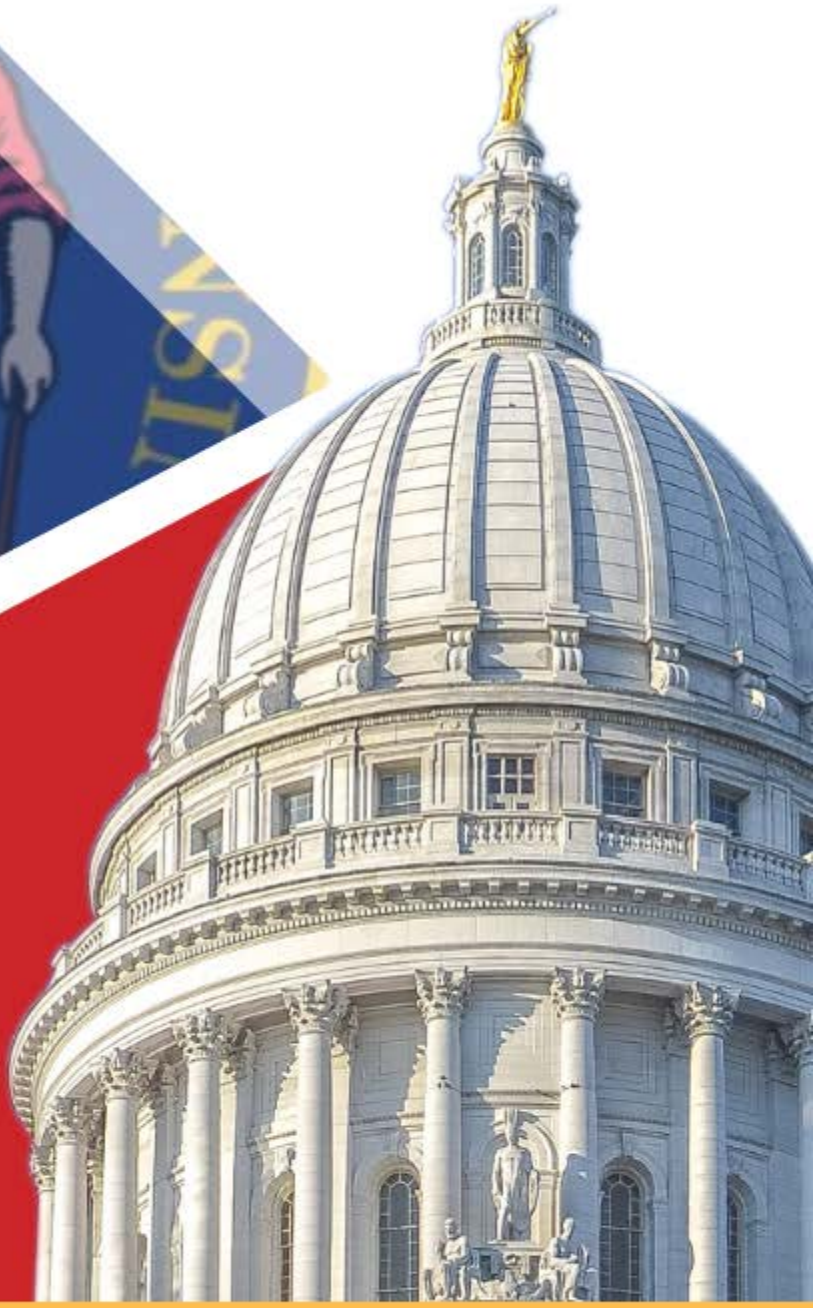
Treating Opioid Abuse



2018

A Report by the Commission on Substance Abuse Treatment Delivery

From the Task Force Co-Chairs

We are proud that Wisconsin is leading the nation in its innovative, multi-faceted approach to the opioid epidemic ravaging our communities. Our multiple rounds of HOPE legislation and agency initiatives are tackling all aspects of this problem, from supply reduction and education to treatment and recovery.

We know, though, that other states are also experimenting with unique approaches to this issue, and it is our duty as policy leaders to study what's working elsewhere. To that end, the last report from the Governor's Task Force on Opioid Abuse, which we are honored to co-chair, requested that Governor Walker empanel the Governor's Commission on Substance Abuse Treatment Delivery to study one specific concept: a hub-and-spoke model of treatment delivery.

We are grateful to Jenny Malcore, our capable assistant deputy secretary at the Department of Health Services, for chairing this commission. We appreciate the hard work of the commissioners and the many experts who testified before it. What follows is the result of thoughtful engagement, broad consultation, and rigorous analysis.

Our partners from across the opioid issue will benefit from studying this in-depth review of a hub-and-spoke model. It assigns statistics to the realities we hear from our constituents: we appreciate what you've done to expand access to care for substance abuse, but it's really far away, or there's a waiting list, or there's no specialist in my county. Given those observations, it then works towards a solution, a hub-and-spoke model that broadens access to care and improves quality through a network of providers dedicated to tackling this problem together.

We applaud the Commission for its work and we look forward to working with the commissioners, legislature, incoming administration, and civil society to implement its recommendations to provide better care for our fellow citizens who struggle with this epidemic of our times.

Forward,

Rebecca Kleefisch

Lt. Governor Rebecca Kleefisch

John Nygren

State Rep. John Nygren

Co-chairs, Governor's Task Force on Opioid Abuse

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I. Executive Summary

On January 18, 2018, Governor Scott Walker created the Commission on Substance Abuse Treatment Delivery to research hub-and-spoke delivery models for opioid treatment, recommend adoption of a hub-and-spoke model for Wisconsin, and identify key implementation considerations. This report describes the work of the Commission and its findings.

A variety of states have implemented a hub-and-spoke model for treatment of SUDs, targeted especially to provide treatment for opioid use disorder (OUD). The Commission conducted research and interviews with representatives of these states, including California, Rhode Island, Vermont, and Washington, who highlighted the initial success of these models in expanding access to evidence-based treatment for OUD and improved outcomes for patients, and outlined potential barriers and facilitators to implementation. The Vermont hub-and-spoke model was instrumental in increasing treatment capacity for OUD to the highest rate in the U.S.[1] Each model reviewed by the Commission included expanded access to MAT, improved integration of behavioral and physical health services, and improved transitions between treatment settings. However, each state's model differed in some aspects, such as the types of participating providers and funding structure. Accordingly, the Commission's report emphasizes the importance of adopting the core clinical components of the existing hub-and-spoke models within Wisconsin while tailoring other aspects of the model to best fit Wisconsin's treatment landscape.

Wisconsin benefits from numerous strengths in addressing the opioid abuse crisis, including but not limited to, a growing statewide capacity for MAT, development of innovative local models for providing recovery supports, and a robust legislative response through the Heroin, Opioid Prevention, and Education (HOPE) agenda. Some gaps in the SUD treatment system remain, including limited access to specialty SUD treatment in rural areas of the state, silos separating SUD treatment providers and other health care professionals, and inconsistent patient engagement through the entire continuum of SUD care including early identification and initiation, treatment, and long-term recovery supports. To address these gaps, the Commission proposes a clinical model for Wisconsin that details expectations for the SUD treatment system across the continuum from initiation of treatment to recovery.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5537005/

II. Commission Overview

In 2016, Governor Walker ordered the creation of a task force on opioid abuse for the purpose of advising and assisting in a coordinated effort to combat the Wisconsin opioid crisis. Per this order, the assistant deputy secretary at the Department of Health Services (DHS) filled the necessary roles for the task force, in addition to those appointed by the Governor's Office. Official responsibilities of the task force include analyzing other state's methods and devising potential action items for the state of Wisconsin. The second round of recommendations from the task force in January 2018 led to Governor Walker signing an Executive Order tasking DHS with convening the Governor's Commission on Substance Abuse Treatment Delivery to research and determine if a hub-and-spoke delivery model should be pursued for Wisconsin.

The Commission on Substance Abuse Treatment Delivery executed the process of designing the basis for, and implementation of, the hub-and-spoke model in Wisconsin. Upon review of the hub-and-spoke model utilized in other states, the Commission has henceforth designed a state-specific model for Wisconsin. After review of the timeline at hand and given feedback, the Commission decided to focus on a clinical model, having identified that as the most crucial piece. The process to create this model included weekly meetings across divisions within DHS, suggestions and information from other states, and the collection of input and feedback from an assortment of professions. Additional areas central to implementing hub-and-spoke, such as a payment model, still need to be discussed and developed if DHS is recommended to continue pursuing a hub-and-spoke model by the Governor's Office after review of the Commission's report.

Input was considered from a wide range of individuals, including the Wisconsin Hospital Association, Federally Qualified Health Centers, the Wisconsin Academy of Family Physicians, the Wisconsin Society of Addiction Medicine, a community-based substance abuse treatment provider, county health officials, and representatives from DHS Division of Medicaid Services, Division of Care and Treatment Services, and Division of Quality Assurance. In addition, various other representatives, including DHS staff, commission members, UW Health, Wisconsin Primary Health Care Association, and members from other health systems, attended meetings in order to contribute to the creation of the hub-and-spoke model.

The Commission began meeting in March 2018 to initiate discussion on how to best approach the task at hand. By June, the Commission began focusing on the general design of the hub-and-spoke system. This included conversation on what should be expected of "hubs," what should be expected of "spokes," and how care is coordinated between the two. In addition to the input from committee members, representatives from other states were brought in to offer insight on their respective models. A later June meeting looked deeper into the models in place in Washington, California, Rhode Island, and Vermont, all states currently utilizing a version of the hub-and-spoke model. More information on the models in place in other states came from The Pew Charitable Trusts.

The August 2018 internal DHS meeting addressed the geography of prescribers in conjunction with Medicaid claims data on members with OUD. This discussion encouraged additional conversation and research on necessary revisions and recommendations in regards to hub-and-spoke locations and MAT

availability. In early September, the expectations for hubs and spokes were honed through multiple meetings that examined the survey completed by UW Health, which dissects components of models in other states. This survey gathered data from those involved in hubs and spokes in other states, and the core team adjusted it by adding Wisconsin-specific recommendations, which were later presented to Commission members. On a congruent schedule, the MAT system diagram was edited and finalized to provide a clear depiction of the desired MAT process. Both the survey and the MAT system diagram were then presented during the September 2018 Commission meeting where feedback was accepted in order to finalize them.

III. Current Landscape

Opioid Misuse Trends

Statewide, opioid and heroin use is on the rise. Between 2005 and 2016, the rate of OUD more than tripled. Additionally, reviews of 2017 data indicate that opioid-related hospitalizations are common throughout the state, impacting every Wisconsin community (Figure 1). Analysis of the opioid type contributing to hospitalizations indicates an increasing role of heroin use. (Figure 2).

Figure 1

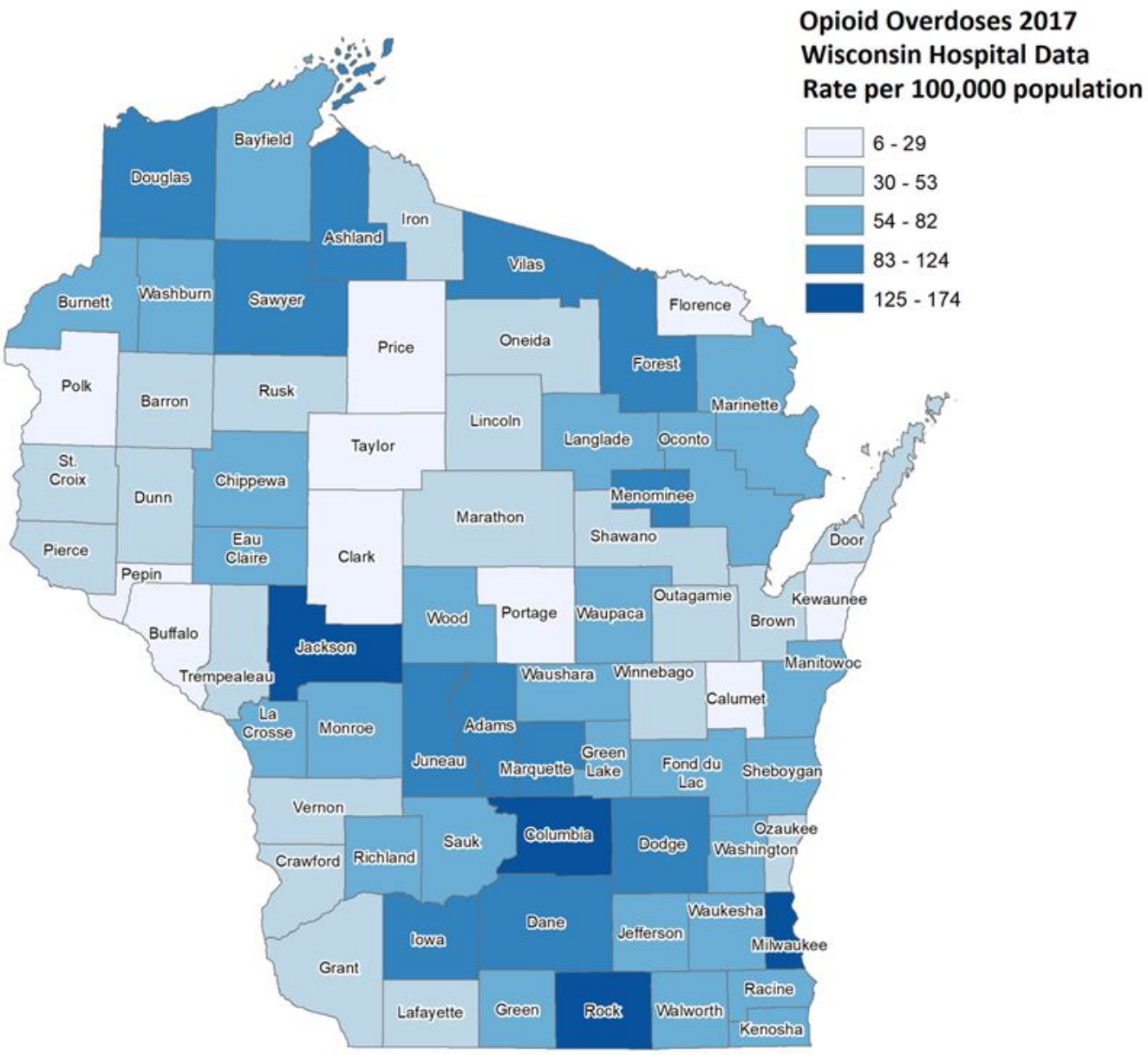
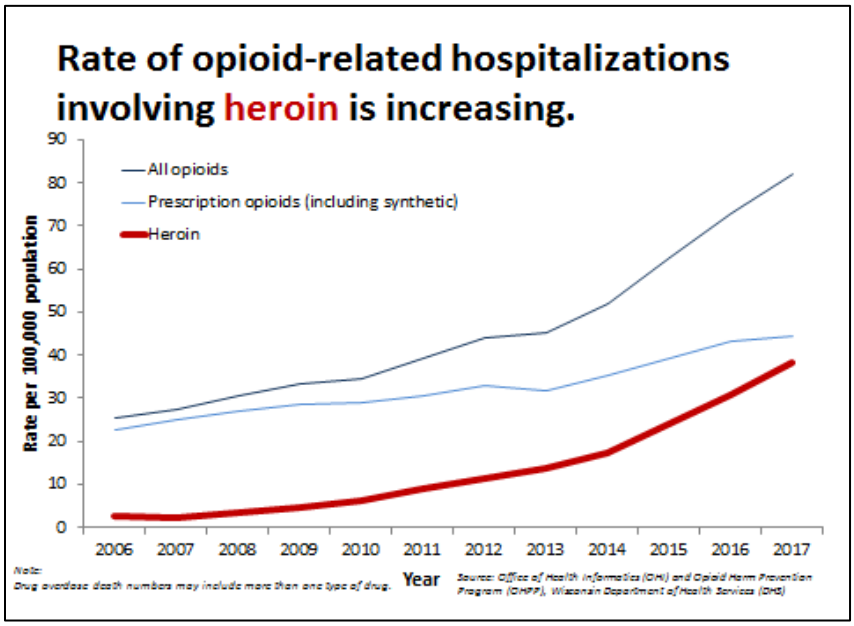
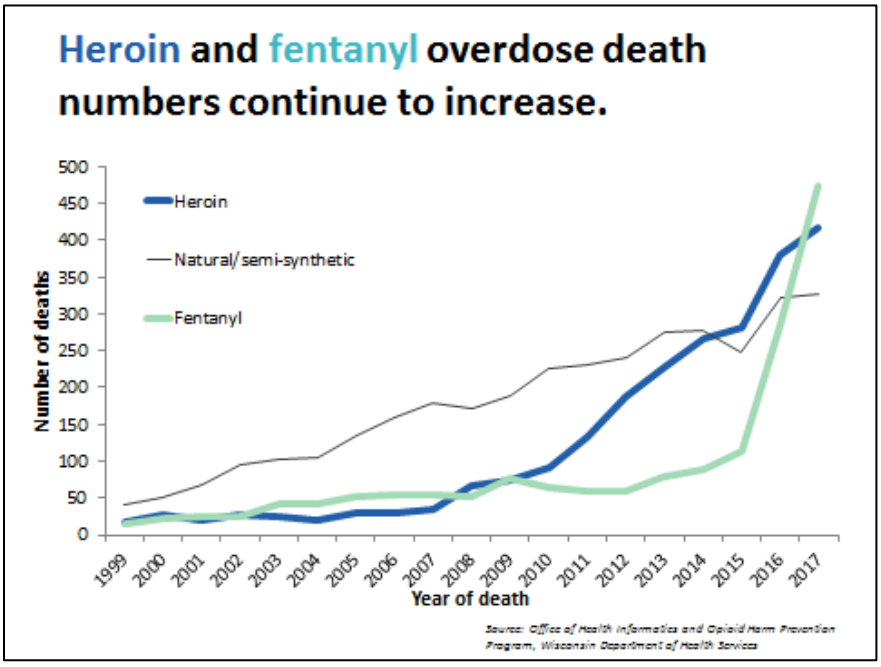


Figure 2



The lethality of opioid misuse also continues to rise. In 2017, 916 people in Wisconsin died from opioid overdoses, more than the number killed in car crashes. Shifting trends in the type of opioids used are also a factor in increasing opioid-related deaths. Testing shows a marked increase in the prevalence of synthetic opioids, such as fentanyl and analogs, in association with opioid overdose deaths (Figure 3). Most fentanyl and analogs are illegally produced and obtained and is often added to other substances of abuse.

Figure 3



Medication-Assisted Treatment for OUD

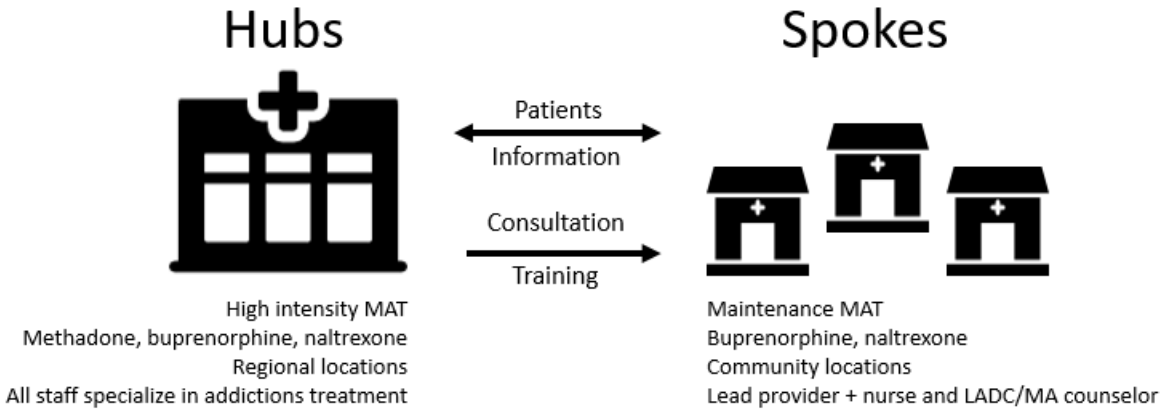
This report focuses on the provision of MAT as an evidence-based approach to treating OUD. MAT is a "whole-patient" treatment approach, consisting of FDA-approved medications for addiction, counseling and behavioral treatment, care coordination, education, and other social supports, thus holistically addressing patient needs. Although MAT is frequently discussed in the context of OUD treatment, the whole-patient approach is applicable to treatment for all SUDs. MAT may be offered by a single health care provider specializing in addiction treatment or by a combination of health care providers, each offering a unique component of the whole-patient MAT treatment model. The use of each MAT medication is supported by clinical evidence demonstrating improved adherence to treatment and reduced morbidity and mortality. There are unique clinical indications for each type of medication.

Table 1. Comparison of medications for the treatment of OUD[2]

Name	Mechanism of Action	Forms	Uses	Restrictions
Methadone	Agonist	Oral Tablet or Liquid	Withdrawal and treatment	Dispensed in certified opioid treatment programs
Buprenorphine	Partial Agonist	Oral Tablet, buccal film, or extended-release implant	Withdrawal and treatment	Prescribed with appropriate federal waiver
Buprenorphine/naloxone	Combination	Oral tablet or buccal film	Withdrawal and treatment	Prescribed with appropriate federal waiver
Naltrexone	Antagonist	Oral tablet or extended-release injectable	Treatment	None noted

The hub-and-spoke model was developed in Vermont to maximize the availability of MAT for patients with restricted access to treatment due to the limited number of providers who met the certification or waiver standards to dispense or prescribe methadone and buprenorphine products. The hub-and-spoke model simultaneously connected patients with existing MAT providers and established a framework for increasing the number of providers qualified and willing to deliver MAT.

[2] https://integrationacademy.ahrq.gov/sites/default/files/mat_for_oud_environmental_scan_volume_1_1.pdf



Subsequent states have implemented variations of Vermont's hub-and-spoke model, with different standards for provider types and funding mechanisms. Each state has increased the availability of MAT and improved patient connection to treatment through their model.

Wisconsin Medication-Assisted Treatment Providers

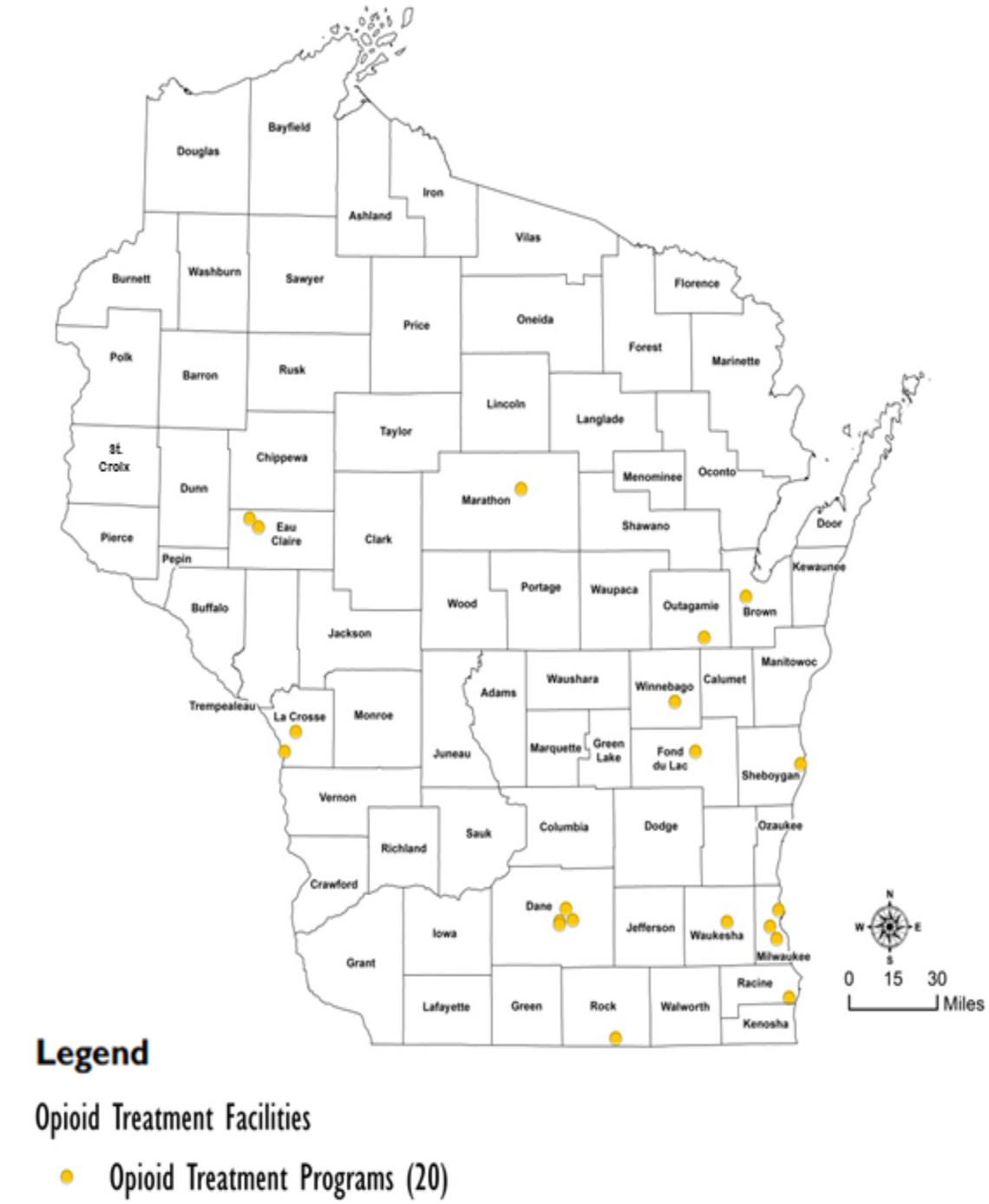
In Wisconsin, the Commission has identified a growing statewide capacity for MAT, including growth in the number of specialty SUD treatment programs providing MAT and the number of general health care providers who have expanded their service arrays to include MAT. This section of the report focuses on a subset of treatment providers using data available to the DHS Division of Care and Treatment Services and Division of Medicaid Services. Although novel and innovative grassroots MAT programs being developed throughout the state may not be represented in this section, the Commission recognizes the commitment these programs have made to expand the availability of high-quality SUD treatment to meet the needs of their communities. The clinical model proposed by the Commission in Section IV of this document is designed to bring additional support to all MAT programs in Wisconsin, not only those highlighted in this report.

Opioid Treatment Programs

For people with complex OUDs who need more intensive, daily monitoring of MAT, along with addiction counseling, case management, and recovery supports, there is a need for more comprehensive opioid treatment programs. In Wisconsin there are 20 privately owned OTPs that offer comprehensive MAT, including access to daily methadone treatment. An OTP is an accredited treatment program under Wis. Admin. Code § DHS 75.15 and regulated by state law (Wis. Stat. §§ 51.4223 and 51.4224), with certification from the Substance Abuse and Mental Health Services Administration and registration with the Drug Enforcement Administration to administer and dispense medications that are approved by the Food and Drug Administration to treat opioid addictions. All programs are required to provide client registration data to a central database registry maintained through the State Opioid Treatment Authority (SOTA) in the Division of Care and Treatment Services. SOTA has responsibility under state law (Wis. Stat. § 51.4224) "to exercise the responsibility and authority for governing the treatment of a narcotic addition with a narcotic drug."

The 20 OTPs are located in the bottom half of the state, leaving over half the state without access to this evidence-based and cost-effective treatment when the individual has an OUD that is highly complex and in need of daily treatment support from methadone and counseling resources. A directory of all OTPs in Wisconsin can be found at www.dhs.wisconsin.gov/opioids/find-treatment.htm.

Figure 4


Opioid Treatment Programs in Wisconsin
Douglas
Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Marinette
Polk
Barron
Rusk
Lincoln
Langlade
Taylor
St. Croix
Dunn
Chippewa
Menominee
Oconto
Marathon
Shawano
Door
Pierce
Eau Claire
Clark
Pepin
Kewaunee
Wood
Portage
Waupaca
Outagamie
Brown
Buffalo
Jackson
Manitowoc
Adams
Waushara
Winnebago
Calumet
Trempealeau
La Crosse
Monroe
Marquette
Green Lake
Fond du Lac
Sheboygan
Juneau
Vernon
Sauk
Columbia
Dodge
Ozaukee
Richland
Crawford
Dane
Jefferson
Waukesha
Milwaukee
Iowa
Grant
Racine
Lafayette
Green
Rock
Walworth
Kenosha
N
W
E
S
0 15 30
Miles
Legend
Opioid Treatment Facilities
Opioid Treatment Programs (20)

In 2017, the OTPs served 10,625 unduplicated individuals. The total number of people served in OTPs has been increasing steadily, by 68% since 2013. As of June 2018, OTPs in Wisconsin could provide treatment for approximately 8,000 unduplicated individuals at any one point in time. Additional information can be found in the 2016 Calendar Year Report on Opioid Treatment Programs in Wisconsin at https://www.dhs.wisconsin.gov/publications/p02115-16.pdf.

Heroin, Opioid Prevention, and Education (HOPE) Regional Comprehensive Opioid Treatment Centers—Office-Based Opioid Treatment Programs

Some buprenorphine prescribers participate in SUD-specialty programs, sometimes referred to as office-based opioid treatment programs. Although there is no unique identifier for office-based opioid treatment programs statewide, several have been funded through HOPE legislation grants. In order to address the needs of the rural communities that lacked the capacity for MAT for OUD, the Wisconsin legislature established a program for the development and support for several regional opioid treatment centers. In 2013 Wisconsin Act 195 and again in 2017 Wisconsin Act 27, the legislature provided DHS with $3 million in GPR funding each year to establish opioid treatment center grants in rural areas that were high need and low capacity for MAT. Three centers were established in 2015, sometimes referred to as HOPE clinics. Two more clinics were awarded contracts in 2018. The initial three clinics served 417 unduplicated people in 2017, which is the third year they have received funding.

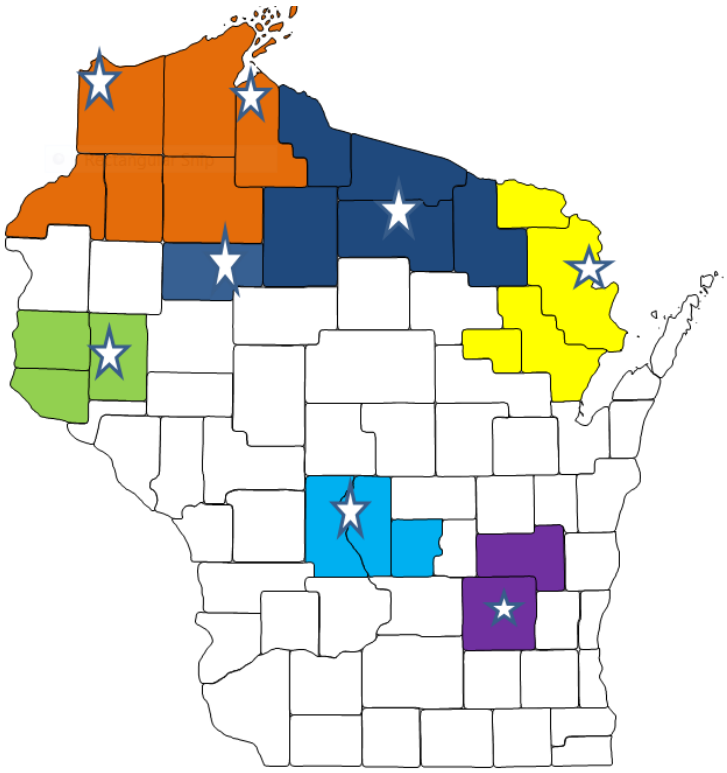
Original HOPE Clinics are:

- **Northeastern Region:** HSHS St. Vincent's Hospital Libertas of Marinette (d.b.a. Northeast Wisconsin Opioid Treatment Services) with offices in Marinette, Wisconsin, serving Florence, Marinette, Menominee, and Oconto counties.
- **North Central Region:** Family Health Center of Marshfield Clinic (d.b.a. HOPE Consortium) with offices in Minocqua, Wisconsin, serving the tribes of Forest County Potawatomi, Lac du Flambeau Chippewa, Sokaogon Chippewa, and the counties of Forest, Iron, Oneida, Price, and Vilas.
- **Northwestern Region:** NorthLakes Community Clinic with offices in Ashland, Wisconsin, serving the tribes of Bad River, Lac Courte Orielles, Red Cliff, and the counties of Ashland, Bayfield, Burnett, Douglas, Sawyer, and Washburn.

The services offered in the HOPE clinics include:

- Assessment for treatment
- Abstinence-based treatment
- Medication-assisted treatment, utilizing buprenorphine and naltrexone
- Licensed, 24-hour residential care
- Outpatient counseling
- Warm handoffs to county-authorized or private continuing care

Figure 5

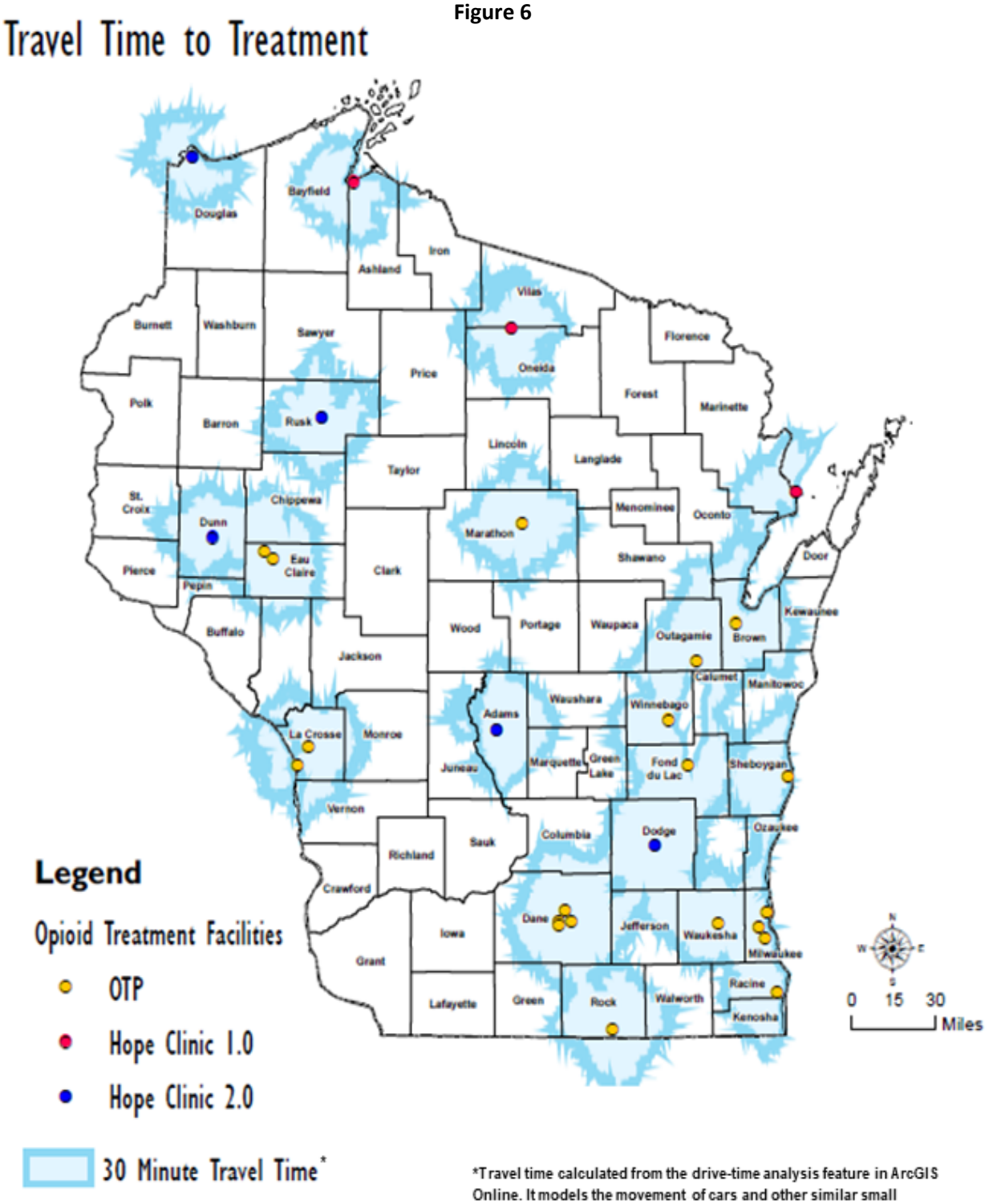


Expansion HOPES Clinics: The HOPE expansion legislation funding and $1 million in federal STR grant funding allowed for three additional new clinics to begin offering services in 2018 and two organizations to expand into two new locations:

- Family Health of LaClinica with offices in Friendship (Adams County) serving Adams, Juneau and Marquette
- Dodge and Fond du Lac counties with program office located in Juneau (Dodge County)
- Arbor Place with offices in Menomonie, Wisconsin, serving Dunn, St. Croix, and Pierce Counties.
- NorthLakes Community Clinic to partner with Lake Superior Community Health Care to open an office in Superior, serving Douglas County.
- Family Health Center of Marshfield Clinic to open an office in Ladysmith (Rusk County)

These clinics are required to provide MAT using buprenorphine and naltrexone products. However, Wis. Stat. § 51.422 currently prohibits these centers from offering methadone treatment, even if that would be the most appropriate treatment for an individual with complex OUD.

Figure 6



*Travel time calculated from the drive-time analysis feature in ArcGIS Online. It models the movement of cars and other similar small automobiles, such as pickup trucks, and finds solutions that optimize travel time. Travel obeys one-way roads, avoids illegal turns, and follows other rules that are specific to cars.

In compliance with state regulations and grant funding contracts, OTPs and grant-funded HOPE clinics are required to provide both the medication and SUD counseling components of MAT on site. As such, the Commission reviewed a map of these clinic locations and the regions of the state within a 30-minute drive of the clinic. Although additional MAT providers may be available to patients, such as prescribers of buprenorphine or naltrexone in a primary care office, the Commission does not have adequate data to determine if any additional locations provide both the medication and counseling components of MAT in a single location. Therefore, programs that are not certified as an OTP or funded through a HOPE initiative are not represented on the map.

DATA 2000 Waiver Prescribers of Buprenorphine

To better understand the availability of buprenorphine prescribers throughout the state, the Commission also reviewed available data on waivered buprenorphine prescribers. As of April 2018, there were 692 prescribers in Wisconsin who were certified under the DATA 2000 waiver to prescribe buprenorphine for OUD. Of these, just over half are listed as of April 2018 on SAMHSA's registry of buprenorphine prescribers. Prescribers who choose not to be listed in the registry may still prescribe buprenorphine and manage care for patients with OUD.

Table 2. Approved Buprenorphine Prescribers in Wisconsin

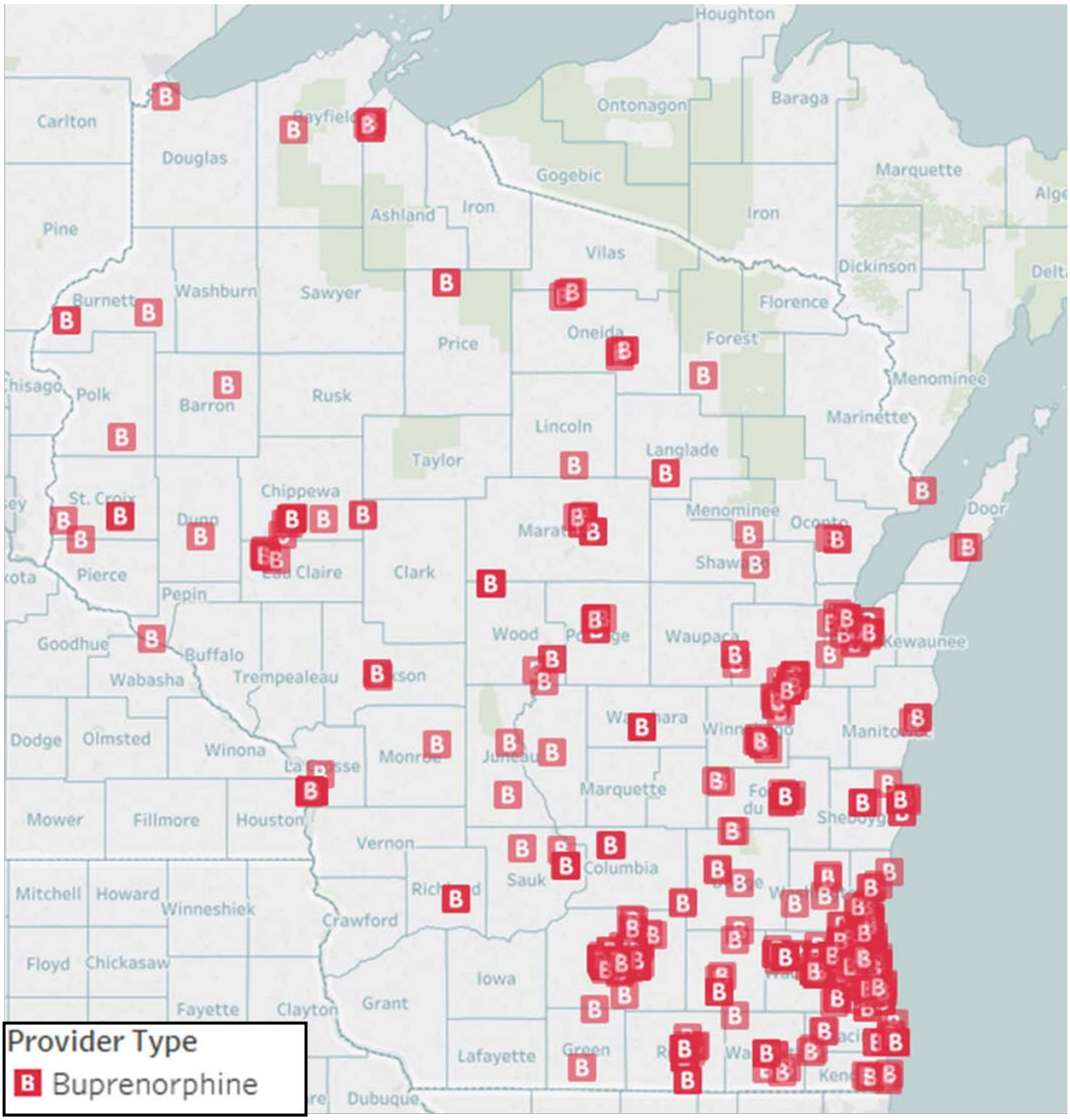
Patient Limit	Number of Prescribers Not Listed	Number of Prescribers Listed in Registry	Total Number of Prescribers	Maximum Treatment Capacity
30	286	220	506	15,180
100	46	88	134	13,400
275	10	42	52	14,300
Grand Total	**342**	**350**	**692**	**42,880**

Although 692 prescribers are authorized to prescribe buprenorphine, only a subset of these providers are actively using this authority.

DATA-2000-waived prescribers who are listed in the SAMHSA registry are depicted below. Although there are some buprenorphine prescribers in rural regions of the state, the majority are concentrated in southeastern and southcentral Wisconsin.

Figure 7

DATA 2000 Waivered Buprenorphine Prescribers



Additional MAT Providers and Models

Pharmacy

Pharmacists play an important role in individuals' health care. Pharmacists are highly accessible and may see patients more frequently than other health care providers; this can be especially important for patients with chronic conditions that require long-term medication therapy. These ongoing interactions provide an opportunity to monitor the patient's condition and provide education or interventions to improve their care. However, pharmacists are often an underutilized resource. Below are options to utilize pharmacists more often in the MAT response to the opioid crisis process.

- Treatment Team: Pharmacists involved in naltrexone injections need to become a part of the member's treatment team when possible. This would allow the pharmacist to have a support system and a team to notify if a member does not show up for their treatment.
- Health care payers can also expand medication therapy management benefits to cover drug-related counseling by a pharmacist for OUD. If pharmacists are certified, they can provide comprehensive medication review/assessment (CMR/A) services for members with this disorder. As part of the CMR/A, pharmacists can obtain information about a member's health, formulate a medication treatment plan, and provide information or support services.

Model Programs for County and Tribal Emergency Services/Crisis Stabilization for People with OUD:

DHS Division of Care and Treatment Services (DCTS) has noted some counties have developed models that have shown promise in providing effective outreach, crisis stabilization, and immediate access to treatment for people affected by OUD. Each of these models includes the county role in assuring that individuals with OUD have an easily accessible access point to effective MAT treatment, irrespective of their insurance coverage. Evidence-based efforts, including motivational interviewing, and recovery support services are being used in these approaches to engage individuals with OUD into an integrated service delivery model.

- **Medication-Assisted Treatment and Recovery (MATRS)**: In a pilot funded by the MAT-PDOA federal grant, Sauk and Columbia counties contracted with Tellurian, Inc. to provide community recovery specialists who respond to calls from law enforcement, jails, hospitals, families, and individuals on an on-call 24/7 basis. They meet people where they are, or at a safe location, to do an initial assessment, develop a response plan, and then support the person to schedule a visit with their primary care physician, or another physician in their insurance network, that is data waived and able to prescribe MAT. The physician completes a health assessment for MAT and then initiates the appropriate MAT treatment for the individual. The community recovery specialist supports the person through the induction process, connects the person to their appropriate psychosocial addiction counseling provider (or to the county's treatment provider), and provides recovery supports until the individual is stabilized in treatment. As appropriate, the county may enroll Medicaid-eligible individuals into Comprehensive Community Services for ongoing substance use and mental health counseling and recovery support services.

The program is now transitioning from federal grant funding by incorporating these services within their existing crisis services. From May 2016 through January 2018, Sauk and Columbia counties have enrolled more than 200 people in MATRS. Follow-up evaluation data by the UW Population Health Institute show that at the six-month follow-up point, participants showed a decrease by 82% in use of prescription opioids and a 62% decrease in injection drug use, an overall consumer satisfaction rate of 88%, and a decrease in incarceration rates from 46% at intake to 26%.

- **Opioid Crisis Response Centers**: A different model for immediate access to OUD response, stabilization, and treatment is facility-based through the establishment of what has been called an "opioid crisis response center." This model is being used in more urban areas, where law enforcement agencies, hospitals, families, and other health care professionals can refer someone or drop off an individual with an OUD at the center. Individuals are assessed for their immediate and longer term needs, provided detoxification and stabilization services, followed by MAT induction, addiction counseling, and case management services. This model responds to the urban law enforcement needs to have a safe place to divert from jail those individuals who would more appropriately respond to immediate access to treatment and support.

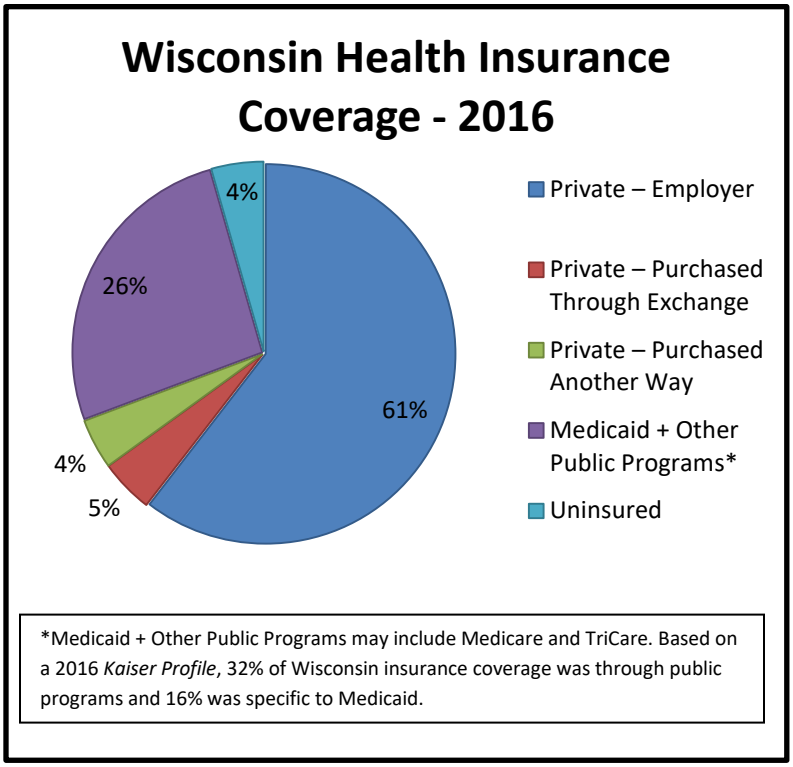
  The Kenosha County Crisis Prevention/Intervention Center combines both mental health and addiction crisis services. In the past year, they have treated over 100 individuals with OUD in an integrated behavioral health crisis response model, including access to MAT services. Tellurian, Inc. in Dane County is establishing such a center with federal State Targeted Response grant funding in 2018. They propose to use community recovery specialists operating out of an urban opioid crisis response center to provide an initial response, access to an assessment, MAT, and counseling services. Milwaukee County Behavioral Health is using STR federal funding to partner with Milwaukee hospitals to respond to overdoses at the emergency room and to provide immediate access to MAT at the hospital before discharge.

Health Care Financing for Substance Use Disorder Treatment

As of 2014, the federal Affordable Care Act (ACA) requires most individual and small group health insurance plans, including plans sold on the Marketplace, to cover mental health and substance use disorder (SUD) services. These plans must contain coverage of essential health benefits, which includes 10 categories of benefits as defined under the health care law. One of those categories is mental health and SUD services; another is rehabilitative and habilitative services. Additionally, these plans must comply with mental health and substance use parity requirements, as set forth in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), meaning coverage for mental health and SUD services generally cannot be more restrictive than coverage for medical and surgical services.

Table 3. [Wisconsin Health Insurance Coverage - 2016]

Type of Insurance	Percent of Wisconsin Residents Covered	Covered Lives
Private – Employer	60%	3,399,000
Private – Purchased Through Exchange	5%	256,000
Private – Purchased Another Way	4%	240,000
Other – Medicaid + Other Public Programs	26%	1,476,00
Uninsured	4%	250,000



In 2016, 69% of Wisconsin residents were covered through private insurance. While Wisconsin's insured rate and coverage requirements have seen encouraging progress, obstacles remain for individuals seeking treatment. Insurers are allowed to develop terms and conditions, including cost-sharing and limits on the number of visits or days of coverage for the amount, duration, and scope of mental health and SUD benefits. Under federal parity requirements, these benefits must be no more restrictive for coverage of the treatment of mental health disorders or SUD than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan. However, ongoing monitoring of MHPAEA compliance suggests that some payers may still disproportionately apply financial limits or other treatment limits to mental health or SUD treatment.[3] [4]

In October 2018, Wisconsin Medicaid received approval from CMS through an 1115 Demonstration Waiver to expand Medicaid coverage of SUD treatment, including expanded coverage of residential treatment and improved connection to MAT. Wisconsin Medicaid will continue to pursue federal funding opportunities (such as the 1115 Waiver) to cover comprehensive, evidence-based SUD treatment.

[3] http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf
[4] https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out

Enabling Technology in Delivery System

Health Information Technology (HIT) Infrastructure for Behavioral Health Providers

In order to effectively collaborate and co-manage patients, MAT providers need mechanisms to document and share records, including mechanisms to managed patient consent to share records. This can be efficiently managed electronically through electronic health records (EHRs) for medical documentation and health information exchange (HIE) for health information sharing. However, we understand there are currently varied levels of technology adoption among MAT providers in Wisconsin.

One of the greatest drivers of EHR adoption are the Medicare and Medicaid EHR Incentive Programs (meaningful use). Surveys conducted through the Wisconsin EHR meaningful use program identify varied adoption between provider types. Within the EHR Incentive Program, providers have made excellent progress in adopting EHR technology and achieving meaningful use. As of December 2016, 93% of participants had attested to Stage 1 or Stage 2 meaningful use as of their most recent attestation, followed by physician assistants (63%), nurse practitioners and nurse service (61%), and dentists (30%).

Wisconsin tribal health centers and Federally Qualified Health Centers have a higher participation rate (93% and 74%, respectively) compared to the average of participating providers (56% overall), but they have a lower proportion of meaningful users (67% and 60%, respectively).

Many behavioral health and long-term care providers are not participants of the EHR Incentive Program, but have provided survey responses on EHR adoption. Approximately 50% of community mental health centers, county human service divisions, and hospitals or health systems providing behavioral health had adopted EHRs. However, the majority of behavioral health and long-term care community-based providers and individual practitioners are not using EHR technology.

HIE is the transmission of electronic information between providers. Behavioral health providers' use of HIE is relatively low, only 15% of respondents reported using HIE. However, those who have adopted an EHR have a slightly higher rate of HIE adoption (18%).

> Top barriers to exchanging health information include concerns about privacy and security, technology infrastructure, and exchanged information not meeting needed use. Notably, while HIE is not the key mechanism by which information is being shared, behavioral health providers are sharing information outside of their organizations. Nearly 60% of respondents reported using paper-based charts, including 39% of EHR users. Survey respondents also reported a desire for more resources for EHR and HIE planning and implementation.

HIE for behavioral health and SUD information requires specific attention to patient consent and compliance with 42 C.F.R. Part II. Some states and providers are investing in technology solutions for consent management. A member-centric platform for collecting and sharing information is being used in the Michigan "Integrated Service Delivery" model, where streamlined information is gathered upon enrollment for all state programs, as well as community-based programs to meet member's needs.[5] Tennessee Medicaid has invested in a shared, web-based, care coordination tool, for primary care and

[5] https://newmibridges.michigan.gov/s/isd-landing-page?language=en_US

behavioral health providers, to support their Health Link and Patient Centered Medical Home initiatives.[6]

Additional information on the current health IT landscape and opportunities for enhancements in Wisconsin can be found in this assessment: https://www.dhs.wisconsin.gov/publications/p0/p00951.pdf.

UW Project ECHO

Technology can also help to facilitate provider education and case assistance, potentially helping more providers feel comfortable serving patients with OUD and other SUDs by providing a remote access to specialists to consult with on those patients. This can be done through Project ECHO, which uses widely accessible technology to provide primary care providers with knowledge and support to manage complex conditions by connecting them with specialty providers, increasing access to specialty treatment in rural and underserved areas. The UW Department of Family Medicine and Community Health and the DHS DCTS have sponsored the Opioid Project ECHO at UW Madison to connect clinical experts with primary care and other providers across Wisconsin in an effort to improve access to quality MAT care and reduce opioid-related complications.

Telehealth

Telehealth, or telemedicine, can refer to a wide range of tools to deliver health care services using electronic communication (for example, live video interaction, store-and-forward transmission, remote patient monitoring. In Wisconsin, the most frequently used definition for telehealth refers to live, interactive, video teleconferencing between a health care provider and patient. Telehealth is supported by a growing evidence base and evolving best practices. Although a patient should always be able to access in-person treatment, telehealth can be a valuable tool to connect patients with health care providers, especially specialty care providers, when physical, geographic, or other barriers otherwise limit a patient's access to health care.

IV. Proposed Clinical Model

The Commission is proposing a clinical model to establish a common understanding of the long-term vision for a high-quality, evidence-based SUD treatment system in Wisconsin. The clinical model was developed through a national review of successful treatment models and interviews with clinical experts. The model can be viewed as a draft, and a goal to move towards, as it will benefit from further input from additional stakeholders and from individuals with lived experience of addiction. Diverse stakeholders can align their long-term planning efforts in order to assist in a statewide system that aims to meet the needs of all who live with a SUD.

[6] https://www.tn.gov/content/dam/tn/tenncare/documents2/CareCoordinationToolOverview.pdf

Guiding Principles

In developing the clinical model, the Commission identified a set of guiding principles regarding SUD treatment. It should be understood that these include long-term goals, with the expectation that we can collectively move in this direction, rather than an expectation that these will all exist from the start of this effort.

- Recovery is a process of change through which individuals achieve a remission to addiction, improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is possible.
- Addiction is a chronic disease and should be treated following a chronic disease care model. Long-term recovery services must be available to support individuals in the maintenance of remission and recovery.
- Active addiction should be seen as an acute exacerbation of a chronic disease when a person presents for treatment—treatment must be evidence-based, intensive, and immediately available. Similar to a heart attack or a stroke, systems should be designed for a rapid, intensive response.
- Open door policy—Treatment should be available to all who seek it, regardless of coverage, ideally 24/7. Treatment should be locally available across the state.
- Choice of treatment approach should include all therapies (i.e., all medications) and should be made through a clinically informed, individually-tailored joint decision of the patient and clinician.
- Achieving recovery without MAT may be a choice of some individuals with OUD, but lack of MAT should not be a requirement for any addiction treatment services, including residential and recovery supports.
- A broad array of care management services, such as coordinating and managing medical care, psychosocial services, and other recovery supports, can promote recovery and should be uniformly covered by health insurance or through other funding. Coordination of care and services must be provided across service sites and through changes in treatment intensity.
- Treatment services for pregnant women must be easily accessed, locally available, of high quality and include support pre and postpartum for the mother, child, and family.

Initiation of Treatment

The treatment initiation process should begin within 24 hours of a person seeking treatment to minimize withdrawal symptoms, should they occur, and maximize success. This capacity is not consistently available in our current, fragmented systems for treatment. One starting point can be through the use of emergency departments. According to a survey completed by the American College of Emergency Physicians, 92% of Wisconsin emergency physicians already report treating a patient suffering from OUD every shift. Emergency physicians can currently do induction and initial buprenorphine prescription (1-3 days) under federal law without having a waiver, but the expanded use of emergency departments will require building capacity for emergency department prescribers to have access to practice support (telehealth, new protocols, etc.), SUD counseling resources, and reliable ability to refer for further evaluation and follow up within 3-4 days. The Team for Evidence-based Addiction Management (TEAM), described below, can play a role in connecting the patient to needed community supports and MAT providers. In addition to emergency departments, hubs, appropriate

spokes, or county crisis services could address initiation of treatment for OUD in timely fashion. Building this capacity is critically dependent upon the ability of the provider to refer or provide prompt follow-up services. Additionally, there is a consensus that there should be the ability to offer or refer any of the treatment alternatives that currently exist in order to most appropriately serve the individual in recovery. Due to many legal and logistical barriers that currently exist, this is considered a long-term goal.

Team for Evidence-based Addiction Management (TEAM)

The next component of the model is an interdisciplinary team that would be able to provide continuity of supports throughout the treatment and recovery process of each individual. The TEAM would bridge the gaps between initiation and the maintenance of treatment, to facilitate the recovery process and provide linkages across systems to meet the "whole-person" needs of each patient. The TEAM would address social determinants (housing, food insufficiencies, transportation needs), provide recovery support, help to access behavioral health and mental health services, assist with care transitions as patients graduate to less supervised treatment, and assist providers with the monitoring of treatment compliance. They could additionally assist in coordinating access to initiation of treatment. The staff composition of this team can vary; however, the services must be provided in an integrated way. This team will serve as a key support for spokes, including primary care offices, as spoke prescribers often do not have the specialized resources needed to address these issues. Depending on the circumstances, this role could be sourced minimally as a care coordinator, or, following the examples of such teams from other states, it could provide the more robust services mentioned above. Flexibility and recognition that this system is not a "one size fits all" is key, but how TEAMs are paid for and establishing bare minimum requirements (e.g. must be licensed behavioral health therapists etc.) that each TEAM must have are necessary components. Finally, the TEAM should have the ability to respond quickly to needs (housing, transportation, child care) that could otherwise derail recovery.

Treatment

Hubs and spokes are the two primary structures for the delivery of treatment for OUD. Hubs are specialized addiction treatment centers able to provide full assessment, MAT initiation, behavioral and mental health services and counseling up to at least intensive outpatient treatment level of care, social support, medications, peer support, and access to residential or higher level of care facilities if such is needed. They would be able to evaluate patients, determine the most appropriate type of therapy, and then provide it. As mental health problems often co-exist with SUD, and can be major contributors to addiction, it is essential that these are identified and addressed. In addition providing direct care, hubs would provide consulting and practice support to affiliated spokes. In order to increase the number of primary care providers willing to provide spoke services, it is essential that hubs are able to provide robust and timely consult support to spokes, as well as maintaining the ability and willingness to accept transfer patients whose needs exceed the scope of services offered by the spoke clinic.

Comparatively, spokes do not have support typical for specialized addiction programs and need to have practice support for prescribers and easy, timely access to specialized resources to support SUD

counseling, mental health services, and social needs. These specialized resources could be provided by the hub (clinical expertise) and, if appropriate, by the TEAM, and could include an initial assessment and initiation of treatment and patient stabilization as well as transfer of patients who require higher-level of care from the spoke to the hub. In order to promote primary care providers' engagement in addiction care and MAT, they must feel confident that they have professional practice support (i.e., hub, telehealth, Project ECHO, etc.) and also a day-to-day support for the psychosocial and additional demands of nursing staff that this patient population presents (via the TEAM). It is critical that spokes have confidence that if a patient becomes unstable, they will be able to timely refer the patient back to a hub. Once underway in treatment, there should be a range of follow-up services available. These include care management services, medical, psychosocial care, family therapy recovery support services and social reintegration support. All services should be available locally across the state.

Recovery Support

Maintaining recovery and minimizing relapse rates is an ongoing challenge. In order to ensure long-term success, it is crucial to understand what services can help to support long-term recovery. Many of these services are supported through community funding sources, but it is essential to pay further attention to key supports for this process. Further interviews with individuals who are in recovery should be part of the exploration of this component. The TEAMs can play a key role here in connecting those in recovery to community resources, such as recovery housing, social networks, and fellowship.

Further discussion and more input can enhance the model. No one system or stakeholder can address all components that are needed. How services are integrated and provided can look very different in different regions and counties, and it indeed should look different. The current expectation is not a finished model, but to align the direction and goals that all partners are moving towards.

V. Roadmap

After review of the information presented and discussion of proposals made during the course of their work, the Commission considers the following steps critical to implementing a hub-and-spoke model in Wisconsin.

Coordinated Funding

The "whole patient" treatment approach of MAT relies on an interdisciplinary health care team providing coordinated services tailored to an individual patient's needs. Historically, these services have been provided by distinct entities and funded through a variety of sources. To effectively integrate these services, all health care payers must consider changes to their payment systems to ensure sufficient provider participation in the proposed model. Changes might include increases in particular reimbursement rates, but should also include incentives with an emphasis on care coordination and comprehensive service delivery, consistent with the principles of an effective treatment system. Wisconsin should also develop a comprehensive monitoring and program evaluation plan to assess the model, determine shared outcome measures for participating providers, and track performance on the outcome measures. This evaluation method should be developed before payment reform is implemented.

In states that have previously implemented hub-and-spoke treatment models, Medicaid programs have implemented new reimbursement methodologies designed to align with and incentivize engagement in the proposed model. States have opted to utilize various programs, such as Section 1115 Demonstration Waivers and Section 2703 Health Homes, to authorize these reimbursement methodologies. The Wisconsin Medicaid program should evaluate available options for federal funding and pursue a waiver or state plan amendment to align the Medicaid payment system with the proposed model.

Development of Supporting Technology

Effective delivery of MAT requires connecting patients directly to specialty health care providers with expertise in SUD treatment as well as extensive communication among the interdisciplinary team providing coordinated care for the individual. Health information technology (HIT) provides standardized and scalable tools to facilitate these connections. The Wisconsin MAT model will utilize HIT tools to bridge gaps in the statewide treatment network, share information electronically, and foster collaborative relationships among providers.

It is crucial to require adequate HIT for hubs and spokes to ensure they have the requisite tools for success from the inception of the treatment model; this should be a condition for enhanced payment. The primary function of HIT in the treatment model is to facilitate care coordination, increase access to SUD treatment across multiple systems and levels of care, and enable outcome evaluation.

At a minimum, HIT to support the clinical model includes:

- Telehealth
- Care coordination
- eRx
- Health information exchange
- Consent management (must be compliant with 42 C.F.R., Part 2)
- Reliable EHR-based measures to be used for outcome tracking

Review Regulatory Framework

MAT providers are subject to a number of federal and state regulations. This oversight is tailored to each type of medication, with opioid agonists (i.e., methadone), the most highly regulated, and antagonists (i.e., naltrexone), the least regulated. The Commission recognizes that additional treatment providers are needed at every level of regulation to ensure the availability of all evidence-based treatment approaches throughout Wisconsin.

Under federal law, methadone may only be dispensed to treat addiction in certified OTPs or OTP medication units (i.e., a satellite location). OTP certification requirements are established in federal regulations and Wis. Admin. Code § DHS 75.15. The Commission has identified the capacity to dispense methadone on site as a core requirement for hubs. This requirement ensures all components of an individual's treatment are immediately available at a hub, including full opioid agonist medication when this treatment approach is clinically indicated. To align state regulations with the integrated clinical vision, DHS has submitted an emergency rulemaking request to rescind language in § DHS 75.15 that potentially restricted OTP certification for providers delivering treatment not directly related to opioid addiction. Removal of this restriction will allow additional providers to seek OTP certification and allow currently certified OTPs to broaden the array of health care services they provide. The Commission recommends finalizing the DHS rule change to ch. DHS 75.

Similarly, federal law limits the types of providers authorized to prescribe buprenorphine products to treat OUD through a federal training and credentialing process. However, recent federal legislation (SUPPORT for Patients and Communities Act) has codified expanded buprenorphine prescribing authority, including increased patient limits for prescribers and authorization for nonphysician providers to prescribe buprenorphine when acting within their scope of practice under state law. In recognition of the critical role of nonphysician providers in expanding statewide MAT capacity, the state should review practice requirements for nonphysician prescribers of buprenorphine to support providers with federal credentials (DATA 2000 waiver) to maximize their availability for patients seeking SUD treatment.

In addition to regulatory limitations impacting provider certification and practice, some state statutes and regulations may limit the availability of funding for SUD treatment expansion. As highlighted in this report's review of HOPE clinics funded through 2013 Wisconsin Act 195 and 2017 Wisconsin Act 27, one of the most successful approaches to expanding availability of evidence-based SUD treatment in underserved areas of the state has been to provide grant funding to existing health care providers willing to expand their health care service array. To date, grant funding authorized under these

provisions has been limited by type of MAT (naltrexone and buprenorphine only) and limited by type of SUD (opioid and methamphetamine use disorders only). Removing these limitations from Wis. Stat. § 51.422 would provide grant funding to clinics expanding to treat all SUDs using all evidence-based treatment approaches, as indicated for individual patients.

Finally, delivery of some services through telehealth will be an important strategy for connecting patients to treatment and recover supports. Some statutory changes may support increased availability of telehealth service delivery. Currently, Medicaid reimbursement for certified mental health programs delivering telehealth services is subject to certification requirements in Wis. Stat. § 49.45(29w)(b). In particular, these certification requirements prohibit delivery of telehealth by narcotic treatment services (aka OTPs). Removal of the limitation in Wis. Stat. § 49.45(29w)(b)2.a. will allow certified OTPs, and eventually hubs, to develop telehealth service delivery tools that will support movement towards the Commission's proposed clinical model. Additional review of telehealth certification requirements is appropriate to ensure providers are able to effectively deliver telehealth services while maintaining a high standard of care.