Substance Use Disorder Treatment and Prevention Policy Recommendations for the State of Wisconsin

Phase One — November 2017

Submitted to the Co-Chairs of the Governor's Task Force on Opioid Abuse

The Pew Charitable Trusts' Substance Use Prevention and Treatment Initiative
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Summary

The Pew Charitable Trusts (Pew) is an independent, nonpartisan research and policy organization dedicated to serving the public. Our substance use prevention and treatment initiative develops and supports state and federal policies that reduce the inappropriate use of prescription opioids; and expands access to effective treatment for substance use disorders (SUDs), such as medication-assisted treatment (MAT). The Pew Charitable Trusts' partnership with states is intended to assist in their efforts to achieve a treatment system that provides quality SUD treatment that is disease-focused, addresses stigma, and supports improved disease management and patient outcomes.

Pew provides technical assistance to states that request Pew's expertise and support with a formal invitation. In response to the state's technical assistance invitation, Pew assesses the state's treatment system using a set of comprehensive treatment principles and conducts an assessment based on stakeholder interviews, data analyses, and policy reviews. These analyses culminate in recommendations for the state's executive and legislative branches of government. This initial report consists of seven policy recommendations for Wisconsin based on discussions with stakeholders across the state, a review of SUD treatment best practices, and conversations with national leaders.

Framework for an effective treatment system

The American Society of Addiction Medicine (ASAM),[1] the U. S. Surgeon General's Report on Alcohol, Drugs, and Health,[2] and the National Academies of Sciences, Engineering, and Medicine[3] support a SUD treatment system that ensures patients have access to evidence-based treatment that is matched with disease severity. Policy options intended to increase access to SUD treatment should include data-informed practices, as well as some emerging and innovative models, that incorporate the following characteristics:

- *Timely*: Ensures that there is adequate capacity to meet treatment demand, including the availability of facilities, providers, and services. A timely system ensures that all services and levels of care recommended by the ASAM guidelines[4] are geographically distributed across the state according to need. To the extent possible, timely includes access to on-demand treatment, or at a minimum, timing of treatment that is consistent with disease severity.
- *Comprehensive*: Coverage by public (such as Medicaid) and private insurers of the full spectrum of treatment services—including screening, diagnosis, withdrawal management, maintenance, and recovery—is a key characteristic of a comprehensive SUD treatment system. A comprehensive treatment system addresses population-specific needs, such as care for juvenile, pregnant, and justice-involved populations, and coordinates care for SUDs, mental health, and physical health.
- *Evidence-based*: Includes coverage and utilization of all Federal Drug Administration (FDA) approved medications for the treatment of SUD and behavioral health services recommended in evidence-based guidelines, as well as the screening and treatment of co-occurring mental health disorders and infectious disease complications. The state

infrastructure, including surveillance systems, will be optimized to document the scope of SUDs, monitor progress, and guide evidence-based interventions.

- *Sustainable*: Uses funding efficiently, optimizes federal funding resources, and collaborates with community-based partners to augment treatment services. A sustainable treatment system retains relevance by adapting to emerging substances of misuse and effectively managing the disease burden in the state.

Phased approach to recommendations

In response to Wisconsin's invitation for technical assistance, Pew will provide policy recommendations to the Governor's Task Force on Opioid Abuse in two phases – (1) fall 2017 recommendations and (2) spring 2018 recommendations. In addition to an initial package of policy reforms (phase one); Pew will provide a full system assessment and data analysis with long-term insights for the state on timely, comprehensive, evidence-based, and sustainable treatment for SUD as part of phase two.

The seven recommendations included in this report are based on work completed by Pew between July and November of this year. This work included discussions about the state's treatment system with stakeholders from state and local government agencies, elected officials, as well as associations representing health care providers, individual prescribers, and patient advocates. In total, Pew had discussions with more than 100 state stakeholders to better understand the strengths and gaps in Wisconsin's existing SUD treatment system and other stakeholder policy priorities. In addition, Pew consulted national experts and reviewed evidence-based and emerging practices found in the gray literature (e.g., reports, briefings, case studies, presentations). These conversations informed the development of the phase one recommendations and will continue to provide context for a comprehensive set of phase two recommendations. Moreover, phase two recommendations will be informed by quantitative analyses using data from state agencies, federal sources, and other proprietary data obtained by Pew. These data will characterize substance use, misuse, and SUD prevalence estimates, calculate treatment capacity gaps, and project treatment needs based on the allocation of resources. The phase two recommendations will also be informed by patient, provider, and family member focus groups, as well as the assessment of existing state regulations relevant to SUD prevention and treatment.

Proposed Recommendations

Workforce

Recommendation 1: Issue an executive order to create an advisory body to advise the state on the potential to implement a state-wide "hub and spoke" treatment delivery system to coordinate and expand access to evidence-based treatment for opioid use disorder.

Recommendation 2: Increase access to buprenorphine by expanding provider training during residency programs and removing barriers to patient access.

Recommendation 3: Evaluate Wisconsin's substance abuse counselor (SAC) certification criteria and processes for psychotherapists (including marriage and family therapists, professional counselors, and social workers) to ensure the state's credentialing for behavioral health treatment for substance use disorder aligns with high quality treatment while avoiding duplicative educational and supervisory requirements to provide care.

Women's Health

Recommendation 4: Facilitate effective substance use disorder treatment for pregnant women by removing barriers to evidence-based treatment.

Data

Recommendation 5: Develop a comprehensive source of information on treatment providers that supports the initiation of care by either providers or people with substance use disorders.

Recommendation 6: Develop a standardized process to compile and maintain information about the number of people in Wisconsin that want, but that have not yet received, substance use disorder treatment, including uniform provider reporting requirements.

Justice-Involved Individuals

Recommendation 7: Improve the reentry process for individuals with substance use disorder by suspending and not terminating Medicaid enrollment upon entry into state correctional facilities, specifying at least one MCO per region that is designated to provide services for adults reentering the community, and establishing a method by which persons re-entering the community would be informed about which MCO will administer their Medicaid benefits upon release.

The structure of this report allows the reader to review and share these recommendations individually or as part of the larger report. Each recommendation is followed by a definition of the treatment barrier, proposed solution and implementation strategy. Each recommendation also describes how the recommendation addresses the treatment framework and identifies the stakeholders with whom Pew held discussions.

Workforce

Recommendation 1: Issue an executive order to create an advisory body to advise the state on the potential to implement a state-wide "hub and spoke" treatment delivery system to coordinate and expand access to evidence-based treatment for opioid use disorder.

Problem:

Wisconsin does not have a treatment delivery system with the capacity to treat the number of people with opioid use disorder (OUD) in the state.

Background on Treatment Barrier:

There is a treatment gap for those in need of substance use disorder (SUD) treatment, including those with OUD, in Wisconsin. In fact, a 2016 Wisconsin Needs Assessment found that only 23 percent of individuals that need treatment in the state receive it. Comprehensive treatment for OUD, which combines FDA-approved medications like buprenorphine and naltrexone, with evidence-based behavioral services is the most effective method of treatment available.

Any comprehensive treatment system for people with OUD must rely heavily on community-based providers for care delivery. These primary care providers, who see patients in office-based settings, are essential for several reasons. First, there are not a sufficient number of addiction medicine specialists to treat the number of people with OUD. Second, given the importance of geographic proximity to treatment, a critical mass of community-based providers ensures that people with OUD do not have to travel too far to access care. Third, primary care providers typically know their community well and can ensure that patients are connected with other needed services. Fourth, primary care providers are on the front lines of the opioid crisis, accounting for 50 percent of opioid prescriptions dispensed, according to the Centers for Disease Control and Prevention (CDC). And lastly, these providers have a number of tools at their disposal to treat individuals with OUD. Given that they are often the first point of contact in the health care system, they can provide education on the risks of opioid overdose, and screen for misuse or disordered use and intervene. Additionally, primary care physicians are authorized to prescribe multiple effective medications for the treatment of OUD.

Community-based providers can treat patients with OUD with buprenorphine, an FDA-approved medication that can be taken by patients at home. For some patients, this regimen has advantages over methadone, which must be taken daily at an outpatient treatment program. In order to prescribe buprenorphine, prescribers must take a Drug Enforcement Agency (DEA)-mandated course and register with the agency. Unfortunately, there is a shortage of providers both nationwide and in Wisconsin who have taken the course and are prescribing buprenorphine.[56] Interviews with Wisconsin providers and community leaders indicate that the shortage of buprenorphine prescribers limits access to OUD treatment in the state.

Community-based providers can also prescribe and administer naltrexone, another FDA-approved medication for the treatment of OUD. The long-acting injectable version of this medication, Vivitrol, lasts for 30 days between administrations. In order to meet the treatment

need in Wisconsin, the state needs to broaden treatment providers beyond addiction medicine specialists to include community-based providers who can prescribe buprenorphine and naltrexone to help meet the demand for treatment.

Medications are an important part of OUD treatment, but the most effective treatment combines these medications with evidence-based behavioral health services such as counseling (see Recommendation 3) and other social supports (e.g., housing, transportation, and job training). These components of treatment are a challenge for community-based providers without support and specialty back-up.

Community-based providers may not be well-suited to treat all OUD patients. For example, patients going through acute withdrawal or with a co-occurring mental health disorder may need a higher level of care than community-based providers can deliver. But community-based providers remain an essential part of the treatment system once patients have been stabilized. Wisconsin providers, community leaders, and experts all cited the shortage of community-based treatment providers in treating this population as one of the major barriers to accessing OUD treatment in Wisconsin.

Some community-based providers in Wisconsin reported that they do not treat patients with OUD because they lack the necessary expertise and are unprepared to handle challenging patients. Research indicates community-based providers have concerns around the lack of psychosocial support, time, specialty back-up, confidence, institutional support, and adequate reimbursement in treating this population.[7] These providers also need additional specialty support, including training and education, to develop the confidence and expertise to engage in the OUD treatment system. These additional services can be provided by addiction medicine specialists that are regionally-based across the state. The support from these providers directly addresses the concerns of community-based providers in treating this population.

Proposed Solution:

To expand access to coordinated and evidence-based OUD treatment and give community-based providers appropriate support to deliver this treatment, the state should create a statewide "hub and spoke" delivery system. This structure ensures patients receive withdrawal management, stabilization, and initial MAT services at "hubs" where needed and maintenance therapy from community-based providers, or "spokes," with support services provided by both. By integrating primary care practices and other community-based providers into the treatment delivery system, this system would expand access to evidence-based treatment for OUD.

There is evidence this structure works. Two states, Vermont and Rhode Island, have implemented state-wide hub and spoke systems. Prior to implementation of this system in Vermont, office-based treatment programs were able to treat only a small number of patients due to concerns about care coordination, complex patient support, and a lack of behavioral health services for patients. Hubs were developed to integrate addiction expertise into existing opioid treatment programs (OTPs) and to alleviate the barriers office-based treatment programs face in treating this population by providing the initial clinical assessment, initiation of MAT, and the management of acute patients. Following the assessment and initial services, hubs then

coordinate with a regional network of community-based providers or spokes made up primarily of office-based treatment programs for ongoing treatment. Patients are referred and care is coordinated through Health Home nurses and licensed clinical case managers that are embedded in both Hub and Spoke providers.

Vermont uses a Medicaid State Plan Amendment for Health Homes under Section 2703 of the Affordable Care Act to help fund its system. By doing so, the state receives a 90 percent match for services delivered under the Health Home model, such as comprehensive care management, care coordination, health promotion, transitions of care, individual and family support, and referral to community services. Additional clinical support staff is supported by the Health Home and other Medicaid payment flexibility programs in Vermont, such as the Global Commitment to Health Demonstration Waiver and the Vermont Blueprint for Health.[8]

Since implementation in 2012, Vermont has reduced its treatment gap to the smallest in the nation, with a capacity to meet 73 percent of the need for OUD treatment in the state.[9] Hubs provide ongoing clinical education on addiction medicine, prepare additional providers to receive their federal buprenorphine waiver, and adapt other forms of training to meet the needs of spoke providers. In Wisconsin, for example, hubs could be used to educate community-based providers around trauma-informed care practices to improve the understanding and responsiveness to the impact of trauma among patients and providers. Due in part to the additional training community-based providers have received, Vermont has seen a 64 percent increase in physicians waivered to prescribe buprenorphine and a 50 percent increase in patients served per waivered physician.[10]

In 2016, Rhode Island developed a similar model with Centers of Excellence for the Treatment of Opioid Use Disorder serving as hubs.[11] These Centers are based in health systems and provide rapid access to a comprehensive set of services, such as evaluation, induction, stabilization, and collaboration with community-based providers delivering ongoing treatment once individuals are stabilized. Like Vermont and Rhode Island, other states such as California, Delaware, Montana, and Washington[12, 13]are considering implementation of the hub and spoke model. Similar models of care have been used to provide treatment for other chronic diseases, such as diabetes,[14] and congestive heart failure.

This recommendation supports a timely, comprehensive, evidence-based, and sustainable treatment system by expanding the capacity of community-based providers to deliver OUD treatment. Developing and implementing a hub and spoke treatment delivery system for OUDs is a potential approach to improve the management of acute patients and the provision and coordination of referrals to necessary behavioral health services to support community-based providers that maintain patients on MAT and address primary health care needs. These delivery system reforms could in turn address the most significant barriers preventing primary care physicians and other community-based providers from treating this population. A hub and spoke system, tailored to the specific operations of the Wisconsin health system and the needs of patients, providers, and other stakeholders, is one approach that would work to build a more robust OUD treatment system, and has interest among many of those stakeholders.

Potential Implementation Strategy:

The Governor of Wisconsin could issue an executive order that establishes and directs an advisory body to assess the potential for a statewide Wisconsin hub and spoke system and, if warranted, to develop implementation recommendations. Such an advisory body should be geographically diverse and include a cross-section of stakeholders (e.g. providers, health systems, and patients) who could be affected by this delivery reform. This body would issue recommendations to the Governor and legislative leadership within twelve months of its first meeting. During this process Pew would continue to serve in a consultative role to link the advisory body to key experts and provide support in order to develop a comprehensive understanding of the barriers, costs, and other critical variables to consider. Since this reform could have a significant impact on the design and function of OUD treatment delivery in the state, the Governor should establish a public process that builds consensus around the necessary legislative, regulatory, and administrative changes to facilitate this model in the state.

Prior to implementation, it is likely that these changes would be necessary to ensure state-wide access to hub and spoke services:

- Elimination of all county-to-county treatment barriers. Access to treatment to any hub should not be determined by geography; an individual in need of treatment should be able to access hubs located outside of the county where he or she resides.
- Medicaid fee-for-service and Medicaid managed care networks should be inclusive of all hubs in the state.
- Creation of incentives for hubs to integrate trauma-informed care practices and support spokes with trauma-informed training. State guidelines for trauma-informed practice should be developed in consultation with experts in the field and state leaders.

The advisory body, at a minimum, should include a representative from the following government bodies:

- Wisconsin Legislature
- The Department of Health Services
- Wisconsin Medicaid program
- The Department of Safety and Professional Services
- County health and/or human services official

The advisory body, at a minimum, should include a representative from the following non-governmental stakeholders:

- Individuals representing potential hubs, such as research hospitals, health systems, or other regionally-based medical providers (e.g. UW Health, Gundersen Health System, Marshfield Clinic Health System, or federally qualified health centers [FQHCs])
- Individuals representing potential spokes, such as community-based SUD treatment providers (e.g. OBOT programs)
- Wisconsin Medical Society
- Wisconsin Hospital Association
- Wisconsin Primary Health Care Association
- Wisconsin Society of Addiction Medicine

- Individuals representing patient advocacy organizations

Recommendation 2: Increase access to buprenorphine by expanding provider training during residency programs and removing barriers to patient access.

Problem:

Many patients have difficulty accessing buprenorphine, one of three FDA-approved medications to treat opioid use disorder.

Background on Treatment Barrier:

Buprenorphine is one of three medications approved by the FDA to treat people with opioid use disorder (OUD). To prescribe buprenorphine in this way, the Drug Enforcement Agency (DEA) requires that providers take an eight-hour course. For practicing physicians, this day-long course removes them from treating their current patients and the financial reimbursement for those services. For physician assistants and nurse practitioners, even more training is required. There is an additional 16-hour course[15] after the initial course, equaling 24-hours of training to prescribe the drug. Depending on who conducts this training session and where it is located, providers may incur additional costs to be able to treat the disease.

Only a small percentage of eligible providers choose to take this training course and get the necessary waiver to prescribe buprenorphine. In 2012, there were over one million people nationally with OUD that could be treated with buprenorphine but just 22,198 buprenorphine-waivered physicians.[16] In Wisconsin that same year, 4.9 of every 1,000 individuals had opioid misuse or dependence, yet prescribers in the state had a maximum capacity to treat only 3.3 per 1,000 with buprenorphine.[17] This likely overstates the ability of providers to treat patients with buprenorphine, as many prescribers who have taken the necessary courses and registered with the DEA do not prescribe buprenorphine at all, or do so infrequently. In fact, an estimated 34 to 56 percent of approved providers do not prescribe any buprenorphine to treat OUD.[18]

Interviews with stakeholders across Wisconsin highlighted the limited interest from primary care physicians and other community-based providers in obtaining a federal waiver to prescribe buprenorphine and subsequently treating individuals with OUD in their practices. Research shows that over 60 percent of non-prescribers chose not to seek the federal waiver due to a lack of psychosocial support, half due to lack of confidence in treating the patient population, and nearly half due to lack of specialty back-up.[19] Many of these barriers would be addressed through the implementation of a "hub and spoke" treatment delivery system (Recommendation 1), but more needs to be done to increase the number of providers who can prescribe buprenorphine. Additional training is needed for physicians, nurse practitioners, and physician assistants to improve understanding of, and comfort with, the provision of effective OUD treatment.

Another barrier to the use of buprenorphine is a requirement for prior authorization for buprenorphine combination products (e.g., Suboxone) in Wisconsin's Medicaid program. The American Medical Association identifies utilization management techniques such as prior authorization as a significant barrier that delays the start or continuation of necessary treatments, often resulting in negative health outcomes.[20] Given the potential impact of delayed treatment for those with OUD, any administrative barriers could affect the success of treatment.

The 2016 federal Comprehensive Addiction and Recovery Act (CARA) gave nurse practitioners and physician assistants the ability to prescribe buprenorphine for OUD. However, Wisconsin limits the ability of these providers to prescribe. Wisconsin is one of 16 states that restrict nurse practitioner practice, such as by requiring collaborative agreements with other health providers. Wisconsin requires that physician assistants have a supervising physician who is also a waivered prescriber in order to prescribe buprenorphine. These restrictions may disproportionately affect rural areas that have a limited number of physicians.

Proposed Solution:

To expand access to effective OUD treatment, additional training and coursework should be incorporated into the medical school curriculum to improve knowledge and access to medical training in addiction medicine. If additional resources are needed to ensure implementation of this training, the State of Wisconsin should establish a grant program to provide funding to Wisconsin-based medical residencies, clinical fellowship programs, and clinical training programs that add a requirement for participants to complete training to obtain buprenorphine prescribing authority prior to completion of the program. Incentives to ensure buprenorphine waivers are used after graduation, such as loan support, should be considered.

Currently, a small number of medical schools provide this training as either part of their curriculum or during residency and fellowship programs, allowing students to apply for a waiver upon completion of their training. For example, starting in 2019, all graduates of Brown University medical school in Rhode Island will have completed the training and obtained the necessary buprenorphine waiver prior to graduation. Integrating this training in residency programs should also be a priority.

This recommendation supports a timely treatment system by increasing the number of federally waivered providers, including physicians, nurse practitioners, and physician assistants, who can prescribe buprenorphine. Developing the knowledge and skills to treat OUD early in clinical training could help grow the provider base that is willing and able to treat this population.

Proposed Implementation Strategy:

The state should begin discussions with the University of Wisconsin School of Medicine, the Medical College of Wisconsin and other academic medical centers, relevant medical residencies, fellowships, associations representing these practitioners, and residency training programs for nurse practitioners and physician assistants. Efforts should focus on general or family practice, obstetrics and gynecology, pain management, and psychiatry residencies programs. If the training programs do not have the resources to implement this change on their own, the state should develop a fund that medical residencies and clinical training programs can use to cover the costs of buprenorphine waiver training.

The state should consider additional steps to encourage graduates to use their federal waivers by ensuring payments to treat patients with OUD are sufficient and through financial incentives to physicians, nurse practitioners, or physician assistants that prescribe to their full authority. Any

incentive program that the state establishes should include standards to ensure that all treatment delivered is evidence-based, such as by including a requirement that the use of buprenorphine must be accompanied by behavioral health services either in the provider's practice or through referral to another licensed provider.

To ensure that barriers to providing timely access to evidence-based treatment are removed, the state should eliminate prior authorization requirements for buprenorphine-naloxone products to ease the administrative burden on prescribers and improve access for patients.

The state should alter current scope of practice requirements that limit nurse practitioners and physician assistants from prescribing buprenorphine without a similarly waivered supervising physician. These potential changes to scopes of practice can be limited to prescribing authority for buprenorphine only. Removing these treatment barriers could impact access, particularly in rural areas of the state that already face even more significant federally waivered physician shortages.

Recommendation 3: Evaluate Wisconsin's substance abuse counselor (SAC) certification criteria and processes for psychotherapists, including marriage and family therapists, professional counselors, and social workers, to ensure the state's credentialing for behavioral health treatment for substance use disorder aligns with high quality treatment while avoiding duplicative educational and supervisory requirements.

Problem:

Wisconsin does not have enough licensed substance use disorder counselors to meet the treatment needs of people in the state.

Background on Treatment Barrier:

Substance use disorder counselors play a critical role in treating people with substance use disorders (SUD). SUD counselors provide one-on-one, group or family counseling, comprehensive case management, and withdrawal support services. Counselors are well versed in medication-assisted treatment (MAT), the most effective treatment for SUD, which combines Food and Drug Administration (FDA)-approved medications with behavioral therapies from these counselors.

Wisconsin has a significant shortage of SUD counselors. According to the 2017 Wisconsin Needs Assessment, Wisconsin has 1.7 SUD counselors per 10,000 persons in comparison to the national average of 2.5 per 10,000 persons.[21]An additional 275 SUD counselors are needed just to match the national average, let alone meet Wisconsin-specific demand for these professionals. In speaking with behavioral health professionals and provider groups around Wisconsin, an increase to meet the national average would be insufficient to meet state needs. Wisconsin is not alone in having high demand for SUD counselors. A recent report from the Bureau of Labor Statistics (BLS) predicts a 20 percent growth in the need for substance use and mental health counselors from 2016 to 2026.[22] The growing need for SUD counselors is due, in part, to increased insurance coverage of mental and behavioral health care services.[23] In Wisconsin, opioid treatment programs (OTPs) and behavioral health clinics, all report significant difficulties in filling vacancies, expanding services, and expanding workforce, with these concerns slightly lower in the more populous Dane, Milwaukee, and Waukesha counties.[24]

In Wisconsin, these workforce challenges are exacerbated by several factors. First, SUD counselor licensure in Wisconsin requires 4,000 hours (approximately two years) of clinical experience while supervised by a certified substance abuse counselor (SAC) in Wisconsin. In contrast, Minnesota and Ohio require 2,000 hours, and Michigan requires 3,000 hours; treatment providers have highlighted the restrictive training requirements as a barrier from hiring counselors from out of state and preventing others from relocating to Wisconsin. Conversations with national counseling organizations have revealed a lack of standardization across the country in what required hours of training to become certified as a SUD counselor. The problem of training requirements is compounded by a lack of clinical supervisors to serve in an oversight role for counselors in training. This presents a second barrier.

A third challenge in Wisconsin is the increased demand placed on licensed psychotherapists interested in obtaining the certification required to work with the SUD population. SUD counselors include psychotherapists—such as marriage and family therapists, professional counselors, or social workers—who have received additional trainings and are then certified by the state to treat patients with SUD. Despite having similar training, coursework, and supervised hours, Wisconsin's Department of Safety and Professional Services (DSPS) requires individuals to undergo the entire SAC credentialing process, including being supervised by a clinical supervisor for an additional 4,000 hours in order to receive the dual certification required to treat SUDs. This occurs despite the fact that many licensed psychotherapists in the state already have experience and training in treating SUD. As result of Wisconsin's requirements, psychotherapists who have received training in other states—and are certified to provide care in those states—may not meet Wisconsin's requirements.

State data demonstrate the gap in potential SUD counselors. As of 2016, Wisconsin has 7,379 licensed psychotherapists but only 13 percent (981) hold the dual-credentials of licensed psychotherapists. If regulations were examined that currently restricts licensed psychotherapists from providing SUD treatment without first obtaining the SAC certification, licensed therapists would eventually begin treating patients with SUD diagnoses.[25]

Overall, the lack of SUD counselors in Wisconsin can be attributed to potentially over restrictive training requirements, both through hours required and supervisory elements, and barriers to involving psychotherapists into the SAC workforce.

Proposed Solution:

To address the shortage of counselors delivering SUD treatment, state agencies should address barriers that restrict Wisconsin providers from becoming dual-certified. Moreover, agencies should evaluate ways to encourage experienced counselors who have relocated from other states to enter practice more easily while providing safeguards that ensure quality care. Wisconsin should compare its current statutes to the education and licensure requirements for these practitioners in other states as well as current research on evidence-based practices for treating SUD. In the meantime, DSPS can play a critical role by reviewing other states to determine those with equivalent or comparable training requirements in order to expedite certification of relocating professionals without requiring seasoned professionals to obtain additional training to practice. In addition to recognizing certified counselors from other states that have similar licensing standards as Wisconsin, the state can attract additional out-of-state counselors, such as those living in areas that border Wisconsin while ensuring quality expectations are met.

Specific to psychotherapists, DSPS should review the requirements for the add-on SUD counseling credential to determine if previous training and experience can count toward achieving dual certification.

In order to maintain the quality of the SAC training and ensure individuals who are SAC-certified are proficient in all core competencies, Wisconsin should conduct a full review of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Addiction Counseling Competencies in conjunction with evidence-based practices from national

organizations devoted to addiction counselor training and licensure. If the evidence suggests the SAC certification requirements should be updated, this improvement will provide assurance that significant evidence-based practices are incorporated for the state. Pew will assist DSPS in these efforts. In addition, in the second phase of our work, Pew will assist the state in efforts to assess that the national landscape of SUD counselor training requirements, including hours, and competencies vary across states in effort to promote consistency in requirements across all states.

This recommendation supports a timely, evidenced-based and sustainable treatment system by increasing the number of treatment providers to meet demand while maintaining quality behavioral health care. Removing barriers to obtaining the state's SAC certification provides an easier entry path to the profession and should create an influx of needed behavioral health care providers to enhance the treatment system. By ensuring quality standards are met through DSPS's licensure requirements and integrated with the latest core competencies from SAMHSA's Addiction Counseling Competencies, Wisconsin will have a new foundation on which to build its workforce.

Proposed Implementation Strategy:

The Legislature should direct the state agencies listed below to evaluate SAC certification criteria and processes and address barriers that restrict qualified providers from obtaining the SAC certification. The following changes would expand the capacity of counselors to meet the need for behavioral health services:

- The Department of Safety and Professional Services (DSPS) should assess the SAC requirements in Wisconsin and recognize SUD counseling certifications from other states that have education and training requirements that are determined to be equivalent.
- The Department of Health Services (DHS) should review Ch. SPS 160-168, administrative rules that govern SAC and DHS Rule 75.02(84)(d) - the MPSW 1.09 specialty requirement - to determine if trained licensed psychotherapists may treat SUD without first obtaining the SAC credential.

During this process, Pew will assist the state by identifying evidence-based and promising practices from national associations and other states, and identify key elements to integrate in DHS's substance abuse counselor requirements including:

- Current counseling structure including core competencies, hours of training required, appropriate supervision, reciprocity standards, and continuing education requirements, and
- Comparison of Wisconsin's structure to best practices from other states (including, but not limited to neighboring states).

Women's Health

Recommendation 4: Facilitate effective substance use disorder treatment for pregnant women by removing barriers to evidence-based treatment.

Problem:

Wisconsin's policies regarding substance use and misuse in pregnant women have the potential to deter women from obtaining evidence-based care for substance use disorder and increase the risk of harm to the mother and child.

Background on Treatment Barrier:

Each year, an estimated 10 to 11 percent of births in the United States are affected by maternal use of alcohol, tobacco or illicit drugs.[26] The incidence of opioid misuse during pregnancy is unknown, but it is an area of heightened concern in light of the increasing incidence of neonatal abstinence syndrome (NAS). NAS is the occurrence of withdrawal symptoms that results from exposure to opioids in the womb. Infants with NAS can suffer symptoms ranging from mild tremors and irritability to fever, excessive weight loss, and seizures.

In an effort to avert unintended opioid exposure during pregnancy, the Wisconsin legislature in 1997 amended Wisconsin Act 292 to allow the Department of Children and Families to require adult pregnant women to receive treatment for a known or suspected opioid or other substance use disorder (SUD). The law has since been used to compel pregnant women to receive treatment, with incarceration as a potential consequence of refusing treatment. The intent of this law was to protect the health of children. However, while there are no systematic data, clinicians in Wisconsin who provide obstetric, perinatal and SUD treatment, as well as patient groups, report that this policy serves as a barrier to SUD treatment for pregnant women by potentially discouraging individuals from seeking SUD treatment for fear of repercussions. This barrier potentially puts pregnant women and their child at greater risk of harm than they would be if this policy did not exist.

While Wisconsin Act 292 does not explicitly require clinicians to report substance use in pregnant women to the Department of Children and Families, practitioners commonly interpret the law as mandated reporting.[27] This misinterpretation was confirmed through conversations with clinicians practicing in the state who described confusion on their role and concerns that the law may discourage early screening and identification of women in need of treatment. Stakeholders also described inconsistences in the quality of SUD treatment available to all pregnant women with SUDs. In particular, providers discussed how pregnant women with opioid use disorder (OUD) may have difficulty accessing FDA-approved medications for the treatment of OUD, since they may not seek care as a result of the law.

Proposed Solution:

Wisconsin should ensure that its laws and regulations support evidence-based treatment of SUDs in pregnant women. This may include addressing misunderstandings of current law and revising

existing policies that serve as a barrier to this care. Organizations with policies that oppose the use of incarceration or forced treatment in pregnant women with SUD include the American Public Health Association, the American Academy of Pediatrics, the National Perinatal Association, and the March of Dimes.[28,29,30,31,32]

From a clinical perspective, the American Congress of Obstetricians and Gynecologists (ACOG) recommends the use of methadone or buprenorphine in pregnant women, noting that this clinician-monitored treatment results in improved health outcomes for the mother and baby as compared to no treatment at all or withdrawal management therapy, which is associated with substantial risks, including miscarriage.[33] Wisconsin should promote best practices for the care of this population by requiring that programs receiving Medicaid reimbursement and other public funding follow guidelines available from ACOG and the American Society of Addiction Medicine (ASAM) that recommend education and screening of women of childbearing age and access to medication-assisted treatment (MAT).[34]

This recommendation supports a comprehensive and evidence-based treatment system by providing care for pregnant women in a manner that is non-punitive and consistent with evidence-based guidelines for addressing SUDs as a disease. Further, it could reduce unintended harms by increasing the likelihood of early screening and identification of at-risk pregnancies.

Proposed Implementation Strategy:

Wisconsin is currently prohibited from enforcing Wisconsin Act 292 as a result of a May 2017 district court decision that declared the law unconstitutional.[35] Specifically, the court found that language describing substance use characterized by "habitual lack of self-control" and "substantial risk to the physical health of the unborn child" lacks sufficient detail to support implementation. This ruling provides the state with an opportunity to revisit the law through the lens of public health with the goal of achieving improved maternal and infant outcomes. Such an approach would:

- Ensure that policies encourage treatment for pregnant women with SUDs, but do not force treatment or otherwise take a punitive approach, and
- Support the provision of evidence-based care by requiring that treatment programs receiving Medicaid or other public funding adhere to national evidence-based guidelines.

The state should also evaluate opportunities to use Medicaid reimbursement to incentivize improved screening, postnatal care and training in parenting skills.

During the review development process, Pew could continue to serve in a consultative role to link the state to key clinical experts, ensure consistency with evidence-based treatment guidelines, and provide examples of legislative and regulatory changes adopted in other states to improve maternal and infant outcomes.

Data

Recommendation 5: Develop a comprehensive source of information on treatment providers that supports the initiation of care by either providers or people with substance use disorders.

Problem:

People with substance use disorder who are ready to access treatment face barriers in initiating care because they have no source of information on available treatment options in the state; providers face the same barrier in making referrals.

Background on Treatment Barrier:

Wisconsin has no formal mechanism by which substance use disorder (SUD) treatment providers, patients, and patient caregivers or other representatives can access information about facilities and clinicians that provide evidence-based SUD treatment. Conversations with a broad range of providers (e.g., primary care physicians, addiction medicine specialists, and behavioral health counselors) and patient advocates from across Wisconsin highlighted the need for improved information, including data on the breadth of services available in communities, current treatment capacity of individual providers, wait times, and types of insurance accepted by each provider. These conversations also expressed the overreliance of the current treatment system on incomplete methods of referral, such as provider relationships and requisite initiative on the part of patient, provider, or patient advocates to locate and connect with treatment providers that are accepting patients and deliver the needed services. Currently, there is no comprehensive tool that can make these critical decisions easier or better informed.

Timely referrals are important to ensure that when individuals are open to receiving treatment, patients can receive a referral without delay. However, individuals in Wisconsin seeking treatment for SUD often confront a delay in accessing treatment, due in part to an inability to match those individuals with available openings for treatment. In 2013, 2,190 individuals statewide were placed on a list of those waiting to receive SUD treatment from county agencies.[36] A lack of information or an inability to make timely referrals can negatively impact the ability to meet the need for treatment for individuals with SUD.

Proposed Solution:

The state should develop a comprehensive source of information on treatment providers that includes treatment site- and provider-specific information, such as types of services offered, available treatment slots or beds, and types of insurance accepted. This information will benefit clinicians by supporting more timely referrals to evidence-based care that meets patient needs. The information would also allow patients to more easily locate treatment providers and set up appointments. The tool should have a public interface but also contain provider-only components, such as a mechanism to facilitate referrals for treatment. Ideally, providers would access the information via other electronic health information technology (HIT) systems, such as electronic health records and the state's prescription drug monitoring program. However, the

state should take a phased development approach to ensure that integration challenges do not delay access to this valuable tool.

The SUD treatment referral tool should include, at a minimum, the following:

- All SUD treatment providers, including information on the medications provided by identifying buprenorphine-waivered prescribers, naltrexone prescribers, and outpatient treatment providers, (including whether these facilities provide methadone only or methadone and other medications), and available behavioral health services.
- To ensure the information supports referrals that are consistent with the full spectrum of quality treatment services, providers/sites should be categorized by available levels of care and/or type of service as defined by treatment guidelines available from the American Society of Addiction Medicine.
- Data on whether the provider has the capacity to accept new patients. See also recommendation 6 for information on a standardized approach for reporting treatment delay information.
- Information on insurance accepted by each provider, including private and public payers.
- Online appointment capability to ensure real-time referral functionality.

This recommendation supports a timely, evidence-based SUD treatment syst**e**m. Further, the proposed tool would help the state to better understand treatment capacity, utilization, and unmet need. For example, the state could use this information to make data-driven decisions on where to incentivize private providers to increase capacity or where to open new state-owned or supported treatment centers, based on need. The state could also use this information to track progress and make key summary statistics available to the public.

Proposed Implementation Strategy:

The state should consider a three-year timeline that begins with the creation of a comprehensive source of information that is capable of functioning as a stand-alone system, but that is developed to be interoperable with electronic health records (EHRs) used in the state, in much the same way that the state's prescription drug monitoring program now integrates with EHRs.

As an initial step, the state should assess the cost of building such a tool—both as a stand-alone resource and as one that would integrate with EHRs. The state should draw upon the experience of building its PDMP and integrating the PDMP with EHRs as part of this process. If feasible, the state should then appropriate the needed resources to build and implement the system. To assist with funding the creation of the tool, integration with EHRs, and needed technical assistance to providers around implementation, the state could consider applying for federal grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Bureau of Justice Assistance (BJA). Of note, the Department of Health and Human Services recently announced that it will release the second phase of funding from the 21st Cures Act, which will administered by SAMHSA and provide an additional $144.1 million in funding for the opioid crisis, with an emphasis on expending access to MAT.[37] BJA's Comprehensive Opioid Abuse Site-based Program Awards may provide an opportunity to support integration efforts.[38]

Recommendation 6: Develop a standardized process to compile and maintain information about the number of people in Wisconsin who want, but have not yet received, substance use disorder treatment, including uniform provider reporting requirements.

Problem:

State policymakers lack needed information on the capacity of Wisconsin providers to treat patients with substance use disorder in order to make informed policy decisions.

Background on Treatment Barrier:

Currently, Wisconsin lacks uniform reporting requirements for providers to document the number of individuals wanting, but not yet receiving treatment at their facility. Stakeholders in the state note that there is reporting of this information, but it is not uniform or complete. Better data would improve the ability of the state and providers to make strategic decisions on where and what types of services are needed across the state. In the absence of clear instructions and definitions on the types of data needed, providers and treatment sites may submit incomplete or incorrect data. This data should be updated as frequently as possible so that providers can use it to make decisions on where to refer patients who are ready to enter treatment.

Individuals in Wisconsin seeking treatment for substance use disorder (SUD) often confront a delay in accessing treatment. This is, in part due to insufficient information on the number of individuals desiring treatment as well as the inability to match those individuals with available openings for treatment. In 2013, 2,190 individuals statewide were placed on a list of those waiting to receive SUD treatment from county agencies.[39] Treatment delays can have a detrimental effect on individuals wanting treatment. Opioid dependent patients on the waiting list are at a high risk for overdose or death until they enter treatment.[40] While on the waitlist and without treatment, patients are at a higher risk of mortality, arrest, and infectious diseases.[41] Incomplete information on provider capacity as well information about the number and needs of individuals needing treatment, such as type of service required, serves as a barrier to the ability to refer individuals to treatment sites or providers with treatment openings. This lack of accurate data limits strategic decisions about resource allocations and obscures the understanding of treatment gaps across the state.

Proposed Solution:

Wisconsin should create a standardized process for providers to use for calculating and submitting information on individuals awaiting treatment. This would serve two purposes.

First, this information would allow the state to make data-driven decisions about the needs of individuals seeking medication-assisted treatment (MAT). For example, the state could use this data to drive decision making on where to open new treatment centers. This is consistent with a report by the University of Wisconsin and Wisconsin Legislative Council that recommended the use of uniform requirements for reporting information about individuals desiring treatment in order for the state to determine treatment needs in the state.[42]

In addition to aiding state policymakers, the information on wait lists will help providers and patients find an appropriate treatment site quickly (see Recommendation #5), especially if this information is integrated with the prescription drug monitoring program (PDMP) and electronic medical record (EMR).

Vermont leads the country in maintaining information on those in need of, but unable to access, treatment. In 2013, a state law mandated that the Department of Health collect and maintain this information.[43] The agency produced instructions and FAQs[44] for providers to standardize the process and ease the administrative burden. The state used this data to map areas of unmet treatment need. They used data to drive decision making on where to open more treatment options. Once the state identified an area of unmet need, they started partnerships with state, local, and community partners, thus reducing the number of people waiting for treatment.
Furthermore, Vermont also provides publicly available reports to track progress and provide transparency.[45]

This recommendation supports a timely, evidence-based SUD treatment system. With uniform reporting requirements, providers will be better equipped to make referrals and make their own treatment capacity known. Further, the state can use this information to improve its understanding of treatment access gaps across the state.

Proposed Implementation Strategy:

Wisconsin could enact legislation directing the Department of Health Services to compile information on those awaiting treatment by using a standardized process to collect information from providers and organizations that provide treatment services for SUD. Implementation of this recommendation could be integrated with a larger comprehensive information source (see Recommendation 5), but should have an expedited timeline to improve the state's ability to make strategic decisions. Relevant information includes the number of individuals seeking but unable to receive care from each provider for all ASAM levels of care, including patients who are awaiting access to specific medications such as methadone or buprenorphine. The Department should require that all providers accepting Medicaid funds provide this information, categorized by ASAM level of care. The Department should develop a uniform set of elements for reporting requirements to ensure that waitlist data is comparable across providers. Before enacting this recommendation, the state should consider what key characteristics the dataset should include. Patients who are currently receiving treatment but are waiting to be transferred to another level of care should be noted as such.

Justice-Involved Individuals

Recommendation 7: Improve the reentry process for individuals with substance use disorder by:

- Suspending rather than terminating Medicaid enrollment upon entry into state correctional facilities;
- Specifying at least one MCO per region that is designated to provide services for adults reentering the community; and
- Establishing a method by which persons re-entering the community would be informed about which MCO will administer their Medicaid benefits upon release.

Problem:

Individuals reentering the community from Department of Corrections facilities face delays in accessing treatment that can lead to negative outcomes, including overdose, death, relapse, or recidivism.

Background on Treatment Barrier:

The prevalence of substance use disorder (SUD) among people who are incarcerated is extremely high nationwide. In Wisconsin, 69 percent of people who are incarcerated have a SUD.[46] Discharge from prison is a particularly dangerous time for people with SUD—in fact overdose deaths are responsible for more than twice as many deaths as any other cause within two weeks of release. Because people in prison have not been using opioids during their incarceration, they have a reduced physiologic tolerance for opioids at the time of release. If they then take an opioid at the same dose they had been taking previously, they are at much higher risk for overdose and death. Given the disease prevalence in this population and potential risk of overdose death, it is important that individuals moving out of the Wisconsin Department of Corrections (DOC) system are connected to community-based care upon release and without a delay in their treatment.

Medicaid can be a critical program for connecting justice-involved individuals with needed services. Continuity of care contributes to improved health outcomes, including reduced criminal activity and incarceration for individuals with SUDs.[47] Barriers to uninterrupted access to care could contribute to negative outcomes for this population. A Government Accountability Office (GAO) report in 2014 estimated that between 80 to 90 percent of state prisoners in Colorado and New York were eligible for Medicaid.[48] Eligibility in Wisconsin may be similar, as the state provides Medicaid benefits to individuals up to 100 percent of the federal poverty level.[49]

However, Wisconsin currently terminates Medicaid enrollment upon entry into correctional facilities, which makes the process longer to reenroll an eligible person reentering the community. Termination policies require that eligible individuals reentering the community reenroll, which typically takes 45 to 90 days. These policies create administrative burdens for the state and eligible individuals. Federal law does not require termination of Medicaid benefits for persons who are incarcerated and the U.S. Department of Health and Human Services encourages states to suspend rather than terminate Medicaid benefits upon incarceration so that individuals do not have to reapply for benefits upon release.[50]

Proposed Solution:

To improve the availability and coordination of mental and physical health care for incarcerated individuals with a SUD, the state should suspend rather than terminate Medicaid benefits during incarceration, identify at least one Medicaid managed care organization (MCO) per region to cover this population, and establish a care coordination process. Suspension of Medicaid benefits instead of termination would ensure that there is no delay in activation of treatment benefits upon reentry, which is important to ensure timely access for individuals with SUD that, are at higher risk for overdose. Along with specifying MCOs to coordinate care for this population, these reforms could help close treatment gaps for this population as they reenter the community.

Previously incarcerated individuals with SUD reentering their communities can have a high-need for comprehensive SUD treatment and other health care needs. Coordinating care by MCOs can reduce risk of relapse, overdose, and death by ensuring quicker access to treatment than what is currently provided in the state.

To ensure that enrollees are aware of their benefits, the state should examine having a responsible party (the DOC, MCO, Medicaid agency, or a combination of these entities) provide a care coordination program that includes personalized assistance to assess the individuals' need and interest in treatment, explain the available treatment options, and connect individuals to health coverage or services. The care coordinator could engage with individuals prior to release to start the health needs assessment and be tasked with providing a warm handoff to providers in the community.

Some states have begun implementing efforts to coordinate these services; for example Colorado and Florida require MCOs to collaborate with the DOC to coordinate the discharge and enrollment of new beneficiaries.[51] Other states have implemented programs to connect individuals re-entering the community with treatment recovery services. For example, the Massachusetts Department of Correction Medication-Assisted Treatment Reentry Program utilizes contracted Recovery Support Navigators (RSN) that meet with persons interested in MAT three months prior to release. RSNs help enroll the individual in health insurance plans and help them access treatment and other support services. An RSN meets each person re-entering the community at the prison gate the day of release and provides transportation for his or her first treatment appointment, which occurs the day of release whenever possible. The RSNs are available to assist persons re-entering the community for up to one year.[52]

This recommendation supports a timely treatment system by ensuring that eligible members of the reentry population receive Medicaid benefits for SUD treatment upon release. Building a more robust reentry plan for individuals with a SUD could improve access and reduce the risk of overdose, death, relapse or recidivism.

Proposed Implementation Strategy:

To promote continuity of care among persons re-entering the community upon release from DOC facilities, Medicaid, in partnership with the DOC and MCOs should:

- Shift from termination to suspension of Medicaid enrollment for individuals entering DOC facilities;
- Formalize the selection of one or more MCOs per region that will serve the re-entry population; and
- Determine which entity—the MCO(s), Medicaid, DOC, or care coordination organization(s)—will coordinate care and provide the MCO-specific explanation of benefits to ensure all individuals with SUD leaving a DOC facility are immediately connected to a treatment provider in the community and are aware of services covered by their insurer.

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