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Scott Walker, Governor
Laura Gutiérrez, Secretary

MEDICAL EXAMINING BOARD
Room N208, 4822 Madison Yards Way, Madison
Contact: Tom Ryan (608) 266-2112
November 14, 2018

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1-4)

B. Approval of Minutes of October 17, 2018 (5-11)

C. Introductions, Announcements and Recognition

D. Conflicts of Interest

E. Administrative Matters
1. Department and Staff Updates
2. Board Members – Term Expiration Dates
   a. Alaa Abd-Elsayed – 07/01/2020
   b. David Bryce – 07/01/2021
   c. Mary Jo Capodice – 07/01/2018
   d. Michael Carton – 07/01/2020
   e. Padmaja Doniparthi – 07/01/2021
   f. Rodney Erickson – 07/01/2019
   g. Bradley Kudick – 07/01/2020
   h. Lee Ann Lau – 07/01/2020
   i. David Roelke – 07/01/2021
   j. Kenneth Simons – 07/01/2018
   k. Timothy Westlake – 07/01/2020
   l. Robert Zoeller – 07/01/2019
   m. Vacant Public Member
3. Screening Panel and Examination Panel Appointments
4. Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards' Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest

F. Legislation and Rule Matters – Discussion and Consideration
1. Update on Legislation and Pending or Possible Rulemaking Projects

G. Governor's Task Force on Opioid Abuse – Timothy Westlake (12-65)

1. Substance Use Disorder Treatment Policy Recommendations for the State of Wisconsin

H. Wisconsin Medical Examining Board Opioid Prescribing Guideline – Review for Possible Amendments (66-67)

I. Controlled Substances Board Report – Timothy Westlake

J. Interstate Medical Licensure Compact Commission (IMLCC) – Report from Wisconsin's Commissioners

K. Federation of State Medical Boards (FSMB) Matters

L. Newsletter Matters

M. Screening Panel Report

N. Informational Items

1. National Practitioners Data Bank Reporting **(68-91)**
2. Patient's Right to Know Act of 2018 **(92-99)**

O. Items Added After Preparation of Agenda

1. Introductions, Announcements and Recognition
2. Administrative Updates
3. Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
4. Council Appointment Matters
5. Education and Examination Matters
6. Credentialing Matters
7. Practice Matters
8. Future Agenda Items
9. Legislation/Administrative Rule Matters
10. Liaison Report(s)
11. Newsletter Matters
12. Annual Report Matters
13. Informational Item(s)
14. Division of Legal Services and Compliance (DLSC) Matters
15. Presentations of Petition(s) for Summary Suspension
16. Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
17. Presentation of Proposed Decisions
18. Presentation of Interim Order(s)
19. Petitions for Re-Hearing
20. Petitions for Assessments
21. Petitions to Vacate Order(s)
22. Petitions for Designation of Hearing Examiner
23. Requests for Disciplinary Proceeding Presentations
24. Motions
25. Petitions
26. Appearances from Requests Received or Renewed
27. Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports

P. Future Agenda Items

Q. Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).

R. Deliberation on Credentialing Matters

1. Full Board Reviews

a. Steven Armus, M.D. **(100-147)**
b. Raul Lupia, M.D. **(148-219)**

S. Deliberation on DLSC Matters

1. Complaints

a. 15 MED 419 – R.S.C. **(220-222)**
b. 16 MED 014 – J.H. **(223-227)**
c. 17 MED 145 – D.B.K. **(228-230)**

2. Administrative Warnings

a. 16 MED 468 – K.L.B. **(231-232)**
b. 17 MED 045 – S.R.P. **(233-235)**
c. 17 MED 427 – R.M.E. **(236-237)**

3. Stipulations, Final Decisions and Orders

a. 16 MED 165 – Geoffrey C. Nkwazi, M.D. **(238-243)**
b. 16 MED 320 – Edgar Basil Jackson, M.D. **(244-249)**
c. 16 MED 366 – Warren Dunn, M.D. **(250-260)**
d. 17 MED 053 – Kwesi K. Grant-Acquah, M.D. **(261-267)**
e. 17 MED 137 – John W. Oren, M.D. **(268-273)**
f. 17 MED 178 – Keith A. Henry, M.D. **(274-280)**
g. 17 MED 273 – Stephen C. Westcott, M.D. **(281-286)**

4. Case Closings

a. 17 MED 015 – G.A.H. **(287-297)**
b. 17 MED 047 – V.V.B. **(298-303)**
c. 17 MED 244 – J.J. **(304-311)**
d. 17 MED 360 – G.Y. **(312-321)**
e. 18 MED 093 – D.S.H. **(322-329)**
f. 18 MED 112 – T.S. **(330-337)**
g. 18 MED 168 – A.F. **(338-348)**

5. Petitions for Extension of Time

a. 15 MED 418 – Ricardo Sinense, M.D. **(349-354)**
b. 15 MED 419 and 15 MED 472 – R. Stephen Callaghan, M.D. **(355-360)**
c. 17 MED 145 – Dixon B. Kaufman, M.D. **(361-366)**
d. 18 MED 001 – Barbara Gonzales, M.D., Ricardo Sinese, M.D., and Douglas Woida, P.A. **(367-372)**

T. Open Cases

U. Consulting with Legal Counsel

V. Deliberation of Items Added After Preparation of the Agenda
1. Education and Examination Matters
2. Credentialing Matters
3. DLSC Matters
4. Monitoring Matters
5. Professional Assistance Procedure (PAP) Matters
6. Petition(s) for Summary Suspensions
7. Proposed Stipulations, Final Decisions and Orders
8. Administrative Warnings
9. Proposed Decisions
10. Matters Relating to Costs
11. Complaints
12. Case Closings
13. Case Status Report
14. Petition(s) for Extension of Time
15. Proposed Interim Orders
16. Petitions for Assessments and Evaluations
17. Petitions to Vacate Orders
18. Remedial Education Cases
19. Motions
20. Petitions for Re-Hearing
21. Appearances from Requests Received or Renewed

W. RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

X. Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

Y. Open Session Items Noticed Above Not Completed in the Initial Open Session

Z. Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

ADJOURNMENT

ORAL EXAMINATION OF CANDIDATES FOR LICENSURE

ROOM N207

10:00 A.M., OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING

CLOSED SESSION – Reviewing Applications and Conducting Oral Examination of one (1) (at time of agenda publication) Candidates for Licensure – Dr. Rodney Erickson and Dr. Robert Zoeller

NEXT MEETING DATE: DECEMBER 19, 2018

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 4822 Madison Yards Way, Madison, Wisconsin, unless otherwise noted. In order to confirm a meeting or to request a complete copy of the council's agenda, please call the listed contact person. The council may

MEDICAL EXAMINING BOARD
MEETING MINUTES
OCTOBER 17, 2018

PRESENT: David Bryce, M.D.; Mary Jo Capodice, D.O.; Padmaja Doniparthi, M.D.; Rodney Erickson, M.D.; Bradley Kudick *(arrived at 8:08 a.m.)*; Lee Ann Lau, M.D. *(via teleconference)*; David Roelke, M.D.; Kenneth Simons, M.D.; Timothy Westlake, M.D.; Robert Zoeller, M.D.; Robert Zondag

EXCUSED: Alaa Abd-Elsayed, M.D.; Michael Carton

STAFF: Tom Ryan, Executive Director; Dale Kleven, Rule Coordinator; Kate Stolarzyk, Bureau Assistant; and other Department staff

CALL TO ORDER

Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of ten (10) members was confirmed.

ADOPTION OF AGENDA

MOTION: David Roelke moved, seconded by Robert Zondag, to adopt the agenda as published. Motion carried unanimously.

MINUTES OF SEPTEMBER 19, 2018

MOTION: Robert Zoeller moved, seconded by Rodney Erickson, to approve the minutes of September 19, 2018 as published. Motion carried unanimously.

Introductions, Announcements, and Recognition – Resignation of Robert Zondag

MOTION: Mary Jo Capodice moved, seconded by David Roelke, to honor and thank Robert Zondag for his service to the Medical Examining Board and the Interstate Medical Licensure Compact Commission. Motion carried unanimously.

Appointment of Liaisons and Alternates

2018 LIAISON APPOINTMENTS	
Newsletter Liaison	Bradley Kudick Alternate – Michael Carton
Website Liaison	Michael Carton Alternate – Lee Ann Lau

MOTION: David Roelke moved, seconded by Rodney Erickson, to appoint Lee Ann Lau to the Interstate Medical Licensure Compact Commission. Motion carried unanimously.

MOTION: David Bryce moved, seconded by Timothy Westlake, to affirm the Chair's appointment of liaisons. Motion carried unanimously.

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LEGISLATION AND RULE MATTERS

Scope Statement for Med 10, Relating to Unprofessional Conduct

MOTION: David Bryce moved, seconded by Padmaja Doniparthi, to approve the Scope Statement revising Med 10, relating to unprofessional conduct, for submission to the Department of Administration and Governor's Office and for publication. Additionally, the Board authorizes the Chair to approve the Scope Statement for implementation no less than 10 days after publication. Motion carried unanimously.

(Bradley Kudick arrived at 8:08 a.m.)

Review of Proposed Changes to MTBT 4, Relating to Requirements for Renewal and Reinstatement; MTBT 5, Relating to Unprofessional Conduct; and OT 4, Relating to Supervision and Practice of Occupational Therapy Assistants

MOTION: Robert Zoeller moved, seconded by Bradley Kudick, to affirm the Board has reviewed the proposed rules revising Wisconsin Administrative Code Chapters MTBT 4, relating to requirements for renewal and reinstatement, and MTBT 5, relating to unprofessional conduct, and has no comments for the Massage Therapy and Bodywork Therapy Affiliated Credentialing Board to consider. Motion carried unanimously.

MOTION: David Roelke moved, seconded by Mary Jo Capodice, to affirm the Board has reviewed the proposed rules revising Wisconsin Administrative Code Chapter OT 4, relating to supervision and practice of occupational therapy assistants, and has no comments for the Occupational Therapists Affiliated Credentialing Board to consider. Motion carried unanimously.

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP) UPDATE – DISCUSSION AND CONSIDERATION

Updated Report Based on PDMP Data for Potential Referrals to Professional Licensing Boards

MOTION: Lee Ann Lau moved, seconded by David Roelke, to refer to DLSC the top seven (7) Physician Assistant prescribers from Section 2 of the Controlled Substances Board Prescription Drug Monitoring Program's October 17th, 2018 MD/DO/PA Prescribing Report to the Medical Examining Board. Motion carried unanimously.

UPDATE ON RE-ENTRY TO PRACTICE – LEE ANN LAU AND TOM RYAN

Recommendations from the September 19, 2018 Re-Entry to Practice Committee Meeting for Full Board Consideration

MOTION: Rodney Erickson moved, seconded by David Bryce, to recommend that the Board initiate legislation to reduce the late renewal time period specified in 440.08(3)(b), from 5 years to 1 year. Motion carried unanimously.

MOTION: Mary Jo Capodice moved, seconded by David Roelke, to terminate the Re-Entry to Practice Committee and create a Licensure Forms Committee consisting of Lee Ann Lau, Padmaja Doniparthi, David Roelke, David Bryce, and Bradley Kudick

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to review initial and renewal application forms for possible revisions. Motion carried unanimously.

APPOINTMENTS, REAPPOINTMENTS, CONFIRMATIONS AND COMMITTEE, PANEL LIAISON AND MENTOR APPOINTMENTS

Consideration of Lois Connolly, M.D., for Reappointment as an Anesthesiologist Member on the Council on Anesthesiologist Assistants

MOTION: Timothy Westlake moved, seconded by Bradley Kudick, to reappoint Lois Connolly, M.D., to the Council on Anesthesiologist Assistants as an Anesthesiologist member, for a term to expire on 7/1/2021. Motion carried unanimously.

CLOSED SESSION

MOTION: Timothy Westlake moved, seconded by David Roelke, to convene to Closed Session to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). Kenneth Simons, Chair, read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: David Bryce-yes; Mary Jo Capodice-yes; Padmaja Doniparthi-yes; Rodney Erickson-yes; Bradley Kudick-yes; Lee Ann Lau-yes; David Roelke-yes; Kenneth Simons-yes; Timothy Westlake-yes; Robert Zondag-yes; and Robert Zoeller-yes. Motion carried unanimously.

The Board convened into Closed Session at 9:12 a.m.

RECONVENE TO OPEN SESSION

MOTION: Mary Jo Capodice moved, seconded by David Bryce, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 10:43 a./p.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

MOTION: Bradley Kudick moved, seconded by Rodney Erickson, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

(Be advised that any recusals or abstentions reflected in the closed session motions stand for the purposes of the affirmation vote.)

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DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

Monitoring

Farid A. Ahmad, M.D. – Requesting Consideration of His Objection to the Denial of Full Licensure

MOTION: David Roelke moved, seconded by Robert Zondag, to affirm the June 19, 2005 (sic) Order Denying Request for Full Licensure (Order 0002832) against Farid A. Ahmad, M.D. Motion carried unanimously.

MOTION: Robert Zoeller moved, seconded by Robert Zondag, to find that Farid A. Ahmad, M.D., is in violation of the December 11, 2013 Final Decision and Order (Order Number 0002832). Motion carried unanimously.

MOTION: Timothy Westlake moved, seconded by David Roelke, to further limit the license of Farid A. Ahmad, M.D., such that beginning November 30, 2018 he may only engage in the practice of medicine and surgery necessary to successfully complete CPEP's educational recommendations. Any petition for removal of this limitation must be accompanied by satisfactory evidence of successful completion of all CPEP educational recommendations. Motion carried unanimously.

Jennifer L. Fick (Nolden), P.A. – Requesting Reduction in Drug and Alcohol Screens and Termination of AA/NA Meetings

MOTION: Padmaja Doniparthi moved, seconded by Robert Zoeller, to grant the request of Jennifer L. Fick (Nolden), P.A., for a reduction in drug and alcohol screens to not less than 14 screens and one annual hair test and termination of AA/NA meetings. Motion carried unanimously.

(Kenneth Simons recused himself and left the room for deliberation and voting in the matter concerning Jennifer L. Fick.)

Abel A. Garibaldi, M.D. – Requesting Reinstatement of Full Licensure

MOTION: Lee Ann Lau moved, seconded by Robert Zoeller, to deny the request of Abel A. Garibaldi, M.D., for consideration of reinstatement of full licensure. Motion carried.

Administrative Warnings

15 MED 398 – S.K.C.

MOTION: Robert Zoeller moved, seconded by Rodney Erickson, to issue an Administrative Warning in the matter of S.K.C., DLSC Case Number 15 MEB 398. Motion carried unanimously.

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16 MED 416 – D.S.

MOTION: Timothy Westlake moved, seconded by Bradley Kudick, to issue an Administrative Warning in the matter of D.S., DLSC Case Number 16 MED 416. Motion carried unanimously.

16 MED 473 – T.E.N.

MOTION: David Roelke moved, seconded by David Bryce, to issue an Administrative Warning in the matter of T.E.N., DLSC Case Number 16 MED 473. Motion carried unanimously.

17 MED 349 – T.A.S.

MOTION: Rodney Erickson moved, seconded by Robert Zondag, to issue an Administrative Warning in the matter of T.A.S., DLSC Case Number 17 MED 349. Motion carried unanimously.

(Robert Zoeller recused himself and left the room for deliberation and voting in the matter concerning T.A.S., DLSC Case Number 17 MEB 349.)

Stipulations, Final Decisions and Orders

16 MED 415 – Alissa Dries, M.D.

MOTION: Bradley Kudick moved, seconded by David Bryce, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Alissa Dries, M.D., DLSC Case Number 16 MED 415. Motion carried unanimously.

(Mary Jo Capodice recused herself and left the room for deliberation and voting in the matter concerning Alissa Dries, M.D., DLSC Case Number 16 MED 415.)

17 MED 104 – John W. Murphy, M.D.

MOTION: Robert Zondag moved, seconded by Mary Jo Capodice, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against John W. Murphy, M.D., DLSC Case Number 17 MED 104. Motion carried unanimously.

(Robert Zoeller recused himself and left the room for deliberation and voting in the matter concerning John W. Murphy, M.D., DLSC Case Number 17 MED 104.)

18 MED 305 – Maud H. Regne- Karlsson, M.D.

MOTION: David Roelke moved, seconded by Bradley Kudick, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Maud H. Regne- Karlsson, M.D., DLSC Case Number 18 MED 305. Motion carried unanimously.

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Case Closings

16 MED 029 – P.G.

MOTION: Timothy Westlake moved, seconded by Bradley Kudick, to close DLSC Case Number 16 MED 029, against P.G., for Prosecutorial Discretion (P5 flag). Motion carried unanimously.

16 MED 127 – J.L.H.

MOTION: Robert Zoeller moved, seconded by David Roelke, to close DLSC Case Number 16 MED 127, against J.L.H., for No Violation. Motion carried unanimously.

16 MED 217 – M.A.D.

MOTION: David Roelke moved, seconded by Mary Jo Capodice, to close DLSC Case Number 16 MED 217, against M.A.D., for No Violation. Motion carried unanimously.

(Kenneth Simons recused himself and left the room for deliberation and voting in the matter concerning DLSC Case Number 16 MED 217.)

17 MED 101 – M.F.D.

MOTION: Lee Ann Lau moved, seconded by David Roelke, to close DLSC Case Number 17 MED 101, against M.F.D., for Insufficient Evidence. Motion carried unanimously.

17 MED 243 – A.F.

MOTION: Bradley Kudick moved, seconded by David Roelke, to close DLSC Case Number 17 MED 243, against A.F., for Insufficient Evidence. Motion carried unanimously.

17 MED 322 – P.S.

MOTION: David Bryce moved, seconded by Robert Zondag, to close DLSC Case Number 17 MED 322, against P.S., for Prosecutorial Discretion (P2). Motion carried unanimously.

17 MED 481 – M.V.

MOTION: Mary Jo Capodice moved, seconded by Padmaja Doniparthi, to close DLSC Case Number 17 MED 481, against M.V., for No Violation. Motion carried unanimously.

17 MED 543 – M.B.

MOTION: David Roelke moved, seconded by Robert Zoeller, to close DLSC Case Number 17 MED 543, against M.B., for Insufficient Evidence. Motion carried unanimously.

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17 MED 549 – D.C.D.

MOTION: David Bryce moved, seconded by Padmaja Doniparthi, to close DLSC Case Number 17 MED 549, against D.C.D., for Prosecutorial Discretion (P1). Motion carried unanimously.

18 MED 073 – T.D.M.

MOTION: Rodney Erickson moved, seconded by Robert Zoeller, to close DLSC Case Number 18 MED 073, against T.D.M., for No Violation. Motion carried unanimously.

18 MED 088 – K.C.

MOTION: Robert Zondag moved, seconded by Lee Ann Lau, to close DLSC Case Number 18 MED 088, against K.C., for Insufficient Evidence. Motion carried unanimously.

18 MED 231 – J.S.

MOTION: Robert Zondag moved, seconded by Rodney Erickson, to close DLSC Case Number 18 MED 231, against J.S., for No Violation. Motion carried unanimously.

DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

MOTION: Robert Zoeller moved, seconded by Mary Jo Capodice, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Lee Ann Lau moved, seconded by Timothy Westlake, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:44 a.m.

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Substance Use Disorder Treatment Policy Recommendations for the State of Wisconsin

Final Report — July 2018

Submitted to the Governor's Task Force on Opioid Abuse

The Pew Charitable Trusts

Executive 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 works with states to expand access to evidence-based treatment, such as medication-assisted treatment (MAT), for substance use disorders (SUDs).

Pew provides technical assistance to states that request Pew's expertise and support with a formal invitation. Pew's 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. 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. This process culminates in recommendations for the state's executive and legislative branches of government.

In response to Wisconsin's invitation for technical assistance, Pew conducted a full system assessment to inform recommendations for the state on timely, comprehensive, evidence-based, and sustainable treatment for SUD. To better understand the strengths and gaps in Wisconsin's existing SUD treatment system and other stakeholder policy priorities, Pew had discussions with more than 150 stakeholders from across the state. In addition, Pew reviewed evidence-based and emerging practices found in the gray literature (e.g., reports, briefings, case studies, presentations) to inform the development of these recommendations. Recommendations were also informed by in-depth interviews with national SUD leaders and persons currently misusing opioids or in recovery, and by focus groups with persons currently misusing opioids; persons in treatment or recovery; health care and other professionals providing treatment or care for individuals with SUD; and family, friends, and/or caregivers of persons with SUD. Finally, Pew assessed existing state regulations relevant to SUD treatment.

Pew provided an initial set of seven policy recommendations to the Governor's Task Force on Opioid Abuse in January 2018.[*] This final report consists of 18 more policy recommendations

[*] The recommendations included:

- 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.
- Increase access to buprenorphine by expanding provider training during residency programs and removing barriers to patient access.
- 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.
- Facilitate effective substance use disorder treatment for pregnant women by removing barriers to evidence-based treatment.

for Wisconsin based on continued discussions with stakeholders across the state and data and policy analyses. Seven of the 18 are follow-up recommendations to those provided by Pew in January. The recommendations are grouped by four key components of an effective treatment system: treatment system transformation, substance use disorder workforce, coverage and reimbursement, and underserved populations.

Treatment System Transformation

***Recommendation 1:** The Commission should recommend changes to Medicaid payment systems to ensure sufficient provider participation in the new treatment model based on Vermont's hub-and-spoke approach.

***Recommendation 2:** The Department of Health Services, in collaboration with experts and key state stakeholders, should develop an implementation plan for creating a provider referral tool that can be integrated with health information technology.

***Recommendation 3:** The Department of Health Services should create a uniform waitlist reporting requirement across settings of care that can be used to improve provider referral capability and strategic decision-making for the state.

Recommendation 4: Allow sites that deliver medical services to operate as Opioid Treatment Programs to increase the availability of methadone in Wisconsin.

Recommendation 5: Develop a definition for recovery housing that would bar discrimination based on the use of evidence-based medications for treatment.

Recommendation 6: Establish an interagency working group tasked with initiating formal cross-agency data sharing on OUD to help drive state actions to expand access to MAT that are informed by analysis of state data and identification of areas of need.

Recommendation 7: Improve the integration of co-occurring mental health and substance use disorders by reviewing and eliminating unnecessary statutory and regulatory barriers.

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

Recommendation 8: Improve the timeliness and accuracy of opioid-related death data to target treatment resources in communities of highest need.

Recommendation 9: Ensure patients entering MAT are placed in the right care setting through use of a single standardized patient placement tool across state-licensed and Medicaid certified providers.

Recommendation 10: Improve initiation of MAT and transition to treatment in emergency departments.

Substance Use Disorder Workforce

Recommendation 11: Provide funds to expand buprenorphine training for providers during residency programs for physicians, nurse practitioners, and physician assistants.

***Recommendation 12:** Use the Behavioral Health Review Committee established by 2017 Wisconsin Act 262 to ensure Wisconsin's Substance Abuse Counselor certification and licensure process aligns with national evidence-based practices and that the number of counselors meets the need for counseling across the state.

Recommendation 13: Align the Professional Assistance Procedure with national best practices for physician health programs.

Underserved Populations

Recommendation 14: Study the availability of MAT in state prisons and county jails and create a pilot in one setting.

***Recommendation 15:** Ensure Medicaid benefits are suspended (rather than terminated) for all eligible justice-involved individuals across the state.

***Recommendation 16:** Increase access to evidence-based substance use disorder treatment for pregnant women by addressing any statutory deterrents and expanding provider capacity to deliver MAT.

Recommendation 17: Incentivize the use of evidence-based post-partum care programs by health care providers for women with substance use disorders across the state.

Recommendation 18: Improve treatment outcomes for babies with neonatal abstinence syndrome (NAS) by integrating best practices into state treatment guidelines and clinical curricula.

Introduction

In July 2017, Pew was invited to provide technical assistance on expanding access to evidence-based treatment for SUD to Wisconsin by the Co-Chairs of the Governor's Task Force on Opioid Abuse, Rep. John Nygren and Lt. Governor Rebecca Kleefisch, with support from Governor Scott Walker, Assembly Speaker Robin Voss, and Senate Majority Leader Scott Fitzgerald. Pew's technical assistance includes a treatment system needs assessment that is based on stakeholder engagement, quantitative and qualitative research, and analysis of existing Wisconsin policies.

Scope of the Opioid Crisis in Wisconsin

Overdose deaths and opioid-related hospital admissions continue to rise in Wisconsin. Emergency department visits due to suspected opioid overdose more than doubled from 2016 to 2017.[1] Drug overdose deaths also increased, to 1,074 in 2016; a doubling since 2010.[2]

Despite the dramatic rise in overdose deaths and opioid-related hospital admissions, treatment capacity has not kept pace with need for services. Based on a 2016 needs assessment conducted by the Department of Health Services, only 23 percent of individuals needing treatment for SUD receive it.[3] As pointed out in a 2015 report conducted by the University of Wisconsin School of Public Affairs,[4] there is clear evidence that individuals that need treatment are often not receiving it, and far too often the treatment they receive is not evidence-based.

Unfortunately, Wisconsin—like many states—lacks good data demonstrating the size of this treatment gap. For example, there is no robust data source that pinpoints treatment capacity, need, or utilization across the state by the level of care provided (for example, intensive outpatient or inpatient). This is one problem that Pew has targeted with recommendations in January 2018 and in this report.

Stakeholder Engagement

Understanding the challenges that Wisconsin patients and providers encounter in accessing treatment or delivering evidence-based care was an important part of developing the recommendations in this report. Since July 2017, Pew has met with more than 150 stakeholders across the state. These discussions strengthened our understanding of state data, highlighted key barriers to evidence-based treatment, and helped to target recommendations towards areas of highest need for reform in Wisconsin. Pew also built off of the extensive efforts and expertise of the Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA) and its members.

We engaged stakeholders with different perspectives and different roles in the treatment system. Broadly these stakeholders included: state agency leaders and program administrators, state legislators, county agency directors and staff, provider professional societies, individual

providers across the continuum of care and across practitioner-type, associations representing various care settings, individuals and organizations in the recovery community, and public and private insurers, among others. The perspectives of these stakeholders are reflected in many of the recommendations in this report.

Qualitative Research

With funding support from the Open Society Foundations, The Pew Charitable Trusts contracted with Prime Group to conduct qualitative research on the lived experiences of persons with OUD to explore motivators and barriers to seeking and receiving treatment for OUD. Prime Group conducted in-depth interviews (IDIs), focus groups (FGs), and QualBoards® (QBs) – online focus groups – as part of this qualitative data collection that helped inform Pew's policy recommendations. Data collection, using a convenience sample, included:

- In-depth interviews with national SUD leaders and persons currently misusing opioids or in recovery.
- In-person and online focus groups in Wisconsin with:
    - Persons currently misusing opioids, and
    - Persons in treatment or recovery.
- In-person focus groups in Wisconsin with:
    - Health care and other professionals providing treatment or care for individuals with OUD, and
    - Family, friends, and/or caregivers of persons with OUD.

Additional information on methodology is discussed in the Findings section and direct quotations are included in relevant recommendations.

Key Qualitative Research Findings

The research findings included themes across all data collection methods. Participants delineated two major categories of barriers – (1) barriers to seeking treatment and (2) barriers to accessing treatment.

It is important to note that the results of the qualitative data collection are anecdotal and directional, but not generalizable. The methods used in recruiting participants qualify as convenience sampling, relying upon networks, referrals, and databases of potential participants rather than pure probability sampling in which every member of the targeted population has an equal chance of being invited to participate. As a result, these findings may not be reflective of the experiences of others with OUD. Nevertheless, the findings from this qualitative research highlight the challenges persons with lived experience of OUD face in seeking and accessing treatment.

Barriers to Seeking Treatment

- **Mental Health:** Most of the participants currently misusing opioids or in recovery had a history of mental health, interpersonal issues, emotional abuse, or trauma prior to their misuse of opioids. Many participants said they feared dealing with the challenges of their mental illness—depression, anxiety, bipolar disorder, post-traumatic stress disorder (PTSD)—without opioids. Many participants reported they used opioids to self-treat their emotional pain.
- **Self-Blame and Internalized Stigma:** When asked, "What prevented you from seeking treatment earlier (or at all)?" The most common answer was, "myself." There was a significant disconnect between most of the participants in the health care and other professionals FGs who thought of these individuals as experiencing OUD, and the individuals themselves who thought they were weak or lacked willpower.
- **Stigma of OUD:** Nearly all the participants believed there was stigma attached to opioid misuse and OUD that served as a barrier to seeking treatment and was prevalent among the public, employers, those in law enforcement and criminal justice, and even some providers of OUD treatment.
- **Stigma of MAT:** While some in treatment participated in and benefitted from MAT programs, many others held negative views of MAT. Many said that persons in a MAT program were still "addicted" or "dependent" and not "sober" or "clean." Many participants considered MAT a "substitution" of one drug for another and there was a suggestion among some that those choosing "sobriety" or "abstinence" were superior to those who "need" MAT. Some believed that MAT inevitably leads to lifelong and ever-increasing dependence upon methadone or buprenorphine.
- **Fear of Detox and Withdrawal:** Those who experienced detox/withdrawal or watched others go through withdrawal without medication were very reluctant to enter any treatment program that did not offer medication assistance as part of the detox program. Interestingly, many of these same individuals rejected medications for long-term treatment as "substituting one drug for another."
- **Loss of Social Network:** Most participants said they felt they could not succeed in treatment if they maintained contact with their opioid-centered social network. But for many, it was the only network they had left. The challenge of disrupted social networks was very frequently cited as a reason to not seek treatment and, in some instances, was a cause of relapse/setbacks.

Barriers to Accessing Treatment

Once an individual with OUD overcomes barriers to seeking treatment, participants reported several additional barriers in accessing an appropriate treatment program.

- **Lack of Accurate, Evidence-Based Treatment Information:** While many participants said they had little problem getting useful and accurate information about treatment options—either online, from friends and family, or from treatment programs in their area—others reported that finding the right program or a convenient program was difficult. This seemed particularly true for individuals in remote or rural areas where there were fewer programs available.

- **Insufficient Treatment Capacity:** Some participants cited the inability to be admitted in outpatient and residential treatment programs. Some participants hypothesized that the few open treatment slots led some treatment programs to expel a patient for a single offense. Individuals in more rural and remote areas also mentioned a lack of residential or outpatient programs in their area and particularly the unavailability of MAT programs or clinicians who can prescribe buprenorphine for OUD.
- **Cost of Treatment and Lack of Coverage:** For many, the cost of treatment was a significant roadblock. Many participants could not begin treatment when ready because of affordability. For others, however, the cost of treatment was not a major barrier even though some were unemployed when they began treatment. Finally, other participants did not even attempt to access treatment because they believed it would be very expensive and had no means to pay. Many participants talked about television and other advertising for 28-day residential treatment programs and seemed much more aware of these programs than outpatient programs. The 28-day residential program was considered by many to be the gold standard and most participants assumed such programs were very expensive and therefore out of their financial reach.
- **Lack of Transportation:** One of the most common barriers centered around transportation to MAT programs and the need to travel to a methadone clinic daily or to travel long distances to a buprenorphine-waivered clinician. Most urban participants said they had little difficulty getting to and from their outpatient treatment. However, those in more rural areas had more difficulty accessing outpatient treatment.
- **Pregnancy:** Becoming pregnant can be a catalyst for seeking treatment; however, the barriers to seeking treatment for pregnant women are especially steep. Some women reported hiding their pregnancy to receive treatment or avoiding treatment altogether out of fear of losing their baby or other children. Health care and other professionals, and national and Wisconsin experts were sensitive to these challenges and generally viewed the involvement of child protective services as negative.
- **Incarceration:** Many of the participants reported having been incarcerated for reasons related to their opioid use. Only a few participants reported being able to move towards recovery because of incarceration. There was general agreement that illegal opioids were readily available in prison (but not in jails). Participants reported that most local jails did not provide MAT but that some state prisons did. There was consensus among those with OUD and the health care and other professionals that incarceration does little to nothing to address the opioid crisis.
- **Inadequate Number of Treatment Providers:** The national and Wisconsin experts and those in the health care and other professionals focus groups reported a lack of adequate treatment providers due to Wisconsin's stricter certification requirements for substance use disorder treatment counselors.

Scope of the Report

OUD is a complex relapsing brain disease caused by the recurrent use of opioids, including prescription opioids, heroin, or other synthetic opioids like fentanyl. Evidence-based treatment is one component of addressing the opioid crisis, but prevention, harm reduction, and recovery support services are also important and often complementary. In this report, Pew has focused on expanding access to treatment that is timely, comprehensive, evidence-based, and sustainable. Although there are some recommendations that touch on aspects of recovery support services, they are in the context of improving treatment initiation and retention. The exclusion of interventions from other domains does not reflect a lack of importance, but rather Pew's expertise and the need for access to evidence-based treatment to curb the current opioid crisis and prepare the treatment system for any future treatment needs.

This report is focused on policy recommendations to expand access to OUD, which is only one form of SUD. A conclusive body of research has demonstrated that MAT is the most effective way to treat OUD. People who receive MAT are less likely to die of overdose, use illicit opioids, and contract infectious diseases such as HIV and hepatitis C.[5] Based on the strength of the evidence of effectiveness and clear lack of availability of MAT, Pew is focusing its efforts on policy changes that could expand access to all three U.S. Food and Drug Administration (FDA)-approved medications and behavioral health counseling. Although the recommendations are focused on OUD, many of the policy recommendations in this report are aimed at strengthening the treatment system to improve the ability to respond statewide to any future drug epidemics with effective evidence-based treatment.

Stigma towards individuals with SUD is also an important issue that is not directly addressed in this report. Many of the recommendations in this report could affect stigma by improving the integration of SUD treatment with physical and mental health care; however, stigma is not the direct target of any single recommendation.

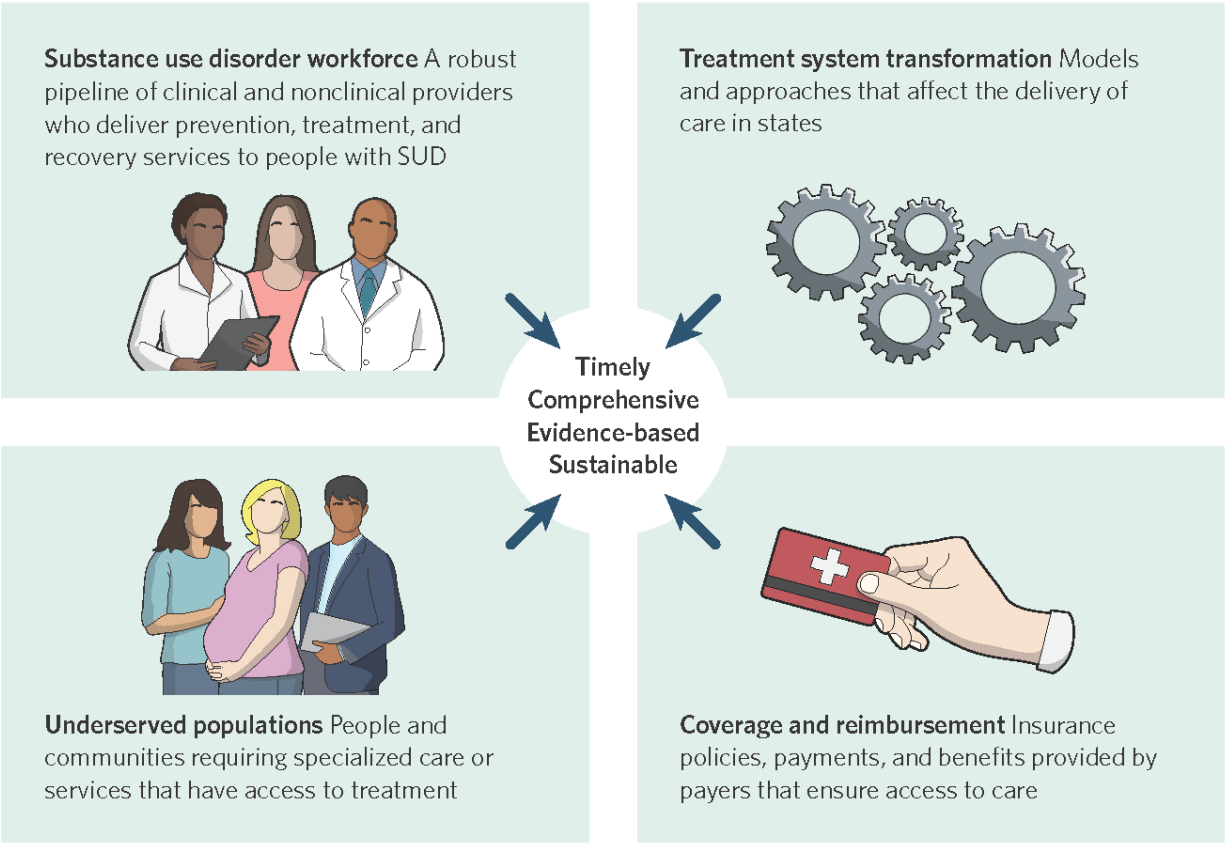
Goals of a comprehensive treatment system

The American Society of Addiction Medicine (ASAM),[6] the U. S. Surgeon General's Report on Alcohol, Drugs, and Health,[7] and the National Academies of Sciences, Engineering, and Medicine[8] 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 capacity exists to meet treatment demands through the availability of facilities, providers, and services. A timely system ensures that all services and levels of care recommended by the ASAM guidelines[9] 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:** Provides coverage of the full spectrum of treatment services—including screening, diagnosis, withdrawal management, maintenance, and recovery—by public (such as Medicaid) and private insurers. 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 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.

Comprehensive Treatment System Framework

An effective and comprehensive treatment system requires several foundational elements to ensure access to high-quality and evidence-based care. Pew has categorized its recommendations into four areas: treatment system transformation, substance use disorder workforce, coverage and reimbursement, and underserved populations. These areas are based upon engagement with state stakeholders and extensive discussions with federal, state, and academic experts. This framework provides a lens to monitor and guide Wisconsin's progress towards building a robust treatment system that can meet the need for substance use disorder care across the state.


Substance use disorder workforce A robust pipeline of clinical and nonclinical providers who deliver prevention, treatment, and recovery services to people with SUD
Treatment system transformation Models and approaches that affect the delivery of care in states
Timely
Comprehensive
Evidence-based
Sustainable
Underserved populations People and communities requiring specialized care or services that have access to treatment
Coverage and reimbursement Insurance policies, payments, and benefits provided by payers that ensure access to care

Proposed Recommendations

Treatment System Transformation

***Recommendation 1:** The Commission should recommend changes to Medicaid payment systems to ensure sufficient provider participation in the new treatment model based on Vermont's hub-and-spoke approach.

***Recommendation 2:** The Department of Health Services, in collaboration with experts and key state stakeholders, should develop an implementation plan for creating a provider referral tool that can be integrated with health information technology.

***Recommendation 3:** The Department of Health Services should create a uniform waitlist reporting requirement across settings of care that can be used to improve provider referral capability and strategic decision making for the state.

Recommendation 4: Allow sites that deliver medical services to operate as Opioid Treatment Programs to increase the availability of methadone in Wisconsin.

Recommendation 5: Develop a definition for recovery housing that would bar discrimination based on the use of evidence-based medications for treatment.

Recommendation 6: Establish an interagency working group tasked with initiating formal cross-agency data sharing on OUD to help drive state actions to expand access to MAT that are informed by analysis of state data and identification of areas of need.

Recommendation 7: Improve the integration of co-occurring mental health and substance use disorders by reviewing and eliminating unnecessary statutory and regulatory barriers.

Recommendation 8: Improve the timeliness and accuracy of opioid-related death data to target treatment resources in communities of highest need.

Recommendation 9: Ensure patients entering MAT are placed in the right care setting through use of a single standardized patient placement tool across state-licensed and Medicaid certified providers.

Recommendation 10: Improve initiation of MAT and transition to treatment in emergency departments.

Substance Use Disorder Workforce

***Recommendation 11:** Provide funds to expand buprenorphine training for providers during residency programs for physicians, nurse practitioners, and physician assistants.

***Recommendation 12:** Use the Behavioral Health Review Committee established by 2017 Wisconsin Act 262 to ensure Wisconsin's Substance Abuse Counselor certification and licensure process is aligns with national evidence-based practices and that the number of counselors meets the need for counseling across the state.

Recommendation 13: Align the Professional Assistance Procedure with national best practices for physician health programs.

Underserved Populations

Recommendation 14: Study the availability of MAT in state prisons and county jails and create a pilot in one setting.

***Recommendation 15:** Ensure Medicaid benefits are suspended (rather than terminated) for all eligible justice-involved individuals across the state.

***Recommendation 16:** Increase access to evidence-based substance use disorder treatment for pregnant women by addressing any statutory deterrents and expanding provider capacity to deliver MAT.

Recommendation 17: Incentivize the use of evidence-based post-partum care programs by health care providers for women with substance use disorders across the state.

Recommendation 18: Improve treatment outcomes for babies with neonatal abstinence syndrome (NAS) by integrating best practices into state treatment guidelines and clinical curricula.

Treatment System Transformation

Background

Nationwide, the treatment system falls short in meeting the needs of people with SUDs. Only one in ten people with a SUD receives any treatment whatsoever; the quality of treatment varies significantly from site-to-site and many do not even offer MAT, the gold standard. When people with SUD seek treatment, they often face barriers related to access, including lack of health care coverage and not being able to afford the cost of treatment (26.9 percent) and not knowing where to go for treatment (19.1 percent).[10] The lack of integration of treatment for physical and mental health conditions is another key shortcoming of the treatment system. In fact, more than eight million adults have co-occurring mental illness and SUD, but only 6.9 percent of this population received treatment for both conditions.[11] Access to affordable care that is integrated across primary, acute, and behavioral health settings is critical to meet the complex needs of patients with SUD.

Through the leadership of Rep. John Nygren, the Heroin, Opioid, Prevention, and Education, or HOPE Agenda, made and is continuing to make significant strides improving care for individuals with SUD across Wisconsin. Of the 29 pieces of legislation passed since 2013, many have put in place innovative approaches to improve care across the state. For instance, 2017 Wisconsin Act 28 established the Addiction Medicine Consultation Program[12] to support community-based providers with case-by-case technical support from addiction medicine specialists.

On January 19, 2018, Governor Scott Walker signed two executive orders to expand access to MAT that carried out recommendations from Pew that had been adopted by the Governor's Task Force on Opioid Abuse earlier that month.

Executive Order 274 established the Commission on Substance Abuse Treatment Delivery, which is expected to deliver recommendations to the Governor on whether and how to pursue implementation of a hub-and-spoke treatment delivery model across the state by November 30, 2018.[13] As the Commission and its members consider this issue, there are key issues that are essential to ensure provider participation in the system.

Accordingly, as part of implementation of Executive Order 274, Pew recommends:

[*][*]Recommendation 1: The Commission should recommend changes to Medicaid payment systems to ensure sufficient provider participation in the new treatment model based on Vermont's hub-and-spoke approach.

[*] These recommendations are intended to inform implementation of recommendations made by Pew in January 2018.

Without a sufficient number of participating clinicians—both primary care providers and facilities with specialized expertise in addiction medicine—any new model of care delivery will not have the capacity to meet the needs of patients.

Accordingly, the Commission should ensure sufficient provider participation in the model by recommending changes to Medicaid's payment structure to entice new providers to participate in the model. Stakeholders identified increasing payment rates and implementing other incentives as key ways to improve provider engagement in the treatment system. These incentives should not only change how services are paid for in both primary and tertiary care settings, but also emphasize care coordination and comprehensive service delivery, consistent with the principles of an effective treatment system.[14] The Commission should also ensure there is robust monitoring and evaluation to assess the model, determine shared outcome measures for participating providers, and track performance on the outcome measures. The monitoring and evaluation plan should be in place before implementation begins.

> *I know that's a huge issue [in Wisconsin] with reimbursement for treatment providers and what Medicaid can reimburse and can you afford to operate a practice and even to integrate Medicaid patients into your normal practice.*
> *- Provider, Milwaukee, Male*

> *Many providers don't accept Medicaid because the reimbursement rates are low and they're very difficult to work with.*
> *- Provider, Milwaukee, Female*

States that have successfully implemented comprehensive models included appropriate payment structures and reforms to ensure system sustainability. For instance, Vermont increased Medicaid Health Home payments under Section 2703 of the Affordable Care Act to encourage comprehensive care delivery. Vermont also covers MAT Teams—nurses and licensed clinical case managers embedded with community-based providers participating as 'Spokes'—through Health Home and other Medicaid waivers, such as the Global Commitment to Health Demonstration Waiver and the Vermont Blueprint for Health.[15] Rhode Island provides increased reimbursement rates for health systems that serve as Centers of Excellence and offer each patient a comprehensive assessment, induction and stabilization services, treatment planning, behavioral health services, provision of at least two of the three FDA-approved medications, education, and care coordination with primary, specialty, and hospital services.[16]

Other states have used reimbursement reforms without hub-and-spoke implementation to improve access to care. For example, Virginia implemented a Medicaid coverage and reimbursement redesign for SUD services in April 2017 using a Medicaid 1115 waiver from CMS. Among other changes, the waiver expanded services to include the following key components:

- The full ASAM continuum of care, which details levels of services that range from early intervention and outpatient treatment to medically-managed intensive inpatient;
- Increased Medicaid reimbursement rates for SUDs to align with average commercial rates in the state; and
- Resources invested for provider education, training, and recruitment to improve network participation.[17]

The Virginia reforms have substantially increased access to treatment across the state. In the first five months following implementation, the number of total outpatient practitioners providing SUD treatment more than doubled. Physician participation quadrupled. Patients enrolled in Medicaid have increased their use of treatment services by 40 percent.[18] These reforms in Virginia demonstrate that aligning reimbursement rates with the private market and the corresponding coverage expansion substantially increase access to evidence-based treatment.

In addition to ensuring adequate payments, Wisconsin should ensure a robust evaluation to aid in strategic implementation decisions, improve the effectiveness of the model, and inform future decisions about the model that the state decides to adopt. Using an agreed upon set of measures ensures that outcomes can be compared across participating providers. These outcomes should help the state and providers continually improve the model. The evaluation should consider questions on implementation, effectiveness, efficiency, and cost-effectiveness.[19]

[*]**Recommendation 2:** The Department of Health Services, in collaboration with experts and key state stakeholders, should develop an implementation plan for creating a provider referral tool that can be integrated with health information technology.

The second executive order signed by Governor Walker on January 19, Executive Order 273, tasked the Department of Health Services with developing a provider referral tool and uniform statewide standards for data reporting on waitlists across SUD treatment care settings. These recommendations were made to improve the ability of providers to make informed referrals and increase the understanding of treatment gaps across the state to inform and target resources. However, the language of the Executive Order is broad. To support the implementation of these tasks, Pew has follow-up recommendations that provide more specifics.

The Department of Health Services should collaborate with experts and key state stakeholders to develop an implementation plan for the provider referral tool that can be integrated with health information technology. The implementation plan should be reported to the Governor no later than July 1, 2019. The tool should include, at a minimum, the following:

[*] These recommendations are intended to inform implementation of recommendations made by Pew in January 2018.

- 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.
- Providers/sites, categorized by available levels of care and/or type of service as defined by treatment guidelines available from ASAM, to ensure referrals that are consistent with the full spectrum of quality treatment services.
- Data on whether the provider has the capacity to accept new patients.
- Information on insurance accepted by each provider, including private and public payers.
- Online appointment capability to ensure real-time referral functionality.

The 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 incentives for private providers to increase capacity in levels of care with long wait lists 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.

[*]**Recommendation 3:** The Department of Health Services should create a uniform waitlist reporting requirement across settings of care that can be used to improve provider referral capability and strategic decision making for the state.

The Department of Health Services should collaborate with experts and key state stakeholders to develop an implementation plan to create statewide uniform reporting requirement for waitlists across care settings. The data reported should integrate with health information technology to improve the ability of the state to target resources and improve provider referral capability.

> *If you try to find out where there is [treatment], it's like, "Good luck." You're calling all over here and there and you can't. I remember thinking to myself, well, it's up to us, the whole family. We would try to get information of what we're supposed to do. You couldn't find anything.*
> *- Family, Wausau, Male*

The implementation plan should contain specific relevant information, such as 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. This implementation plan should be provided to the Governor and the Co-Chairs of the Governor's Task Force on Opioid Abuse no later than December 1, 2018. All providers accepting Medicaid funds should be expected to provide this information. A uniform

[*] These recommendations are intended to inform implementation of recommendations made by Pew in January 2018.

set of elements for reporting requirements should be developed to ensure that waitlist data is comparable across providers.

Additional Recommendations

To build on the HOPE Agenda and Pew's recommendations to the Task Force in January, Pew recommends six additional policy changes to improve care integration and transform systems of care for substance use disorder treatment in Wisconsin.

Recommendation 4: Allow sites that deliver medical services to operate as Opioid Treatment Programs to increase the availability of methadone in Wisconsin.

Problem

Wisconsin does not have enough methadone providers across the state to meet the need for OUD treatment.

Background

Methadone is one of three FDA-approved medications to treat OUD. Under federal law, methadone is available only through licensed opioid treatment programs (OTPs), which are state and federally-regulated facilities. Wisconsin regulations prohibit the integration of methadone maintenance therapy with physical and mental health care. These restrictions can impose burdens on treatment access that limit the ability of the state to meet the OUD treatment need.

Methadone is the most rigorously studied medication available for the treatment of OUD, with a large body of research demonstrating its effectiveness.[20] The safety of methadone maintenance therapy as a treatment for OUD is also well established. Methadone-related overdoses are primarily associated with its use for the treatment of pain, not for its use in treatment of OUD.[21]

Like other chronic diseases, the right medication to use to treat OUD may vary for each patient. For example, MAT with buprenorphine or methadone is considered the standard of care for pregnant women with OUD because of improved maternal and neonatal outcomes when combined with comprehensive prenatal care.[22] Therefore, availability of methadone, as one of three FDA-approved medications to treat OUD, is critical to a high-performing OUD treatment system.

Due to state regulation that prohibit the integration of OTPs with physical and mental health care service providers, methadone maintenance therapy is delivered in standalone settings. This limits access to methadone and creates burdens for individuals with OUD to access comprehensive health care. Furthermore, in Wisconsin these facilities are often not accessible without substantial travel. The average travel distance to access methadone maintenance therapy in the state is 26 miles, with rural areas of the state facing longer travel time.[23]

Allowing for care integration could improve the availability of methadone maintenance therapy by increasing the number of community-based providers offering those services. Care integration could also reduce stigma against MAT, which was also identified by focus group participants as a barrier to treatment access.

Integration of OTPs with other services and care coordination is common in other states. For example, three states have recently used "opioid health homes" to improve coordination between primary and specialty care, help members navigate the health system, and achieve better access to OUD treatment.[24] For example, Maryland used a State Plan Amendment to deliver team-based care from designated OTPs for Medicaid recipients with an OUD diagnosis at risk for an additional chronic illness. Evaluation of Maryland's program indicates that as the length of members' enrollment increased, their likelihood of using the emergency department declined by 27 percent and their likelihood of using inpatient services declined by 83 percent.[25]

Proposed Solution

To expand access to evidence-based methadone maintenance therapy and improve integration with physical and mental health services, the Governor approved an emergency rule submitted by the Department of Health Services that removes regulatory language that prevents facilities that provide medical services from serving as an OTP.[26] This emergency rules expires November 7, 2020. To ensure access remains available beyond 2020, the Legislature should enact legislation that permanently removes this restriction.[27] Removing this prohibition could result in additional methadone providers in community-based clinics, hospitals, correctional facilities, and other health care settings.

Additionally, as the Commission on Substance Abuse Treatment Delivery develops a new comprehensive care model for the state, this change would allow providers that offer medical services to also offer all three FDA-approved medications. Currently, providers offering medical services—such as a hospital or a federally qualified health clinic—could not provide methadone.

To ensure that additional providers offer methadone maintenance therapy, the Department of Health Services should coordinate with community-based clinics, hospitals, correctional facilities, and other health care settings to address any remaining policy concerns that would prevent them from operating as an OTP. The Department of Health Services should also coordinate with current methadone providers to address additional policy restrictions that could prevent co-location or delivery of integrated care.

Recommendation 5: Develop a definition for recovery housing that would bar discrimination based on the use of evidence-based medications for treatment.

Problem

At many locations, substance use disorder patients on MAT are barred from accessing recovery housing in Wisconsin.

Background

The length of treatment for people with OUD varies based on severity of need, medication used, and individual circumstance.[28] For example, the National Institute on Drug Abuse states that a minimum of 12 months of treatment is needed for patients on methadone maintenance.[29] It also states that least 90 days of residential or intensive outpatient treatment is required for patients to maintain positive outcomes, noting that treatment lasting significantly longer is recommended.[30] During this time, patients may need to stay in recovery housing; patients with SUD frequently report housing as one of their top concerns during their recovery.[31]

Recovery houses are residential environments that provide individuals in recovery from SUD with alcohol- and drug-free cohabitation spaces and often include peer support and other services such as individual and group therapy, employment opportunities, and assistance with social, personal, and living skills.[32] Patients with SUD who reside in recovery housing have reduced substance use, reduced risk of relapse, lowered incarceration rates, and increased employment compared with those not in recovery homes.[33,34] Further, recovery houses have been shown to be cost-effective, with cost savings between $17,830 and $29,000 per person; these savings factor in the cost of substance use, illegal activity, and incarceration that might occur without the support that recovery housing offers.[35] Despite the positive role of recovery housing in an individual's recovery, many of these residences prohibit or actively discourage the use of MAT.[36,37]

Wisconsin currently lacks a legal definition for recovery housing, which leaves OUD patients vulnerable to being excluded from or discriminated against in these facilities if they continue to take medications as part of their treatment. Conversations with relevant stakeholders in Wisconsin have confirmed the existence of this issue within the state. A representative of an in-state homelessness and housing association with knowledge of the Wisconsin recovery community commented that MAT was still not widely accepted in the recovery residences. Moreover, during stakeholder conversations, a representative of a prominent Wisconsin recovery housing group emphasized the importance of having an abstinence-based approach. Wisconsin is not unique in experiencing this problem, as other states have had difficulties in ensuring the adoption of MAT in their state-funded recovery residences.[38]

Proposed Solution

The Governor should propose and the legislature should pass legislation creating a legal definition of recovery housing with an affirmative emphasis on ensuring that patients are able to use MAT in these facilities. The National Council for Behavioral Health (NCBH) offers broad parameters on what would be included in an adequate legal definition of recovery housing as well as draft legislative language.[39] While the NCBH offers a solid foundation to work with, additional steps should be taken to dissuade discrimination against MAT. In New Jersey, for example, the state legislature passed anti-discrimination legislation that explicitly "prohibits residential substance use disorder treatment facilities…from denying admission to individuals receiving medication-assisted treatment for substance use disorder." In Ohio, legislators

integrated similar anti-discriminatory language into recovery housing law, specifying that patients are permitted to take their prescribed medication while residing in these facilities.[40]

Recommendation 6: Establish an interagency working group tasked with initiating formal cross-agency data sharing on OUD to help drive state actions to expand access to MAT that are informed by analysis of state data and identification of areas of need.

Problem

Although the opioid crisis affects multiple agencies, there is no mechanism for cross-agency data sharing or coordination of policy reforms that could improve access to MAT.

Background

Although Wisconsin state agencies coordinate on the opioid epidemic as needed, the cooperation is informal and without specific tasks and accountability. Without cross-agency engagement, it is challenging for state policymakers and treatment providers to understand and comprehensively respond to the various issues of the opioid crisis, which include such cross-agency challenges as opioid-related foster care placements and commercial insurer treatment claim denials. Given the reach of the crisis across agency responsibilities, structured coordination is important to make significant headway.

In 2016, Governor Walker signed Executive Order 214 to create the Task Force on Opioid Abuse. As part of that Executive Order, eight state agencies—the Department of Children and Families, the Department of Corrections, the Department of Health Services, the Office of the Commissioner of Insurance, the Department of Safety and Professional Services, the Department of Veteran Affairs, the Wisconsin Economic Development Corporation, and the Department of Workforce Development—are each required to establish their own steering committee to develop a strategic plan for that agency to address the opioid crisis and coordinate with the Task Force on that plan.[41]

Despite this mandate, these agency-specific steering committees face challenges in aligning their priorities and coordinating with the Governor's Task Force. Each agency is currently conducting analyses of data they collect and developing a strategic plan to address the opioid crisis, but there is no formal cross-agency group charged with aligning those priorities and conducting analyses of data and policy that affect multiple agencies. Given the role of the Governor's Task Force in recommending policy changes to the Governor and Legislature, agency steering committee integration could bolster its work.

Proposed Solution

To improve interagency coordination and responsiveness to the need for MAT, the Governor should establish an interagency steering committee composed of, at a minimum, the eight agencies identified by Executive Order 214. The steering committee should be tasked with aligning their agency strategic plans to address the opioid crisis, analyzing state data, assessing stakeholder policy barriers, and providing annual recommendations on action to improve

access to and quality of evidence-based treatment for OUD to the Governor's Task Force on Opioid Abuse. This steering committee should, at a minimum, assess:

- Prescription drug monitoring data;
- Poison control call center data;
- Toxicology data;
- Hospital data;
- State Medicaid and commercial claims data;
- Health care provider reimbursement rates;
- EMS incidents;
- Death demographic data; and
- Emergency rooms visits.

The steering committee should consist of staff-level representation that includes members of each agency's opioid steering committee. Each agency should be responsible for analyzing and sharing data collected by their respective department that impacts OUD treatment. Areas for exploration could include the impact of the opioid crisis on the child welfare system, and opioid-related law enforcement encounters.

Recommendation 7: Improve the integration of co-occurring mental health and substance use disorders by reviewing and eliminating unnecessary statutory and regulatory barriers.

Problem

The lack of integrated SUD and mental health services can impede access to MAT for those in mental health treatment.

Background

Over 35 percent of people with an SUD also have a co-occurring mental health disorder.[42] According to SAMHSA, only 7.4 percent of individuals in need of treatment for both disorders receive it.[43] The majority of focus group participants with OUD reported having mental health issues as well. Although mental health services are often critical to successful treatment, many focus group participants mentioned that their mental health issues were not addressed during their treatment. A contributing factor may be the siloed health care system that hinders treatment of SUD and mental health disorders.

Restricting the ability to integrate care for these individuals can negatively affect SUD treatment outcomes. For instance, research shows that untreated co-occurring disorders are associated with lower rates of treatment engagement and adherence.[44] One woman in recovery recounted the effects of her inability to obtain mental health care:

> *My relapse at 24 was mostly because of the difficulty [in finding] mental health providers that accept BadgerCare and the year-long waiting lists to get in.*

- *Female in Recovery, Wisconsin*

Individuals with co-occurring SUD and mental health disorders also have increased odds of suffering from other chronic illnesses, suicide, and early death.[45] Moreover, studies show that integrated service systems—such as single-point entry or co-located assessment, treatment, and case management services—may increase treatment access.[46,47,48]

Stakeholders expressed frustration with the difficulty of treating co-occurring disorders in Wisconsin. In particular, providers were concerned with the lack of integration of training and licensure for the behavioral health workforce and with limitations placed on integrating services for mental health and SUDs. Studies indicate that some of these limitations, such as diagnostic and billing restrictions, and limited support for co-occurring disorder training, are common restrictions on integrated care in many states.[49] The lack of service integration can cause delays in treatment initiation and otherwise impede access to MAT for individuals with co-occurring disorders in the mental health treatment system and access to mental health services for those in the SUD treatment system.

The integration of treatment for co-occurring disorders is supported by many organizations, such as the Institute of Medicine, the World Health Organization, the Agency for Healthcare Research and Quality, the American College of Physicians, and the Substance Abuse and Mental Health Services Administration.

Proposed Solution

The Secretary of the Department of Safety and Professional Services should direct the Behavioral Health Review Committee, established by Section 8 of 2017 Wisconsin Act 262, with assessing barriers to treatment for co-occurring substance use and mental health disorders. The Committee should provide recommendations to the Secretary, Governor, and Legislature on actions that would remove identified barriers while ensuring maintenance of quality care by December 31, 2019. The Committee's recommendations should ensure that MAT is available in all integrated care settings. The Committee should engage membership from all agencies with regulatory authority over SUD or mental health treatment, providers, and patients. There should be active participation, at a minimum, from the following:

- Department of Health Services
- Division of Medicaid Services
- Department of Safety and Professional Services
- Medical Examining Board
- Wisconsin Medical Society
- Wisconsin Hospital Association
- Wisconsin Society of Addiction Medicine
- Wisconsin Psychiatric Association

Recommendation 8: Improve the timeliness and accuracy of opioid-related death data to target treatment resources in communities of highest need.

Problem

Opioid-related data are often not timely or accurate, which impedes the ability to strategically target treatment resources to areas of the state with the highest need.

Background

Access to timely information is an important component of a coordinated and targeted response to any public health epidemic, but is especially critical to address the opioid crisis. For example, the substances used by people with OUD include prescription drugs, synthetic opioids (such as fentanyl), and illicit opioids (heroin). Timely and accurate data can help public health and public safety officials understand what substances are available in which communities and the effect of these substances on overdoses and deaths. This information can improve the ability to distribute harm reduction strategies, such as increasing the availability of naloxone, and to target investigations into the sources of high-potency fentanyl that may be causing overdoses. Availability of this data could support early intervention, strengthen treatment initiation efforts, and reduce the threat of fatal overdoses.[50,51,52]

As of February 2017, only five board-certified forensic pathologists served as medical examiners, covering just 10 out of 72 counties in Wisconsin—Brown, Dane, Door, Fond du Lac, Milwaukee, Oconto, Rock, Walworth, Washington, and Waukesha.[53] Coroners or medical examiners with limited training in forensic pathology serve the remaining 62 counties. Coroners are elected and are not required to have any qualifications. However, autopsies must be conducted by a licensed physician with training in forensic pathology under state law.[54,55] Without training in forensic pathology, adequate staffing, and equipment across counties, comprehensive overdose data from complete autopsies and toxicology screens remain difficult to produce for the 62 counties without direct access to forensic pathology. This decentralized system forces counties to contract with out-of-state providers or one of the five board-certified forensic pathologists to conduct autopsies or screenings. The resulting administrative and logistical strains can lead to slower data reporting and increased county costs.

Fifteen states fund a unified statewide medical examiner system.[56] These unified systems ensure consistent and accurate death investigations, including autopsies, on all people who die through injury, homicide or suicide, or deaths that are sudden, accidental, untimely, suspicious, or not attended by a doctor—such as opioid-related overdoses. Statewide medical examiner systems can improve the quality of death investigations and forensic pathology services, compensate for differences in county budgets and population sizes, budget differences, promote consistency of practice, and generate efficiencies from centralized administration.[57] Maryland has 18 forensic pathologists and 21 autopsy labs in its Baltimore-based unified system. Unlike offices in many other states with substantial case backlogs, Maryland's medical examiner's office can complete an investigation of a drug-related death within a week, including autopsies within 24 hours and toxicology tests within three to five days.[58]

Wisconsin stakeholders noted that toxicology screens for individuals with fentanyl-related overdoses can take six to seven weeks to process. These long delays are affected by staffing shortages and inadequate equipment to screen for fentanyl analogues. These delays result in challenges for public health and law enforcement agencies that must respond to overdose outbreaks quickly to prevent additional overdoses and deaths. Increasing the capacity of medical examiners fully trained in forensic pathology to conduct comprehensive autopsies and toxicology screens could strengthen the state's response to the opioid crisis, especially when the speed of reporting also increases.

Proposed Solution

The Governor should direct the Department of Health Services and the Department of Justice to consider a unified medical examiner or other alternative system to improve access to timely and comprehensive overdose death data. The Departments should focus on strategies to reduce costs for conducting autopsies and toxicology screens out-of-state while utilizing and expanding the availability of forensic pathologists in Wisconsin.

Any system reforms must be mindful of the burden on forensic pathologists; the National Association of Medicaid Examiners recommends no more than 325 autopsies per year for a forensic pathologist.[59] Accordingly, consideration should be given to recruiting additional forensic pathologists to support any alternative system. Additionally, the state should examine whether additional equipment is needed to conduct the appropriate toxicology screen to detect fentanyl analogues.

The Departments should consult medical examiners across the state as they consider these alternative approaches. The Governor should direct the Departments to issue a report within a year. Examples from other states show that these approaches improve the ability of medical examiners to quickly respond to overdose deaths with the tools required to share the data that public health and law enforcement agencies need. The Departments should consider these state examples in any plan for an enhanced medical examiner system.

Recommendation 9: Ensure patients entering MAT are placed in the right care setting through use of a single standardized patient placement tool across state-licensed and Medicaid certified providers.

Problem

Individuals seeking treatment are often not referred to the appropriate level of care, which can lead to administrative waste and impose undue burdens on both people seeking treatment and providers of care.

Background

Clinical assessment tools ensure evidence-based placement of patients based upon addiction severity and patient treatment needs, and provide a baseline for clinical decision-making on treatment across providers. Wisconsin statute permits providers to choose from among

multiple patient placement criteria while treating patients within the care networks. The Department of Health Services 75.01(1)(a) "provides that service recommendations for initial placement, continued stay, level of care transfer and discharge of a patient be made through the use of Wisconsin uniform placement criteria (WI-UPC), ASAM placement criteria or similar placement criteria that may be approved by the department."[60] Although studies have support the predictive validity of the ASAM patient placement criteria,[61,62] other placement criteria may not be validated or evidence-based.

Since patient placement criteria can vary significantly by both methodology and levels of care designations, movement between providers who use different criteria can precipitate the need for multiple assessments on the same patient. Conversations with providers across the state confirmed that this does occur because they either did not share assessments or did not use the same patient placement criteria. This duplicative work reduces time spent treating patients, thereby lowering access to care and placing unnecessary burdens on both people seeking treatment and providers.

The use of multiple assessment tools can also lead to inconsistencies in patient placement based on how a patient is evaluated. Referring patients to an inappropriate level of care could have negative consequences for the patient, such as lower retention rates and potential relapse, and may generate more costs for public or private payers. Matching patients with the appropriate levels of care, however, has been shown to reduce treatment no-shows to initial care by 25 percent.[63] Finally, using uniform placement criteria can help providers consult each other about patients by ensuring the use of a common vocabulary.[64]

The Centers for Medicare & Medicaid Services (CMS) recognize the importance of using patient placement criteria based on a multi-dimensional assessment tool that reflects evidence-based clinical treatment guidelines, such as those published by ASAM. Incorporating this type of tool statewide is required for states seeking an 1115 waiver to expand SUD services, as detailed in a letter to state Medicaid directors in November 2017.[65] Widespread use of evidence-based SUD-specific patient placement criteria is one of six milestones measured during these five-year demonstrations. For example, Vermont requires use of the ASAM patient placement criteria by all licensed providers and ensures compliance with that requirement by conducting periodic chart reviews.[66] Virginia also requires the use of the ASAM patient placement criteria for all providers accepting Medicaid. Virginia Medicaid uses the outcomes of each ASAM assessment to determine medical necessity, except for OTPs, OBOTs, and other outpatient services.[67] Using a uniform assessment helps to ensure that patients are placed in the appropriate level of care.

Finally, patient placement assessment tools are typically not integrated in health information technology, such as electronic health records or health information exchanges. Conducting these assessments by hand can cause delays in treatment access due to challenges in sharing that information with other providers. Integrating these assessments with electronic health records could improve care coordination among providers and support easier transitions between levels of care for patients. Use of an assessment tool that can be integrated within provider workflows could improve standardization and lessen administrative burden.

Proposed Solution

The Governor should direct the Department of Health Services to establish requirements for the use of a single standardized patient placement tool across state-licensed and Medicaid-certified providers, assess the cost of licensing a standardized patient placement tool to participating providers statewide, and support participating providers with technical assistance to integrate the tool with available health information technology. To avoid undue administrative burdens for providers, any established requirements should allow providers sufficient time and technical assistance before they are expected to complete implementation.

The Department should consider using availability of this tool as an incentive to providers who deliver evidence-based treatment or participate in statewide treatment models, such as the result of the Commission on Substance Abuse Treatment Delivery. If resources are necessary to mitigate undue burden for providers, the Legislature should provide necessary funds to make this patient placement tool available to participating providers statewide.

Recommendation 10: Improve initiation of MAT and transition to treatment in emergency departments.

Problem

Opportunities to initiate MAT for people with OUD—such as when they arrive in the emergency room with an opioid-related overdose—are often missed.

Background

Emergency departments, where opioid-related visits increased more than 99 percent between 2005 and 2014,[68] represent a critical opportunity for to initiate treatment and connect people with OUD to care. This is particularly relevant in Wisconsin, where the state's increase in opioid-related emergency department visits between July 2016 and September 2017 (108 percent) was the largest of any state included in a recent CDC study.[69]

Recognizing the potential to initiate care in emergency rooms, federal regulations do allow the administration of methadone and buprenorphine in emergency situations to treat withdrawal symptoms and arrange for treatment.[70] For example, physicians do not need the waiver usually required to prescribe buprenorphine and methadone can be administered outside of an OTP, but treatment can last no longer than three days. A clinical trial shows that patients were more successful in sustaining treatment engagement when buprenorphine was initiated in the emergency department and coupled with a referral, compared to interventions that did not include buprenorphine.[71]

Care coordination is an important component of ensuring overdose patients receive continued treatment following emergency care. There are multiple types of providers that can provide these services; some local programs have used peer recovery coaches, which are individuals in recovery from substance use or co-occurring mental health disorders, to fill this role. For

example, Rhode Island's AnchorED program connects patients with a certified peer recovery specialist prior to discharge from the ED. Peer recovery specialists are on call 24 hours, 7 days a week at each of the state's 12 hospital EDs. This person maintains follow-up with the patient for 10 days following release from the ED to aid in navigating the treatment system and support their recovery. More than 1,400 individuals met with a peer recovery coach in the emergency department through AnchorED during the first 29 months of the program. Eighty percent of those individuals engaged in recovery support services upon discharge.[72]

New Jersey offers another example of care coordination offered for those that experience an opioid-related overdose. In 2015, the state implemented the Opioid Overdose Recovery Program (OORP), a program modeled after AnchorED, to facilitate the entry of individuals who receive naloxone into substance use disorder treatment.[73] OORP utilizes recovery specialists who provide non-clinical assistance to individuals to help them gain skills and resources needed to initiate and maintain recovery and patient navigators who refer patients to treatment.[74] Recovery specialists are on call from Thursday evening through Monday morning. Of the 293 overdose patients admitted to EDs in five counties from January 2016 to June 2016, roughly 37 percent (109 patients) entered treatment.

A pilot program in Wisconsin uses peer recovery coaches to support treatment initiation from emergency departments—ED2Recovery. However, the pilot lacks a robust evaluation, which is necessary to further the evidence of effectiveness needed to continue scaling up the program.

Proposed Solution

The Governor should direct the Department of Health Services to partner with emergency departments in hospitals and other health clinics to support induction on MAT in that setting. The Department should provide guidance based upon federal and state regulations on protocols emergency departments can employ to include this care in their practice for individuals admitted for an opioid-related overdose. The Department should work with the Wisconsin Hospital Association, the Wisconsin Medical Society, and others to disseminate these best practices and provide technical assistance to emergency department staff. The Department should work with providers to assess the current resources available for care coordination services in emergency departments and address any gaps that might impede the availability of these services in this setting statewide.

Additionally, the Legislature should provide sufficient resources to evaluate the current pilot that incorporates peer recovery coaches in transitioning individuals from emergency departments to treatment—ED2Recovery. These funds should be allocated to a comprehensive evaluation that measures the impact of peer services in this setting.

Substance Use Disorder Workforce

Background

An effective treatment system must have enough providers to meet the need for services across the state. Recognizing the need for additional providers, the HOPE Agenda included multiple measures to help expand the workforce. 2017 Wisconsin Act 26 allocated funds to support additional addiction medicine fellowships and create addiction medicine specialty training programs at hospitals across the state.[75] 2017 Wisconsin Act 28 established the Addiction Medicine Consultation program to support community-based physicians interested in providing evidence-based SUD treatment services with clinical guidance and training from addiction medicine specialists.[76] Both measures strengthen the workforce by either training new physicians or supporting practicing physicians beginning to provide substance use disorder treatment services.

In January, Pew provided multiple recommendations to the Governor's Task Force on Opioid Abuse aimed at removing barriers that limit the workforce needed to meet the need for effective substance use disorder treatment in Wisconsin. These recommendations included:

- Removing barriers that restrict licensed mental health therapists from providing counseling services for substance use disorders.
- Improving reciprocity for certified counselors from other states with similar criteria.
- Aligning certification standards for Substance Abuse Counselors with national best practices.
- Removing prior authorization in Medicaid for buprenorphine combination products.
- Clarifying state law that nurse practitioners and physician assistants can obtain a waiver to prescribe buprenorphine without their collaborating/supervising physician also obtaining the waiver.
- Engaging residency programs for physicians, nurse practitioners, and physician assistants to ensure buprenorphine waiver is included in their training.

On April 9th, the Governor signed 2017 Wisconsin Act 262.[77] The law enacted the recommendations from Pew, which were endorsed by the Task Force in January. Among other changes such as supporting graduate training of psychiatric nurses, the law expands access to buprenorphine and could increase the number of qualified substance abuse counselors, or SACs. The law also created a Behavioral Health Review Committee tasked with recommending changes to the certification and licensure criteria semiannually.

[*]**Recommendation 11:** Provide funds to expand buprenorphine training for providers during residency programs for physicians, nurse practitioners, and physician assistants.

[*] These recommendations are intended to inform implementation of recommendations made by Pew in January 2018.

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 treat 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 mental health and psychosocial support, 41 percent due to lack of confidence in treating the patient population, and nearly half (45 percent) due to lack of specialty back-up.[78] Many of these barriers would be addressed through the implementation of a "hub and spoke" treatment delivery system (Executive Order #274, 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.

Following up on a recommendation provided to the Task Force in January, the state should allocate the necessary funds to support buprenorphine training in residency programs for physicians, nurse practitioners, and physician assistants. Training should be limited to relevant specialties. In conjunction with the increased specialty back-up and psychosocial support provided by the implementation of a "hub and spoke" treatment delivery system and other reforms the state is pursuing to incentive provider engagement, supporting these trainings could help increase the number of providers available in the state to treat OUD with buprenorphine at minimal cost.

Qualified behavioral health counselors are an important part of effective MAT. Throughout our stakeholder conversations, Pew heard from providers and patients that there are not enough counselors to provide care to those that need it. Providers in various care settings, such as OTPs, Office-Based Opioid Treatment (OBOT), and FQHCs, experienced challenges filling vacancies with qualified counselors, which in some cases resulted in fewer patients served. Many of these challenges could be addressed by 2017 Wisconsin Act 262.

To further address provider shortages and increase access to evidence-based treatment, late last year Governor Walker directed the Department of Health Services to increase Medicaid reimbursement rates for mental health and SUD outpatient treatment. Effective January 1, 2018,[79] these changes simplify the rate structure and increase reimbursement rates for each outpatient covered service provided by physicians, psychiatrists, advanced practice nurse prescribers, psychotherapists, and SACs. These changes invest $17 million to raise these rates, including $7 million in state funds. The new rates are competitive with surrounding state Medicaid and Medicare programs.

To build from the HOPE Agenda and Pew's recommendations to the Task Force in January, Pew recommends four additional policy changes to enhance the quantity and quality of the substance use disorder workforce in Wisconsin.

Recommendations

***Recommendation 12:** Use the Behavioral Health Review Committee established through 2017 Wisconsin Act 262 to ensure Wisconsin's Substance Abuse Counselor certification and licensure process aligns with national best practices and that the number of counselors meets the need for counseling across the state.

Problem

People with OUD are unable to access sufficient behavioral therapists as part of MAT.

Background

SACs are certified and licensed to deliver behavioral health services, such as cognitive behavioral therapy, and are a key component of MAT, the most effective therapy for OUD and other SUDs. According to the 2017 Wisconsin Needs Assessment, Wisconsin has only 1.7 SUD counselors per 10,000 persons in comparison to the national average of 2.5 per 10,000 persons.[80] However, in speaking with behavioral health professionals and provider groups around Wisconsin, even an increase to meet the national average—which would require an additional 275 counselors—would still be insufficient to meet state needs.

We heard about this problem during many of our conversations with providers in Wisconsin, with reports of significant difficulties in filling vacancies, expanding services, and expanding workforce.[81] During the focus groups, providers also reported that strict certification requirements for counselors and treatment providers hinder increased access to treatment in Wisconsin. These requirements make it difficult to staff treatment centers and lead to fewer opportunities for individuals to receive treatment.

> *I had more than enough of the education, experience, and qualifications then, more than Wisconsin requires, and they would not license me here because it did not come from the state of Wisconsin, did not come from a school that they recognized. I was like, "It's Wichita State University. It's a huge university. People know that school."*
> *- Provider, Green Bay, Female*

> *What [Wisconsin] will do is they will honor the fact that you took the international test, but they don't honor it unless your education meets the state requirements, and we have the same exact credentials as the state you came from.*
> *-Clinical Director, MAT center, Wisconsin*

In January, Pew recommended the state address this shortage by assessing certification and licensure criteria that unnecessarily restrict qualified providers. In response, the state passed 2017 Wisconsin Act 262. This law focused on addressing this problem by aligning state certification and licensure criteria for counselors with surrounding state standards. Statutory changes included decreasing the supervisory hour burden to attain certification, improving reciprocity with certified counselors from other states, and removing barriers for licensed mental health therapists to deliver services to individuals with SUD.

Section 8 of the bill directed the Secretary of the Department of Safety and Professional Services (DSPS) to appoint an advisory board to provide a semiannual review and recommendations on behavioral health. This Behavioral Health Review Committee is tasked with reviewing state requirements for SACs and mental health therapists to obtaining a credential in the state. The Committee, however, is not explicitly given authority to provide analysis on the need for counselors. The scope of the Committee is also limited to certification and licensure.

Proposed Solution

The Behavioral Health Review Committee's recommendations for changes should be informed by national best practices, such as guidelines from the University of Michigan's Behavioral Health Workforce Research Center[82] and SAMHSA[83]. The Secretary of the Department of Safety and Professional Services (DSPS) should also task the Committee with evaluating the need for counselors across the state and propose changes to ensure there are enough providers without negatively impacting quality of care.

The adequacy of the counselor workforce could be evaluated based on: patient and provider surveys that assess whether patients accessing MAT are able to obtain counseling services; or an analysis of the number of patients receiving MAT per month across providers and the number of patients receiving counseling services per month across providers; or another method identified by the state. The Committee's proposed changes should not be limited to certification and licensure, but could include other areas like scope of practice, continuing education, and regulatory barriers that limit access to evidence-based practice.

To ensure that the Committee is responsive to the needs of each certified profession, the Secretary of DSPS should appoint at least one member from each of these professions (e.g. Substance Abuse Counselors, Clinical Substance Abuse Counselors, Licensed Professional Counselors, Marriage and Family Therapists, Clinical Social Workers, Psychiatrists, and Psychologists) to the Committee. Any findings or recommendations reached by the Committee should be available to the Legislature and the public to ensure accountability. The Committee should issue its first report no later than one year after the adoption of this recommendation by the Task Force.

Recommendation 13: Align the Professional Assistance Procedure with national best practices for physician health programs.

Problem

Wisconsin's physician health program, known as the Professional Assistance Procedure or PAP,[84] does not effectively provide access to SUD treatment for providers that aligns with national best practices.

Background

Providers, including nurses, counselors, physicians, and others, suffer from SUD at a similar rate to the general population of about 10 to 12 percent.[85,86] Wisconsin has a program that is designed to meet the needs of these providers, called the Professional Assistance Procedure (PAP). However, this program does not effectively engage participants with SUD in evidence-based treatment, such as MAT.

Key stakeholders in the state have expressed concern that the program has limited reach and barriers that prevent practitioners with SUD from taking advantage of the program and receiving treatment for their SUD. In particular, participants in the program have also expressed concerns over the excessive costs, inaccessibility, and lack of support seeking supervised employment during the program process. These aspects of the program could limit the number of providers willing to self-report their SUD and access treatment.

The Federation of State Physician Health Programs (FSPHP), a national organization focused on strengthening physician health programs across the country, recently released guidelines on physician health programs that summarize national best practices. According to FSPHP guidelines[87], the design and structure of the PAP misses many of these best practices. For instance, PAP participants are not given full confidentiality while seeking treatment through the program and[88] the program does not advocate to the state medical boards to avoid discrimination against participants. Additionally, the program has such a limited reach that many providers in need are not able to enter the program.

The AMA released model legislation in 2016 to support states interested in establishing or strengthening their physician health program.[89] The act protects the confidentiality of self-reporting providers that want to participate in the program without disclosing participation as a condition of employment or credentialing. It also protects the confidentiality of providers referred to the program by their peers. The protection of confidentiality by the program, argues AMA, encourages providers with SUD to come forward and reduces the likelihood of their disorder from progressing to negatively impact the safety of the provider or their patients. According to seven findings by the AMA, an effective PHP:

- Provides availability to evidence-based care
- Reduces stigma associated with substance use disorders
- Maintains confidential referral, evaluation, and treatment protocols to ensure access to treatment without professional sanction while in compliance with the program
- Supports the integrity of the health care workforce by enhancing patient safety and providing a cost-effective method for licensing boards to balance the needs of the state and its individual health care professionals
- Relies upon clinical guidelines and treatment protocols from organizations with expertise in substance use disorder treatment
- Protects the privacy of program participants
- Contains a stable funding stream to sustain and expand the scope of services to meet the need for treatment from the health care workforce

Proposed Solution

The Governor should direct the Department of Safety and Professional Services to coordinate with experts and key stakeholders to reform the Professional Assistance Procedure to incorporate national best practices to improve access to treatment for providers. A representative from these key stakeholders, at a minimum, should be consulted by the Department:

- Wisconsin Medical Society
- Wisconsin Hospital Association
- Medical Examining Board
- Wisconsin Society of Addiction Medicine
- Department of Health Services

If statutory changes are needed to enact reforms to the Professional Assistance Procedure, the Legislature should take necessary action.

Underserved Populations

Background

Many populations in Wisconsin face specific barriers in accessing evidence-based treatment; two groups stood out from conversations with patients and providers across the state. First, pregnant women are deterred from seeking effective prenatal and SUD treatment for fear of punitive action taken against them. According to these conversations, there is also a lack of treatment providers that can deliver comprehensive treatment—in particular, MAT—for pregnant women with SUDs.

Second, justice-involved individuals are largely unable to access any MAT while incarcerated regardless of whether they were maintained on medications upon entry into prison or jail. This disruption in access to effective treatment can put individuals reentering the community at a high risk for relapse, overdose, or death. In fact, within two weeks of release overdose deaths are responsible for more than twice as many deaths as any other cause.[90] A comprehensive system addresses population-specific needs and coordinates care for at-risk individuals.

As part of the HOPE Agenda, Wisconsin has taken steps to improve access to treatment for the justice-involved population with substance use disorders. 2015 Wisconsin Act 338 provided $2 million annually to support alternatives to prosecution and incarceration known as Treatment and Diversion, or TAD, programs.[91] The Legislature provided additional funding to these programs through 2017 Wisconsin Act 32.[92] Finally, 2017 Wisconsin Act 261 provides grants to counties to administer naltrexone for individuals that are reentering the community and additional funds to scale up family drug treatment courts.[93]

To expand on those steps to support access for justice-involved individuals, Governor Walker signed Executive Order #273 on January 19 based on a recommendation from Pew.[94] The Executive Order in part directed the Department of Health Services to collaborate with the Department of Corrections to improve continuity of care for individuals reentering the community by developing care coordination programs with Medicaid managed care organizations across the state.

Pew recommends four additional policy changes to improve access to evidence-based substance use disorder treatment for underserved populations.

Recommendations

Recommendation 14: Study the availability of MAT in state prisons and county jails and create a pilot in one setting.

Problem

Medications approved by the FDA for the treatment of OUD are not available to those in Wisconsin prisons and jails. In most cases, individuals in need of treatment have no access to any of these medications during incarceration.

Background

The criminal justice system provides an opportunity to connect patients with OUD to needed treatment in a controlled space; however, support for MAT—the most effective therapy for OUD—is inadequate in these settings. Historically, more emphasis has been placed on drug-free treatment although evidence demonstrating the effectiveness of that approach is limited.[95] In Wisconsin, 69 percent of people who are incarcerated have a SUD.[96] Funding for one of the three medications, naltrexone, has been made available in Wisconsin to a limited number of prisons and jails through state grants.[97,98] As of September 2017, only 24 offenders completed the program, which does not offer[99] access to buprenorphine or methadone. Individuals entering jail or prison that are receiving either medication are weaned off.

Providing adequate clinically-appropriate treatment in criminal justice settings, as well as ensuring continuity of care for patients moving from these settings to community-based treatment, is critical to addressing a public health crisis resulting in more than 42,000 opioid overdose deaths each year. For example, a 2010 study found that less than one percent of justice-involved individuals received MAT while in the criminal justice system.[100] Access to MAT in prison is also associated with reduced recidivism rates. In fact, individuals released from prison after receiving methadone for an OUD are 33 percent more likely to stay out of prison and reenter the community successfully than individuals receiving no methadone[101] Though evidence-based behavioral therapies—such as cognitive behavioral therapy—have become more commonplace, most therapeutic alternatives do not incorporate medications, including buprenorphine, methadone, and naltrexone.

> *The good news is, [we have] obviously, a captive, literally, captive audience for intervention. There is an opportunity as part of the reentry process to, first of all, educate people about overdose risk and equip them with naloxone, the antidote. And to put people on maintenance therapy [MAT], which has shown to reduce overdose risks substantially. Estimates are that your overdose risk goes down anywhere from 50-80% when you are on maintenance.*
> *- IDI 1001, National Expert, Professor, MA*

> *No, I feel like there is not enough information. Specially jails, and police officers. I feel treatment should be an option instead of just throwing somebody in jail. I tried all of them out: inpatient, outpatient, neither works. So I tried [medication-assisted] treatment and that worked.*
> *- In Recovery, Wisconsin, QualBoard, Female*

There is limited data on availability of MAT in correctional facilities. According to a Pew report published in 2017, few states facilitate access to MAT upon re-entry and even fewer provide

medication directly. Only 13 states, which includes Wisconsin, make available a supply of naltrexone and only three a supply of buprenorphine.[102] Although a 2011 survey of prison medical directors found that 55 percent of prisons offered methadone, over half of those prisons surveyed only offered treatment to pregnant women. The same study found that only 14 percent of prisons offered buprenorphine, and estimated that only 2,000 prisoners (0.1 percent of all prisoners) received any kind of MAT as an ongoing treatment. Prisons also overwhelmingly failed to refer individuals to community-based methadone and buprenorphine providers as they transition out of prisons, with only 45 and 29 percent respectively doing so in 2011.

Jails are typically operated at the county-level, usually housing nonviolent offenders and individuals awaiting trial but unable to post bail. Individuals held in jail serve, on average, short terms. Over 10.9 million individuals cycled through the nation's jails in 2015 with a 57 percent weekly turnover rate.[103] Despite the large number of individuals cycling in and out of jails each year, there is limited exposure to medically appropriate treatment for OUD.

In 2016 the Rhode Island Department of Corrections launched a treatment program that provided all FDA-approved medications for those that screened positive for OUD. Initial outcome evaluations of the program showed a 61 percent decrease in post-incarceration deaths and an overall 12 percent reduction in overdose deaths in the state's general population.[104] A partnership with Rhode Island's treatment hubs, known as Centers of Excellence, has established a warm handoff that has helped inmates released transition into community treatment.

Proposed Solution

The Governor should direct the Department of Health Services to develop a plan with the Department of Corrections or identified county leaders to pilot the availability of all three medications in at least one prison or jail. If necessary, the Legislature should enact legislation to authorize and fund this pilot. As part of this plan, the Departments should conduct a systematic review of prisons and jails to document the current availability of treatment.

This review should identify whether the following services are available in each prison and jail:

- Availability of behavioral health counseling on premises as measured by the number of SACs on staff
- Facilities for inpatient detoxification, including the number of rooms available
- Availability of FDA-approved medications for the treatment of OUD—what forms of medication are available and how many individuals receive each medication per month.

The Departments should report this plan to the Governor's Task Force on Opioid Abuse within a year of the enactment of this recommendation.

***Recommendation 15:** Ensure Medicaid benefits are suspended (rather than terminated) for all eligible justice-involved individuals across the state.

Problem

Medicaid-eligible individuals with an SUD face delays in treatment initiation as they transition to the community from prisons and jails.

Background

The prevalence of SUD among people who are incarcerated is extremely high nationwide. In Wisconsin, 69 percent of people who are incarcerated have a SUD.[105] There are heightened risks after discharge from prison or jail for people with SUD; justice-involved individuals reentering the community with SUD are at over 10 times the risk for overdose compared to the general population with SUD.[106] Because people in prison or jail have not typically 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 and Wisconsin county jails are connected without delay to community-based treatment upon release, including initiation or continuation on MAT.

Medicaid is a critical program for connecting justice-involved individuals with MAT. 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.[107] Eligibility in Wisconsin may be similar, as the state provides Medicaid benefits to individuals up to 100 percent of the federal poverty level.[108] Maintaining continuous care before, during, and immediately after release contributes to improved health outcomes, including reduced criminal activity and incarceration for individuals with SUDs.[109] This includes initiation or maintenance of MAT after release.

Although the Department of Health Services has made efforts to support suspension policies in prisons and many county jails, Wisconsin still terminates Medicaid enrollment upon entry into correctional facilities for many individuals. 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, county, 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.[110]

Proposed Solution

To improve the continuity of care, increase treatment initiation, and expand the availability and coordination of mental and physical health care for incarcerated individuals with SUD, the Governor should direct the Department of Health Services and the Department of Corrections to suspend rather than terminate Medicaid benefits during incarceration in prisons and jails

statewide. Given the administrative burden of making this change, the departments should be tasked with developing an implementation timeline and providing any necessary funding requests to the Legislature.

***Recommendation 16:** Increase access to evidence-based substance use disorder treatment for pregnant women by addressing any statutory deterrents and expanding provider capacity to deliver to MAT.

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.[111]

Background

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).[112] 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 focus groups of patients, 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.

Among focus group participants, pregnancy compelled some women to seek treatment. But for many others, they either hid their pregnancy to receive treatment or avoided treatment altogether out of fear of losing their baby or other children.

> *There's no treatment for pregnant women, no one want is to take them. What are you supposed to do?*
> *- Provider, Green Bay, Female*

> *I think that there ... needs to be very clear that people [working at treatment centers] are there to help them, not to take their children away or anything like that.*
> *- In Recovery, Sheboygan, Male*

> *Well, my last time using was pretty much was I got pregnant, and I went to the doctor because I just didn't want to stop. First of all, withdrawal could kill the baby ... So, I went to the doctor and I got prescribed Subutex and now I stayed clean...Then I got arrested actually because I was on probation, it was my third time going to prison because no*

treatment wanted me either because I was on Subutex or because I was pregnant. So, I had to go to prison.
- In Recovery, Green Bay, Female

While Wisconsin Act 262 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.[113] 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. Providers discussed how pregnant women with OUD may have difficulty accessing FDA-approved medications for the treatment of OUD, since they may not seek care because of the law.

Additionally, stakeholders also described inconsistences in the quality of SUD treatment available to all pregnant women with SUDs. Providing evidence-based treatment for pregnant women improves health outcomes for the mother and baby. From a clinical perspective, the American College 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.[114]

Proposed Solution

First, the Legislature should issue legislation that revises existing policies for the treatment of pregnant women with SUD to make it easier for them to seek and receive evidence-based treatment. Additionally, the Governor should direct the Department of Justice, Department of Health Services, and other relevant agencies to address misunderstandings of current law while the Legislature revises existing policies.

Second, the Governor should direct the Department of Health Services to promote best practices for the care of pregnant women with OUD by requiring that programs receiving Medicaid reimbursement and other public funding follow guidelines available from ACOG, SAMHSA,[115] and ASAM that recommend education and screening of women of childbearing age and access to MAT.[116] These requirements should apply to any Medicaid certified or state-certified treatment facility serving women with SUDs.

Recommendation 17: Incentivize the use of evidence-based post-partum care programs for women with substance use disorders across the state.

Problem

Women with substance use disorders in the state face barriers in accessing comprehensive care after childbirth.

Background

Women with SUDs experience heightened vulnerability in the postpartum period. Many factors contribute to this risk, such as increased stress associated with motherhood, limited social support and resources, and pain and physical recovery. These factors increase the risk of relapse and reduce treatment retention. Research indicates that only 30 to 44 percent of women with OUD attend their postpartum visit four to six weeks after delivery, compared to at least 60 percent of women without OUD.[117,118,119] These low retention rates from traditional postpartum care have led many experts to advocate for alternative strategies tailored towards women with OUD. Better treatment modalities would focus on more comprehensive, intensive, and coordinated care after delivery.[120]

These experts point to several alternative strategies to improve care, including the following:

- Delivering services earlier than the standard postpartum visit, such as during the immediate postpartum period (prior to discharge after delivery) and two to three weeks post-delivery;
- Integrating postpartum care into treatment programs, such as co-locating family planning, breastfeeding, psychiatric services, and home visiting programs.[121] Home visiting programs have shown evidence of improving maternal life course outcomes, child cognitive outcomes, and parent behaviors and skills.[122]

Despite the evidence of effectiveness for general postpartum populations, many comprehensive, intensive postpartum care programs are not tailored to women with SUDs.

GunderKids (located within the Gundersen Health System in La Crosse) is one example of an intensive post-partum care program that delivers supportive services and parenting education. This program developed from and was patterned after the work of a high-risk obstetrics team at Gundersen. GunderKids participants are referred through the team and closely coordinate with pediatric hospitalists and addiction medicine specialists in the system. Using a team led by two pediatricians and supported by three pediatric nurses, a nurse practitioner, a social worker, and a child psychologist, the program provides 17 care visits within the first year after birth. Because the program was started in 2015, there is limited data regarding short or long-term outcomes. However, promising signs indicate that care coordination and intensive support yield improved treatment retention and better long-term outcomes for the mother and baby.[123]

Proposed Solution

The Governor should direct the Department of Health Services to provide incentives, such as alternative payments, increased access to care coordination services, and improved training, to obstetricians and gynecologists, pediatricians, and other appropriate providers to either directly provide or partner with organizations delivering comprehensive evidence-based post-partum care programs. If additional resources are necessary to help expand these programs across the state, the Legislature should make adequate funding available to the Department for this purpose.

Recommendation 18: Improve treatment outcomes for babies with neonatal abstinence syndrome (NAS) by integrating best practices into state treatment guidelines and clinical curricula.

Problem

The treatment of NAS is not uniform across the state, which can result in some babies receiving treatment that is out of line with best practice guidelines.

Background

Neonatal abstinence syndrome (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. 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.[124] The incidence of opioid misuse during pregnancy is unknown, but it is an area of heightened concern considering the increasing incidence of NAS.

In Wisconsin, the rate of babies diagnosed with NAS more than doubled as the rate of maternal opioid use more than tripled between 2009 and 2014.[125] In conversations with providers, there are concerns that effective care is not uniformly available across the state for babies born with NAS. The state needs to support providers with implementing evidence-based guidelines to properly address the growing number of NAS cases that is a result of the ongoing opioid crisis. Use of a stringent protocol to treat NAS has been shown to reduce the duration of opioid exposure by nearly 50 percent and the length of hospital stays for babies by as much as ten days.[126] Furthermore, health system engagement in multicenter, multistate quality improvement collaboratives that focus on infants that require pharmacologic treatment for NAS has been shown to be associated with increases in more standardized hospital patient care policies and reductions in health care utilization.[127]

Proposed Solution

To improve outcomes for babies with NAS, the Legislature should direct the Medical Examining Board to establish and disseminate guidelines for the treatment of NAS. The Medical Examining Board should consult with obstetricians and gynecologists, pediatricians, and relevant state associations, such as the Wisconsin Association for Perinatal Care, across the state to ensure the guidelines are appropriate and reflective of evidence-based best practices for the treatment of NAS. Dissemination of state guidelines for the treatment of NAS could encourage hospitals and other providers to establish protocols. Protocols can help identify babies at risk for NAS, ensure treatment consistency, and reduce the length of stay for babies that receive pharmacologic treatment.[128]

Findings

Qualitative Research into the Barriers and Facilitators to Accessing OUD Treatment

Quantitative data on opioid-related indicators, such as overdose deaths, types of opioids misused, and the number of people with an OUD diagnosis, help measure the opioid crisis. However, it is harder to ascertain from quantitative data why there is a crisis and recommendations to alleviate barriers to treatment. The lived experiences of those with OUD, the reasons why some individuals eventually seek and successfully engage in treatment and others do not, and the incentives and barriers to access treatment, are best learned through qualitative data collection.

The qualitative research included three data collection methods, (1) in-depth interviews, (2) in-person focus groups, and (3) QualBoards®, online focus groups. Institutional review board (IRB) approval was obtained from IntegReview. Participants discussed the barriers and facilitators to accessing treatment for OUD. NVivo 11 was used to assist with coding and data analysis. The qualitative findings, which were presented earlier in this document, informed Pew's understanding of the gaps in the SUD treatment system and the 18 recommendations highlighted in this report.

In-depth Interviews

Pew conducted eight in-depth interviews (IDIs) by telephone with experts in OUD policy and programs, one IDI with an individual currently misusing opioids and one IDI with an individual in recovery from OUD. The in-depth interviews were intended to give a national and Wisconsin-specific perspective on barriers and facilitators to accessing treatment of OUD. Ten interviews were conducted between December 29, 2017 and February 15, 2018. Each interview lasted 30-60 minutes and was audio-recorded and transcribed verbatim. See Table 2 for demographic characteristics of the IDI participants.

Table 2. Demographic Characteristics of In-depth Interview Participants

Respondent ID	Demographic information for ten of the in-depth interview respondents
1001	Expert-National. Professor, Massachusetts, Male
1002	Expert-National. Professor, Washington, Male
1010	Expert-National. National journalist, who is also in OUD recovery, Male
1013	Expert-National. Neuroscience journalist, Female
1024	Expert-Wisconsin. Recovery coach, Male
1025	Expert-National. Director of methadone clinic, New Jersey, Male
1026	Expert-Wisconsin. Clinical Director, medication-assisted treatment center, Male
1027	Expert-Indiana. Executive Director, women's recovery center, Female
1030	Individual currently in OUD treatment, Wisconsin, Male
1031	Individual currently using opioids, Wisconsin, Female

In-person Focus Groups

Pew conducted twelve focus groups (FGs) in Milwaukee, Green Bay, Sheboygan, and Wausau from January 9 to January 18, 2018. Two FGs were with individuals currently misusing opioids (n=12); six were with individuals in treatment for and/or recovery from OUD (n=34); two were with family, friends, and/or caregivers of individuals living with or in recovery from OUD (n=16); and two were with health care and other professionals providing treatment or care for individuals with OUD (n=18).

All participants were screened for eligibility. The screening questionnaire was designed to achieve geographic, racial, ethnic, sex, age, and socioeconomic diversity in the FGs. The screening questionnaire for the health care and other professionals group was designed to ensure representation from individuals in social work, law enforcement, SUD treatment counselors, and staff from medication-assisted treatment* (MAT) programs and other OUD treatment clinics/centers. Each FG lasted 120 minutes and were audio-recorded and transcribed verbatim. See Table 3 for demographic characteristics of the FG participants.

Table 3. Demographic Characteristics of Focus Group Participants

Date	City	Group	Recruited	Participated	Demographics
1/9/2018	Green Bay, WI	Health Care & Other Professionals	10	10	Male (4) Female (6) African American (1) White (8) Multi-racial (1) Age Range (31-65)

* FDA-approved medications for the treatment of OUD in combination with behavioral health therapy like counseling.

Date	City	Group	Recruited	Participated	Demographics
1/9/2018	Green Bay, WI	Family/Friends	10	9	Male (3) Female (6) African American (1) White (5) Multi-racial (2) Native American (1) Age Range (25-54)
1/10/2018	Green Bay, WI	Currently misusing	10	8	Male (4) Female (4) African American (1) White (3) Hispanic (1) Multi-racial (2) Native American (1) Age Range (32-56)
1/10/2018	Green Bay, WI	In recovery	10	9	Male (3) Female (6) White (9) Age Range (24-64)
1/11/2018	Wausau, WI	In recovery	6	5	Female (5) White (5) Age Range (23-41)
1/11/2018	Wausau, WI	Family/Friends	10	7	Male (2) Female (5) White (7) Age Range (22-65)
1/16/2018	Milwaukee, WI	Currently Misusing	5	4	Male (2) Female (2) African American (2) White (2) Age Range (33-54)

Date	City	Group	Recruited	Participated	Demographics
1/16/2018	Milwaukee, WI	In recovery	7	6	Male (3) Female (3) African American (1) White (4) Hispanic (1) Age Range (32-61)
1/17/2018	Milwaukee, WI	In recovery	10	8	Male (5) Female (3) African American (1) White (6) Multi-racial (1) Age Range (29-61)
1/17/2018	Milwaukee, WI	Health Care & Other Professionals	8	8	Male (4) Female (4) African American (1) White (7) Age Range (29-73)
1/18/2018	Sheboygan, WI	In recovery	5	3	Female (3) White (3) Age Range (28-39)
1/18/2018	Sheboygan, WI	In recovery	5	3	Male (1) Female (2) White (3) Age Range (24-46)

QualBoard, Online Focus-Groups

Pew conducted two QualBoards (QBs; asynchronous, anonymous, moderated, online discussions) over a three-day period between February 27 and March 1, 2018 with participants in Wisconsin (n=13) and Indiana (n=26). QBs offer more opportunities for inclusion of individuals with OUD who might have been uncomfortable with an in-person discussion of their opioid use, those whose schedule did not allow them to participate in-person, and/or those who resided in areas outside of the in-person focus group locations. The QB recruitment used the same screening protocol that was used to recruit for the in-person focus groups. The two QBs were divided by experience – those currently misusing opioids and those in treatment for

and/or in recovery from OUD to minimize the risk of triggering relapse/set-backs among those in recovery. Participants were asked to spend 30 minutes per day for a total of 90 minutes over a three-day period. Participants responded to a series of moderator-initiated questions each day and commented on posts by other participants. See Table 4 for demographic characteristics of the QB participants.

Table 4. Demographic Characteristics of QualBoard Participants Group

	Recruited	Participated	Demographics
Currently Misusing Opioids	20	15	Male (7) Female (8) African American (1) White (13) Multi-racial (1) Rural Location (4) Age Range (26-62) Indiana (12) Wisconsin (3)
In Recovery	35	24	Male (11) Female (13) African American (2) White (20) Hispanic (1) Multi-racial (1) Rural Location (4) Age Range (24-67) Indiana (14) Wisconsin (10)

[1] Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017. MMWR Morb Mortal Wkly Rep 2018;67:279–285. DOI: http://dx.doi.org/10.15585/mmwr.mm6709e1

[2] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Drug Overdose Death Data, https://www.cdc.gov/drugoverdose/data/statedeaths.html.

[3] 2016 Wisconsin Mental Health and Substance Abuse Needs Assessment Update, https://www.dhs.wisconsin.gov/publications/p00613-16.pdf.

[4] University of Wisconsin School of Public Affairs, Opioid Addiction Treatment in Wisconsin: An Assessment of Need and Options for Expanding Access, Spring 2015, https://www.lafollette.wisc.edu/images/publications/workshops/2015-opioids.pdf.

[5] Richard P. Mattick et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," Cochrane Database of Systematic Reviews 3 (2009): CD002209, http://www.ncbi.nlm.nih.gov/pubmed/19588333; Sandra D. Comer et al., "Injectable, Sustained-Release Naltrexone for the Treatment of Opioid Dependence: A Randomized, Placebo-Controlled Trial," JAMA Psychiatry 63, no. 2 (2006): 210–8, http://archpsyc.jamanetwork.com/article.aspx?articleid=209312; Paul J. Fudala et al.,

"Office-Based Treatment of Opiate Addiction With a Sublingual-Tablet Formulation of Buprenorphine and Naloxone," New England Journal of Medicine 349, no. 10 (2003): 949–58, http://www.ncbi.nlm.nih.gov/pubmed/12954743. Robert P. Schwartz et al., "Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009," American Journal of Public Health 103, no. 5 (2013): 917–22, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670653.

[6] American Society of Addiction Medicine, National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Available at https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf (accessed November 28, 2017).

[7] U.S. Department of Health and Human Services, Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Available at https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf (accessed November 28, 2017).

[8] National Academies of Sciences, Engineering, and Medicine, Pain management and the opioid epidemic: Balancing societal and individual benefits and risks of prescription opioid use. National Academies Press (2017), doi: 10.17226/24781.

[9] American Society of Addiction Medicine. National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, 2015. Available at https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf (accessed November 28, 2017.

[10] Substance Abuse and Mental Health Services Administration, "Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health," accessed December 1, 2017, https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR2-2016/NSDUH-DR-FFR2-2016.pdf.

[11] Ibid.

[12] 2017 Wisconsin Act 28, https://docs.legis.wisconsin.gov/2017/related/acts/28

[13] Wisconsin Executive Order 274, https://walker.wi.gov/sites/default/files/executive-orders/Executive_Order_274_0.pdf

[14] Korthuis PT, McCarty D, Weimer M, Bougatsos C, Blazina I, Zakher B, et al. Primary Care–Based Models for the Treatment of Opioid Use Disorder: A Scoping Review. Ann Intern Med. 2017;166:268–278. doi: 10.7326/M16-2149

[15] Vermont Senate Health and Welfare Committee Workgroup Report, April 2014. Available at http://legislature.vermont.gov/assets/Documents/2014/WorkGroups/Senate%20Health%20and%20Welfare/Substance%20Abuse%20Treatment/W~Beth%20Tanzman~Vermont%20Health%20Homes%20for%20Opioid%20Addiction%C2%A6%20Hub%20and%20Spoke~4-23-2014.pdf (accessed November 28, 2017).

[16]Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, Certification Standards for Centers of Excellence, June 23, 2016, http://www.bhddh.ri.gov/quick_links/pdf/COE%20cert.%20standards_Final.pdf?.

[17] Katherine Neuhausen, "Update on Virginia Medicaid Addiction and Recovery Treatment Services (ARTS) Program," August 30, 2017 PowerPoint Presentation, http://www.dmas.virginia.gov/Content_atchs/bh/Medicaid%20Addiction%20and%20Recovery%20Treatment%20Services%20Update%20-%20August%202017.pdf.

[18] Virginia Commonwealth University School of Medicine, "Addiction and Recovery Treatment Services: Access, Utilization, and Spending for the Perioid of April 1 – August 31, 2017," December 2017, https://hbp.vcu.edu/media/hbp/policybriefs/pdfs/VCUARTS5monthreport.1.04.18.pdf.

[19] Centers for Disease Control and Prevention, Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide, https://www.cdc.gov/eval/guide/introduction/index.htm.

[20] Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev*. 2014; (2): CD002207.

[21] Bart, G. (2012). Maintenance Medication for Opiate Addiction: The Foundation of Recovery. *Journal of Addictive Diseases*, *31*(3), 207–225. http://doi.org/10.1080/10550887.2012.694598

[22] The American College of Obstetricians and Gynecologists, "Opioid Use and Opioid Use Disorder in Pregnancy," (August 2017), ACOG Committee Opinion, https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy.
[23] Wisconsin Department of Health Services, 2016 Calendar Year Report on Opioid Treatment Programs in Wisconsin, April 2018, https://www.dhs.wisconsin.gov/publications/p02115-16.pdf.
[24] Lisa Clemans-Cope, Jane B Wishner, Eva H Allen, Nicole Lallemand, Marni Epstein, Brenda C Spillman. "Experiences of three states implementing the Medicaid health home model to address opioid use disorder: case studies in Maryland, Rhode Island, and Vermont." *Journal of Substance Abuse Treatment*. October 2017.
[25] The Hilltop Institute. "2016 Health Home Evaluation Report." June 2017. Univ. of Maryland Baltimore County.
[26] Department of Health Services, Statement of Scope 044-18, https://docs.legis.wisconsin.gov/code/register/2018/749A1/register/ss/ss_044_18/ss_044_18
[27] Wisconsin Administrative Code, DHS 75.15 (9)(a), https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/75/15
[28] National Institute on Drug Abuse (NIDA), Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) (January 2018), accessed May 23, 2018, https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/675-principles-of-drug-addiction-treatment-a-research-based-guide-third-edition.pdf.
[29] Ibid.
[30] Ibid.
[31] Laudet A. B., White W. What are your priorities right now? Identifying service needs across recovery stages to inform service development. J Subst Abuse Treat 2010; 38: 51–9.
[32] Criss, L., Molloy, P., Polin, S. G., Post, R., & Sheridan, D. M. (2018, April 27). Building Recovery: State Policy Guide for Supporting Recovery Housing (Rep.). Retrieved May 6, 2018, from The National Council website: https://www.thenationalcouncil.org/wp-content/uploads/2018/04/18_Recovery-Housing-Toolkit_5.3.2018.pdf
[33]Jason, L. A., Davis, M. I., & Ferrari, J. R. (2007). The need for substance abuse after-care: Longitudinal analysis of Oxford House. Addictive Behaviors, 32(4), 803–818.
[34] Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. American Journal of Public Health, 96(10), 1727–1729.
[35] Anthony T. Lo Sasso, Erik Byro, Leonard A. Jason, Joseph R. Ferrari, Bradley Olson. Benefits and costs associated with mutual-help community-based recovery homes: The Oxford House model, Evaluation and Program Planning, Volume 35, Issue 1, 2012, 47-53, http://www.sciencedirect.com/science/article/pii/S014971891100067X
[36] Knopf, A. (2016). For methadone, buprenorphine patients, sober housing may be hard to find. Alcoholism & Drug Abuse Weekly, 28(9), 1-3. doi:10.1002/adaw.30486
[37] Iritani, K. M. (2018, March 22). Information on Recovery Housing Prevalence, Selected States' Oversight, and Funding. Retrieved May 3, 2018, from United States Government Accountability Office website: https://www.gao.gov/products/GAO-18-315
[38] Rayasam, R. (2018, May 3). Texas pushes sober recovery homes to embrace opioid treatment. Politico. Retrieved May 4, 2018, from https://subscriber.politicopro.com/health-care/article/2018/05/texas-pushes-sober-recovery-homes-to-embrace-opioid-treatment-516299.
[39] Criss, L., Molloy, P., Polin, S. G., Post, R., & Sheridan, D. M. (2018, April 27). Building Recovery: State Policy Guide for Supporting Recovery Housing (Rep.). Retrieved May 6, 2018, from The National Council website: https://www.thenationalcouncil.org/wp-content/uploads/2018/04/18_Recovery-Housing-Toolkit_5.3.2018.pdf
[40] Ibid.
[41] Wisconsin Executive Order 214, https://walker.wi.gov/sites/default/files/executive-orders/EO_2016_214.pdf.
[42] Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/ data/.
[43] Substance Abuse and Mental Health Services Administration About co-occurring disorders. 2015 Feb 11; Retrieved from http://media.samhsa.gov/co-occurring/
[44] Center for Substance Abuse Treatment. Substance abuse treatment for persons with co-occurring disorders. Substance Abuse and Mental Health Services Administration; Rockville, MD: 2005.

[45] Ann Priester, Mary et al. "Treatment Access Barriers and Disparities Among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review." *Journal of substance abuse treatment* 61 (2016): 47–59. *PMC*. Web. 3 May 2018.
[46] Drake RE, Mueser KT, Brunette MF, McHugo GJ. A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. Psychiatric Rehabilitation Journal. 2004;27(4):360.
[47] Kola LA, Kruszynski R. Adapting the Integrated Dual-Disorder Treatment Model for Addiction Services. Alcoholism Treatment Quarterly. 2010;28(4):437–450.
[48] Minkoff K. Best practices: Developing standards of care for individuals with cooccurring psychiatric and substance use disorders. Psychiatric Services. 2014;52(5):597–599.
[49] Padwa H, Guerrero EG, Braslow JT, Fenwick KM. Barriers to Serving Clients With Co-occurring Disorders in a Transformed Mental Health System. *Psychiatric services (Washington, DC)*. 2015;66(5):547-550. doi:10.1176/appi.ps.201400190.
[50] Dr. Anne Schuchat, Combating the Opioid Crisis: Prevention and Public Health Solutions, Testimony to the House Energy and Commerce Subcommitte on Health, March 21, 2018, https://www.cdc.gov/washington/testimony/2018/t20180321.html
[51] Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017. MMWR Morb Mortal Wkly Rep 2018;67:279–285. DOI: http://dx.doi.org/10.15585/mmwr.mm6709e1
[52] Kathryn Casteel, There is More Than One Opioid Crisis, January 17, 2018, https://fivethirtyeight.com/features/there-is-more-than-one-opioid-crisis/
[53] Department of Health Services, Division of Public Health, State Vital Records Office, "Wisconsin Coroners and Medical Examiners," February 2017, http://wcmea.com/wp-content/uploads/2018/01/LgMap-Rev2017.pdf.
[54] Wis. Stat. Ann. § 979.02
[55] Centers for Disease Control and Prevention, Coroner/Medical Examiner Laws, https://www.cdc.gov/phlp/publications/coroner/wisconsin.html.
[56] Centers for Disease Control and Prevention, Death Investigation Systems, https://www.cdc.gov/phlp/publications/coroner/death.html.
[57] Institute of Medicine (US) Committee for the Workshop on the Medicolegal Death Investigation System. Medicolegal Death Investigation System: Workshop Summary. Washington (DC): National Academies Press (US); 2003. 6, COMPARING MEDICAL EXAMINER AND CORONER SYSTEMS. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221913/
[58] The Pew Charitable Trusts, Opioid Overdoses Swamp Medical Examiners, Stateline, July 6 2017, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/07/06/opioid-overdose-deaths-swamp-medical-examiners.
[59] National Association of Medical Examiners, Forensic Autopsy Performance Standards, 2016, https://name.memberclicks.net/assets/docs/684b2442-ae68-4e64-9ecc-015f8d0f849e.pdf.
[60] Wisconsin Department of Health Services Chapter 75.01(1)(a), https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/75.
[61] Sharon et al, Predictive Validity of the ASAM Patient Placement Criteria for Hospital Utilization. Journal of Addictive Disease 22(supplement 1):79-93, https://www.ncbi.nlm.nih.gov/pubmed/15991591
[62] Stallvik M, Gastfriend DR. Predictive and Convergent Validity of the ASAM Criteria Software in Norway. Addiction Research & Theory 2014, 22(6):515-523, doi:10.3109/16066359.2014.910512.
[63] Gastfriend, Addiction Treatment Matching, Haworth Press, Binghampton NY 2004.
[64] http://adaiclearinghouse.org/downloads/TIP-13-Role-and-Current-Status-of-Patient-Placement-Criteria-in-the-Treatment-of-Substance-Abuse-Disorders-75.pdf
[65] Centers for Medicare and Medicaid Services, SMD # 17-003 RE: Strategies to Address the Opioid Epidemic, November 2017, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.
[66] Vermont Global Commitment to Health, Section 1115(a) Demonstration Amendment Request to CMS, Submitted January, 29, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-pa2.pdf.

[67] Virginia Administrative Code, 12VAC30-130-5040. Covered Services: Requirements; Limits; Standards. https://law.lis.virginia.gov/admincode/title12/agency30/chapter130/section5040/.
[68] Agency for Healthcare Research and Quality, "Statistical Brief #219: Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009-2014," accessed April 6, 2017, https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf
[69] Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017. MMWR Morb Mortal Wkly Rep 2018;67:279–285. DOI: http://dx.doi.org/10.15585/mmwr.mm6709e1
[70] https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm
[71] https://www.ncbi.nlm.nih.gov/pubmed/25919527
[72] Addiction Policy Forum, National Criminal Justice Association, Center for Health & Justice at TASC, and Faces & Voices of Recovery, "Innovation Spotlight: AnchorED Rhode Island," accessed February 8, 2017, http://docs.wixstatic.com/ugd/bfe1ed_738334c420ec4258a2d8f10d1b481339.pdf.
[73] Suzanne Borys, "Opioid Overdose Recovery Program (OORP) in New Jersey." PowerPoint Presentation, Division of Mental Health and Addiction Services Quarterly Provider Meeting, Trenton, July 14, 2016; Donald Hallcom, New Jersey Department of Health, Division of Mental Health and Addiction Services, pers. comm., December 2017.
[74] State of New Jersey Department of Human Services Division of Mental Health and Addiction Services, "Request for Proposals: Opioid Overdose Recovery Program, accessed February 28, 2018, http://www.state.nj.us/humanservices/providers/grants/nofa/NOFAfiles/OORP%20Atlantic%20Passaic%20RFP%20100915.pdf.
[75] 2017 Wisconsin Act 26 (2017 Special Session Assembly Bill 7), https://docs.legis.wisconsin.gov/2017/related/acts/26
[76] 2017 Wisconsin Act 28 (2017 Special Session Assembly Bill 9), https://docs.legis.wisconsin.gov/2017/related/acts/28.
[77] 2017 Wisconsin Act 262 (2017-18 Assembly Bill 907), https://docs.legis.wisconsin.gov/2017/related/acts/262.
[78] Eliza Hutchinson et al, "Barriers to Primary Care Physicians Prescribing Buprenorphine," *Annals of Family Medicine* 12(2014): 128-133, doi:10.1370/afm.1595.
[79] ForwardHealth, December 2017 Update, No. 2017-41, https://www.forwardhealth.wi.gov/kw/pdf/2017-41.pdf
[80] 2017 Wisconsin Mental Health and Substance Use Needs Assessment, June 7, 2017 Draft
[81] 2017 Report on the Workforce for the Treatment of Substance Use Disorders in Wisconsin.
[82] University of Michigan Behavioral Health Workforce Research Center, Scope of Practice Alignment with Job Tasks for Paraprofessionals and Addiction Counselors, March 2017, http://www.behavioralhealthworkforce.org/wp-content/uploads/2017/05/FA3P3_SOP-Parapro_Addiction-Couns_Full-Report_v2.pdf.
[83] Center for Substance Abuse Treatment. *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*. Technical Assistance Publication (TAP) Series 21. HHS Publication No. (SMA) 15-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.
[84] Department of Safety and Professional Services, Chapter 7, https://docs.legis.wisconsin.gov/code/admin_code/sps/professional_services/001/7.pdf.
[85] The American Psychiatric Publishing Textbook of Substance Abuse Treatment, Chapter 46. Substance Use Disorders Among Physicians, https://doi.org/10.1176/appi.books.9781615370030.mg46.
[86] Robert DuPont et al, "How are addicted physicians treated? A national survey of physician health programs," Journal of Substance Abuse Treatment, 37 (2009) 1-7, doi:10.1016/j.jsat.2009.03.010.
[87] Federation of State Physician Health Programs, Physician Health Program Guidelines, 2005, https://www.fsphp.org/sites/default/files/pdfs/2005_fsphp_guidelines-master_0.pdf.
[88] For instance, under SPS 7.05(3) states that "the board or board liaison may include a promise of confidentiality that all or certain records shall remain closed and not available for public inspection and copying. Any promise is subject to SPS 7.08 and ends upon a referral to the division. Information and records may be available to staff within the department on as as-needed basis, to be determined by the coordinator."

[89] American Medical Association, Physician Health Programs Act Model Legislation, December 14, 2016, https://www.fsphp.org/sites/default/files/pdfs/ama_physicians_health_programs_act_-_2016.pdf.
[90] Binswanger, Ingrid A. et al. "Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009." *Annals of internal medicine* 159.9 (2013): 592–600. *PMC*. Web. 3 May 2018.
[91] 2015 Wisconsin Act 338 (2015-16 Assembly Bill 657), http://docs.legis.wisconsin.gov/2015/related/acts/388.pdf.
[92] 2017 Wisconsin Act 32 (2017 Special Session Assembly Bill), https://docs.legis.wisconsin.gov/2017/related/acts/32.
[93] 2017 Wisconsin Act 261 (2017-18 Assembly Bill 906), https://docs.legis.wisconsin.gov/2017/related/acts/261.
[94] Wisconsin Executive Order #273, Relating to the Implementation of the Recommendations of the Co-Chairs of the Governor's Task Force on Opioid Abuse, January 19, 2018, https://walker.wi.gov/sites/default/files/executive-orders/Executive_Order_273_0.pdf.
[95] Michael Gordon, Timothy Kinlock, and Patrice Miller, "Medication-assisted treatment research with criminal justice populations: challenges of implementation," Behavioral sciences & the law 29.6:829-845, doi: 10.1002/bsl.1015.
[96] https://doc.wi.gov/DataResearch/DataAndReports/DrugOffenderPrisonAdmissions2000to2016.pdf
[97] Wisconsin Department of Corrections, Opioid Addiction Treatment Pilot Program, https://doc.wi.gov/Documents/AboutDOC/PressReleases/170912VivitrolPilotFactSheet.pdf
[98] 2017 Wisconsin Act 261, https://docs.legis.wisconsin.gov/2017/related/acts/261
[99] Wisconsin Department of Corrections, Opioid Addiction Treatment Pilot Program, https://doc.wi.gov/Documents/AboutDOC/PressReleases/170912VivitrolPilotFactSheet.pdf
[100] National Center on Addiction & Substance Abuse, Columbia University, "Behind Bars II: Substance Abuse and America's Prison Population," accessed March 9, 2017, http://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america%E2%80%99s-prison-population.
[101] Verner Westerberg et al., "Community-Based Methadone Maintenance in a Large Detention Center is Associated with Decreases in Inmate Recidivism," Journal of Substance Abuse Treatment, https://doi.org/10.1016/j.jsat.2016.07.007.
[102] The Pew Charitable Trusts, Prison Health Care: Costs and Quality, October 2017, http://www.pewtrusts.org/~/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf.
[103] Bureau of Justice Statistics, "Jail Inmates in 2015," accessed March 12, 2017, https://www.bjs.gov/content/pub/pdf/ji15.pdf.
[104] Traci Green et al. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. JAMA Psychiatry.2018;75(4):405-407. doi:10.1001/jamapsychiatry.2017.4614
[105]https://doc.wi.gov/Documents/DataResearch/DataAndReports/DrugOffenderPrisonAdmissions2000to2016.pdf
[106] Binswanger, Ingrid A. et al. "Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009." *Annals of internal medicine* 159.9 (2013): 592–600. *PMC*. Web. 3 May 2018.
[107] Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, *The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities* (April 2016). Available at https://aspe.hhs.gov/system/files/pdf/201476/MedicaidJustice.pdf (accessed November 28, 2017).
[108] Wisconsin Department of Health Services, Medicaid Eligibility Handbook. Available at www.emhandbooks.wisconsin.gov/meh-ebd/ (accessed November 28, 2017).
[109] Perry A.E., Neilson M., Martyn-St James M., Glanville J.M., McCool R., Duffy S., Godfrey C., Hewitt C. "Pharmacological interventions for drug-using offenders". Cochrane Database Systematic Review. (2015):19(12). doi: 10.1002/14651858.CD010862.
[110] Catherine McKee et al., "State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration," Kaiser Family Foundation, August 2015, http://files.kff.org/attachment/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration; The Pew Charitable Trusts, Prison Health Care: Costs and Quality, How and why states strive for high-performing systems. Available at

http://www.pewtrusts.org/~/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf (accessed November 28, 2017).

[111] Cara Angelotta et al., "A Moral or Medical Problem? The Relationship between Legal Penalties and Treatment Practices for Opioid Use Disorders in Pregnant Women." *Women's Health Issues*, *26*(6), 595-601, doi: https://doi.org/10.1016/j.whi.2016.09.002.

[112] 1997 Wisconsin Act 292, https://docs.legis.wisconsin.gov/1997/related/acts/292

[113] Leipold AJ, Regulatory Compliance Attorney, WPS Health Solutions. Legal Aspects of Substance Misuse During Pregnancy. Presentation at the Wisconsin Society of Addiction Medicine Annul Conference, September 2016. Available at http://www.fammed.wisc.edu/files/webfm-uploads/documents/outreach/wisam/2016/Leipold_Legal%20Aspects%20of%20Substance%20Misuse%20During%20in%20WI%20FINAL.pdf (accessed October 19, 2017).

[114] The American Congress of Obstetricians and Gynecologists, Toolkit on State Legislation. Pregnant Women & Prescription Drug Abuse, Dependence and Addiction. Available at https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf (accessed October 19, 2017).

[115] Substance Abuse and Mental Health Services Administration, A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorder: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers, https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf.

[116] ACOG. Improving Treatment for Pregnant and Postpartum Women Act. Available at https://www.acog.org/About_ACOG/ACOG_Departments/Government_Relations_and_Outreach/~/media/Departments/Government%20Relations%20and%20Outreach/2016CLCReqReading.pdf (accessed November 12, 2017).

[117] Mishka Terplan, Care in Context: Treating the whole mother from preconception to postpartum, Premie Parent Alliance Summit 2016, http://www.ppasummit.com/wp-content/uploads/2016/11/Care_in_Context-Treating_the_Whole_Mother_from_Preconception_to_Postpartum.pdf.

[118] American College of Obstreticians and Gynecologists, ACOG Committee Opinion Number 736 (May 2018), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care

[119] Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e140–50.

[120] Anna Parlier et al., "Prenatal Care, Pregnancy Outcomes, and Postpartum Birth Control Plans Among Pregnant Women with Opiate Addictions," Southern Medical Journal, 107:11 (November 2014), DOI: 10.14423/SMJ.0000000000000189

[121] Mishka Terplan, Care in Context: Treating the whole mother from preconception to postpartum, Premie Parent Alliance Summit 2016, http://www.ppasummit.com/wp-content/uploads/2016/11/Care_in_Context-Treating_the_Whole_Mother_from_Preconception_to_Postpartum.pdf.

[122] Jill Filene et al. "Components Associated with Home Visiting Program Outcomes: A Meta-Analysis." *Pediatrics* 132.0 2 (2013): S100–S109, doi: 10.1542/peds.2013-1021H

[123] Ann Budzak-Garza et al., GunderKids: Design of a Clinical Care Management Program for Parents with Substance Abuse and Their Newborn Children with a Focus on Preventing Child Abuse, Wisconsin Medical Journal, https://www.wisconsinmedicalsociety.org/_WMS/publications/wmj/pdf/117/1/29.pdf.

[124] Substance Abuse and Mental Health Services Administration. Substance-Exposed Infants: State Responses to the Problem. Available at https://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf (accessed November 25, 2017).

[125] Atwell, Karina A et al. "Neonatal Abstinence Syndrome and Maternal Substance Use in Wisconsin, 2009-2014." *WMJ : official publication of the State Medical Society of Wisconsin* 115 6 (2016): 287-94.

[126] Eric Hall et al., "A Multicenter Cohort Study of Treatments and Hospital Outcomes in Neonatal Abstinence Syndrome," *Pediatrics* 134 (2014): 527-534, doi: https://dx.doi.org/10.1542%2Fpeds.2013-4036

[127] Patrick SW, Schumacher RE, Horbar JD, et al. Improving Care for Neonatal Abstinence Syndrome. Pediatrics. 2016;137(5):e20153835

[128] Government Accountability Office, Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome, October 2017, https://www.gao.gov/assets/690/687580.pdf.

1. Discontinuing Opioid Therapy

    a. If a lack of efficacy for opioid therapy is determined, ie opioids do not (or no longer) provide at least 30% improvement in symptoms and function, or for mild recurrent evidence of inappropriate use, discontinuation of therapy should be performed.

        i. Opioid weaning can be performed by reducing the MED by 10% weekly until 5-10 mg MED remain at which time the opioid can be fully discontinued.\

        ii. Prescription of clonidine 0.2 mg po BID or tizanidine 4 mg po 1tabs TID can be provided to patients complaining of opioid withdrawal related symptoms.

        iii. If the patient is non-compliant with the weaning protocol, termination of opioids should be performed and the patient treated for withdrawal if present.

        iv. If the patient has not been diagnosed with opioid use disorder and has no other contraindication, tramadol 50 mg 2 tabs qid can be considered as an alternative withdrawal treatment, with the dose reduced by one pill every other day.

    b. If opioids appear to represent an imminent risk to the patient (overdose requiring medical attention, severe overtaking, pill tampering, unprescribed opioids on urine drug screen, etc.), discontinuation of opioids should be performed immediately and the patient treated for withdrawal if needed.

        i. Severe withdrawal may require doses of clonidine 0.2 mg po up to q 4 hrs (if BP > 90 systolic and pulse > 50 before each dose) or tizanidine 2 mg 1-2 tabs po TID.

    c. Exceptions to abrupt opioid discontinuation include patients with unstable cardiovascular disease and pregnant patients, especially in the third trimester. These patients should be admitted to the hospital and weaned under observation and monitoring.

    d. If the patient is determined to have opioid use disorder, assistance if obtaining medication-assisted treatment (MAT) should be provided (see Guideline #21).

    e. The practice of giving a patient a one-month prescription for their opioid and discharging them from the practice is usually not appropriate. It can be difficult to find another prescriber by the time the prescription runs out. If patients then go through withdrawal without treatment, the risk that they will turn to illicit opioids is high, which may lead to illicit heroin or fentanyl use, causing imminent danger. If opioids are determined to be inappropriate for a patient- either weaning, discontinuation with treatment for withdrawal, or referral to MAT should be provided.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:	2) Date When Request Submitted:
Tim Westlake, Vice Chair	11/2/2018
	Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others

3) Name of Board, Committee, Council, Sections:

Wisconsin Medical Examining Board

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
11/14/2018	x Yes ☐ No	Wisconsin Medical Examining Board Opioid Prescribing Guideline – Review for Possible Amendments

7) Place Item in:	8) Is an appearance before the Board being scheduled? If yes, who is appearing?	9) Name of Case Advisor(s), if required:
x Open Session ☐ Closed Session ☐ Both	No	

10) Describe the issue and action that should be addressed:

Dr. Westlake would like to discuss 2 items related to the Wisconsin Medical Examining Board Opioid Prescribing Guideline:

1) The PEW Charitable Trusts Final Report, "Substance Use Disorder Treatment Policy Recommendations for the State of Wisconsin – July 2018." The PEW recommendation is to "Improve treatment outcomes for babies with Neonatal Abstinence Syndrome (NAS) by integrating best practices into state treatment guidelines and clinical curricula." See recommendation No. 18, on page 42 of the report, which is included by attachment and can also be located online: http://legis.wisconsin.gov/assembly/hope/media/1161/wisconsin-final-report-final.pdf

2) Clarify Wisconsin Responsible Opioid Prescribing Guideline, No. 22 (discontinuing opioid therapy). A suggested draft change is included by separate attachment.

See also, Recommendation Nos. 6, 7, 8, 11. 12, 13, 16, 17

The Wisconsin MEB Opioid Prescribing Guideline can be located here: https://dsps.wi.gov/Documents/BoardCouncils/MED/20180321MEBGuidelinesv8.pdf

11) Authorization

Signature of person making this request	Date
Supervisor (if required)	Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)	Date

National Practitioner Data Bank Reporting

Michael Dugan, CIO/SVP Operations

NPDB Timeline

- 1986 – Health Care Quality Improvement Act
- 1990 – NPDB opens
- 1992 – Electronic Query implemented
- 1996 – Health Insurance Portability and Accountability Act
- 1999 – HIPDB opens
- 2001 – Self Query implemented
- 2010 – NPDB expands/implements Section 1921
- 2011 – Continuous Query implemented
- 2013 – NPDB and HIPDB merge

NATIONAL PRACTITIONER DATA BANK
NPDB

National Practitioner Data Bank:

A Valuable Health Workforce Tool

VAMSS 2018 Annual Education Conference
October 12, 2018

Division of Practitioner Data Bank
Bureau of Health Workforce (BHW)
Health Resources and Services Administration (HRSA)

HRSA Health Workforce

Purpose

Mission: ***To improve health care quality, protect the public, and reduce health care fraud and abuse in the United States.***

- The National Practitioner Data Bank (NPDB) is a health workforce tool, created by Congress, to assist organizations in making well-informed credentialing, privileging, and licensing decisions.

- Contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers, and suppliers.

NATIONAL PRACTITIONER DATA BANK
NPDB

NPDB Statistics

(as of June 2018)

1.4 million REPORTS
in the NPDB

75+ thousand NEW REPORTS
submitted last year

7 million QUERIES
last year

24 thousand ORGANIZATIONS
represented in NPDB Reports

680 thousand PRACTITIONERS
represented in NPDB Reports

HRSA
Health Workforce

General Provisions

Types of Information Collected

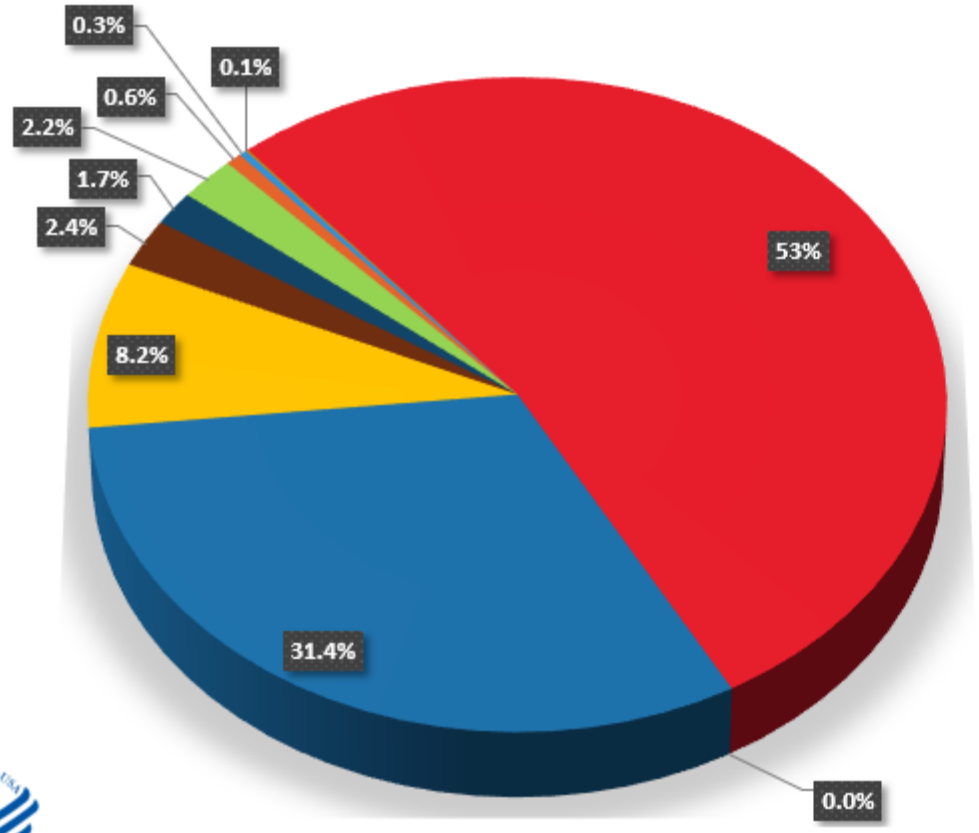
- Medical malpractice judgments and settlements
- Adverse licensing and certification actions
- Clinical privileges actions
- Health plan contract terminations
- Professional society membership actions
- Negative actions/findings from private accreditation organizations and peer review organizations
- Government administrative actions, e.g., exclusions from programs
- Civil and criminal health care-related judgments

NATIONAL PRACTITIONER DATA BANK
NPDB

NPDB Statistics

Reports in the NPDB

NPDB Individual Reports by Type (N=1,406,727)
9/1/1990-12/31/2017

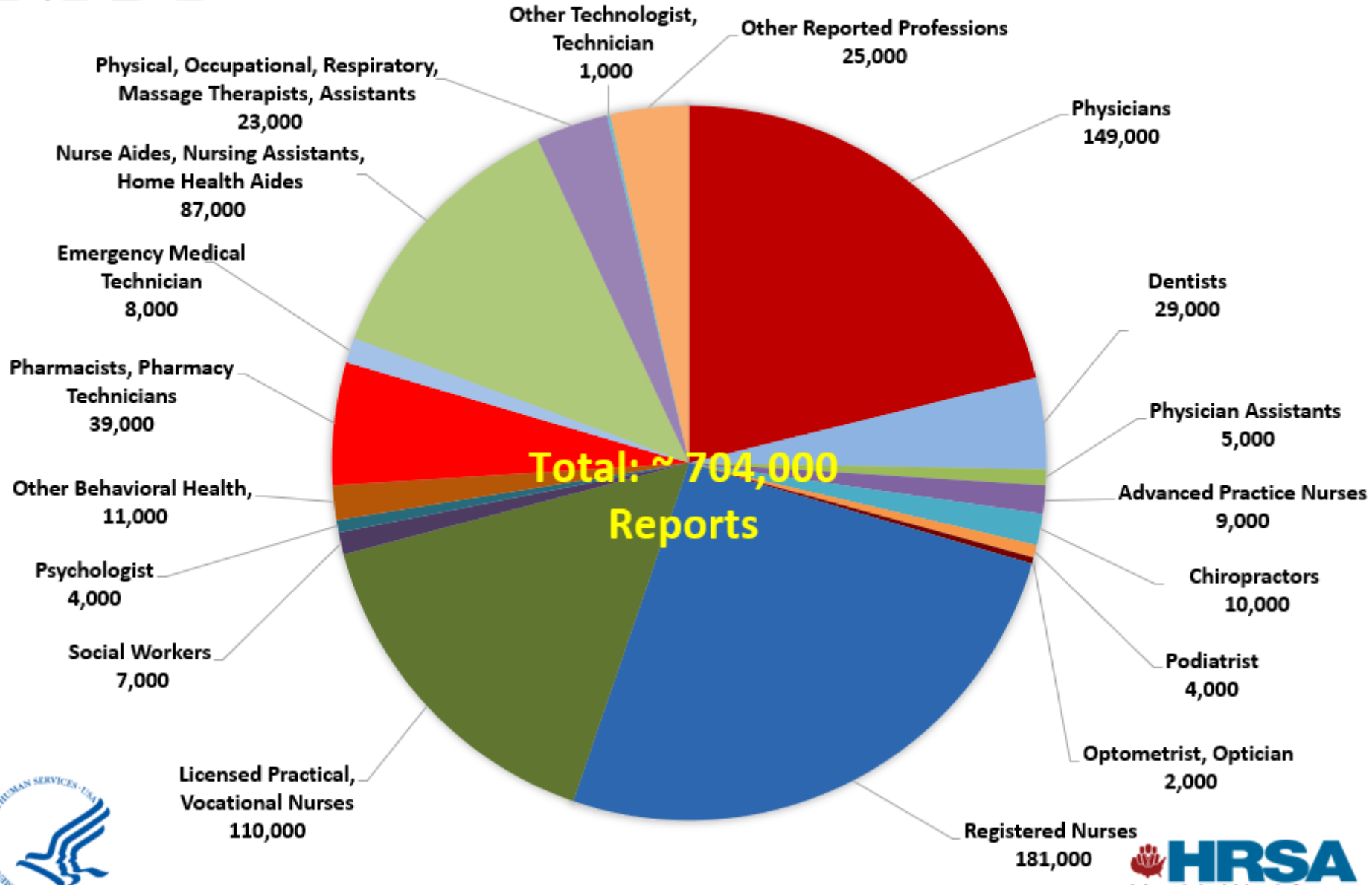


- State Licensure: 53%, N=746,124
- Accreditation: 0.0025%, N=35
- Medical Malpractice Payment: 31.4%, N=442,285
- Exclusion/Debarment Action: 8.2%, N=115,525
- Judgment or Conviction: 2.4%, N=33,551
- Clinical Privileges: 1.7%, N=23,931
- Government Admin: 2.2%, N=30,917
- Health Plan: 0.6%, N=8,837
- DEA/Federal Licensure: 0.3%, N=4,099
- Professional Society: 0.1%, N=1,423

HRSA Health Workforce

NATIONAL PRACTITIONER DATA BANK
NPDB

NUMBER OF NEW NPDB REPORTS SUBMITTED ON INDIVIDUAL SUBJECTS FROM 2010 – 2017 BY PROFESSIONS



HRSA Health Workforce

General Provisions

Recovering Costs

- By law, the NPDB must recover the full cost of operations. It does so by collecting fees for each query.

Types of Transactions

- Fees modified as of October 2016
- Reporting (no charge)
- Querying (by hospitals and health care organizations)
  - $2 for a one-year continuous query subscription
  - $2 for a one-time query
- Self-Query
  - $4

General Provisions

Confidentiality

- Information reported to the NPDB is confidential, not available to the general public, and may not be disclosed except as provided by law.
- Penalty up to $21,916 per confidentiality violation.

General Provisions

Civil Liability Protection

- Immunity provisions in Title IV of Public Law 99-660, Section 1921 and Section 1128E of the Social Security Act protect individuals, entities, and their authorized agents from being held liable in civil actions for reports made to the NPDB unless they have actual knowledge that the information in the report is false
- Health care entity professional review bodies, their members, and their agents are immune from civil liability in most cases

NATIONAL PRACTITIONER DATA BANK
NPDB

Who Reports and Queries?

ENTITY TYPE	REPORT	QUERY
Hospitals	✔	✔
Health plans	✔	✚
Other health care entities with formal peer review	✔	✚
State agencies that license and certify health care practitioners and entities, including boards of medical and dental examiners	✔	✚
State agencies administering or supervising state health care programs	✔	✚
State law enforcement or fraud enforcement agencies (including state Medicaid fraud control units and state prosecutors)	✔	✚
Federal licensing and certification agencies	✔	✚
Agencies administering federal health care programs, including private entities administering such programs under contract	✔	✚
Federal law enforcement officials and agencies (including Drug Enforcement Agency, HHS Office of Inspector General, and federal prosecutors)	✔	✚
Medical malpractice payers	✔	✘
Professional societies with formal peer review	✔	✚
Peer review organizations (excluding quality improvement organizations)	✔	✘
Private accreditation organizations	✔	✘
Quality improvement organizations	✘	✚
Individual practitioners, providers, and suppliers (self-query only)	✘	✚

✔ Required ✘ Not Authorized ✚ Optional

HRSA Health Workforce

NATIONAL PRACTITIONER DATA BANK
NPDB

Hospital Querying

Continuous Query

Purpose

- A subscription service that notifies subscribers of new information on any of their enrolled practitioners within one business day of the NPDB's receipt of the information
- Designed and developed to help meet accreditation standards that require ongoing monitoring of practitioners
- Between 2010 through 2016, health care providers have enrolled more than 2.22 million practitioners

HRSA Health Workforce

Hospital Querying

Continuous Query

Using Continuous Query

- Requires the same practitioner information
- Subscribers continue using their subject databases
- **Fee: $2.00 per enrollee per year**
- No separate query fee
- Upon enrollment, receive the same report information as a one-time query response
- Continuously queries the NPDB and notifies subscribers of any new reports
- No need to re-query for reappointments or temporary privileges extensions

NATIONAL PRACTITIONER DATA BANK
NPDB

	Board	State
1	PA STATE BOARD OF MEDICINE	PA
2	MAINE BOARD OSTEOPATHIC LICENSURE	ME
3	OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA	CA
4	WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE	WV
5	IDAHO STATE BOARD OF MEDICINE	ID
6	NV STATE BOARD OF OSTEOPATHIC MEDICINE	NV
7	OREGON MEDICAL BOARD	OR
8	HEALTH CARE PROFESSIONS LICENSING BOARD	SAIPAN, MP
9	DIVISION OF MEDICAL QUALITY ASSURANCE	FL
10	SD BOARD OF MEDICAL & OSTEOPATHIC EXAMINERS	SD
11	DEPARTMENT OF HEALTH	DC
12	WYOMING BOARD OF MEDICINE	WY

Project Background

Many boards require physicians to supply an NPDB self-query during the licensing process

This process can be slow and adds additional steps by both the physician and the board

Several boards requested that FSMB include the NPDB report in FCVS

Project Background

Development took over one year – primarily due to a variety of data scenarios and formatting

Feedback and interaction with Pilot boards was a critical success factor

Response from boards has been overwhelmingly positive

Pilot Results:

Kentucky

- Saves time and money. Physicians forget to order the NPDB, resulting in a time delay and Fedex charges to expedite the report to the board. 50% come in via Fedex.
- Allows the board to see issues early on because the NPDB report is often times received earlier in the process.
- The reports looks good and have matched what is received from the applicant

Indiana

Results are much more efficient.

Iowa

Saves 2-5 days at the end of the process. Saves staff time.

Maine

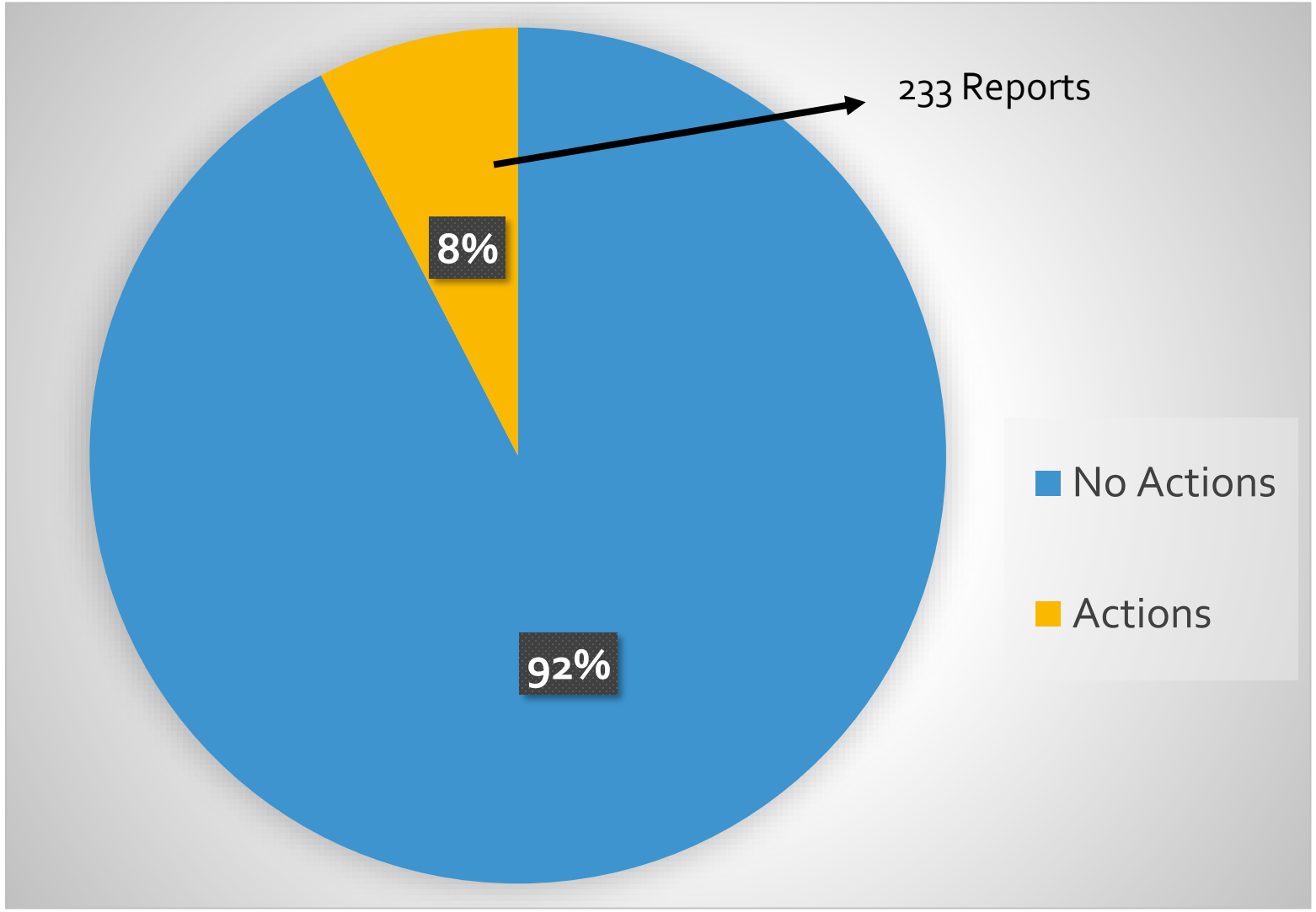
My staff is thrilled with how this is working. They are already talking about the time being saved. Thank You!!

New Boards since Pilot

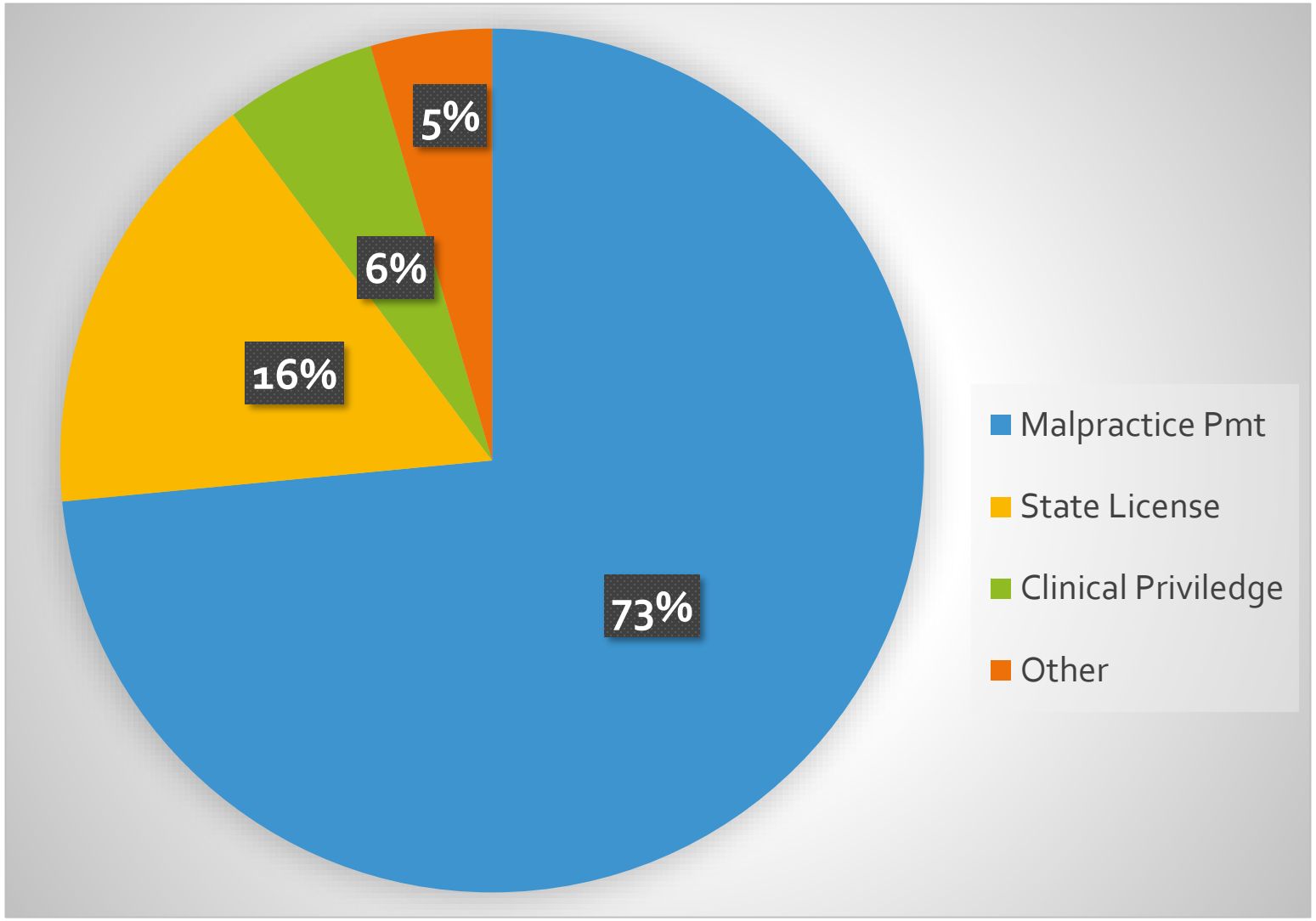
- California
- New Hampshire
- North Carolina
- Ohio

2,934
Total Reports

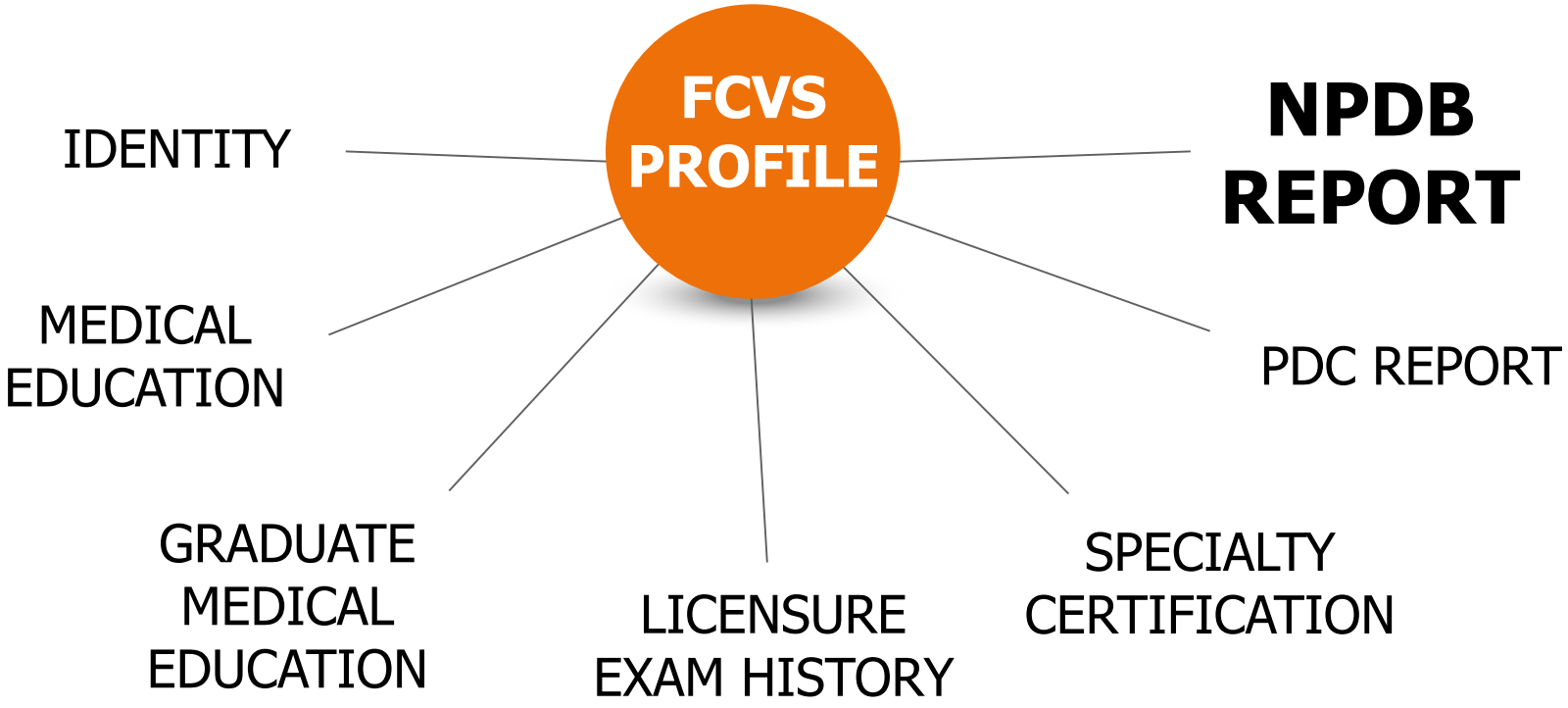
April - Present



Action Categories



FCVS Elements



Request for future modifications

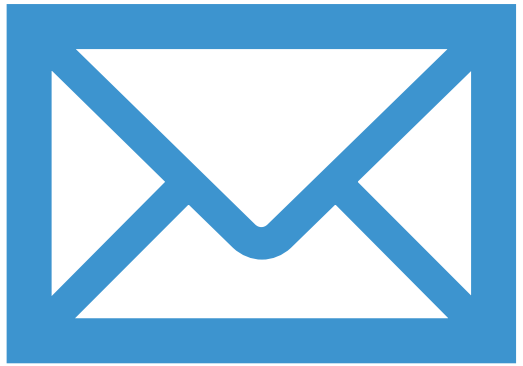
Add to PDC Report – this would require payment by the board

Build Physician 'Self Query' portal that allows physician paid report to be sent to the board

Discussion

Contact:

Mike Dugan
mdugan@fsmb.org



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STATE OF CALIFORNIA
AUTHENTICATED
ELECTRONIC LEGAL MATERIAL

Senate Bill No. 1448

CHAPTER 570

An act to add Sections 1007, 2228.1, 2228.5, 2459.4, 3663.5, and 4962 to the Business and Professions Code, relating to healing arts.

[Approved by Governor September 19, 2018. Filed with Secretary of State September 19, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1448, Hill. Healing arts licensees: probation status: disclosure.

Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. Existing law establishes the California Board of Podiatric Medicine within the Medical Board of California for the licensing, regulation, and discipline of podiatrists. Existing law, the Osteopathic Act, enacted by an initiative measure, establishes the Osteopathic Medical Board of California for the licensing and regulation of osteopathic physicians and surgeons and requires the Osteopathic Medical Board of California to enforce specified provisions of the Medical Practice Act with respect to its licensees. Existing law, the Naturopathic Doctors Act, establishes the Naturopathic Medicine Committee within the Osteopathic Medical Board of California for the licensing and regulation of naturopathic doctors. Existing law, the Chiropractic Act, enacted by an initiative measure, establishes the State Board of Chiropractic Examiners for the licensing and regulation of chiropractors. Existing law, the Acupuncture Licensure Act, establishes the Acupuncture Board for the licensing and regulation of acupuncturists. Existing law authorizes each of these regulatory entities to discipline its licensee by placing her or him on probation, as specified.

This bill, on and after July 1, 2019, would require the California Board of Podiatric Medicine, the Naturopathic Medicine Committee, the State Board of Chiropractic Examiners, and the Acupuncture Board to require a licensee to provide a separate disclosure, as specified, to a patient or a patient's guardian or health care surrogate before the patient's first visit if the licensee is on probation pursuant to a probationary order made on and after July 1, 2019. The bill, on and after July 1, 2019, would require the Medical Board of California and the Osteopathic Medical Board of California to require a licensee to provide a separate disclosure, as specified, to a patient or a patient's guardian or health care surrogate before the patient's first visit if the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, under specified circumstances. The bill would also require the California Board of Podiatric Medicine, the Naturopathic Medicine Committee, the State Board of Chiropractic Examiners, the Acupuncture Board, the Medical Board of California, and the Osteopathic Medical Board

of California to provide specified information relating to licensees on probation on the regulatory entity's online license information Internet Web site.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known, and may be cited, as the Patient's Right to Know Act of 2018.

SEC. 2. Section 1007 is added to the Business and Professions Code, to read:

1007. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) "Board" for purposes of this section means the State Board of Chiropractic Examiners.

SEC. 3. Section 2228.1 is added to the Business and Professions Code, to read:

2228.1. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

SEC. 4. Section 2228.5 is added to the Business and Professions Code, to read:

2228.5. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

(f) For purposes of this section:

(1) "Board" means the California Board of Podiatric Medicine.

(2) "Licensee" means a person licensed by the California Board of Podiatric Medicine.

SEC. 5. Section 2459.4 is added to the Business and Professions Code, to read:

2459.4. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment

that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) A violation of this section shall not be punishable as a crime.

(f) For purposes of this section:

(1) "Board" means the Osteopathic Medical Board of California.

(2) "Licensee" means a person licensed by the Osteopathic Medical Board of California.

SEC. 6. Section 3663.5 is added to the Business and Professions Code, to read:

3663.5. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the committee shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the committee, the committee's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the committee's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary

order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the committee shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the committee's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the committee, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the committee.

(e) A violation of this section shall not be punishable as a crime.

SEC. 7. Section 4962 is added to the Business and Professions Code, to read:

4962. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) A violation of this section shall not be punishable as a crime.

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