriving and leaving NorthStar Regional
9. Assist in developing and implementing Alumni Community events
10. Maintaining and processing confidential client records.
11. Perform miscellaneous administrative tasks
12. Attend weekly clinical staff meetings
13. Must receive ongoing consistent supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor

Qualifications

1. Comply with MN 245G and program policies and procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
4. High school diploma or equivalent
5. Must complete DHS background check and be cleared to work in human service programs
6. Acknowledge freedom from substance abuse problems for 1 or more years
7. Capable of handling basic computing functions, including email, file navigation, and web-based clinical software
8. Hold a current credential from Minnesota Certification Board, the Upper Midwest Indian Council on Addictive Disorders, or the National Association for Alcoholism and Drug Abuse Counselors. An individual may also receive a credential from a tribal nation when providing peer recovery support services in a tribally licensed program.
9. Good driving record, valid Minnesota Driver's License, and current insurance.

3.7.10 Residential Intake Coordinator

Management Reports: Program Director

Responsibilities

1. Complete intake process with incoming clients
    a. Verify and imputing accurate information into client system
    b. Uploading completed documents in to appropriate client file
    c. Properly documenting court/commitment paperwork, incoming medications, dietary needs, and any other pertinent information
    d. Communication of all necessary information to clinical staff, Directors, technicians, and counselors
2. Assist clients with completing Medical Assistance, MNSure, and General Assistance applications
3. Navigate Procentive, Sharepoint, Outlook, MNSure, and Insurance provider websites
4. Maintenance of master client tracker to reflect incoming clients, and assigning clients effectively.
5. Maintenance of insurance tracker
    a. Checking weekly status
    b. Following up with State and various Insurance companies on application/update status

   c. Checking beginning of every month for any change in activity
6. Communication with counties to check on applications sent
   a. Communication of updates to billing, counselors, and program director
7. Update client charts as needed
8. Weekly supply order for facility needs
9. Inventory and maintenance of vending machine supplies
10. Additional administrative duties as needed or required

Qualifications
1. Comply with 245G and Program Policies & Procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
4. Must have High School Diploma or GED equivalent
5. Must complete DHS background check and be cleared to work in human service programs
6. Acknowledge freedom from substance abuse problems for 1 or more years
7. 1 Year of customer service, administration and/or chemical dependency environment experience
8. Proficient knowledge of Microsoft Excel
9. Post-secondary degree preferred

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

Management Reports: Program Director, Designated Clinical Supervisors

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

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

3.7.12 Lead Tech/Recovery Support Specialist

Management Reports: Program Director

Responsibilities (All responsibilities of a Tech) and:
1. Perform client intakes
2. Inform Community Center of client movement.
3. Evaluate Tech performance and report to Program Director
4. Continually evaluate the physical condition of the lodging and grounds and coordinate necessary repairs
5. Hold Techs accountable for doing their job and write up poor performance when necessary
6. Participate in Weekly Consultation

Qualifications

1. Comply with MN 245G and program policies and procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
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. CPR/First Aid Training

3.7.13 Tech/Recovery Support Specialist

Management Reports: Lead Tech

Responsibilities

1. Appropriately share personal experiences, wisdom, and knowledge as appropriate
2. Assist with other program duties as directed
3. Administration of medication or assistance with self-medication
4. Completes administrative tasks thoroughly, accurately and efficiently.
5. Follow facility policies and procedures to ensure patient, staff, guest, and community safety
6. Responsive towards the needs of clients and their clinical staff
7. Displays positive and supportive communication towards a vulnerable patient population
8. Sensitive of multicultural issues that may significantly impact the patient experience
9. Keen observer and prompt reporter of client behavioral progression to the clinical team

Qualifications

1. Comply with MN 245G and program policies and procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
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. Capable of handling basic computing functions, including email, file navigation, and web-based clinical software
7. Willing to learn new skills and work in a fast-paced, challenging environment
8. Be trained in medication administration or assistance with self-medication via one of the following:
    a. Successfully completed a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution; or
    b. Be trained according to a formalized training program which is taught by a registered nurse and offered by the license holder; or
    c. Demonstrate to a registered nurse competency to perform the delegated activity

3.7.14 Overnight Tech/Recovery Support Specialist

Management Reports: Lead Tech

Responsibilities

1. Appropriately share personal experiences, wisdom, and knowledge as appropriate
2. Provide comfort measures, care, crises intervention for clients as needed
    a. Document with incident reports and/or communication with appropriate staff
3. Assist with other program duties as directed
    a. DAANES
    b. Laundry
    c. Rounds every 45 minutes
4. Administration of medication or assistance with self-medication
    a. Document in Medication Administration Record (MAR)
    b. Daily vitals

Qualifications

1. Comply with MN 245G and program policies and procedures
2. Acknowledge understanding of Client Rights, per MN 245G and MN Statute 148F.165
3. Must be at least 18 years of age
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. Be trained in medication administration or assistance with self-medication via one of the following:
    a. Successfully completed a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution; or
    b. Be trained according to a formalized training program which is taught by a registered nurse and offered by the license holder; or
    c. Demonstrate to a registered nurse competency to perform the delegated activity

3.7.15 Volunteer

Management Reports: Program Director

Responsibilities

1. Appropriately share personal experiences, wisdom, and knowledge under physical supervision of a LADC
2. 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

3.7.16 Driver

Management Reports: Program Director

Responsibilities

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

Qualifications

1. Must be at least 18 years of age
2. Driver's license with clean driving record
3. Must complete DHS background check and be cleared to work in human service programs
4. Acknowledge freedom from substance abuse problems for 1 or more years
5.

3.7.17 Individuals with a Temporary Permit (ADC-T)

Management Reports: Program Director, LADC Supervisor

Responsibilities

1. Provide direct clinical and case management services, in compliance with MN 245G regulations and program policies and procedures, under appropriate supervision
    a. Clinical assessment
    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
2. Must be supervised by a licensed alcohol and drug counselor assigned by the license holder.

   a. The supervising licensed alcohol and drug counselor must document the amount and type of supervision
   b. The supervision must relate to the clinical practice
   c. The supervision must occur at least on a weekly basis
3. Attend weekly program meeting/clinical consultation
4. Attend monthly clinical consultation
5. Attend required staff trainings
6. Complete clinical documentation in compliance with MN 245G and per program policy and procedure
7. Assist with other program duties as needed

Qualifications
1. Comply with MN 245G and program policies and procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
4. High school diploma or equivalent
5. Post-secondary education relating to drug and alcohol treatment
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. Hold current temporary permit from the Board of Behavioral Health and Therapy

3.7.18 Nursing Director

Management Reports: Chief of Programs & Services

Responsibilities
1. Direct & Develop Nursing staff
   a. Assist & support in HR functions
      i. Participate in hiring, termination, and disciplinary actions involving nursing.
      ii. Complete annual performance evaluations
      iii. Ensure licensure and certifications are current and on file for members of the medical team
   b. Knowledge of policies and procedures outlined by DHS
      i. Ensure all staff members are trained and adhering to DHS guidelines, as well as NorthStar Regional policies & procedures
   c. Ensure adequate staffing levels
      i. Follow DHS standards and NSR staffing requirements in all facilities staffed by medical team personnel
      ii. Collect, monitor, and utilize medical team members' availability and time off requests
      iii. Understand and allocate payroll hours
2. Establish and maintain a compassionate, positive, and professional environment
3. Availability to work a mixture of day, mid-shift, evening, and weekend shifts, as needed to ensure that the medical program is performing properly
   a. In the case of staff shortage or emergency, the Nurse Manager is expected to fill in staffing shifts
4. Update policies & procedures based on patient and facility needs, in conjunction with DHS regulation.
5. Develop and implement patient education
   a. Update educational materials as needed
6. Develop and implement staff education
7. Oversee and control supplies that directly impact patient care
   a. Medical supplies
   b. Patient care equipment
   c. Medications
8. Maintain a cooperative relationship with all departments

   a. Participation in team problem solving methods
   b. Proper and timely communication
9. Work with Medical Director, COO, and Program Directors to ensure that nursing staff are meeting patient care goals and regulatory requirements
10. Attend routine meetings
   a. Management
   b. Medical
   c. Staffing
11. Accurately use Electronic Medication Administration Record (EMAR)
12. Follow procedures for administration and storage of medication
13. Develop and implement infection control procedures
   a. Decimation of information
   b. Compliance to axillary parties

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 three (3) years' experience in patient care setting
9. Active Minnesota Registered Nurse Licensure
10. First Aid/CPR/AED Certification
11. Bachelor of Science Degree in Nursing
12. Experience in mental health setting preferred

3.7.19 RN

Management Reports: Program Director

Responsibilities

1. The Registered Nurse provides comprehensive nursing care services utilizing various skills including assessment, planning, intervention, and evaluation. Must promote the maintenance of quality care and physical health for our patients. Additionally, he/she is expected to provide supervision to other members of the nursing team and function as a contributing member of the multidisciplinary team.
2. Adheres to, and oversees delegated staff adhere to, the safe practice of medication administration in compliance with the facility's medication administration policies.
3. Facilitates medication and other patient education utilizing good knowledge and effective communication skills.
4. Facilitate and/or review client health assessment to build client plan of care and determine the need for additional medical referrals.
5. Complete all documentation while maintaining compliance with the policies and procedures of the facility and its regulating agencies.
6. Collaborate with physicians, LPNs, and other members of the treatment team when making decisions about patient's medications and additional nursing care.
7. Plans and implements the nursing care for patients in accordance with physician orders, policies and procedures of the facility, and safe nursing practice.
8. Demonstrates an ability to intervene appropriately with patients who are in crisis or in need of a higher level of medical care.
9. Responds to inquiries, concerns, or complaints of clients.

10. Maintains compliance with all 245G, state and federal laws and regulations pertaining to the practice of medicine.

3.7.20 LPN

Management Reports: RN, Program Director

Responsibilities

1. Job type: Full-time
2. Perform client intake and complete necessary paperwork
3. Monitor vital signs and administer detox screen to new clients
4. Assist in monitoring client's physical health and coordination of care for areas of need
5. Assist in maintaining high quality, timely nursing documentation in client's chart
6. Assist in creating and updating each client's medication administration record
7. Assist in keeping medical supplies well stocked and up to date
8. Administration of medication or assistance with self-medication

Qualifications

1. Required licenses or certifications:
    a. BLS/CPR/LPN
2. Comply with MN 245G and program policies and procedures
3. Acknowledge understanding of Client Rights, per MN 245G and MN Statute 148F.165
4. Knowledge of people with mental health and substance use problems
5. Must completed DHS background check and be cleared to work in human services programs
6. Acknowledge freedom from substance abuse problems for 1 or more years
7. Be trained in medication administration or assistance with self-medication
8. Currently licensed as a Licensed Practical Nurse in the State of Minnesota
9. Ability to work as part of an interdisciplinary team
10.

3.7.21 Billing and Funding Manager

Management Reports: CCO, CEO, Director of Billing & Funding

Responsibilities

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

Qualifications

1. Organized, task oriented and self-directed
2. Experience and competencies in billing, authorizations
3. Ability to work with a multidisciplinary team in a positive and cooperative fashion
4. Consent to background check and be cleared by DHS to work within a human services program
5. Freedom from chemical use problems for at least 1 years preceding hiring
6.

3.7.22 Billing Specialist-CD IOP/Mental Health/Labs/Psychiatry

Management Reports: Billing and Funding Manager

Responsibilities

1. Bill previous days' CD IOP groups, laboratories, Psychiatry sessions, COVID 19 testing, and Mental Health dates of service
2. Back billing for laboratory, Psychiatry, and Mental Health dates of service once client active with Medical Assistance
3. Monitor outstanding Mental Health billings and follow up with Therapists
4. Send out Supportive Housing Funding Combined application forms to county
5. Work errors in time module within billing system to resolve issues with billing
6. Back up for CD billing & authorizations when Insurance and Authorization Specialist out of office
7. Assist with exit DAANES as needed
8. Upload all completed billing sheets for future audits
9. Locate missing insurance payments
10. Bill testing and send outstanding list to appropriate parties

Qualifications

1. Comply with 245G and Program Policies & Procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
4. Must have High School Diploma or GED equivalent
5. Must complete DHS background check and be cleared to work in human service programs
6. Acknowledge freedom from substance abuse problems for 1 or more years

3.7.23 Residential Billing Specialist

Management Reports: Billing and Funding Manager

Responsibilities

1. Bill for Residential & Lodging
2. Track & maintain all bed movement
3. Request authorizations for Residential clients
4. Work with Residential Counselors on authorization extensions
    a. Track concurrent reviews and authorization deadlines
5. Check for errors in time module
6. Set-up pending authorizations that are expired or out of units
7. Submitting authorization numbers/Direct Access into DAANES
8. Create and maintain professional relationships with all referral sources
9. Assist Admissions HUB with insurance plan & approvals reviews prior to placement of client
10. Knowledge of all insurance plans and requirements
11. Obtain Medical Assistance for clients with no coverage

12. Back billing laboratory, Psychiatry, and Mental Health dates of service once a client becomes active with Medical Assistance

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 1 or more years

3.7.24 Insurance and Authorization Specialist

Management Reports: Billing and Funding Manager

Responsibilities
1. Bill for Residential & Lodging
2. Bill for all CD clients
3. Track & maintain all bed movement
4. Request all authorizations for all levels of CD care for all locations
5. Work with Residential Counselors on authorization extensions
    a. Track concurrent reviews and authorization deadlines
6. Obtain GRH/SHF funding for all sober housing clients
7. Check for errors in time module
8. Set-up pending authorizations that are expired or out of units
9. Submitting authorization numbers/Direct Access into DAANES
10. Address all CD tickets/issues in billing system
11. Create and maintain professional relationships with all referral sources
12. Assist Admissions HUB with insurance plan & approvals reviews prior to placement of client
13. Knowledge of all insurance plans and requirements
14. Back-up when Billing Specialist is out of office

Qualifications
1. Experience & knowledge in billing, authorizations, and approvals
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 1 or more years

3.7.25 Contracting & Credentialing Specialist

Management Reports: Billing and Funding Manager

Responsibilities
1. Handle contracting for all locations
2. Oversee credentialing for Mental Health Therapists
    a. Submit initial request for credentialing
    b. Track status for re-credentialing of locations & Therapists
3. Track & update approved insurance for Therapists
4. Entry and filing of exit DAANES for all locations

5. Administrative upload into client charts
6. Assist with additional administrative tasks

Qualifications

1. Comply with 245G and Program Policies & Procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
4. Must have High School Diploma or GED equivalent
5. Must complete DHS background check and be cleared to work in human service programs
6. Acknowledge freedom from substance abuse problems for 1 or more years

3.7.26 Front Desk Administrative Lead

Management Reports: Administrative Supervisor

Responsibilities

1. Send Daily Psychiatry report to all CD Counselors & Psychiatry staff with appointments
2. Enter all Psychiatry appointments into billing system
    a. Ensure all data/insurance information is complete
    b. Ensuring that every client is set-up for reminders
3. Post the daily report for Front Desk staff on Sharepoint
4. Manage NorthStar Regional Information email box
5. Answer phones& manage the NorthStar Regional voicemails to ensure all calls are returned by the appropriate staff
6. Oversees in-house UA distribution
7. Assist on and address any client account questions
8. Order office supplies
9. Supervision of Front Desk Administrators
    a. Interview/hire new staff
    b. Orientation/training
    c. Job shadow
    d. Approval of time off requests and time cards
    e. Ensure all duties and locations are covered if an administrator is out of office
    f. Communication of updates & changes for administrative team
    g. Audit of work to ensure all duties are being performed
    h. Performance improvement plans and/or disciplinary actions
    i. Annual performance reviews
10. Verify online payments are being applied by all staff
11. Collections
    a. Send collections list to billing system and debt collection company
    b. Manage all balances 120 days past due
12. Record Requests

Qualifications

1. Experience & knowledge in billing, authorizations, and approvals
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 1 or more years

3.7.27 Front Desk Administrator

Management Reports: Administrative Supervisor

Responsibilities

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

3.7.28 Human Resource Director

Management Reports: Chief Operating Officer

Responsibilities

1. Oversee daily workflow of Human Resource Department
    a. Recruit, interview, hire, and train new department staff
    b. Knowledge of company staffing needs
2. Audit HR processes
    a. Onboarding
    b. Employee files
    c. Terminations
    d. Hiring/recruitment
3. Provide constructive and timely performance evaluations
4. Audit, review, and maintain budget
5. Participate in professional development and networking conferences and events with ownership & Marketing
6. Manage talent acquisition process for managerial, exempt, and professional roles
    a. Recruitment
    b. Interviewing
    c. Hiring
    d. Collaborate with departmental leaders to understand skills and competencies for required openings
7. Analyze trends in compensation & benefits
    a. Research and propose competitive base & incentive pay
8. Create learning and developmental programs and initiatives that provide internal development opportunities for employees

9. Maintain compliance with federal, state, and local employment laws and regulations & recommended best practices
    a. Review policies & practices
10. Maintain knowledge of trends, best practices, regulatory changes, and new technologies in human resource, talent management, and employment law
11. Perform other duties as assigned or needed. Reference below for HR Specialist and HR assistant.

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. Bachelor's degree in business administration or human Resources
9. Minimum three (3) years' experience in Human Resources
10. Minimum one (1) year experience in management
11. Must be able to work in the United States without company sponsorship both now and in the future
12. Master's degree in human resources or business Administration with Human Resources concentration from an accredited institution preferred
13. SHRM-CP/SCP Certification preferred

3.7.29 Human Resource Assistant

Management Reports: Human Resource 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 ad 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

3.7.30 Compliance Officer

Management Reports: CEO
Job Title: Clinical Operations & Compliance Officer

Responsibilities

1. Oversee 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. Serve as the HIPAA Privacy and Security Officer
4. Create and implement an effective program aligned around the seven elements described in the Federal Sentencing Guidelines
5. Provide oversight and is responsible for execution of the compliance program
6. Serve 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. Advocate for compliant business practices and the development of a strong commitment to ethical decision-making
8. Demonstrate familiarity with healthcare laws and regulations, coding and billing requirements
9. Initiate and create polices as-needed
10. Review and update 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. Contribute to long-term and short-term planning for the organization
14. Initiate, manage, and update provider contracting and credentialing for the mental health clinic and clinical laboratory
15. Serve as an Electronic Health Record (EHR) Champion to leverage and enhance the system functionality for full ROI
16. Onboard, train, and orient all staff and mental health contractors
17. Develops and nurture positive working relationships with all referral sources to the mental health clinic
18. Engage in community outreach and marketing activities including the website for the mental health clinic

3.7.31 NorthStar Regional Medical Laboratory Technician:

Management Reports: Chief of Programs and Services

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

Responsibilities:

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

Qualifications

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

3.7.32 NorthStar Regional UA Specimen Collector:

Management Reports: Compliance Officer, Program Director, Chief of Programs and Services

NorthStar Regional UA Collectors perform observed urinalysis collection procedures with our clients.

Responsibilities:

1. Greet patients professionally and ensure patient privacy.
2. Ensure that all patient paperwork is filled out correctly and all necessary information has been captured at the time of collection (including Ordering Physician, Ordered Tests, Patient Signature, Date, etc.).
3. Adhere to all Laboratory Collector protocols, procedures and requirements.
4. Utilize appropriate laboratory practices in handling specimens, requisitions, chain of custody.
5. Dress according to clinic requirements (closed toe, laboratory safe shoes).
6. Data entry into patient Electronic Health Records, fax, scan, copying of documents as necessary.
7. Monitor and maintain supplies for laboratory needs and communicate supply requests in a timely manner.
8. Conduct self in an ethical, legal, responsible manner at all times with both patients and clinic staff.

Competencies:

1. Ability to read, write and comprehend English.
2. Ability to solve practical problems and deal with a variety of variables and situations.
3. Must have excellent organizational skills and attention to detail.
4. Must be able to accommodate required scheduling needs.
5. Must be comfortable working with specimens (urine, oral fluids).

6. Must be a self-motivated and independent worker.
7. Must be reliable.

3.7.33 NorthStar Regional Kitchen Manager

Management Reports: Chief of Programs and Services

Responsibilities

1. Attention to Detail: Food and beverage managers have to keep their eyes on a lot of elements: food standards, costs, safety, etc.
2. Leadership: Food and beverage managers must be leaders in the back of house, rallying their team during heavy shifts, resolving conflicts and getting the job done.
3. Management Skills: Food and beverage managers not only deal with food, they also have to deal with costs, pricing, creating work schedules and more.
4. Organizational Skills: Keeping work schedules, shipments, cleaning schedules and more organized is crucial to the job.
5. Problem-Solving Skills: Dealing with employee conflict, client complaints, and wrong stock orders is part of a food and beverage manager's job. Being able to come up with a solution quickly is a needed skill.
6. Speaking Skills: Food and beverage managers need to accurately and easily communicate standards and cooking methods to staff, give orders and speak with clients clearly.
7. Stamina: Food and beverage managers can expect long days around hot cooking elements, much of it on their feet.

Requirements

1. Proven food and beverage management experience
2. Working knowledge of various computer software programs (MS Office, including Excel and Word)
3. Ability to spot and resolve problems efficiently
4. Mastery in delegating multiple tasks
5. Communication and leadership skills
6. Up to date with food and beverages trends and best practices
7. Ability to manage personnel and meet financial targets
8. Guest-oriented and service-minded
9. Must pass background MN Background study
10. Ability to lift up to 25lbs on occasion
11. High school diploma or equivalent; Diploma from a culinary school will be an advantage

3.7.34 NorthStar Regional Cook

Management Reports: Director of Food and Beverage

Responsibilities

1. Set up workstations with all needed ingredients and cooking equipment
2. Prepare ingredients to use in cooking (chopping and peeling vegetables, cutting meat etc.)
3. Cook food with various utensils or grillers
4. Check food while cooking to stir or turn
5. Keep a sanitized and orderly environment in the kitchen
6. Ensure all food and other items are stored properly
7. Check quality of ingredients
8. Monitor stock reporting any needs to Director of Food and Beverage
9. Knowledge of Food Safety and Safe Temperature Guidelines
10. Locking dining hall doors 30 minutes prior to breakfast and lunch; 1 hour prior to dinner

Requirements

1. Proven experience as cook
2. Experience in using cutting tools, cookware and bakeware
3. Knowledge of various cooking procedures and methods (grilling, baking, boiling etc.)
4. Ability to follow all sanitation procedures
5. Ability to follow recipes
6. Ability to work in a team
7. Very good communication skills
8. Excellent physical condition and stamina
9. Must pass background MN Background study
10. Ability to lift up to 25lbs on occasion
11. High school diploma or equivalent; Diploma from a culinary school will be an advantage

3.7.35 NorthStar Regional Dishwasher

Management Reports: Director of Food and Beverage

Responsibilities

1. Collect used kitchenware from dining and kitchen areas after all clients have exited
2. Load and unload dishwashing machines
3. Wash specific items by hand (e.g. wooden cutting boards, large pots and delicate china)
4. Store clean dishes, glasses and equipment appropriately
5. Set up workstations before meal prep begins
6. Ensure there are always enough clean dishes, glasses and utensils, especially during peak hours
7. Maintain cleaning supplies stock (e.g. detergents) and place orders when necessary
8. Check washing machines' operation and promptly report any technical/performance issues
9. Remove garbage regularly
10. Sanitize the kitchen area, including the floor
11. Complete Nightly Closing Checklist

Requirements

1. Work experience as a Dishwasher
2. Hands-on experience with industrial washing machines
3. Ability to follow instructions and help with various tasks, as needed
4. Time management skills
5. Attention to detail and sanitation rules
6. Availability to work in shifts, during weekends and evenings
7. Ability to lift up to 25lbs on occasion
8. Must be able to handle standing 8 plus hours in a hot environment
9. High school diploma is a plus

3.7.36 Lead Admissions Coordinator

Management Reports: COO, Admissions Manager, Chief of Programs and Services

Responsibilities

1. Lead the Admissions HUB in screening, orienting, and intake clients into all programs
   a. Provide training & support to Admissions Coordinators and Assistants
   b. Lead and motivate Admissions HUB to meet and exceed department goals
2. Work in conjunction with COO & Program directors to maintain procedures and processes
3. Manage waitlists and bed availabili8ty to optimize occupancy
4. Work internally or cross-staffed on assigned projects
5. Develop meaningful measures and metrics for Admissions processes
6. Lead quality assurance measure and metrics for Admissions processes
7. Develop referral source relationships and maintain regular communications

8. Assist clients/referents in completing administrative admissions process into NSR program
    a. Review of assessment
    b. Checking background & insurance
    c. Complete referral screening
    d. Schedule intake appointment for appropriate level of care
9. Facilitate and maintain the bed board with the HER
    a. Communicate with Program Directors, Medical Team, Billing, and Intake Coordinators
10. Following DHS & HIPAA guidelines
11. Creation & maintenance of client profiles, program calendars, and program trackers

Qualifications

1. Comply with 245G and Program Policies & Procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
4. Must have High School Diploma or GED equivalent
5. Must complete DHS background check and be cleared to work in human service programs
6. Acknowledge freedom from substance abuse problems for 1 or more years
7. 1 Year of customer service experience, admissions, and/or office management
8. Post-secondary preferred

3.7.37 Admissions Coordinator

Management Reports: Lead Admissions Coordinator, Chief of Programs and Services, COO

Responsibilities

1. Provide general education regarding the Co-occurring disorder continuum of treatment services via phone and/or email.
2. Ensure the admission/transfer process of clients to NorthStar Regional
    a. Customer focused experience for the client, family, and/or referent
3. Work in conjunction with COO & Lead Admissions Coordinator to maintain procedures and processes
4. Develop referral source relationships and maintain regular communications
    a. Follow up on status of possible clients
    b. Providing updates on status of intake/movement
    c. Communication of needed updates or required information
5. Assist clients/referents in completing administrative admissions process into NSR program
    a. Review of assessment
    b. Checking background & insurance
    c. Complete referral screening
    d. Schedule intake appointment for appropriate level of care
6. Facilitate and maintain the bed board with the HER
    a. Communicate with Program Directors, Medical Team, Billing, and Intake Coordinators
7. Following DHS & HIPAA guidelines
8. Creation & maintenance of client profiles, program calendars, and program trackers

Qualifications

1. Comply with 245G and Program Policies & Procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
4. Must have High School Diploma or GED equivalent
5. Must complete DHS background check and be cleared to work in human service programs

6. Acknowledge freedom from substance abuse problems for 1 or more years
7. 1 Year of customer service experience, admissions, and/or office management
8. Post-secondary preferred

3.7.38 Admissions Assistant

Management Reports: Lead Admissions Coordinator, Chief of Programs and Services, COO

Responsibilities

1. Provide general education regarding the Co-occurring disorder continuum of treatment services via phone and/or email.
2. Ensure the admission/transfer process of clients to NorthStar Regional
    a. Customer focused experience for the client, family, and/or referent
3. Work in conjunction with the Managing Director, Lead Admissions Coordinator, and Admissions Coordinators to maintain procedures and processes
4. Develop referral source relationships and maintain regular communications
    a. Follow up on status of possible clients
    b. Providing updates on status of intake/movement
    c. Communication of needed updates or required information
5. Checking background and insurance
6. Assist Admissions Coordinators in review of assessments if needed
    a. Follow up with referents or clients on missing assessment information
        i. Tracking the status of requested information
7. Following DHS & HIPAA guidelines
8. Creation & maintenance of client profiles, program calendars, and program trackers
    a. Proper data input
9. Answer incoming phone calls
10. Timely response to email inquiries and correspondence
11. Assist Admissions HUB with any other additional administrative duties

Qualifications

1. Comply with 245G and Program Policies & Procedures
2. Acknowledge understanding of Client Rights, per MN 245G
3. Must be at least 18 years of age
4. Must have High School Diploma or GED equivalent
5. Must complete DHS background check and be cleared to work in human service programs
6. Acknowledge freedom from substance abuse problems for 1 or more years
7. 1 Year of customer service experience, admissions, and/or office management
8. Post-secondary preferred

3.7.39 Finance Manager

Management Reports: COO

Responsibilities

1. Oversee all accounting/bookkeeping functions
2. Financial reporting
    a. Forecasting income & expenses
    b. Prepare monthly financial reports for Owners
    c. Coordinate with program directors and executives to discuss program P&L

3. Financial Advisor to executive staff
4. Payroll of contractors
5. Audit of financials
6. Manage purchasing of company supplies
    a. Train and oversee AP/Purchasing Administrator
7. Account reconciliation
8. Adhere to company expectations and budgets
9. Other financial or administrative duties as assigned or 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 2 or more years
6. Degree in Finance, Business Management, Accounting, other related field, or equivalent experience
7. Strong proficiency in Microsoft Excel
8. Quickbooks and AP experience
9. Minimum five (5) years' experience in healthcare financial environment
10. Minimum three (3) years' experience in supervisor or managerial role

3.7.40 Accounts Payable and Purchasing Administrator

Management Reports: Finance Manager

Responsibilities

1. Process accounts payable invoices
2. Data entry
3. Check and credit reconciliation
4. Account reconciliation as needed
5. Communication with vendors on discrepancies or missing information
6. Purchase of supplies for company
    a. Coordinate with all locations for office/supply needs
    b. Research and analyzation of most cost effective choices
7. Work in conjunction with Finance Manager to adhere to company expectations and budgets

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. Strong proficiency in Microsoft Excel
7. Quickbooks and previous AP experience
8. Post-secondary education preferred

3.7.41 Director of Technology

Management Reports: CEO

Responsibilities

1. Oversee all technology systems, both hardware and software
    a. Work with contractor to develop and maintain company IT services
2. Troubleshoot IT issues & helpdesk concerns
3. Coordinate with HR & Program Directors on staff technology needs and requirements
4. Work in conjunction with Leadership and Marketing to ensure the connection for clients and referents is in line with the goals for company growth
5. Work with Finance to forecast and adhere to necessary budgets
6. Research and analyze different systems and formats that may be conducive to company growth
7. Communicate with vendors who supply hardware and software systems used by the company
8. Communicate with staff in regards to new equipment or software updates
9. Coordinate with Leadership to set-up and roll-out new locations and facilities

Qualifications

1. Comply with 245G and Program Policies & Procedures
2. Must be at least 18 years of age
3. Bachelor's Degree required
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. Strong proficiency in Microsoft Office
7. Experience with multiline phone systems
8. Minimum seven (7) years' experience in IT environment or related field
9. Minimum five (5) years' experience in customer service and/or communications role
10. Bachelor's degree in Information Technology, Communications, related field, or equivalent experience preferred

3.7.42 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

3.7.43 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

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

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

Clinical Staff

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

1. Tim Walsh, M.A., L.P.; DPA; CEO
2. John McGinnis, LADC; NorthStar Regional's COO
3. Jessica Hart, LADC Residential Program Director
4. Dr. Alonzo Morales, Medical Director, and Addictions Psychiatrist
5. Tanya Middlestrat, LADC Primary CD Counselor
6. Dawn Burke, MA, LPCC, LADC

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
7. The LPN will provide direct 1:1 supervision to unlicensed staff (paraprofessionals/tech) on a monthly basis and document in the supervision log

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

NorthStar Regional's Treatment, Education, and Prevention Programs will maintain compliance with Minnesota 245G.13, subdivision 1 and vendor eligibility requirements outlined in Minnesota Statutes, section 254B.05, subdivision 5, by meeting staffing requirements, ratios, credentialing, and scheduling as follows.

All staff members employed under NorthStar Regional's Treatment, Education, and Prevention Programs will meet staffing qualifications outlined in job descriptions in compliance with Minnesota 245G.13, subdivision 1. Supportive documentation will be retained by the Program Director in personnel files.

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
10. Former Students can work supervised for up to 90 days after completing coursework related to being LADC or MH professional

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 LADC Supervisor and the LMHP supervisor
        ii. School contracts and/or supervision plans, as well as weekly supervision documentation will be retained by the program

3.10 Staff Expectations

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

Pursuant to Minnesota 245G.11, subdivision 2, staff members providing direct client care cannot have active chemical use problems and must sign acknowledgement of freedom from chemical use problems 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, 260E, 626.557, and 626.5572 prohibiting client abuse of any kind.

1. Active chemical use problems include:
    a. Receiving treatment for chemical use within 1 year 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. Fraternization
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 an acknowledgement of the following upon hire:
   a. Statement of Freedom from Chemical Use Problems
   b. Personal Client Involvement (Personnel Training Acknowledgment)
   c. Client Abuse Prohibition (Personnel Training Acknowledgment)
2. Job descriptions are clearly outlined and available to staff members in the program policy and procedure manual
   a. All staff members will attend scheduled team meetings, consultations, and supervision meetings
   b. All staff members will check and respond to all correspondence, including email and staff boxes daily
3. The Program Director will conduct annual Performance Evaluations which will include a written annual review, and will be based upon standards of job performance and utilized to build upon staff strengths, as well as address improvement goals
   a. Clinical supervisors will provide feedback for evaluation of supervisees
4. Inappropriate behaviors that interfere with provisions of treatment and program staff functioning will be documented in staff member's personnel file and addressed in the following manner:
   a. Staff will receive a verbal warning upon first infraction
   b. Staff will receive a written warning upon second infraction
   c. The Program Director will develop and implement a Performance Improvement Plan (PIP) third infraction
      i. Failure to satisfactorily meet requirements of PIP may result in termination of employment
5. Staff members are encouraged to resolve interpersonal conflicts directly, and in a professional and productive manner
   a. If staff members are unable to resolve interpersonal conflicts independently, they are expected to seek assistance from their direct report. In order to maintain a positive and productive work environment, gossiping and "third-party" involvement of other staff members will not be tolerated
   b. If a staff member is experiencing a conflict with his or her direct report, a report can be made to the COO or CEO who will address concerns with management as appropriate
   c. All management staff will address interpersonal conflicts and grievances appropriately and professionally, consulting with the management team as needed
      i. Management will not evoke or allow unnecessary and "third-party" involvement of other staff members
6. Inappropriate behavior that poses potential danger to clients or other staff members may result in immediate suspension or termination
7. Active chemical use problems among staff members will be addressed respectfully and discretely; however, the staff member will immediately cease direct client contact until problems are sufficiently resolved
8. Staff members are encouraged not to develop friendships with clients outside of the treatment program for at least 2 years after their last professional interaction

3.11 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.

Procedures

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

NorthStar Regional will:

1. If the following behaviors are observed, we will notify the Program Director and/or the Chief of Programs and 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 Chief of Programs and Services 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 Officer to begin an internal investigation.

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

The Program Director will ensure that each clinical staff member will be trained in compliance with Minnesota 245G13. Subd. 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 144.651, 148F.165, and 253B.03. NorthStar Regional policies, bi-annually (bi-annually)
    - **c.** Pre-Natal Exposure and Human Immunodeficiency Virus (HIV) minimum standards according to Minnesota Statutes, section 245A.19, upon hire and annually
    - **d.** Mandatory Reporting pursuant Minnesota Statutes, sections 245A.65, 260E, 260E1, 260E3, 626.557, and 626.5572, including NorthStar Regional policies concerning obtaining client releases on information, annually
    - **e.** 12 hours of co-occurring mental health and substance use disorder training, within 6 months of hire and 8 hours annually, addressing the following:
        - **i.** Philosophy, screening, assessment, diagnosis, treatment planning, documentation, programming, medication, collaboration, mental health consultation, and discharge planning
2. The Program Director will ensure that acknowledgment of training documentation is maintained in staff personnel files

3.13 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 Communicable Diseases

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

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

1 144.4804 REPORTING RELATING TO TUBERCULOSIS

4.2 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.

4.3 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.

4.4 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.

4.5 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.

4.6 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.

4.7 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.

4.8 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.

4.9 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

4.2 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. NorthStar Regional will utilize the 2023 DHS Commissioner-Approved HIV Training tool, see Appendix A.

Procedure

1. All staff members will be oriented to this policy within 72 hours of hire, and will participate in an annual in-service training addressing updates to HIV Minimum Standards and NorthStar Regional's policy and procedure; records of training provision and attendance will be maintained in personnel files
2. All clients will be oriented to HIV Minimum Standards Policy and will be provided with a list of HIV testing and treatment resources, updated annually, within 72 hours of admittance
3. Program curriculum will include HIV and communicable disease education to including transmission prevention addressing sexual safety and intravenous drug use, scheduled once per treatment cycle
4. Treatment services will include sensitive and informed support and referral services for clients diagnosed with HIV, including consultation with medical providers
5. Program staff will treat clients respectfully and provide services appropriate to sexual orientation, language, and culture
6. Program staff will apply motivational interviewing skills and use of a harm reduction model when addressing HIV issues.
7. This program will maintain strict confidentiality of any clients' HIV diagnosis, except when disclosure is legally mandated
8. NorthStar Regional provides equal access to services for all clinically appropriate clients, despite HIV status

9. Program staff will make all efforts to prevent exposure to avoid occupational HIV transmission; however, in the event of exposure the following procedure should be followed:
    a. Immediate vigorous hand washing with soap and water for 30 or more seconds
    b. Gloves should be worn in the presence of bodily fluids
    c. Surfaces and floors must be disinfected immediately
    d. Center for Disease Control's recommendations for post exposure prophylaxis, located on premises, should be followed

HIV Training & Resources for Substance Use Disorder

Programs

People with substance use disorder (SUD) are disproportionally 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	06-20-23

4.3 Communicable Diseases Information and Referral Resources

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

1. Tuberculosis
   a. Bacterial disease that affects the lungs
   b. People with weak immune systems, such as substance abusers, are at high risk

   c. Spread through close contact with infected person, such as co-habitation
   d. Symptoms include fever, night sweats, persistent cough, fatigue, and weight loss
   e. Some strains are treatable, but some are resistant to treatment and require long-term hospitalization
   f. 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.mnaidsproject.org
d. Minnesota Department of Health STD and HIV Section
  i. 612-676-5698
  ii. http://www.health.state.mn.us
e. Minnesota Family Planning and STD Hotline:1-800-738-2287
f. American Red Cross: http://www.stpaulredcross.org
g. Rural AIDS Action Network: http://www.raan.org
h. Minnesota Office of Multicultural and Minority Health: http://www.health.state.mn.us/ommh/index
i. MN Dept. of Human Services HIV/AIDS Program
  i. PO Box 64972, St. Paul, MN 55164-0972
  ii. 651-431-2414, 1-800-657-3761
  iii. http://www.dhs.state.mn.us/hivaids

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

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

5.1 Client Rights

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

Client Bill of Rights

148F.165 CLIENT WELFARE.

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

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

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

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

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

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

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

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

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

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

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

(10) know the intended recipients of assessment results;

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

(12) a nontechnical description of assessment procedures; and

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

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

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

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

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

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

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

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

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

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

253B.03 RIGHTS OF PATIENTS.

Subdivision 1. Restraints.

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

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

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

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

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

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

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

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

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

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

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

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

(c) If the head of the treatment facility determines that the patient is not competent to consent to the treatment and the patient has not been adjudicated incompetent, written, informed consent for the surgery or medical treatment shall be obtained from the nearest proper relative. For this purpose, the following persons are proper relatives, in the order listed: the patient's spouse, parent, adult child, or adult sibling. If the nearest proper relatives cannot be located, refuse to consent to the procedure, or are unable to consent, the head of the treatment facility or an interested person may petition the committing court for approval for the treatment or may petition a court of competent jurisdiction for the appointment of a guardian. The determination that the patient is not competent, and the reasons for the determination, shall be documented in the patient's clinical record.

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

(e) In the case of an emergency when the persons ordinarily qualified to give consent cannot be located, the head of the treatment facility may give consent.

No person who consents to treatment pursuant to the provisions of this subdivision shall be civilly or criminally liable for the performance or the manner of performing the treatment. No person shall be liable for performing treatment without consent if written, informed consent was given pursuant to this subdivision. This provision shall not affect any other liability which may result from the manner in which the treatment is performed.

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

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

Subd. 6c. Adult mental health treatment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

144.651 HEALTH CARE BILL OF RIGHTS

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

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

Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

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

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

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

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

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

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

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

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

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

Procedure

1. Staff will try to resolve any issue or complaint brought to them immediately. This will be documented and dated in the client record by the staff member should this occur
2. IF resolution cannot be accommodated: Staff will explain the grievance procedure to clients, former clients and their representative, as applicable, 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.

5.3 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.

5.4 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 must be 18 years or older
4. Adults must be willing to participate in appropriate daily structured activity
5. Participants will be expected to invite family or significant supportive others to be involved in their treatment
6. 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.
7. Participants will commit to the entire treatment process, including screening and diagnostic assessment, treatment planning, and Continuing Care
8. Participants will be expected to treat all clients and staff members with respect; this will include maintaining the confidentiality of group members
9. Any behavior that poses a threat to the safety of NorthStar Regional's clients and staff may be grounds for discharge from the program
10. 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.

Procedure

1. Clients will be oriented to this policy upon admission

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6 Program Safety

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

6.1 Program Abuse Prevention Plan *(245A, subd. 2; 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 will have an 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 320 N. Walnut St Chaska, MN 55318
   The program is housed in a two-story commercial building constructed in 2004, on the corner of North Walnut St and East 4th St in the heart of downtown Chaska. The building meets all fire and building codes. The building is located across from the Northeast corner of City Square, and next door to the Klein Mansion, which is a GRH facility managed by NorthStar Regional. The campus is surrounded by residential and commercial areas. There are sidewalks in the front and side of the building. Parking is in the back (east) side of the building and is accessible via E. 4th Street. 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. There are 14 surveillance cameras on the property: one at the front door facing incoming traffic and one at the back door facing incoming traffic, 1 in the front hall, three upstairs, two in the lower level, and three in dining room in various spots, one in the tech office one in the laundry room. Cameras will not be in the clinical treatment rooms, bathrooms, or in the bedrooms.

   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 but not limited to parking lots, bathrooms, and the blind spots around the exterior of buildings. These areas are not supervised by NorthStar Regional's Program staff 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 without direct staff supervision.

   b. Clients will be oriented to emergency procedures and the location of emergency exits upon admission

2. All staff members and volunteers providing direct services to clients must undergo a background check which documents their appropriateness for working in a human services program. NSR clearly prohibits any substance use during work hours and states that staff providing direct client services must have at least 1 year free from problematic substance use and 2 years free from problematic substance use for clinical staff members
   a. For all treatment programming, NorthStar Regional will always have a minimum of one staff member present.
   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. Treatment and recovery focused assignments will be used to minimize relapse and increase personal responsibility. All staff will be oriented to the general operations of the program.
   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.

Population

1. Age and Gender: This program serves 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 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 abuse 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 if possible, 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 vulnerable adult status is assessed; IAPP is developed and managed in accordance with program assessment and treatment planning procedures
   e. 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
   f. 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
   g. 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
   h. Any client who exhibits or threatens violent behavior will be removed from all group interactions until client safety can be assured
   i. Any client who reports suicidal ideation will be assessed and referred as appropriate
   j. 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.
   k. At any time, knowledge may be obtained regarding previous abuse that is relevant to minimizing the risk of abuse for clients. This information will be immediately documented, and the corresponding Individual Abuse Prevention Plan (IAPP) will be updated.
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. Residential program operating hours will be Monday through Friday 8am-10pm and will be adjusted appropriately to accommodate client scheduling needs.
   b. The residential program will be staffed 24/7/365
   c. One or more staff members will be present in the office any time a client is present.

d. Staffing requirements for Co-occurring treatment services are in compliance with Minnesota Statutes, section 254B.05, Subdivision 5, item 4, (ii) as follows:

i. At least 25% of full-time counselors are MHPs

§ 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

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

e. 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

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

4. Residential programs will have awake-overnight staff. These staff will conduct bed checks at a minimum of every two hours.

PAPP Policy and Procedure Reviewed Annually	Who Reviewed	Date
Yes	Lisette Wright	12/4/18
Yes	Jessica Hart	12/1/23

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. Clinical staff will develop an IAPP within 24 hours

b. Clinical staff will review and update, as applicable, IAPP's weekly

3. A written copy of the Program Abuse Prevention Plan will be posted in the program's lobby and will available upon request

4. Program Abuse Prevention Plan will be reviewed and updated annually by the Program Director; reflective revisions will be made

a. Review will include an assessment of factors that encourage or permit measures to minimize abuse can be effectively taken

b. Reviews will be made available to the commissioner upon request.

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

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

1. Medical emergencies (i.e. profuse bleeding, seizure, inability to breath or move, loss of consciousness)

2. Intoxication or potentially dangerous withdrawal symptoms

3. Physically aggressive behaviors or threats toward self, others, or property

4. Report of suicidal or homicidal ideation and refusal to commit to a safety contract

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

Procedure

1. Clinical staff members, including the program director, LMHP, LADC, 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: Someone who has entered the building unknowingly, is trespassing, or who is an intruder.
    c. Involved clinical staff members will document emergency and interventions in client chart and complete a **Critical Incident Report** within 24 hours
        i. If clinical staff was not present, the Program Director will complete a Critical Incident Report with involved office staff
    d. All emergencies will be reported to the Program Director and consulted within 24 hours
        i. Staff can contact program director via personal cell phone contact provided, as needed
        ii. Program Director will provide staff support and make off-site counseling referrals as necessary
    e. If a client is taken by an emergency medical technician (EMT) or police, staff member will inform next of kin (if a release of information form has been completed), as appropriate
2. Medical Emergencies
    a. If a client is experiencing a medical emergency, CPR and First Aid certified clinical and office staff will provide CPR and first aid services, as appropriate.
        i. All staff members will be oriented to the location of the First Aid kit in the tech office
        ii. If the client appears medically stabilized by staff members and has a significant other present who is willing to transport the client, staff will direct them to a local hospital
        iii. If the medical emergency is outside of the scope of program staff skills, staff will contact 911 and follow instructions of the emergency medical professionals
3. Intoxication and Withdrawal Emergencies
    a. If a client smells of alcohol, or appears intoxicated or experiencing withdrawal symptoms, clinical staff or clinical laboratory technician will meet with the client and administer a drug screen or breathalyzer to determine impairment
        i. If it is determined that a client is impaired, staff will assess safety risks and make appropriate recommendations
        ii. If client is in need of detoxification services, clinical staff will inform the client of this recommendation and assist in obtaining services
            - If client refuses or is unable to obtain services staff will contact 911.

- If client's supportive other is present and agrees to transport the client to client's primary care physician if appropriate, or staff will direct them to a local hospital or detoxification unit:
  - **a.** Mission Detox Center, 3409 E Medicine Lake Blvd, Plymouth, MN 55441; phone: 763-559-1402

iii. If client does not appear to need detoxification services, clinical staff will assist the client in arranging transportation for the client, informing the client that if he or she attempts to drive away from the premises 911 will be called
- Staff will not restrain client, but will contact 911 immediately if the client attempts to operate a vehicle

4. Physically Aggressive or Threatened Client Emergencies

a. Clinical staff will develop and implement Individual Abuse Prevention Plans (IAPP) for clients. IAPP's will address the following:

i. Interventions for providing a safe environment (i.e. removing dangerous materials from treatment space)

ii. Implementation of distress tolerance skills, as appropriate (i.e. client exits treatment space and walks, deep breathing, distress tolerance skills, emotional processing under staff supervision)

b. If a client engages in or threatens physically aggressive behaviors staff will:

i. Implement IAPP

ii. Direct client to leave a group setting; if client refuses, staff will direct other group members to vacate group room to ensure safety
- When co-facilitating one clinician will remain with the group while the other manages client issue. Program Director will assist as needed

iii. If behaviors cannot be managed by crisis diffusion interventions, program staff will contact the local Police Department by calling 911

5. Suicidal or Homicidal Ideation Emergencies

a. If a client reports suicidal or homicidal ideation, ask about plan, means and intent. If 2 of those are present, the client is at higher risk of suicide. Either way, clinical staff (Therapist, Counselor, Tech) will sit with client and complete the Patient Safety Plan

b. Clinical staff will seek consultation with Mental Health Director Dr. Hal Baumchen at 952-210-7722 immediately. If staff mental health professional is not available, staff will call Suicide Prevention Lifeline Phone at 1-800-273-8255, who should route the call to Carver County Crises Center 952-442-7601. Call 911 for transport

i. Clients needing higher level of care should be transported via Ambulance

ii. If client is transported to a higher level of care, such as a mental health hospital, and there is a release on file for an emergency contact, staff will notify the contact and document

6. Reporting a Death in the Program

a. Within 24 hours of receiving knowledge of the death of an individual served by the program, the Program Director shall notify the commissioner of the death by calling the DHS at 651-431-6500

7. Environmental Emergencies

a. In the case of threatening weather, fire, terroristic threat, or other emergency clients will be escorted by program staff to a safe place

i. In the case of a tornado or similarly threatening weather, staff will direct clients to safety in an interior room on the lower level of the building, such as the lobby, group room, or other interior offices
- Staff will direct clients to cover their faces with blankets or available clothing

ii. Office staff will monitor weather conditions and report to program director to determine safety measure taken

iii. Program Director will work with office staff to determine office closure and communicate this to clients and staff members efficiently

b. In the case of a fire or terroristic threat, clients and personnel will reassemble in the parking lot southeast of the residential main entrance and will not re-enter the building until safety is secured

   i. All staff members will be oriented to the location of nearest fire extinguisher
   ii. Clients will be directed to emergency exits
- **c.** Upon awareness of potential environmental emergency, all staff will ensure that computers and paper files containing sensitive client information are secured to ensure client confidentiality

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

9. Receipt of Fact Sheet from Law Enforcement
- **a.** If we are in receipt of a Fact Sheet from law Enforcement notifying us that one of our residents or outpatient 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.	ST. Francis Medical Center/212 Medical Center)	952-428-3000
3.	NorthStar Regional Main Office Location	
	a. Chaska	952-448-6557
4.	Minnesota Adult Abuse Reporting Center	844-880-1574
5.	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
6.	Minnesota Department of Human Services Mental Health Crisis	651-296-3971

- **a.** Anoka County 763-755-3801
- **b.** Carver and Scott Counties 952-442-7601
- **c.** Dakota County 952-891-7171
- **d.** Hennepin County
  - **i.** Adult Division 612-593-1223
  - **ii.** Child Division 612-348-2233
- **e.** Ramsey County
  - **i.** Adult Division 651-266-7900
  - **ii.** Child Division 651-774-7000
- **f.** Washington County 651-777-5222

7. Centerpoint Energy 1-800-722-9326

8. Xcel Energy 1-800-895-1999

I approve these policies and procedures

_____ _____

Dr. Alonzo Morales M.D. Date

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

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

Procedure

1. Staff members will be oriented to the Maltreatment of Vulnerable Adult Reporting Policy and Procedures within 72 hours of hire and will follow procedures as outlined. The orientation and annual review shall inform the mandated reporters of the reporting requirements and definitions specified under Minnesota Statutes, sections 626.557 and 626.5572, the requirements of Minnesota Statutes, section 245A.65, the license holder's program abuse prevention plan, and all internal policies and procedures related to the prevention and reporting of maltreatment of individuals receiving services. The license holder must document the provision of this training, monitor implementation by staff, and ensure that the policy is readily accessible to staff, as specified under Minnesota Statutes, section 245A.04, subdivision 14
2. Clients will be oriented to the Maltreatment of Vulnerable Adult Reporting Policy and Procedure within 24 hours of program admission
   - **a.** This policy and procedure will be posted in the NorthStar Regional'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 (MAARC) 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 Chief of Programs and Services

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 Chief of Programs & Services 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 & Service or Compliance Officer will be responsible for completing the internal review.
    a. The facility must document completion of the internal review and provide documentation of the review to the commissioner upon the commissioner's request
    b. Based on the results of the internal review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by individuals or the license holder, if any

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

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

Procedure

1. Staff members will be oriented to the Maltreatment of Minors Reporting Policy and Procedures upon hire and will follow procedures as outlined
2. Clients will be oriented to the Maltreatment of Minors Reporting Policy and Procedures upon admission
3. Staff members will assist clients with making reports as appropriate
4. Maltreatment of Minors Reporting Policy and Procedure will be posted in the program lobby; a written copy will be provided upon request
5. A person who knows or has reason to believe a child is being neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department or county sheriff.
6. Staff members will make an oral report within 24 hours to the appropriate agency

a. A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the Department of Human Services, which is the agency responsible for licensing the facility. Reports shall be made to Department of Human Services, Licensing Division, Maltreatment Intake line at 651-431-6600
b. Suspected maltreatment of a minor in a licensed facility should be made to Department of Human Services, Licensing Division, Maltreatment Intake line at 651-431-6600
c. Suspected abuse or neglect of a minor within the community should be made to the local county social services agency or law enforcement; Carver County Social Services can be reached at 952-361-1600
d. Other reports of possible violation of minor rights should be reported to the Department of human Services, Licensing Division at 651-431-6500
e. If there is any abuse occurring, staff will report to the Minnesota Department of Human Services
f. Staff members must provide the following information:
    i. Names of maltreated minor and caregiver
    ii. Nature and extent of suspected maltreatment
    iii. Evidence of previous maltreatment
    iv. Name and address of the reporter
    v. Time, date, and location of the reported incident
    vi. Any additional information that may assist in investigation of the reported case
e. The Program Director will assist staff with making reports as needed, and will do so in a manner that protects the confidentiality of the reporter
    i. If a staff member files a report on behalf of a client, the reporting client will be informed in writing, within 2 days, that the report has been made

7. An internal review will be conducted within 30 calendar days and corrective action taken to protect the health and safety of Minors, if a report of alleged abuse within the program is made. This internal review will include:
    a. Evaluation of compliance with program policies and procedures
    b. Adequacy of policies and procedures
    c. Determination of a need for additional staff training
    d. Assessment of any similarity of past reports involving minors and services involved
    e. Determination of a need for corrective action
        i. If corrective action is required, a corrective action plan will be developed, documented, and implemented to correct current and prevent future lapses in performance of individual staff members or program
8. The Program Director is designated as the primary, and NorthStar Regional's Chief of Programs & Service the secondary, person responsible to ensure completion of internal reviews when required.
9. Internal reviews will be documented and made available to the commissioner upon request.

6.5 Client Property Management Policy *(245G.21 subd. 3)*

Clients of NorthStar Regional Residential program may retain control of all possessions that do not present a danger to self or others or are not medically contraindicated. Personal property that is used in such a manner as to disrupt program activities or to infringe on the rights of other clients may be temporarily taken into custody and held in trust. Personal property that meets the definitions of parts A, B or C below shall be taken into custody upon admission or discovery and disposed of or transferred as indicated. A majority of clients admitted bring limited personal possessions with them and are able to keep these possessions in their assigned room. Program staff must not borrow money from a person served by the program; must not purchase personal items; must not sell merchandise or personal services, must not require a person to purchase items for which the license holder is eligible for reimbursement; and must not use funds of persons served by the program to purchase items for which the facility is already receiving public or private payments.

Property Records:
A written record of each personal property item held in trust by NorthStar Regional shall be made and signed by a staff member and the client. If the client is uncooperative, two staff members shall make and sign the record. The record shall be kept in the client's individual treatment record. When some or all of the property is returned to the client or otherwise disposed of, it shall be so noted in the record.

Client Funds:
Client funds are not supervised by the program.

Abandoned Property:
Personal property retained by NorthStar Regional after a client is discharged shall be held in trust for a period of at least 30 days. This policy is stated on the "House Expectations" form signed by staff and client upon admission.

Return of Property:

- **A.** All property held in trust shall be returned to the client upon discharge, regardless of discharge status, or upon the client's personally appearing on program premises and requesting the return of abandoned property held at least 30 days, with the following exceptions:
- **B.** Drugs, drug paraphernalia, and drug containers that are forfeited under Minnesota Statutes, section 152.19 shall be destroyed by staff or given over to the custody of a local law enforcement agency, in accordance with the Code of Federal Regulations, title 42, sections 2.1 to 2.67-1, as amended through August 10,1987
- **C.** Weapons, explosives, and other property which may cause serious harm to self or others shall be given over to the custody of a local law enforcement agency, and the client shall be notified of the transfer and of the right to reclaim any licit property transferred, and
- **D.** Legal chemicals which have been determined harmful by a physician after examining the client, except when approved for continued use by the client's personal physician
- **E.** Client property which may be returned, with prior reference to and consideration of 5(A), 5(B) and (C) above, shall be returned to the client within 72 hours of the request for return of this property

Note: This does not alter the agency policy which provides that all clients shall manage their own property (including funds) while a client within the agency program.

6.6 Visitation Policy *(245G.21 subd. 2)*

Background: NorthStar Regional looks with favor upon visits of friends and relatives of clients, as this builds on recovery and re-establishing family and other relationships. This policy shall be posted in a conspicuous place in the facility.

Policy: Clients shall be allowed to receive visits at all reasonable times from their personal physicians, religious advisors, county case manager, parole or probation officers, and attorneys.

Visiting Rules and Hours: Visiting hours will be Sunday's from 2pm-6pm. Visitors will be required to sign in and sign out. Visitors will be given written confidentiality guidelines and will sign a confidentiality agreement to comply with confidentiality laws protecting our clientele. Visitors will wear a visitor's badge.

Limitations: The program director may impose limitations as necessary for the welfare of the client, provided the program director documents the limitations and reasons in the client's individual treatment plan or chart.

6.7 Search of Clients Policy

1. **Search Procedure (ongoing throughout treatment)**
   - **a.** Any items brought in must be documented on the inventory form.
   - **b.** Both the client and staff receiving the items will sign in agreement as to what came into the facility.
   - **c.** These items will be searched by staff and then placed in a secure and locked area.
   - **d.** Client items will be held for up to 3 business days.
   - **e.** As deemed appropriate by leadership, the scent detection dog will search client properties and items on these properties.
   - **f.** Clients will not be in the vicinity during scent dog searches and designated staff will stay with the scent dog and handler for the duration of the searches. Scent dogs will not be utilized to search persons.
   - **g.** When items are given back to the client, both the staff and client will sign agreeing to the items received.
   - **h.** If prohibited items are found, staff must notify the Supervisor and/or Director immediately and document the findings.
   - **i.** Scents dog are allowed to search the parking lot and perimeter of the building
   - **j.** No clients will be in the building during any searches involving scent detention dogs.

Searches

2. Client Search

- Women are to be searched by women's staff and men are to be searched by men's staff.
- **WEAR GLOVES AT ALL TIMES**
- **NEVER PLACE YOUR HAND INTO A SMALL POCKET**
- Staff shall never pat down a client, go hands-on with a client, or view a client who is nude.
- Start by asking the client "is there anything I may find while searching or anything that may prick or poke me?"
- If a client refuses to participate in any part of the search they are to wait away from the general population under staff supervision. Staff needs to contact the Supervisor or Director for further instruction.
- Refusal may lead to discharge.
- Whenever possible have two staff available (Security, witness, consistency and training)
- Perform client personal searches in a discreet, respectful area; do not do these searches in the client's room.
- Start from the head down, have client feel ponytails/ buns, removing hats and searching as well.
- Women need to unhook their bra to ensure nothing is placed in the sides or front. **note: women leave their shirt on during this process.**
- Ask client to pull their front pant pockets inside out (never stick your hand in a client's pocket)
- Have the client place their own hand in their back pocket performing a swift scooping motion from side to side, pulling their hand out each time they get to one side of the back pocket.

- The client will need to grab the top front of their pants pulling back and forth rapidly, this will
  ensure nothing has been pinned to the front inside of their pants.
- Clients need to remove their shoes and socks. Check the soles of their shoes and bottom of their feet.
- Check the client's wallet/bag thoroughly checking all pockets, look for tears or seams that have
  been altered to hide contraband
- Remove all items
- Have client pull up shirt high enough to see their waist band, ask client to run their fingers along
  the inside of their waistline all the way around their waist.
- Have client pull tight on the front/ rear of shirt, looking for hidden items/bulges in front or back
  of shirt.
- If client is wearing a jacket, make sure to check all pockets If an object is observed under the clothing, staff will ask the client to remove the object. If the client refuses, staff should follow the refusal procedure listed above
- Use phone detector/wand when searching clients

3. Room Searches

- **WEAR GLOVES AT ALL TIMES**
- Courtesy knock before entering the room
- When searching a client's room be respectful and leave the room looking the way you found it.
- Search all areas of the room
- Dressers (search clothing)
- Bags/laundry bins
- Mattresses (under, in sheets, look for tears)
- Pillows and pillowcases
- Garbage cans
- In shoes
- Closets
- Ceiling tiles
- Any areas that could hide contraband
- After searching a client's room staff must place the programs "your room has been searched
- note" on the client's bed, listing anything that was taken.
- Food found can be placed in the client's snack bin. Perishable food must be thrown away.
- Money found needs to be deposited into the client's account. Follow policy
- Drugs, tobacco, alcohol or weapons found in a client's room must be reported to the supervisor and director immediately. Follow policy
- Other contraband prohibited by NSR, but not illegal must be placed in the clients send home
- bin. Follow policy

- Any prohibited items found in a client's room must be documented and communicated to the supervisor and director.

4. **Clothing Search:** Clothing searches are conducted as part of the inventory of the client's belongings when the individual arrives or returns from a pass
    a. **Clothing searches shall be conducted as follows:**
        i. Physically examine the following areas:
            - All clothing;
            - Run fingers over lining, seams, collars, cuffs, waistbands, and fly;
            - Shoes, inside soles and heels, and
            - Socks, turning them inside out
5. **Toiletry Search:** Toiletry searches are conducted as part of the inventory of the client's belongings when the individual arrives or returns from a pass.
    a. **Toiletry searches shall be conducted as follows:**
        i. Remove objects from toiletries bag or suitcase
        ii. Look over each object carefully
        iii. Shake object and run fingers on surface to check for any removable/loose parts
        iv. Examine any loose / removable parts

6.8 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.

6.9 Transportation

Responsibilities for Transportation
All clients are responsible for their own transportation to and from non-treatment-related services. This includes Kai Shin and psychiatry appointments, doctor/dentist/vision appointments, court, work/pass/leisure, etc. NorthStar Regional drivers are prioritized to provide transportation to and from programming and client intakes. Personal ride options include personal vehicle, sober family and friends, sponsor, med ride through insurance, southwest transit, taxi/uber, case worker, etc. Clients are encouraged to use Medical Rides for transportation to and from medical appointments. This is done through insurance and will not cost you money out of pocket. Please see "Med Rides" sheet given upon intake for the number to call based off your current insurance. If you are unfamiliar with the process of scheduling medical rides, please inform staff and we will help you through this process.
Medical rides often need a minimum of 72 hours to be scheduled through insurance. If within the 72 hours, still call and attempt to schedule an "emergency" Medical Ride if they can not schedule a normal med ride in this timeframe. Be proactive in your recovery and schedule your appointments appropriately. Rides can usually be reoccurring for a whole month if needed and will need to be resubmitted at the end of the month for the following month.
If you are unable to utilize medical rides and/or exhausted all other options and are unable, with enough notice to staff, you can request transportation through NorthStar Regional drivers. **By making a request, this does not mean you will be given a ride**, rather we will check availability and provide transportation if able.
If any questions or concerns arise, please discuss immediately with staff. By signing the line below, I hereby acknowledge a clinician/staff has discussed transportation with me, I have read the above information and I acknowledge it is my responsibility to provide transportation to all non-treatment-related services.

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 Cites, 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.uofmmedicalcenter.org/Clinics/InfectiousDiseaseHIVClinicDelawareStClinic
Hennepin County Public Health/ Red Door Clinic- Minnesota's largest HIV and STD testing site.
http://www.reddoorclinic.org/
Hope House- Provides housing and assisted care to individuals living with HIV who can no longer live independently. http://www.hopehousescv.org/
Indigenous People's Task Force- HIV/AIDS education, prevention, case management and support services to the Native American community. http://indigenouspeoplestf.org/
Minnesota AIDS Project- Harm reduction services, legal services, benefit counseling, case management, transportation, chemical health, and peer support services with other persons living with HIV and advocacy for the gay and lesbian community.
One Heartland- Camping and support for kids and teens with HIV/AIDS.
http://www.oneheartland.org/
Open Arms of Minnesota- Prepares and delivers meals to people living with HIV/AIDS and other chronic illnesses. http://www.openarmsmn.org/
Positive Care Center at Hennepin County Medical Center- Provides education, Case Management and serves as a community and family resource and contributes extensively to the advancement of HIV related knowledge.
http://www.hcmc.org/clinics/HCMC_CONDITIONS_80

Rural AIDS Action Network - Locates rural primary health care providers, HIV testing, outreach, and case management. http://www.raan.org/
Sub-Saharan African Youth and Family Services in Minnesota- Provides HIV education and materials appropriate to African-born persons throughout Minnesota, with focus on the Ethiopian and Oromo communities. http://www.sayfsm.org/
Tubman/Chrysalis-
Provides health and human service programs to women, children, and families.
http://tubman.org/
Turning Point, Inc.- Provides social services and public health programs to the African American community in the Twin Cities metro area, including housing and HIV/AIDS case management.
http://www.ourturningpoint.org/
Westside Community Support Services, La Clinic
Provides HIV support and counseling for Spanish speaking clients.
http://www.westsidechs.org/programs.php?clinic=4
Youth and AIDS Projects- Prevention programs, counseling and testing services, financial assistance, case management, mental health services and advocacy services. http://www.yapmn.com/
See chapter 6 for additional resources for people living with HIV available in Minnesota.

Chapter 6-Accessing and Obtaining Services-
A case management approach recognizes that satisfying such basic needs as general health and adequate housing and food when an individual is actively abusing substances can be overwhelming and that substance abusing behavior will impair a person's ability to gain access to a formalized system of services. For best outcomes, case management should be utilized in dealing with the multiple problems presented by HIV/AIDS in combination with substance abuse. Case management promotes teamwork among the various care providers. For example, linkages among the client's primary care provider, Medical/HIV case manager, mental health provider, and substance abuse treatment provider can greatly benefit the client and improve care. It is sometimes difficult for the HIV-infected substance abuser to find and fund needed services. The case manager can play an important role in helping find specific services and navigate the plethora of public and private funding options. The counselor should be familiar with funding options for services such as substance abuse treatment, mental health treatment, medical and dental care, and HIV/AIDS drug therapy. Counselors should be knowledgeable about the eligibility criteria, duration of service, and amount of assistance for basic financial assistance programs, including welfare, unemployment insurance, disability income, food stamps, and vocational rehabilitation. For specific information on economic assistance available in Minnesota visit the Department of Human Services website: http://mn.gov/dhs/.
In response to implementation of the Affordable Care Act, Minnesota's health care exchange, MNSURE has partnered with six health insurance agencies across the state to offer free, in-person enrollment assistance. Certified agents and navigators will be available to answer questions, recommend plan selection and work to help you complete your enrollment. Whether you seek a competitively priced private health insurance plan or qualify for a public program like Medical Assistance or MinnesotaCare, you can contact a lead agency listed below to schedule an appointment or request walk-in hours. For more information, please visit the MNSURE webpage at https://www.mnsure.org/ , or contact MNSURE by phone at 1-855-366-7873.
The Ryan White Care Act provides additional coverage for those living with HIV that may be uninsured or under-insured. More information regarding Ryan White programs can be found in Chapter 10., Funding and Policy Considerations. For information about Ryan White Programs in Minnesota please visit the Minnesota Department of Human Services webpage:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=HA_01

For a comprehensive guide to HIV related resources in Minnesota please visit the Minnesota AIDS Projects 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 612-373-2437 or consult with the Minnesota AIDS project's legal department. Legal staff are available to assist with a variety of legal services related to HIV including confidentiality, estate planning, debt counseling, discrimination and accessibility, and benefits assistance. Please use the link below for additional information.
http://www.mnaidsproject.org/services/support-services/legal-services.php

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

National HIV Strategy-
In 2010, President Barack Obama committed to developing a National HIV/AIDS Strategy with three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.
This strategy focuses on effective treatment as prevention. More must be done to ensure that new prevention methods are identified and that prevention resources are more strategically concentrated in specific communities at high risk for HIV infection. People who are aware of their HIV status and who are effectively engaged in antiretroviral treatment are much less likely to transmit the virus to others. For more information related to The National HIV Strategy please visit the White House's Office of National AIDS Policy:
http://www.whitehouse.gov/administration/eop/onap/nhas

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

- Awarding Housing Opportunities for Persons with AIDS (HOPWA) contracts to private housing brokers who maintain lists and links of available housing units, manage vendor payments, and provide home management skills training to residents.
- Awarding home-based meal services to meal delivery organizations such as Meals on Wheels.

- Providing transportation by private bus companies and taxi-jitney services.
- Providing contracts to private providers for mental health services and spiritual counseling.
- Awarding dollars for return-to-work initiatives to work placement companies such as Goodwill Industries and Manpower Development Services.

There are several advantages to mainstreaming:

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

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

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

Ryan White HIV/AIDS Program-

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

The Ryan White HIV/AIDS Program, first authorized in 1990, is funded at $2.32 billion in fiscal year 2014. The Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). (HRSA, 2014). Program and enrollment information on Minnesota's Ryan White assistance program, Program HH, can be found on the Minnesota Department of Human Services website:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=HA_01
For more information on current initiatives and recent information on HIV related funding and services can be located on the Health Services and Resources Administration HIV/AIDS programs webpage http://hab.hrsa.gov/.

HIV/AIDS Policy Recommendations for Minnesota

Investments in HIV Prevention and Services is Smart Public Policy-
In 2012, Minnesota experienced an 8 percent overall increase in new HIV infections, followed by a 4% reduction in 2013. Government has a responsibility to the state's public health, and HIV is a public health issue. Investment in HIV prevention and services is smart public policy and saves taxpayers in the long run ensuring that people living with HIV receive necessary medical treatment and support, assisting them with living their lives to the fullest potential, and help prevent new HIV infections.

HIV Prevention Programs Can Save Taxpayer Dollars
Minnesota currently provides approximately $1.4 million for HIV prevention programming to targeted communities. In a cost–benefit analysis of HIV prevention programs, researchers found that the lifetime costs of caring for a person living with HIV are far greater than the funding needed to reach that same individual with prevention messages. The study found that even a greatly expanded HIV prevention program in the U.S. could pay for itself through savings in averted medical care costs.

Treatment and Services for People Living with HIV are Essential
Minnesota currently provides approximately $1.2 million per fiscal year for insurance premiums and case management program support. While HIV prevention programs are a public health priority, we must also commit to ensuring that people living with HIV receive the medical care and services they need. State resources currently fund important services for people living with HIV. This includes subsidized insurance premiums for low income, or uninsured individuals. Case management programs rely on state funds to help people living with HIV manage the disease and access services necessary for their health and well-being. When HIV positive individuals learn their status, receive education about HIV and how it is transmitted, and begin to receive necessary medical care and support services, they are less likely to transmit the virus to others.

Take Action
Minnesota funds targeted HIV prevention programming and services for people living with HIV with state resources from the General Fund. These resources are vital to preventing new HIV infections and helping people living with HIV to do so with respect and dignity. In these difficult financial times, it is all the more important to invest in these vital programs. Please protect state resources for HIV prevention and services.

APPENDIX B

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Division of Tuberculosis Elimination
TB 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
http://www.cdc.gov/tb/publications/faqs/default.htm http://www.cdc.gov/tbOctober
2011