WISCONSIN
STATE COUNCIL ON
ALCOHOL AND
OTHER DRUG ABUSE

September 7, 2018
MEETING

Duncan Shrout
Chairperson

SCOTT WALKER
Governor

Tobacco-Free Environment

American Family Insurance is a tobacco-free environment. We prohibit the use of tobacco products and electronic cigarettes (e-cigarettes) everywhere, by anyone, at all times.

Use of tobacco products and e-cigarettes is prohibited in all interior and exterior spaces, including inside your vehicle while on company-property and in parking ramps and parking lots.

We ask that you refrain from using tobacco products and e-cigarettes while using our facility.

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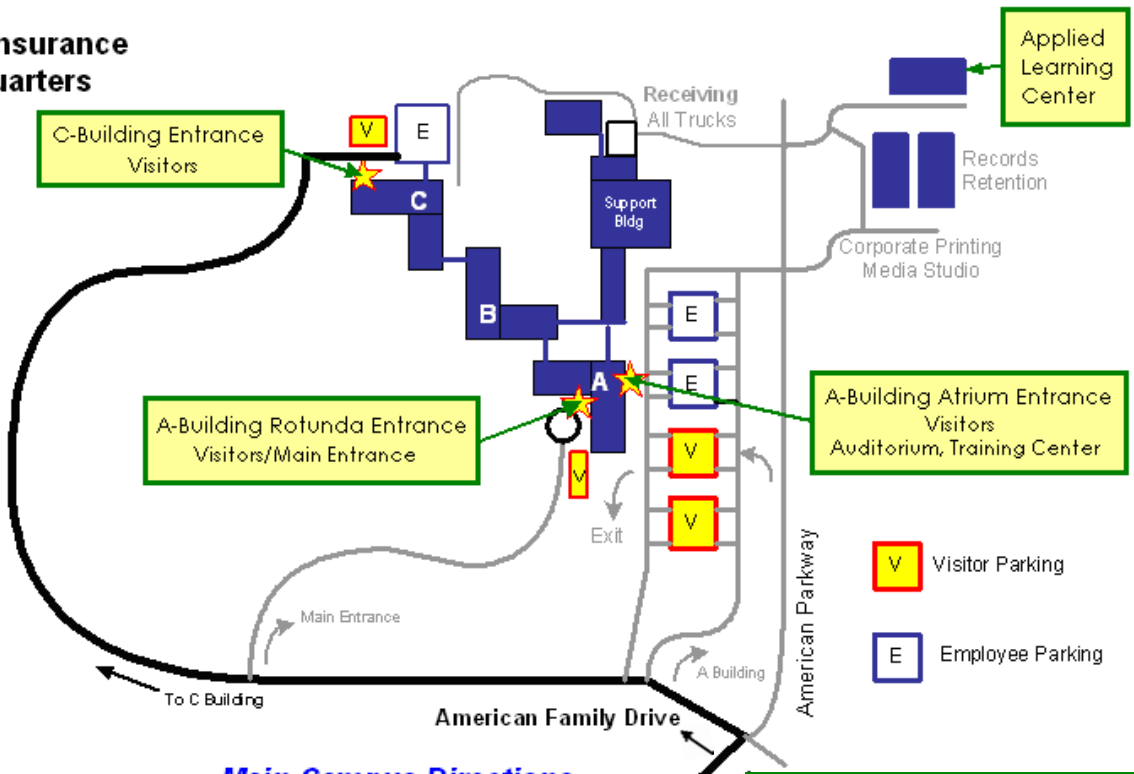
Directions

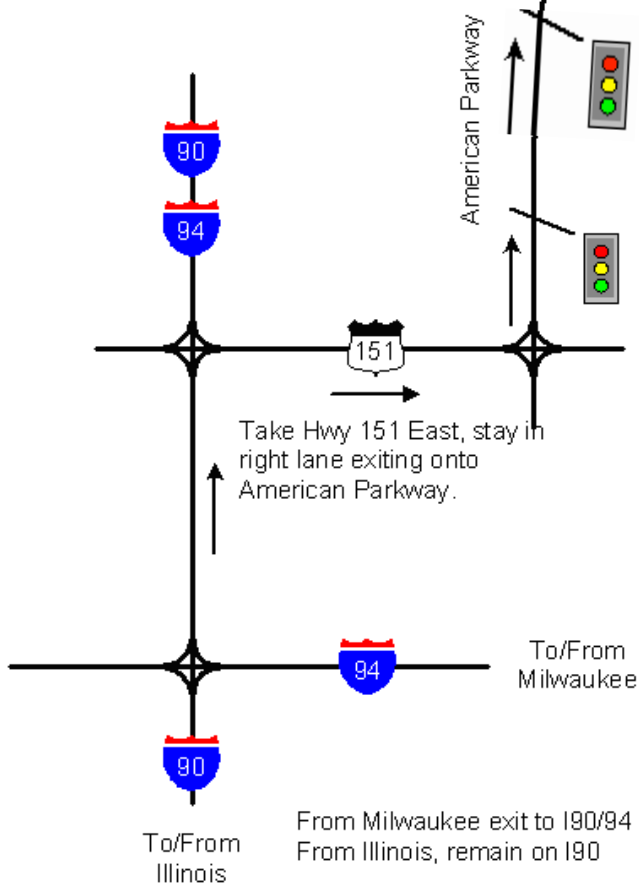
American Family Insurance
National Headquarters



Main Campus Directions

Turn left onto American Family Ins. Dr and take the 1st right to access A bldg./Training Center visitors parking

- **Visitors are able to use both flat lots for parking only**
- **If you need to drop off materials/attendees please follow the road around the parking ramps to the A bldg. visitors entrance**
- **Please note roads around parking are one way**



Merge to left lane on American Parkway. Second intersection past stop light is American Family Drive.

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Highway Directions to AF-NHQ Campus

Scott Walker
Governor

Duncan Shrout
Chairperson

Sandy Hardie
Vice Chairperson

Norman Briggs
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE

September 7, 2018, 9:30 AM to 2:30 PM
American Family Insurance Conference Center
6000 American Parkway, Madison, WI 53783
A-Building, South Café in Training Center

MEETING AGENDA

1. Welcome and introductions…….....Duncan Shrout, SCAODA Chairperson

2. Approval of June 1, 2018 meeting minutes……p. 7

3. Public input (maximum five minutes per person)…….....Duncan Shrout

4. Election of SCAODA Officers……..Duncan Shrout

5. Committee reports:
   - Executive Committee……Norm Briggs….. p. 13
     - ✓ Review Committee meeting minutes and agenda
   - Diversity Committee……...Thai Vue….. p. 15
     - ✓ Review Committee meeting minutes and agenda
   - Intervention & Treatment Committee…Norman Briggs & Roger Frings.....p. 17
     - ✓ Review Committee meeting minutes and agenda
     - ✓ Children, Youth and Family Treatment Sub-Committee
     - ✓ Motion: SUD Treatment Professionals Demonstrating Competency
   - Planning and Funding Committee…….Christine Ullstrup…… p. 27
     - ✓ Review Committee meeting minutes and agenda
   - Prevention Committee…….....Chris Wardlow..... p. 35
     - ✓ Review Committee meeting minutes and agenda
     - ✓ Workplace Prevention Ad Hoc Committee

6. Proposed 2018-22 SCAODA Strategic Plan……SCAODA Executive Comm…p. 41

7. Presentations from SUD Treatment & Prevention Programs……..Guest Presenters...p. 43
    - Taycheedah Correctional Institution SUD Programming -- *Jill Wolf*
    - DOC, Division of Adult Corrections SUD Treatment -- *Dr. Autumn Lacy*
    - WiNTiP, SUD Tobacco Integration Online Training -- *UW-CTRI Steering Committee Members*

8. Lunch

9. PEW's SUD Treatment Policy Recommendations, July 2018……Andrew Whitacre….p. 80

10. Agency reports:
    - Department of Health Services…….Jennifer Malcore
    - Department of Revenue……Matthew Sweeney..... p. 133
    - Department of Public Instruction…….....Brenda Jennings
    - Department of Safety & Professional Services….....Brittany Lewin
    - Department of Veterans Affairs……Mike Ayers
    - Wisconsin Technical Colleges…….....Katie Roberts
    - UW Systems…….....Gary Bennett
    - WI Board for People with Developmental Disabilities……Fil Clissa

11. Bureau of Prevention, Treatment and Recovery Update…….Joyce Allen, DHS… p. 134
    - 2018-19 Training Programs and Conferences
    - Other Program Updates

12. Report from Wisconsin Council on Mental Health ….……..Mishelle O'Shasky, WCMH Chair

13. Dec. 7, 2018 Meeting Agenda Items……Council Members

14. Adjournment…… SCAODA Chair

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. Members of the State Council are appointed by the Governor. The Council's primary function is charged with providing leadership in Wisconsin around substance use disorder issues, advising Wisconsin state agencies on substance use disorder prevention, treatment and recovery activities, and coordinating substance use disorder planning and funding initiatives across state agencies. The Bureau of Prevention Treatment and Recovery within DHS staffs the Council. DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, if you need an interpreter or translator, or if you need this material in another language or in alternative format, you may request assistance to participate by contacting Mike Derr at 608-267-7704 or at Michael.Derr@wisconsin.gov.

Conference Call: (via Skype) 844-341-6886 [608-316-9000 in Madison]
Conference ID Code: 2762361
See also https://scaoda.wisconsin.gov/meetings.htm for instructions on joining by phone.

Scott Walker
Governor

Duncan Shrout
Chairperson

Sandy Hardie
Vice Chairperson

Norman Briggs
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse
1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE
DRAFT MEETING MINUTES

June 1, 2018
9:30 a.m.
Wisconsin Department of Agriculture, Trade and Consumer Protection - Madison, WI

Members present: Sen. Janet Bewley; Sen. Jill Billings (via Skype); Roger Frings; Jennifer Fyock; Jan Grebel; Sandy Hardie; Brenda Jennings; Autumn Lacy; Jennifer Malcore; Tina Virgil (for Ryan Shogren); Duncan Shrout; Kristi Sullivan; Christine Ullstrup

Members excused: Subhadeep Barman; Chris Borgerding (for Rep. John Nygren); Norman Briggs; Michael Knetzger; Sen. Devin LeMahieu; Caroline Miller; Sue Shemanski; Thai Vue

Ex-officio Members present: Mike Ayers; Karen Doster (for Mark Wegner); David Galbis-Reig; Brittany Lewin; Mishelle O'Shasky; Matthew Sweeney; Dashal Young

Ex-officio Members excused: Gary Bennett; BJ Dernbach; Katie Wagner-Roberts; Ann Sievert

Staff: Chino Amah Mbah; Joyce Allen; Beth Collier; LeeAnn Mueller; Sarah Coyle; Mike Derr; Raina Haralampopoulos; Bernestine Jeffers; Paul Krupski; Christy Niemuth; Kristine Palmer; Dennis Radloff; Kate Rifken; Gary Roth; Joann Stephens (via Skype); Scott Stokes; Mai Zong Vue; Allison Weber; Alex Wright-O'Neil

Guests: Sue Clark; Janet Fleege; Kristen Grimes; Laura Gutierrez; Laurie Heesen; Sharon Henes; Raeanna Johnson; Denise Johnson; Bill Lauer; David Macmaster; Andrea Magersman; James Pearson; Meagan Sukilowski; Tera Carter Vorpahl

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Call to Order: Duncan Shrout called the meeting to order at 9:35 a.m.

Introductions: Members introduced themselves.

Approval of March 2, 2018 Minutes: The March 2 minutes were unanimously approved by Council members. Roger Fringes abstained.

Public input:

Bill Lauer announced that he was recently hired by Oxford House to open up a new Peer Recovery Level 1 services program.

Committee Reports:

Executive Committee – The Executive Committee last met on May 15th and discussed three topics relating to how the Council interacts with policy and other policy bodies. First, they discussed measures for supporting SCAODA's efforts to insert itself into SUD treatment policies. Second, the Committee talked about SCAODA advocating for policies across broad SUD problems and needs, rather than focusing exclusively on the opioid crisis. Third, Committee members discussed potential candidates for serving as Council officers in the upcoming fall. Is a legislative member needed as the chair to increase the Council's presence? In response to the committee's report, Sen. Bewley discussed ways to better include the legislature in Council policymaking, and she asked Rep. Billings if she would consider bipartisan support, and Rep. Billings said that she would defer to the governor's opinion. She noted that Rep. Nygren is a very strong presence on the Governor's Opioid Task Force and also a member of SCAODA, and Rep. Billings suggested that he would be a good person to support the Council. Sen. Bewley stated that the Task Force is temporary, and she was looking for more permanent support. Rep. Billings responded that the issue is not going away, regardless of the party majority. Duncan Shrout proposed that committee members discuss this topic at the next Executive Committee meeting and also invite Jennifer Malcore and possibly members of the legislature, Governor's and Lt. Governor's offices.

Diversity Committee – The Diversity Committee last met on Feb. 2nd, and that meeting was reported out at the Council's March meeting. Sandy Hardie, on behalf of Thai Vue, reported that member Tish Minor passed away in May. Mai Zong Vue of DHS gave the CLAS Standards update: She is currently conducting trainings, and will offer advanced training. She will make a comprehensive presentation at a later Council meeting. During March, some Committee members met to discuss a strategic review. At upcoming Mental Health and Substance Use Disorder statewide conferences, the Committee will no longer hosting breakout sessions on CLAS. However, important conversations on diversity are still happening and it's become an acceptable topic. Mishelle O'Shasky asked about gender-specific treatment initiatives. Hardie said there the Intervention & Treatment Committee is currently addressing that topic.

Intervention and Treatment Committee – The Intervention and Treatment Committee last met on May 8th. Roger Frings did not present an update on Act 262 or on the activities of the Children, Youth and Family Treatment Subcommittee. The IT Committee has been very busy reviewing both the Phase 1 and 2 PEW reports and recommendations to the Governor's Opioid Task Force. At the May meeting, Lou Oppor also presented an overview of the mission and focus of the Wisconsin Behavioral Health Association. After Frings' report out, David Galbis-Reig expressed concern about the recent expansion of professionals who can be licensed as substance abuse counselors. DHS staff noted that Chapter DHS 75 of the Wisconsin administrative code has a different definition of a substance abuse counselor (SAC), so figuring out current and future staffing has become ambiguous and difficult. Sen. Bewley asked about the shortage of SACs –

was there any conversation about increasing the amount of payments or Medicaid coverage? Jennifer Malcore said that DHS is waiting for recent rate increases to go into effect.

Planning and Funding Committee –The P&F Committee last met on May 17th. Christine Ullstrup reported that the committee continues looking for new members. One potential committee project is to review past needs assessments and other Council reports and develop a shorter document that focuses on specific SUD needs throughout the state both in prevention and treatment. The report would describe needs in a factual, concise way that can be shared with both legislative branches to promote SUD policy. Also, many residential treatment providers are struggling to keep their doors open and fill empty beds; is there a role for the P&F Committee to examine this phenomenon further and recommend possible solutions? Medicaid rate increases could help, but to date have not solved this problem. Many treatment programs face major cash flow issues. The Committee has issued a survey to residential treatment programs attempting to collect data on licensure and bed days. There was also concern expressed about waiting lists for residential treatment, and in some instances counties with policies of not placing any consumers in residential treatment. What role should the State play in resolving these issues? Council members suggested that a survey also explore whether beds are empty because of poor service. Mishelle O'Shasky mentioned a needs assessment from the 2013 Mental Health Council that had similar needs that still needed addressing. Ullstrup replied that she was aware of these issues, but that the 2017 and next needs assessment could give a more accurate snapshot of current priorities. David Galbis-Reig mentioned issues with patients who have health co-morbidities that need IVs, but providers cannot send them home with IVs because they are addicted to IV drugs. His hospital would like to open a residential setting for these patients, but cannot secure the funds, and the hospital has to house them and eat the costs. Paul Krupski said that DHS' waiver proposal to expand Medicaid coverage has been submitted to the federal Center for Medicaid Services, but it is currently stuck in the process of approval/disapproval. Sandy Hardie said that just because a bed is available doesn't necessarily mean it's appropriate for the patients that need them – licensure issues, trauma-informed care, and gender-specific needs are also a factor. Further questions can be directed to Mike Derr.

Prevention Committee – The Prevention Committee last met on April 19th. At its January meeting, staff from Division of Public Health worked on the Healthy Wisconsin Plan to create an Alcohol Priority Purpose Plan. One immediate milestone is to review and update current goals. The Plan's June addendum will serve as the primary plan until 2020. Also, workgroups met in March, and there will be several fact sheets coming out of the Epidemiology work group focusing on veterans and suicide. The DHS prevention team is presently creating and updating AODA fact sheets for 2018, which will be released in September. At its March 28th meeting the Prevention in the Workplace Ad Hoc Committee discussed preventative steps for reducing of AODA in the workplace.

Presentations from IV Drug Prevention & Treatment Programs:

Milwaukee County – Janet Fleege and Sue Clark gave a presentation on Milwaukee County's Behavioral Health Division. Copies of the presentation will be sent out to all Council members. Page 57 of the booklet contains a handout describing three Recovery Support Coordinator (RSC) agencies. On the second slide, WCS was erroneously not included. Dashal Young asked what

ASAM stands for – Fleege replied that it stands for American Society of Addiction Medicine, and it is used as a standard set of criteria for diagnosis and placement. Duncan Shrout asked about targeted case management – Fleege replied that typically those patients require less supervision than those in CSP and RSC, but more than CCS. Raeanna Johnson asked about success of interim services on waitlist – Fleege replied that it's difficult to provide that hard data because it tends to be paid for by alternate providers. She added that keeping contact with patients is difficult, and that warm handoffs are usually the best way to ensure success. Her program uses locator forms to try to keep in touch with patients, but it's challenging. Mishelle O'Shasky wondered whether these different providers can present to SCAODA so everyone can learn more and duplicate successes. Shrout noted the interest, and added that Milwaukee County is both complicated and well-managed, and attributed success to warm handoffs and a centralized intake system.

AIDS Resource Center of Wisconsin (ARCW) – Kristin Grimes, director of prevention at the AIDS Resource Center of Wisconsin (ARCW), gave a presentation on the accomplishments of the ARCW. The presentation is available as a supplemental handout, and will be emailed to Council members. Sen. Bewley thanked ARCW for opening its center in Superior and for the needle exchange program. She asked about the Native American community participation. Grimes answered that many tribal events are conducted during the summer, and that good communications allows more services to be rendered on reservations.

Dane County – James Pearson, Clinical Team Leader at Journey Mental Health, gave a presentation on Dane County's Drug Court Treatment Program. The presentation is available as a supplemental handout, and will be emailed to Council members. Mishelle O'Shasky asked if Dane County's drug treatment court is following HIPAA guidelines, not forcing client sponsorship into Alcoholics Anonymous and Narcotics Anonymous, whether certified peer specialists are involved in this process, how charges are assigned, and other questions and concerns. Pearson responded that Journey Mental Health adheres very closely to HIPAA guidelines, is very protective of information, and welcomes observation of meetings and hearings. Recovery support meetings and traditional 12-step models can be required, but typically are not. Mentor programs are not currently in place, but Journey is looking to implement them once funding and staff are acquired. Sen. Bewley asked whether services are restricted when someone is on the sexual offender registry. The response from Pearson and some Council members: There are certain DOC standards that need to be met, but they do receive services with higher supervision and comprehensive monitoring. Specific cases can be argued in front of a judge.

ePDMP – The Prescription Drug Monitoring Program

Andrea Magermans from the Wisconsin Department of Safety and Professional Services (DSPS) gave a presentation on the ePDMP, which stands for Wisconsin Enhanced Prescription Drug Monitoring Program. The presentation slides can be found on page 64 of the SCAODA booklet, and will be emailed to Council members. David Galbis-Reig asked if providers across the state are aware of their ability to enter alerts, and expressed concerns about potential HIPAA violations being caused by those alerts. Magermans assured that the prescriber-led alerts are only

released to those actually treating the patient, and thus do not violate patient confidentiality. DSPS plans to provide more training sessions on this tool to prescribers across the state. Sen. Bewley asked for clarification on when PDMP went into effect – Magermans replied that though the legislation passed in 2009, the platform was not in place until 2013.

Agency Reports

DHS – Jennifer Malcore announced the recent formation of a Hub and Spoke Model Committee. Christine Ullstrup asked what the timeline looks like. Malcore replied that an outline will be completed by November, but conversations will still need to continue afterwards regarding public input, funding, and member involvement. Several other states have existing hub-and-spoke models, and Wisconsin is looking to emulate the successes from those efforts.

DOR – Matthew Sweeney presented the excise tax revenue collection figures. In total, revenues are down about 3%. The 2018 fiscal year's total results will be available in September.

DPI – The Department of Public Instruction had nothing to report.

DSPS – The Department of Safety and Professional Services had nothing to report. Brittany Lewin is available to answer questions from the ePDMP presentation.

DVA – Mike Ayers announced that VORP has picked up an additional one-year continuation pilot through 2018 Wisconsin legislation. Eight new positions are being filled for the Madison/Milwaukee metro area. The program is slated to be made permanent after the pilot concludes. A new 16-bed program will be opening in Green Bay. Sandy Hardie asked when the pilot ends – Ayers responded that it concludes at the end of June 2019.

Wisconsin Technical Colleges – The Wisconsin Technical Colleges system had nothing to report.

University of Wisconsin (UW) Systems – UW Systems had nothing to report.

WI Board for People with Developmental Disabilities – The Wisconsin Board had nothing to report.

Bureau of Prevention Treatment and Recovery Update:

Joyce Allen announced upcoming SUD related trainings that are coming up. These trainings can be found on page 83-84 of the SCAODA booklet. She also described the ECHO project. Information on this project is included in this meeting's supplemental materials. The Opioid STR grant has concluded its first year. Lock boxes and opioid disposal efforts have been successful, and a considerable number of coalitions provided naloxone trainings. Nearly 900 people were served by 16 counties and five tribes so far under STR grant funding. Medication-assisted treatment programs are also expanding across the state. BPTR is currently in the process of awarding second-year STR grants. HOPE-funded clinics have been expanded.

Wisconsin Council on Mental Health (WCMH) Report:

Mishelle O'Shasky reported that the Mental Health Council been working hard on strategic planning. Structure, orientation, onboarding, etc. were mentioned. Council members have concluded that it usually takes about a year of membership for new members to become accustomed. The Council is reviewing its bylaws to make sure they still make sense and are current. The Council is also discussing integration between WCMH and SCAODA. On June 13th the Council's criminal justice committee will be meeting in Milwaukee.

Next Meeting Agenda Items

- Dr. Barman has expressed an interest in presenting on MAT programs.
- The Council's new four-year strategic plan for 2018-22.
- Election of new officers for SCAODA
- Presentations on Department of Corrections SUD treatment programs
- The PEW Center is developing a second round of recommendations for the Opioid Task Force; those recommendations can be shared with the Council.

The meeting was adjourned at 1:26 p.m.

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Executive Committee, State Council on Alcohol and Other Drug Abuse (SCAODA)			Attending: See narrative below.
Date: 5/15/2018	Time Started: 9:37 am	Time Ended: 10:10 am	
Location: DHS, 1 W. Wilson St., Room 850, Madison, WI			Presiding Officer: Sandy Hardie, Committee Vice Chair

Minutes

Present: Sandy Hardie and Norman Briggs (both by phone)

Absent: Duncan Shrout

Staff: Mike Derr

Sandy Hardie called the meeting to order at 9:37 a.m.

Norman Briggs moved that the Committee's Feb. 5, 2018 draft minutes be approved. Sandy Hardie seconded the motion. Motion carried – minutes are approved.

The committee members reviewed the draft agenda for the upcoming June 1, 2018 meeting and both expressed their general approval. Sandy Hardie requested that item #4 (Election of New SCAODA Officers/Officer's Roles) be removed from the agenda. Instead, Executive Committee members should approach individual Council members who might be interested in serving as an officer, and spend time discussing the officer's roles with them. Norman Briggs noted that SCAODA has not had the same impact on statewide SUD policymaking as it had when higher-level elected officials served as the chair. Current legislators on the Council should be approached and encouraged to seek the chair or other office.

Hardie and Briggs discussed some reasons why SCAODA's policymaking profile seems diminished. Briggs noted that policymaking bodies such as the Governor's Task Force on Opioid Abuse focus on the most current SUD needs and problems that are in the headlines, while the Council continues to examine SUD and programs across the full gamut of alcohol and drug use. Both committee members were in favor of the Council continuing taking that broader perspective. Both requested that Duncan Shrout raise this point at the June 1st Council meeting.

Hardie mentioned that Rep. Billings and Nygren and Sen. Bewley serve on both the Council and Task Force; the Council should involve them more in its policymaking to help improve its link with the Task Force and legislative policymaking. Both Briggs and Hardie strongly supported the Council taking efforts to increase its profile on SUD policymaking.

No public comments were offered during the meeting.

The meeting adjourned at 10:10 a.m.

Prepared by: Michael Derr on 7/31/2018.

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE

Executive Committee

July 31, 2018

10:00 – 10:45 AM, Room 736A
Via conference call

MEETING AGENDA

1. Call to Order ……Duncan Shrout
2. Review of May 15, 2018 Meeting Minutes……...Duncan Shrout
3. SCAODA Council Sept. 7, 2018 Meeting Agenda……Duncan Shrout/Mike Derr
4. Officer Elections……..Meeting Participants
5. 2018-22 Strategic Planning Goals & Priorities……Duncan Shrout/Mike Derr
6. SCAODA Relationship with Other Policy Councils/Task Forces…….....Committee Members
7. Public Comment: Substance Use Disorder (SUD) Planning Topics……Duncan Shrout
8. Other Topics……...Committee Members
9. Adjournment……..Duncan Shrout

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Executive Committee serves under the State Council on Alcohol and Other Drug Abuse (SCAODA), and consists of the Council's three officers. The Committee's primary objective is to provide leadership and direction to the Council in the setting of Council meeting agendas and prioritizing of Council activities.

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, if you need an interpreter or translator, or if you need this material in another language or in alternative format, you may request assistance to participate by contacting Mike Derr at 608-267-7704 or at Michael.Derr@wisconsin.gov.

Conference Call: 1-877-820-7831 **Access Code:** 554523#

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE

Diversity Committee

August 3, 2018

9:30 AM to 2:30 PM
Independent Living Council
3810 Milwaukee Street
Madison, Wisconsin 53714

MEETING AGENDA

1. Welcome and Introductions…… Committee Chair
2. Public Comment: The committee will accept comments from the public relating to any committee business……Committee Chair
3. Approve Minutes from February 2, 2018 Meeting……Committee Chair
4. DCTS Updates…….. ……...Allison Weber
5. DSPS Updates……Everyone
6. Diversity Strategic Planning Update……Committee Chair
7. SCAODA 4-Year Goal..……Thai Vue
8. Diversity Reception 2018……....All
9. Membership Recruitment……All
10. Future Agenda Items……Committee Members

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Diversity Committee serves under the State Council on Alcohol and Other Drug Abuse (SCAODA). The Committee's mission is to enhance and honor the lives of Diverse Populations of Wisconsin by providing access to culturally and linguistically appropriate substance disorder use related services.

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, if you need an interpreter or translator, or if you need this material in another language or in alternative format, you may request assistance to participate by contacting Mai Zong Vue at 608-266-9218 or at maizong2.vue@wisconsin.gov.

Conference Call: 1-877-820-7831 **Access Code:** 554523#

SCAODA Motion Introduction

Committee Introducing Motion: Intervention and Treatment Committee
Motion: In response to Act 262, the State Council on Alcohol and Other Drug Abuse holds the firm belief in the best practice that professionals who deliver substance use disorder treatment have demonstrated competency as evidenced by documented relevant education, experience and supervision that align with the scope of practice and professional ethical standards.
Related SCAODA Goal: 4. Advocate for adequate funding, capacity, and infrastructure to implement effective outreach, prevention, treatment, and recovery services for all in need.
Background: Wisconsin Act 262 removed the requirement that licensed mental health professionals (Licensed Clinical Social Workers, Licensed Professional Counselors and Licensed Marriage and Family Therapists) must obtain a substance abuse counselor certification or substance abuse specialty authorization in order to practice as substance abuse counselor. Specific education and experience is required to obtain that credential. Further, it removed the requirement that these licensed mental health professionals obtain the education and experience mandated in the DSPS rule governing the use of the title Clinical Supervisor for individuals practicing as substance abuse counselors. The Act included the caveat that the licensed mental health professionals, in either case, must act within their scope of practice. The change has a positive impact by increasing the number of professionals who can provide treatment for substance use disorders. However, not all education and training programs leading to a mental health professional license place an emphasis on the treatment of substance use disorders. This motion asserts that some level of education and training is necessary to effectively treat substance use disorders within the individual's scope of practice without stipulating any specific number of hours, courses or other mandates. • Positive impact: Affirms 'Best Practice' and assures the public of minimum standards of competence. • Potential Opposition: Currently licensed Mental Health Providers
Rationale for Supporting Motion: Act 262, which became law in 2018, did not include the recognition nor cite best practice methods for the treatment of Substance Use Disorders.The statement affirms that the members of the State Council on Alcohol and Other Drug Abuse believe that the effective treatment of substance use disorders requires a body of knowledge specific to the treatment of those disorders.

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE
INTERVENTION AND TREATMENT COMMITTEE (ITC)

July 10th, 2018
10:00 a.m. to 2:30 p.m.
Location of the Meeting:
Department of Corrections
3099 E. Washington Ave.
Room 1M-M
Madison, WI

AGENDA

1. Call to Order and Roll Call
2. Review and Approval of May minutes
3. Act 262 and its impact on reimbursements.
4. Lack of access to residential treatment, and all levels of care, due to funding. (Jill Gamez)
5. Facing Addiction with NCADD/legislative updates (Joe Muchka/attachment)
6. WINTIP/UW-CTRI Substance Use Disorder Resource (David Macmaster)
7. Update on DHS 75 revision (David Nelson)
8. Section updates
    - Children, Youth and Families (Jason Cram)
    - Treatment for Women and their Children (Norman Briggs)
      Urban Rural Women's Grants
9. Public Comments
10. Announcements and/or additional information
11. Future Agenda Items
12. Adjourn

The purpose of this meeting is to conduct the governmental business outlined in the above agenda for the Intervention and Treatment Committee of the State Council on Alcohol and Other Drug Abuse. The mission of the State Council on Alcohol and Other Drug Abuse (SCAODA) is to enhance the quality of life for Wisconsin citizens by preventing alcohol and other drug abuse and its consequences through prevention, treatment, recovery, and enforcement and control activities.

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, if you need an interpreter or translator, or if you need this material in another language or in alternate format, you may request assistance to participate by contacting David Nelson at (608) 266-8113 or david.nelson@dhs.wisconsin.gov .

Conference Call: 1-877-820-7831 Passcode: 793544

Next ITC Meeting: August 14th, 2018

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Intervention and Treatment Committee			Attending: Norman Briggs, Alan Frank, Lindsey Just, Joe Muchka, Jill Gamez, Sheila Weix, David Macmaster, Bill Lauer, David Nelson, Meagan Sulikowski
Date: 7/10/2018	Time Started: 10:00 am	Time Ended: 2:30 pm	
Location: Dept of Corrections, 3099 E. Washington Ave., Madison, WI			Presiding Officer: Norman Briggs

Minutes

1. Roll call and introductions. Guests: Tanya Lettman of Journey Mental Health and Amy Anderson of UW-Madison Division of Continuing Studies.

2. May minutes were approved with one minor revision. David Macmaster motioned for approval, Sheila Weix seconded. Approved.

3. Act 262 and Reimbursements: Tanya Lettman presented on her concerns regarding billing and reimbursement post-enactment of Act 262. Concerns over Licensed Mental Health professionals no longer receiving substance use certificates and how to bill for substance use. Sheila Weix was helpful and reviewed the codes they could bill for psychotherapists engaged in SUD counseling. It was recommended if there are billing questions with Medicaid that Sophie Lee at the State level is the contact.

Also discussed, Scope of Practice for Licensed Mental Health professsionals engaged in SUD Counseling. It was suggested ITC consider a motion for education and training of Licensed Mental Health professionals with a SUD Scope of Practice based on Best Practice and present this to SCAODA for their review. Jill Gamez put together a quick recommendation for ITC review and submission then to SCAODA.

She wrote: "In response to Act 262, SCAODA holds the firm belief in the best practice that professionals who deliver SUD treatment have demonstrated competency as evidenced by documented, relevant education and experience that align with a scope of practice and professional ethical standards."

It was recommended this statement be sent to ITC members for review and discussed at August's meeting. Motioned by Al Frank to table this till August, seconded by Jill Gamez. Approved.

4. Lack of Access to Residential Treatment: Jill Gamez expressed concerns over lack of reimbursement for residential services and that many patients face a variety of roadblocks to get funded for needed services, especially if your SUD is alcohol, with no drug involvment. A concern was raised that we are too opioid and meth focused and othe SUD's are being forgotten, and that services need to be designed around a comprehensive design for all SUD. Joe Muchka discussed some grass root efforts happening in Waukesha and Sheila Weix mentioned similar efforts happening in Eagle River to address the issues in the gaps of services. A resolution was discussed with a focus and push towards the State of Wis to insure funding for every individual in every level of care is available for recovery of SUD. This was motioned by Jill Gamez, seconded by Sheila Weix. Approved.

5. Joe Muchka presented information regarding NCADD (National Council on Alcoholism and Drug Dependence) and the Legislative Health Updates and discussion happening on the national level. He could get ITC the information to receive these updates and help in the seeing what could be filtering down to the State and Local levels.

6. David Macmaster shared information regarding WINTIP/UW-CTRI Substance Use Disorder resource that offers 6 free continuing education and training opportunities and information. A link to this resource: "https://ce.icep.wisc.edu/tobacco-and-behavioral-health". David Macmaster also discussed the necessity of keeping smoking cessation in the forefront of any DHS 75 revision.

7. David Nelson gave an update on the DHS 75 revision. The Statement of Scope has been approved by Pat Cork and sent onward to the Governor's Office for signature. Once it is signed the formal revision can begin. Once the 75 Committee meets there is a timeline of 90 days for completion, however, a waiver for this timeline will be submitted considering the larger scale of DHS 75.

8. Section Updates: No new updates from the Children, Youth and Families Section. Treatment for Women and their Children, Norman Briggs mentioned the extension of the grants to the end of 2018 and in the fall new opportunities for ongoing funding will be coming forth.

9. Public Comments: None.

10. Announcements and/or additional information: the SCAODA committee was discussed briefly, but mostly business as usual. Norman Briggs did mention the Chairs of the SCAODA committees are preparing the strategic plan for SCAODA for the next four years. He presented a variety of priorities/goals (13 in all) to be a part of the overall plan, and ITC members voted on the top four they feel is most crucial to ITC. The top four: 1. Address rising level of SUD needs for senior population. 2. Enhance Council visibility as SUD policy body and increase level of advocacy to the WI Governor and Legislature. 3. Support and advocate for innovative and promising, emerging SUD practices. 4. Propose a "Beer Tax" earmarked for SUD treatment.

11: Future Agenda Items: David Macmaster to bring in information to discuss Gambling Disorders. Andrew Whitacre to call in from the Pew Foundation with updates. Invite Kenya Bright from DHS to update ITC on Recovery Coaching and Peer Specialists. Norman to update ITC on SCAODA Strategic Plan. Review and discuss ITC statement regarding Scope of Practice.

12: Adjourned at 2:30 pm. Motioned by Joe Muchka. Seconded by Sheila Weix. Approved.

Prepared by: David Nelson on 8/15/2018.

Approved: 8/14/2018

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE
INTERVENTION AND TREATMENT COMMITTEE (ITC)

August 14th, 2018
10:00 a.m. to 2:30 p.m.
Location of the Meeting:
Department of Corrections
3099 E. Washington Ave.
Room 1M-M
Madison, WI

AGENDA

1. Call to Order and Roll Call
2. Review and Approval of July minutes
3. Guest Saima Chauhan from Journey Mental Health to discuss how they influenced legislators in Arkansas regarding changes in behavioral health.
4. David Macmaster Gambling Survey results
5. Guest Andrew Whitacre from the Pew Trust Foundation (call in 11 a.m.)
6. Guest Kenya Bright from DHS re: Recovery Coaches (call in 12:45 pm)
7. SCAODA Strategic Plan (Norman Briggs)
8. Discussion on motion to SCAODA regarding the scope of practice for mental health professionals providing treatment for substance use disorders.
9. Recommendation to Planning and Funding regarding funding of residential treatment services.
10. Section updates
    - Children, Youth and Families (Jason Cram)
    - Treatment for Women and their Children (Norman Briggs)
      Urban Rural Women's Grants
    - Treatment for Senior's Workgroup (Steve Dakai)

The purpose of this meeting is to conduct the governmental business outlined in the above agenda for the Intervention and Treatment Committee of the State Council on Alcohol and Other

Drug Abuse. The mission of the State Council on Alcohol and Other Drug Abuse (SCAODA) is to enhance the quality of life for Wisconsin citizens by preventing alcohol and other drug abuse and its consequences through prevention, treatment, recovery, and enforcement and control activities.

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Conference Call: 1-877-820-7831 Passcode: 793544#

Next ITC Meeting: October 9th, 2018
Next SCAODA Meeting: September 7th, 2018

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE

Children, Youth, and Family Treatment Subcommittee (CYFT)
August 13, 2018
10:00 AM – 1:00 PM
Location of the Meeting:
Department of Corrections
3099 E. Washington Avenue; Madison, WI
Room 1E-D

AGENDA

1. Call to order and roll call
2. Report: 05/08/2018 Intervention and Treatment Committee
3. Discussion: "Mission, Action Plan, Membership, Expectations" document
4. Discussion: "Suggested Priorities/Goals for SCAODA 2018-22 Strategic Plan" document
5. Membership recruitment
6. Project Planning: Capacity and Demand Report
7. Youth Treatment Initiatives Grant – Interagency Council Meeting and CYFT
8. Public comments
9. Announcements and/or additional information
10. Future agenda items
11. Adjourn

The purpose of this meeting is to conduct the governmental business outlined in the above agenda for the Children, Youth, and Family Treatment Subcommittee of the Intervention and Treatment Committee of the State Council on Alcohol and Other Drug Abuse (SCAODA). The mission of SCAODA is to enhance the quality of life for Wisconsin citizens by preventing alcohol and other drug abuse and its consequences through prevention, treatment, recovery, and enforcement and control activities.

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Conference Call: 1-877-820-7831 Passcode: 458043

Remaining 2018 CYFT Meeting Dates (all meetings scheduled for 10:00 AM – 1:00 PM):

- October 8 and December 10

Children Youth and Family Treatment Sub-Committee

A Subcommittee of the Intervention and Treatment Committee of the
State Council on Alcohol and Other Drug Abuse

Mission, Action Plan, Membership, Expectations

Mission:
Ensure access to and effectiveness of substance use disorder treatment services and recovery supports for youth and their families.

Action Plan Relating to Children, Youth, and Families:

- Review and make recommendations for substance use disorder treatment
- Evidence based practice research, dissemination, and training
- Policy and data analysis, advising, and recommendations
- Service gap analysis
- Workforce issues

Committee Membership Representation May Include:

1. State Agencies:
    a. Department of Corrections -Division of Juvenile Corrections
    b. Department of Public Instruction
    c. Department of Children and Families
    d. Department of Health Services
2. County/Tribe Agencies:
    a. Tribal Social Services and/or Human Services
    b. County Social Services and/or Human Services
    c. Juvenile Justice
    d. School Liaison Officer
3. Private Agencies
    a. Treatment Providers
    b. Prevention Providers
4. Councils and Coalitions
    a. Alliance for Wisconsin Youth
    b. Wisconsin Alliance for Drug Endangered Children
    c. Council on Problem Gambling
    d. Tobacco Coalition
5. Citizen Participation
    a. Parent/Person with Lived Experience
    b. Others as interested/referred

Committee Membership Expectations:

All Members Shall:

1. Adhere to the State Council on Alcohol and other Drug Abuse (SCAODA) by-laws.
2. Attend all meetings of the committee; attendance means presence in the room or on phone or similar medium for more than half the meeting.

3. Any committee member that has two unexcused absences in a 12 month period may be subject to removal.
4. Committee members shall agree to a term of at least two years.

The Chairperson/Co-Chairperson Shall:

1. Be responsible for carrying out the business of the CYFT including motions that are passed be acted upon in an orderly and expeditious manner and assuring that the rights of the members are recognized.
2. Appoint a designee to preside at a meeting if they are unavailable.
3. Be responsible for organizing the work of the CYFT, scheduling meetings, and setting the agenda.
4. Work with DHS staff to coordinate meeting logistics and disseminate meeting information, minutes and notices.
5. Attend or have designee attend Intervention and Treatment Committee (ITC) meetings and SCAODA meetings and be prepared to report on CYFT business.

Approved by ITC: 05/08/2018

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Planning and Funding Committee, State Council on Alcohol and other Drug Abuse (SCAODA)			Attending: Members: Christine Ullstrup; Raeanna Johnson; Brian Dean; Vonda Benson; Karen Kinsey; Kevin Florak Guests: Norman Briggs DHS Staff: Mike Derr
Date: 5/17/2018	Time Started: 9:33 am	Time Ended: 11:55 am	
Location: ARC Community Services, 1409 Emil St., Madison, WI			Presiding Officer: Christine Ullstrup, Interim Committee Chair

Minutes

Call to Order:

Interim Committee Chair Christine Ullstrup called the meeting to order at 9:3e a.m. Attendees introduced themselves.

Review of 4/12/2018 Meeting Minutes:

Christine Ullstrup referenced the draft minutes from the last Committee meeting and asked for comments and corrections. None were offered. Kevin Florek moved that the minutes be approved and Raeanna Johnson seconded the motion. Motion carried unanimously.

Public Comment:

No persons offered any public comment on Committee business either in person or via telephone.

Continue Discussion of Committee's SUD Priorities and Concerns:

Committee members brought up the concerns of unfilled beds in residential treatment facilities, and lack of sources for reimbursements as well as low reimbursement rates. Kevin Florek and Karen Kinsey mentioned that non-profit agencies struggle with cash flow due to a very cumbersome process for completing financial reports and reimbursement claims. Also, state and federal agencies are taking longer to pay reimbursement claims. They suggested the Committee add a county fiscal person as a member, or invite such a person to present on this issue to help propose solutions. Brian Dean and Vonda Benson suggested that government agencies must do a better job to explain how record keeping should be done, and the reasons why for specific records and information.

Committee members focused on the need to fill residential treatment beds, understand why there are empty beds, and provide adequate funding as a major focus area for this Committee moving forward. Members suggested holding an additional meeting on July 18th, and inviting Dan Kiernan of DHS, Division of Medicaid Services, to discuss the current status of MA coverage, the IMD exclusion allowing MA coverage of residential treatment for up to 15 days, current state and federal law permitting Comprehensive Community Services (CCS) programs to bill MA for services (but not room and board), and the Federal Section 1115 Waiver Project. Committee members and Norman Briggs also noted that crisis stabilization beds are covered under MA, and that MA covers state mental health institute placements for certain populations.

The Committee would like to explore further the reasons and factors behind the decisions whether to place consumers in residential treatment, including the role and adoption of ASAM placement and level of care criteria by counties. Kevin Florek gave as one example situations where counties are diverting consumers to county jails and hospitals instead of residential treatment, which end up absorbing those costs and saves money for specific county accounts. Christine Ullstrup posed the question, what are the best ways to reach

policymakers to promote additional funding for residential treatment, and development of systems or protocols for finding available beds? This would include increasing the level of reimbursement rates issued to residential treatment providers, and adopting policies adding residential treatment within the array of AODA services covered under MA. Kevin Florek emphasized that unfilled residential treatment beds and similar concerns are topics that SCAODA members need to know about. Ullstrup noted that some programs will not accept MA clients due to the lower rates, so some MA and indigent clients can't access residential treatment. Yet providers note that their service costs are very high such that MA rates are too low to recoup all those costs.

Christine Ullstrup recommended that the committee perform a study on these issues by phone surveying residential treatment providers statewide, asking them to report on their occupancy rate, and the cost of residential treatment. From this the committee could write up a report that explains the favorable reasons for residential treatment compared to other forms of placements or services, and provides cost comparisons with hospitals and explains why residential treatment is cost-effective. The report would be written and approved by the Committee in time for the Sept. 7th SCAODA meeting. DHS staff will provide a list of DHS 75 residential treatment providers to Ullstrup, who will work with Florek and Tellurian in taking the lead on the phone survey. The report will summarize the survey findings, incorporate research on the benefits of residential treatment, and educate readers on what residential treatment is, compare it to in-patient treatment, and explore how ASAM criteria can be used to promote the use of residential treatment. Currently, Wisconsin has fewer residential treatment placements than other similarly-populated states.

Also at the July 18th committee meeting, members would like Dave Nelson of DHS to discuss ways that ASAM could serve as a major impetus for filling residential treatment beds, and also discuss how DHS' past and current ASAM training programs could accomplish this outcome.

2018-22 SCAODA Strategic Plan Discussion:

The Committee reviewed the list of suggested priorities and goals for the next SCAODA four-year Strategic Plan; this list was created during the first meeting of the SCAODA Executive Committee and various committee chairpersons. Each committee was asked to select 3-4 priorities/goals for the Executive Committee to incorporate into the new Strategic Plan. P&F Committee members Priority/Goal nos. 1, 4, 5 and 8:

- No. 1 is increased focus and resources for youth and adolescent prevention and treatment programs.
- No. 4 is reduced public stigma attached to seeking and obtain substance use disorder (and mental health) services. Members recommended that this priority/goal also reference increasing access to such services, and increasing development and utilization of those services.
- No. 5 is promoting training and preparation of entire SUD workforce, to include social workers, peer recovery coaches and specialists, and prevention specialists.
- No. 8 is enhancing the Council's visibility as a major SUD policy body, and increasing the level of advocacy to the Wisconsin Governor and Legislature.

Bureau of Prevention Treatment and Recovery Update:

Mike Derr's normal update was tabled to provide Committee members more time to discuss upcoming substance use disorder (SUD) priorities and concerns, and the 2018-22 SCAODA Strategic Plan.
Karen Kinsey proposed that the August Committee meeting include a discussion of the finalized SAMHSA compliance monitoring findings on SABG Program administration from the Aug. 2016 site visit.

Regarding 2017 Wisconsin Act 262, Christine Ullstrup stated that the Committee should support low-cost training for mental health workers on the meaning of a SAC's scope of practice, including best practices. Norman Briggs mentioned a Beta database that was recently developed that is being used by some states to track available bed space. Minnesota has a similar database called "Minnesota Track."

Also, Mike Derr briefly summarized two reports that were shared with Community members: the 2013 *Burden of Excessive Alcohol Use in Wisconsin,* and *Regional Shared-Services Pilots: Final Report,* written by DHS, Division of Care and Treatment. The latter report gave several preliminary findings on the work completed in implementing a shared-services model for delivering core mental health and SUD services across the member counties, along with some preliminary findings on outcomes. Karen Kinsey would like the Committee to discuss this report further at an upcoming meeting.

Adjournment:

By consensus, the Committee agreed that the meeting should be adjourned. Adjournment at 11:55 a.m.

Prepared by: Michael Derr on 7/16/2018.

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE

Planning and Funding Committee

July 18, 2018

9:30 AM to 12:00 PM
ARC Community Services Building, 1409 Emil Street
Madison, Wisconsin 53707

MEETING AGENDA

1. Call to Order and Roll Call……Christine Ullstrup
2. Review May 17, 2018 meeting minutes……Christine Ullstrup
3. Public Comment: Substance Use Disorder Planning Topics……..Christine Ullstrup
4. Residential Treatment: Funding Sources & Reimbursement Rates……Committee Members
5. Residential Treatment: Medicaid……..Dan Kiernan DHS/DMS
6. Filling Committee Vacancies……Christine Ullstrup
7. Bureau & Prevention Treatment & Recovery Updates……..Mike Derr
8. Agency and Provider Updates……...Committee Members
9. Agenda Items for August 9, 2018 Committee meeting……..Committee Members
10. Adjournment……All

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Planning & Funding Committee serves under the State Council on Alcohol and Other Drug Abuse (SCAODA). The Committee's primary objective is to assist SCAODA with coordinating substance use disorder planning and funding initiatives across state agencies.

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Conference Call: 1-877-820-7831 **Access Code:** 554523#

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Planning and Funding Committee, State Council on Alcohol and other Drug Abuse (SCAODA)			Attending: Members: Christine Ullstrup; Raeanna Johnson; Brian Dean; Vonda Benson; Norman Briggs (for Karen Kinsey); Duncan Shrout (called in) Not Present: Kevin Florek Guests: Dan Kiernan, DHS; David Nelson, DHS DHS Staff: Mike Derr
Date: 7/18/2018	Time Started: 9:50 am	Time Ended: 12:01 pm	
Location: ARC Community Services, 1409 Emil St., Madison, WI			Presiding Officer: Christine Ullstrup, Committee Co-Chair

Minutes

Call to Order:

Committee Co-Chairperson Christine Ullstrup called the meeting to order at 9:50 a.m. Attendees introduced themselves.

Review of 5/17/2018 Meeting Minutes:

Christine Ullstrup referenced the draft minutes from the May 2018 Committee meeting and asked for comments and corrections. None were offered. Norman Briggs moved that the minutes be approved and Raeanna Johnson seconded the motion. Motion carried unanimously.

Public Comment:

No persons offered any public comment on Committee business either in person or via telephone.

Discussion on Residential Treatment Beds and Funding:

Christine Ullstrup gave an update on the activities and status of the survey that was sent out during the summer to all AODA residential treatment providers certified under DHS 75.11 or 75.14. Ullstrup received responses from 26 providers, highlighted in yellow on the spreadsheet handout. (Other committee members noted though that some of the providers who also responded were not highlighted in yellow.) Ullstrup read off a few of the responses verbally to indicate the survey questions and provide a sample of responses. Mike Derr will assist her with tabulating and sharing the results for the Committee's August meeting. When reviewing the spreadsheet, Ullstrup explained that Meta House and other providers can hold both 75.11 and 75.14 certifications. Norman Briggs questioned this, stating that ARC was told by DHS, Division of Quality Assurance that treatment providers could hold only one or the other certification, not both. DHS staff will review this question and report back to the Committee.

Norman Briggs brought up discussion at July Intervention & Treatment Committee meeting about the process for approving client placements into residential treatment that are publicly-funded by Dane County. Committee members related that counties employ various processes and approaches for approving such placements. Briggs suggested that the P&F Committee consider adopting a motion that recommends the state coordinate and manage residential placements statewide, given that some programs (especially in Milwaukee) are full while other programs across the state regularly have available beds.

Overview of Medicaid-funded AODA Services:

Dan Kiernan with DHS Division of Medicaid Services introduced himself and gave a brief overview of his division and of the Wisconsin Medicaid program. He went over the Section 1115 BadgerCare Reform

Demonstration Waiver webpage and the status of that request to the federal Center for Medicaid Services. He also reviewed the May 2017 ForwardHealth update on coverage of residential treatment services offered by the Comprehensive Community Services (CCS) providers. The Section 1115 Waiver. Presently in Wisconsin, Medicaid (MA) does not generally cover residential treatment is for substance use disorder (SUD) and mental health services One exception to that exclusion requested in the Section 1115 Waiver project would be SUD treatment facilities that qualify as IMDs. Norman Briggs asked if this exception would cover programs with more than 16 beds, and Kiernan responded not necessarily, there are other factors. Also, MA does not cover room and board costs in non-institution, non-hospital settings. There was also some discussion regarding a new federal bill, passed by the House, which would remove the current IBD exclusion from MA for opioid treatment programs.

In addition, Kiernan expressed interest in working with both the P&F and Intervention & Treatment committees on crafting policy questions and responses for residential treatment providers; he and Mike Derr will maintain contact on that front. Kiernan also briefly shared his knowledge and understanding regarding 2018 Wisconsin Act 262's impact on substance use disorder counselors and other professionals. Norman Briggs noted the discordance of the overall SAC certification and approval process. DSPS has recently returned licensure applications to C-SACs stating that applications are no longer needed. Yet MA offices are still requesting evidence of licensure for C-SACs, causing confusion. Kiernan concurred with Duncan Shrout's suggestion that SCAODA more formally partner with Division of Medicaid Services to secure information from residential treatment providers and issue out policy statements regarding Medicaid coverage and similar funding decisions.

Bureau of Prevention Treatment and Recovery Update:

David Nelson and Mike Derr of the bureau gave a brief update on the DHS 75 administrative rulemaking project. DHS 75 is being updated to align with ASAM placement levels and terms. Nelson gave brief description of the two-page Crosswalk of DHS 75 with ASAM standards. Nelson mentioned that intensive outpatient programs are not referenced in the current rule; that program will included. He also stated that DHS 75 will state 'floor-level' criteria for providers to meet. BPTR will advocate for providers to incorporate best practices. Norman Briggs stated that rule criteria needs to be less prescriptive. Finally, he noted that the Act 262 changes and their impact need to be fleshed out further with DSPS and other agencies.

Mike Derr handed out the draft Statement of Scope of the DHS 75 rulemaking project and a list of the Advisory Committee members for the project that DHS has selected. (Since the meeting, Governor Walker approved the Statement of Scope on July 26th.)

Filling Committee Vacancies:

Christine Ullstrup and committee members briefly discussed themes for filling 1-2 committee vacancies. Members agreed that one slot should include a prevention specialist, and that new members should represent the geographic and cultural/ethnic diversity of the state. Seeking new members with information on available funding would also be helpful. Norman Briggs stated that the IT Committee members can assist this committee by contacting prospective members. Ullstrup would like the Committee to continue addressing this at the August meeting.

Next Meeting and Adjournment:

Committee members agreed that an August meeting needs to still be held to consider the residential treatment provider survey results and decide how to proceed. The meeting date will be moved from August 9th to 15th in the morning.

Christine Ullstrup moved that the meeting adjourn; Vonda Benson seconded the motion. Motion carried. Meeting adjourned at 12:01 pm.

Prepared by: Michael Derr on 8/13/2018.

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE

Planning and Funding Committee

August 15, 2018

9:30 AM to 12:00 PM
ARC Community Services Building, 1409 Emil Street
Madison, Wisconsin 53707

MEETING AGENDA

1. Call to Order and Roll Call……Christine Ullstrup
2. Review July 18, 2018 meeting minutes……Christine Ullstrup
3. Public Comment: Substance Use Disorder Planning Topics……..Christine Ullstrup
4. Residential Treatment Survey Results……C. Ullstrup and Mike Derr
5. Possible Actions Stemming from Survey Results……..Committee Members
6. School Climate Transformation Grant Proposal by DPI……John Bowser, DPI
7. Recruiting New Committee Members……..Christine Ullstrup
8. Agency and Provider Updates……...Committee Members
9. Agenda Items for October 11, 2018 Committee meeting……..Committee Members
10. Adjournment……All

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Planning & Funding Committee serves under the State Council on Alcohol and Other Drug Abuse (SCAODA). The Committee's primary objective is to assist SCAODA with coordinating substance use disorder planning and funding initiatives across state agencies.

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Conference Call: 1-877-820-7831 **Access Code:** 554523#

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: SCAODA Prevention Committee - Alcohol Priority Action Team			Attending: Caroline Miller, Christy Niemuth, Raina Haralampopoulos, Allison Weber, Kimberly Wild, Sarah Johnson, Margarita Northrop, Matthew Collie, Annie Short, Nicole Butt, Frank Buress, Emily Holder, Danielle Luther, Sarah Linnan, Kari Lerch,
Date: 4/19/2018	Time Started: 12:30 p.m.	Time Ended: 3:30 p.m.	
Location: Wisconsin State Patrol DeForest Post, 911 W. North Street, DeForest, Wisconsin 53532			Presiding Officer: Caroline Miller and Chris Wardlow, Co-Chairs

Minutes

1). Welcome and Introductions: Caroline Miller welcomed members and guests to the Governor's State Council on Alcohol and Other Drug Abuse's (SCAODA) Prevention Committee and Alcohol Priority Action Team meeting. Caroline is continuing to be the Co-Chair of the Committee until her maternity leave with the assistance from Chris Wardlow. Chris, Co-Chair introduced himself and asked members and guests to introduced themselves and their organizational affiliations.

2). Public Comment: No public comment.

3). Approve Minutes from the January 18 and March 1 Meetings: Chris Wardlow asked for the members to review the meeting minutes from the January 18th and March 1st meetings of the Prevention Committee. Sarah Johnson made a motion to approve the both sets of meeting minutes, seconded by Kari Lerch, no discussion, and motion passed. Caroline abstained from voting on the January meeting minutes.

4). Updates on Discretionary Prevention Grants
- Great Lakes Inter Tribal Council/Tribal Grant PFS: Nicole Butt, has been the Acting Project Director and the Epidemiologist for the grant. The grantees are implementing strategies and collecting surveys. The strategies that are being implemented focus on raising awareness within the tribal communities.
- Opioid State Targeted Response – Christy Niemuth shared that Wisconsin had recently received the notice to award grant announcement. The funding has stayed the same and the prevention set aside is around $730,000. All Alliance for Wisconsin Youth's coalitions are eligible to apply. There won't be a lot of changes from the previous year in regards to the prevention strategies that coalitions can select.
- Partnership for Success 2015 – Raina Haralampopoulos shared that they have not received approval for the grant's carryover request and hopes they will receive more information shortly. The Regional Prevention Centers and coalitions are continuing to implement their strategies and will be working on the next year's plan.
- Prevent Prescription Drug/Opioid Overdose-Related Deaths – Christy shared that the grant is focused on reducing harm and the goal is disseminate naloxone and train providers and community members on its use. Local health departments have reported not having the street outreach skills to reach individuals who are at high risk for experiencing an overdose so they are working with ARCW. Recently, the carryover request was approved. Future work will be writing up "lessons learned" and "tips and tricks" to share statewide.
- State Epidemiological Outcomes Workgroup – Raina shared that they have postponed the SEOW's meeting because many members were attending the Opioid Forum. A smaller workgroup has been working on updating the 2018 Epi report.
- Strategic Prevention Framework Rx – Kimberly Wild reported that the two grantees, Sauk and Dodge counties are coming along. There will be a Substance Abuse Prevention Skills Training (SAPST) in June for Dodge county to get them up to speed on substance use prevention. Work has been focused on coalition development in these two counties. The counties have been sending individuals to the Opioid Forum and Prescription Drug and Heroin Summit. The grant is still waiting for approval on their carryover request.

5). Prevention in the Workplace Ad hoc Committee– Allison Weber, shared that the Committee has been meeting monthly and they have had invited guests to present and educate them on the following topics, trauma informed care,

drug court, and programs and policies from the Wisconsin Department of Workforce Development. The Committee has started to identify recommendations and will be meeting next week in Montello (Marquette county). The plan is to have a draft report completed by early fall to present to the Prevention Committee for their approval at the December meeting.
- Opioid Advisory Workgroup – The OAW has been meeting prior to the Prevention Committee's meetings. They have been asked and have accepted to be the Opioid Priority Action Team for *Healthy Wisconsin*. They are working on the same items that the Prevention Committee has been working on, only for opioids.

6). Review the Prevention Committee Workplan: Raina shared the workplan document. The full SCAODA will be updating their Strategic Plan and are asking its Committees to provide feedback and input on the Councils goals and priorities. At the Prevention Committee's July meeting there will be more discussion about it. The Co-Chairs will then present the Prevention Committee's priorities to the full Council at their September meeting.

7). Update on the Alcohol Priority Action Team and *Healthy Wisconsin*: Matthew Collie presented the Healthy Wisconsin Alcohol Priority Purpose Plan document. The document will be updated and the Committee is merely accepting it with the understanding that it will change. The discussion continued and there was a request to add: "Tribal government, agencies, and organization" to the Stakeholders/Partners section. Another addition to the section would be "other interested agencies," "community coalitions," and the "Alliance for Wisconsin Youth". Another change was requested to the Timeline section, to include a bullet point that would be about "disseminating and sharing information about emerging trends and promising practices statewide". A motion was made by Frank Buress to accept the suggested changes to the Plan and that the document will be shared at future meetings, seconded by Kari Lerch, and the motion passed. At the next Public Health Council's meeting, Julia Sherman will be presenting the work of the Alcohol PAT and Prevention Committee. She will keep everyone informed and will provide an update at a future Prevention Committee meeting.

8). Agency Member Updates:
- Emily Holder, from the Wisconsin Department of Public Instruction (WI DPI) provided handouts on the recent Youth Risk Behavioral Survey (YRBS) and said if anyone needs more she would be happy to give them away. They are getting ready for the 2019 YRBS and will be hosting stakeholder meetings for input. The online format of the survey can be used in 2019. Discussed the new "safe and drug free school funding" that allows schools districts to apply for grant dollars to enhance their activities on broad topics and the effective use of technology.
WI DPI will also be launching the fourth cohort of trauma sensitive schools. They will continue to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Mental Health First Aid and the training will be done by the WISH Center.
- Allison shared information about the Wisconsin's Substance Abuse Prevention Services Information System (SAPSIS) that included the recent memo on the changes and upgrades and the required Substance Abuse Block Grant reporting.
- Danielle Luther, from the Center for Community Health Advancement shared information about the upcoming regional Annual Meeting and Training (AMAT) that will be taking place in Stevens Point on June 20 and 21. She also shared information on the two campaigns they have been working on; the KNOW Meth campaign and the Dose of Reality materials for tribal communities.
- Frank Buress, shared information about the recent addiction workshop about medication and alcohol that was hosted by the Healthy Communities Healthy Youth of Marquette County. The evaluations from the workshop requested that the coalition host another event like this one in the future.

Prepared by: Mary Raina Haralampopoulos on 7/17/2018.

These minutes are in draft form. They will be presented for approval by the governmental body on: 7/19/2018

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE
Prevention Committee

July 19, 2018

12:30 PM to 3:30 PM

Wisconsin State Patrol DeForest Post
911 W. North Street
DeForest, Wisconsin 53532

MEETING AGENDA

1. Welcome and Introductions…….Chris Wardlow, Interim Chair
2. Public Comment: The committee will accept comments from the public relating to any committee business……Interim Chair
3. Approve Minutes from April 19 Meeting…….Interim Chair
4. SCAODA 2018-22 Strategic Plan Discussion and Review…….Interim Chair
5. Update on the Alcohol Priority Action Team (PAT) and *Healthy Wisconsin*…….Team from the Office of Policy and Practice Alignment, Division of Public Health, Wisconsin Department of Health Services (OPPA, DPH, DHS)
    - Briefing on Public Health Council Meeting (June 1st)
    - Public Health Council's Feedback to the Alcohol PAT
    - Annual Addendum
    - Discussion and Selection of the Alcohol PAT's Strategy to Implement and Complete by December 31
6. Agency Member Updates…….Committee Members
7. Updates on Discretionary Prevention Grants…….Nicole Butt, Raina Haralampopoulos, Sarah Linnan, Christy Niemuth, and Kimberly Wild
    - Great Lakes Inter Tribal Council/Tribal Grant PFS (GLITC)
    - Opioid State Targeted Response (STR)
    - Partnership for Success 2015 (PFS 15) and State Epidemiological Outcomes Workgroup (SEOW)
    - Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO)
    - Strategic Prevention Framework for Prescription Drug (SPF Rx)

8. Updates on the Ad Hoc and Workgroup

    - Prevention in the Workplace Ad hoc Committee…….Allison Weber
    - Opioid Advisory Workgroup…….Christy Niemuth

9. Future Agenda Items…….Committee Members

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Prevention Committee serves under the State Council on Alcohol and Other Drug Abuse (SCAODA). The Committee's primary objective is to assist SCAODA with coordinating substance abuse prevention initiatives across state agencies.

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, if you need an interpreter or translator, or if you need this material in another language or in alternative format, you may request assistance to participate by contacting Raina Haralampopoulos at 608-267-3783 or at Mary.Haralampopoulos@wisconsin.gov.

Conference Call: 1-877-820-7831 Passcode: 441096

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: SCAODA Workplace Prevention Ad-hoc Meeting			Attending: Frank Buress, Allison Weber, Chino Amah Mbah, Jill Gamez, Michelle Devine
Date: 7/18/2018	Time Started: 10:00 a.m.	Time Ended: 2:00 p.m.	
Location: 1 West Wilson, Madison WI, 53703. Department of Health Services, CR 750			Presiding Officer: Jill Gamez

Minutes

1). Welcome and introductions: Members present were welcomed.

2). Approval of previous meeting minutes: Michelle made a motion to approve the meeting minutes and Frank seconded it. The meeting minutes were approved.

3). Public comment: There were no public comments made at this meeting.

4). Working meeting to develop content for the report to the Prevention Committee: Jill will post a document on Basecamp that will provide guidance to other members when writing their recommendations. A group member will also like to have or know the number of people in recovery in Wisconsin.

The group went over who was writing different sections of the recommendations. The group was also made aware of the changes to the table of contents which is now more detailed to also serve as a guide. The group would also like to reach out to the DCTS staff person responsible for doing trauma-informed trainngs to get language and a general write up for an introductory paragraph about trauma and how trauma impacts workers and how it can also contribute to substance misuse and disorders.

Group members were also aksed to keep a list of all the acronyms they use when writing their pieces for the report as this will be pulled together when drafting the frequently used acronyms page.

The group plans to have a complete draft shown to the Prevention Committee at their meeting in October and hoepefully have the draft presented to large SCAODA at the meeting in December.

Members started to draft their sections for the reports.

5). Future Ad Hoc Committee Meeting Dates and Agenda Items

The next meeting is on August 15, 2018 at the Deforest State Patrol Office from 10:00 a.m. - 2:00 p.m.

The meeting in September will be on September 19, 2018, from 12:00 – 3:00 p.m. at Deforest State Patrol Office.

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE
Prevention Committee:
Workplace Prevention Ad-Hoc Committee

August 15, 2018
Division of State Patrol
Southwest Region Headquarters
911 W. North Street
DeForest, WI 53532
10:00AM-2:00PM

MEETING AGENDA

1. Welcome and Introductions…….Jill Gamez, chairperson
2. Approval of previous meeting minutes
3. Public Comment: The committee will accept comments from the public relating to any committee business
4. Working meeting to develop content for the report to the Prevention Committee
5. Future Ad Hoc Committee Meeting Dates and Agenda Items

   September 19, 2018: 12:00-3:00 PM

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Workplace Prevention Ad Hoc Committee's primary mission is to consider preventing substance use with the goal of creating safe and productive workplaces by researching, evaluating and developing recommendations for Wisconsin workplaces.

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, if you need an interpreter or translator, or if you need this material in another language or in alternative format, you may request assistance to participate by contacting Allison Weber at 608-266-5156 or at allison.weber@wisconsin.gov

Conference Call: 1-877-820-7831 Passcode: 441096

SCAODA Four-Year Strategic Plan: 2018-2022

SCAODA Mission Statement: Provide leadership and direction on substance use disorder (SUD) issues in Wisconsin by serving as the voice to whom the Governor, legislators, local coalitions, and media turn for guidance on SUD issues, and promote collaboration across multiple sectors to advance and monitor progress of SCAODA's goals.

SCAODA Primary Goals and Objectives for 2018-22
1. Change Wisconsin's cultural norms to transform the state's AODA problems into healthy behavioral outcomes. Objectives: (a) Reduce public stigma attached to seeking and obtaining SUD treatment and mental health services.
2. **Inform Wisconsin citizens on the negative fiscal, individual, and societal impacts of substance use disorders.** Objectives: (a) Enhance Council visibility as an SUD policy body and increase its level of advocacy to the Wisconsin Governor, Legislature and interested citizens.
3. **Advocate for adequate funding, capacity, and infrastructure to implement effective outreach, prevention, treatment, and recovery services for all in need.** Objectives: (a) Increase focus and resources for youth and adolescent prevention and treatment programs, to include: (1) collegiate recovery and support resources; and (2) continue revitalizing the Children, Youth and Family Treatment Sub-Committee. (b) Address the rising levels of SUD needs for the senior population. (c) Expand and train substance use disorder workforce capacity of prevention specialists and peer recovery specialists and coaches, including their capacity to understand and address the SUD needs of underserved populations with specific language and cultural issues as recommended in the Culturally and Linguistically Appropriate Services (CLAS) Standards. (d) Continue supporting and advocating the use of SBIRT (Screening, Brief Intervention and Referral to Treatment) models throughout schools and communities. (e) Support and advocate adoption of emerging innovative and promising SUD programs and practices. (f) Increase the excise tax on fermented beverages to meet the average tax of all states, and increase the portion of excise tax revenue apportioned to SUD programs.
4. **Remedy historical, racial /ethnic, gender, and other bias in substance use disorder systems, policies, and practices.** Objectives: (a) Improve the effectiveness of addressing the SUD needs of underserved populations. (b) Expand focus beyond services targeting needs of cultural/ethnic population groups to include the needs of socio-economic groups and geographic areas. (c) Support research and identification of SUD-related social determinants of health. (d) Support and advocate adoption of emerging innovative and promising SUD programs and practices that are incorporated within the national CLAS standards.

Committee	Objective/Plan to address SCAODA Primary Goal	Goal & Objective No.
Diversity	Enhance Council visibility as an SUD policy body and increase its level of advocacy to the Wisconsin Governor, Legislature and interested citizens.	2(a)
	Improve the effectiveness of addressing populations-specific SUD needs.	4(a)
	Expand focus beyond services targeting needs of cultural/ethnic population groups to include the needs of socio-economic groups and geographic areas.	4(b)
	Support research and identification of SUD-related social determinants of health.	4(c)
	Support and advocate adoption of merging innovative and promising SUD programs and practices that are incorporated within the national CLAS standards.	4(d)
Intervention and Treatment	Increase focus and resources for youth and adolescent prevention and treatment programs, to include: (1) collegiate recovery and support resources; and (2) continue revitalizing the Children, Youth and Family Treatment Sub-Committee.	3(a)
	Address the rising levels of SUD needs for the senior population.	3(b)
	Support and advocate adoption of emerging innovative and promising SUD programs and practices.	3(e)
Planning & Funding	Reduce public stigma attached to seeking and obtaining SUD treatment and mental health services.	1(a)
	Enhance Council visibility as an SUD policy body and increase its level of advocacy to the Wisconsin Governor, Legislature and interested citizens.	2(a)
	Increase focus and resources for youth and adolescent prevention and treatment programs, to include: (1) collegiate recovery and support resources; and (2) continue revitalizing the Children, Youth and Family Treatment Sub-Committee.	3(a)
	Expand and train substance use disorder workforce capacity of prevention specialists and peer recovery specialists and coaches, including their capacity to understand and address the SUD needs of underserved populations with specific language and cultural issues as recommended in the Culturally and Linguistically Appropriate Services (CLAS) Standards.	3(c)
	Continue supporting and advocating the use of SBIRT (Screening, Brief Intervention and Referral to Treatment) models throughout schools and communities.	3(d)
	Increase the excise tax on fermented beverages to meet the avg. tax of all states; increase portion of excise tax revenue apportioned to SUD programs.	3(f)
Prevention	Reduce public stigma attached to seeking and obtaining SUD treatment and mental health services.	1(a)
	Expand and train substance use disorder workforce capacity of prevention specialists and peer recovery specialists and coaches, including their capacity to understand and address the SUD needs of underserved populations with specific language and cultural issues as recommended in the Culturally and Linguistically Appropriate Services (CLAS) Standards.	3(c)
	Support and advocate adoption of emerging innovative and promising SUD programs and practices.	3(e)
	Improve the effectiveness of addressing the needs of underserved populations.	4(a)

TCI SUD PROGRAMMING

September 7, 2018

Jill Wolf, MSW, LCSW, CSAC, CS-IT

OVERVIEW

- Taycheedah Correctional Institution is an intake institution for female inmates
- Current population 970
- Medium/Maximum custody

- The women's system has two minimum centers

1. Robert E. Ellsworth Correctional Center
2. Milwaukee Women's Correctional Center

SUBSTANCE USE DISORDER OVERVIEW

- TCI receives $129,890 federal block grant
  - 50% - Salary/Fringe – funds 1 provider
  - Remainder is for supplies, training/ conferences, in-state travel, consultant/contractual cost to supplement treatment specialists for the group
- Six month reviews done by Correctional Program Supervisor, treatment specialist and Program and Policy Analyst – Advanced

TCI ASSESSMENT PROCESS

- Credentialed assessor completes a TAAD-5 within 2 weeks of intake
- The TAAD-5 is a triaged assessment that provides a diagnosis of severity in accordance with the DSM-V
- The results of the substance use disorder diagnosis and the risk for recidivism determines the level (dosage) of SUD treatment

SUD Levels
ASSIGNED SAME AS MALE SYSTEM

Assessment result	Low Risk	Moderate Risk	High Risk
No Diagnosis	No treatment	No Treatment	No Treatment
Mild SUD	No Treatment	SUD-2	SUD-4
Moderate SUD	SUD-1	SUD-3	SUD-4
Severe SUD	SUD-1	SUD-3	SUD-4

Curricula

- Helping Women Recover
- Seeking Safety
- Connections
- Moving On
- Beyond Violence

HELPING WOMEN RECOVER

Integrates theories of women's:

- Psychological Development
- Trauma
- Addiction

There are 4 modules:

1. Self
2. Relationships
3. Sexuality
4. Spirituality

SEEKING SAFETY

- Present-based counseling model
- Helps clients attain safety from trauma and substance abuse

Topics covered:

- PTSD
- Healthy Relationships
- Coping Skills
- Grounding Techniques

Key principles are helping clients attain safety in relationships, thinking, behavior and emotions while working on trauma and substance abuse.

CONNECTIONS

Psycho-educational shame resilience curriculum

MOVING ON

- Targets at risk women
- Combines cognitive restructuring theory with cognitive skills
- Aimed at helping women take control of their lives by taking control of their thinking

BEYOND VIOLENCE

Targets justice involved women with histories of aggression or violence

Four Modules explores interplay between:

1. Individual
2. Relationship
3. Community
4. Societal Factors

SUD LEVELS

SUD 1	No formal treatment	Case Plan Intervention
SUD 2	12 Weeks	Helping Women Recover Connections
SUD 3	14 Weeks	Helping Women Recover Seeking Safety Connections Moving On
SUD 4	16 Weeks	Helping Women Recover Seeking Safety Moving On Connections Beyond Violence

DUAL DIAGNOSIS

- 20 weeks
- Helping Women Recover
- Seeking Safety
- Moving On
- Connections
- Beyond Violence
- Coping with Feelings (DBT informed)
- Picking Up the Pieces-Grief/loss program
- Mental Health Education (psychological services)

TCI SUD PROGRAM EVALUATION

- 77.78% completion rate
- 70% of participants who completed the program display 12% decrease on the criminal rationalization scale
- 100% negative UA's
- 100% of participants had a discharge plan in place when releasing back to the community

STAFF PERSPECTIVE

- Seeking Safety: The formatting is great. The two hour time frame is sufficient and I like the consistency of the process of checking in/out, the quote, and discussions. I love that there are discussion questions for each handout. This acts as a basic "go to" and can initiate some very deep relevant discussions that we can expand on, which is very helpful for us as busy facilitators.
- Beyond Violence: This curriculum has generated very deep discussions with groups. They relate very well to the DVD that is shown at various times throughout the curriculum. I like the journaling exercises. I love hearing the assignment given including page 431 writing about a random act of kindness, working though remorse, making amends, and writing about personal growth (It is Six Months from this date). More often than not; the ladies will ask to see the DVD in its entirety at the end of program/after last session.
- Helping Women Recover: The women sharing their people, places, and experiences of their lives. The "mother's" activity.
- Connections: Really helps clients to develop an understanding of shame; the differences between shame/guilt, and how to become resilient to our shame. I have had personal experiences in this curriculum several times where a client will say "I don't have any shame" and then they have lightbulb moments a week or two later and share with a good understanding of shame and how it has affected them.

SUCCESS STORIES

- I didn't think I needed SUD treatment because I was sober for four years in prison and was only doing groups because the judge said I had to. I didn't realize that my sobriety included my relationships, self-esteem and religious beliefs until I started listening to my facilitator and other staff I was working with. I was on a behavioral contract which helped me be able to have lots of staff help me out on the changes I was needing to make. Now I am seeing that even though I have been sober, I really wasn't in recovery and living a healthy lifestyle.

SUCCESS STORIES CONTINUED

- I came into programming scared this was going to be the others I had before. Go to group, tell them what they want to hear, and I get to graduate to get my family's trust back and agent off my back. The shame group and SUD groups really helped me see others opening up, sharing and saying the coping skills were helping them. I tried some of the communication skills with my roommate when we had issues and it worked. I kept trying stuff and it kept working. The staff helped me when I would want to isolate again and I graduated program with actually being honest!

FUTURE GOALS

- Track program participants after release
- Train the Trainer for Helping Women Recover and Beyond Violence
- Seeking Safety Training
- Incorporating peer specialists
- More trauma responsive training with treatment and uniform staff

DEPARTMENT OF CORRECTIONS
DIVISION OF ADULT INSTITUTIONS

Substance Use Disorder treatment

Dr. Autumn Lacy PhD, LPC, ICS

ASSESSMENT

Every inmate will have the following:

- Case review
- COMPAS
- TAAD-5

LEVEL OF SERVICE

A&E classification staff assign programing based on the SUD diagnosis (left side – received after the TAAD-5) and COMPAS risk rating (top) at the initial classification. Decisions will be made based on the graph below:

Assessment result	Low Risk	Moderate Risk	High Risk
No Diagnosis	No treatment	No Treatment	No Treatment
Mild SUD	No Treatment	SUD-2	SUD-4
Moderate SUD	SUD-1	SUD-3	SUD-4
Severe SUD	SUD-1	SUD-3	SUD-4

- **Low risk inmates** with liberty interest issues will receive a program designation **SUD-2**
- **Low risk inmates** in prison due to repeated OWI offenses will receive a program designation **SUD-2**

PROGRAMMING LEVELS - MALES

- **SUD-1** = Case Plan Intervention
- **SUD-2**=CBISA
- **SUD-3**=CBISA/T4C
- **SUD-4**=CBISA/T4C + ancillary (Anger Management, Domestic Violence, Epictetus, and General Social Skills)

All sites that provide Substance Use Disorder treatment will have the ability to treat all levels.

CURRICULA & DOSAGE

- **Substance Abuse – Cognitive Behavioral Interventions for Substance Abuse Offenders (CBISA)**
  - Apply social and emotion regulation skills in risky, substance abusing situations
  - 39 lessons (60 hours) towards CBT dosage
- **Cognitive Behavioral Program– Thinking for a Change (T4C)**
  - Apply problem solving and social skills to risky situations
  - 25 lessons (50 hours) towards CBT dosage
- **Anger – Anger Management (AM) - SAMHSA Curriculum**
  - Learn to regulate high risk emotions with healthy coping and problem solving skills through the understanding and monitoring of personal anger triggers, cues, and patterns
  - 12 lessons (18 hours) towards CBT dosage
- **Anger - Anger Control Training (ACT)**
  - To help participants "unlearn" old, ineffective and/or risky behavior and "learn" new behaviors that can help them make pro-social choices and reach their personal goals
  - 20 lessons (30 hours) towards CBT dosage. Additional sessions may be offered to provide further practice

CURRICULA & DOSAGE CONT.

- **Recidivism – Epictetus**
  - Understand criminal behavior with cognitive behavioral approaches. Learn the use of practical philosophy.
  - 16 lessons (24 hours) towards CBT dosage (high risk inmates)
- **General Social Skills**
  - Learn pro-social behaviors through interpreting social cues and practicing empathy.
  - 16 lessons (24 hours) towards CBT dosage (high risk inmates)
- **Advanced Practice**
  - Utilizes the skills learned from the core programming including T4C and CBISA. The group will use recent events and identify the situation which they encountered. They will identify which skill they could utilize to address the situation in a pro-social manner.
  - 10 lessons (20 hours) towards CBT dosage

INITIAL ENTRY INTO PROGRAM
TCU BATTERY OF ASSESSMENTS

Within one week of initial entry into program, the TCU battery of assessments is administered by treatment staff to each inmate.

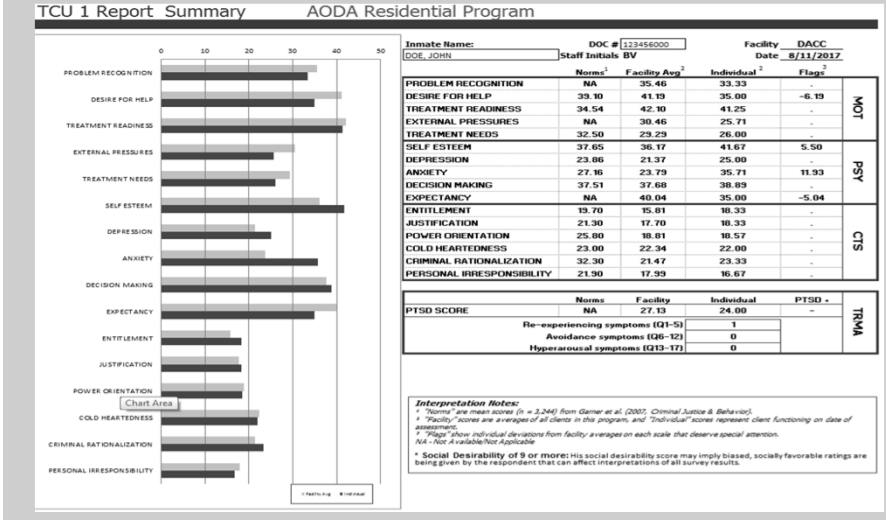
ASSESSMENTS:

- TCU Treatment Needs and Motivation (TCU MOTForm)
- TCU Psychological Functioning (TCU PSYForm)
- TCU Criminal Thinking Scales (TCU CTSForm)
- TCU Mental Trauma and PTSD Screen (TCU TRMAForm)

PURPOSE:

- To supplement the COMPAS Assessment
- To provide useful information to support additional needs for case planning and treatment planning purposes

INITIAL TCU REPORT1 SUMMARY



TCU 1 Report Summary AODA Residential Program

Inmate Name: DOE, JOHN | DOC # 123456000 | Staff Initials BV | Facility DACC | Date 8/11/2017

	Norms[1]	Facility Avg[2]	Individual[2]	Flags[2]	
PROBLEM RECOGNITION	NA	35.46	33.33	.	MOT
DESIRE FOR HELP	39.10	41.19	35.00	-6.19	
TREATMENT READINESS	34.54	42.10	41.25	.	
EXTERNAL PRESSURES	NA	30.46	25.71	.	
TREATMENT NEEDS	32.50	29.29	26.00	.	
SELF ESTEEM	37.65	36.17	41.67	5.50	PSY
DEPRESSION	23.86	21.37	25.00	.	
ANXIETY	27.16	23.79	35.71	11.93	
DECISION MAKING	37.51	37.68	38.89	.	
EXPECTANCY	NA	40.04	35.00	-5.04	
ENTITLEMENT	19.70	15.81	18.33	.	CTS
JUSTIFICATION	21.30	17.70	18.33	.	
POWER ORIENTATION	25.80	18.81	18.57	.	
COLD HEARTEDNESS	23.00	22.34	22.00	.	
CRIMINAL RATIONALIZATION	32.30	21.47	23.33	.	
PERSONAL IRRESPONSIBILITY	21.90	17.39	16.67	.	

	Norms	Facility	Individual	PTSD -	
PTSD SCORE	NA	27.13	24.00	-	TRMA
Re-experiencing symptoms (Q1-5)			1		
Avoidance symptoms (Q6-12)			0		
Hyperarousal symptoms (Q13-17)			0		

Interpretation Notes:
* "Norms" are mean scores (n = 3,244) from Garner et al. (2007, Criminal Justice & Behavior).
* "Facility" scores are averages of all clients in this program, and "Individual" scores represent client functioning on date of assessment.
* "Flags" show individual deviations from facility averages on each scale that deserve special attention.
NA - Not Available/Not Applicable

* **Social Desirability of 9 or more:** His social desirability score may imply biased, socially favorable ratings are being given by the respondent that can affect interpretations of all survey results.

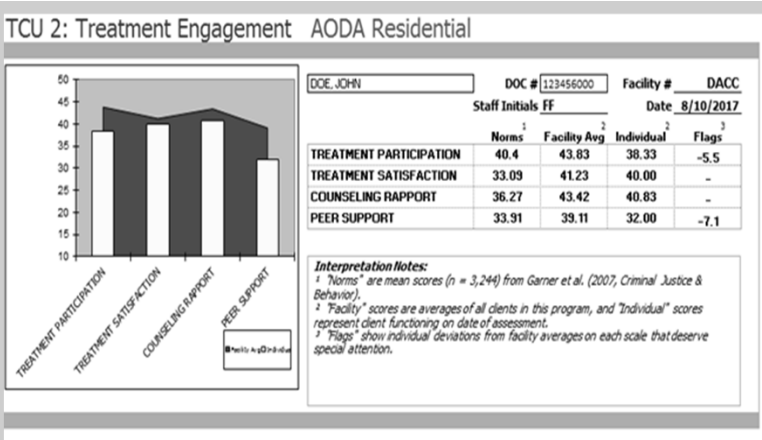
MIDWAY IN PROGRAM
TCU TREATMENT ENGAGEMENT

Midway through program, the TCU Treatment Engagement (TCU ENGForm) will be administered by treatment staff to each inmate.

PURPOSE:

- To measure the inmates' engagement in treatment and to determine a need for additional goals

MIDWAY TCU REPORT2 SUMMARY



TCU 2: Treatment Engagement AODA Residential

DOE, JOHN | DOC # 123456000 | Facility # DACC | Staff Initials FF | Date 8/10/2017

	Norms [1]	Facility Avg [2]	Individual [2]	Flags [3]
TREATMENT PARTICIPATION	40.4	43.83	38.33	-5.5
TREATMENT SATISFACTION	33.09	41.23	40.00	-
COUNSELING RAPPORT	36.27	43.42	40.83	-
PEER SUPPORT	33.91	39.11	32.00	-7.1

Interpretation Notes:

[1] "Norms" are mean scores (n = 3,244) from Garner et al. (2007, Criminal Justice & Behavior).

[2] "Facility" scores are averages of all clients in this program, and "Individual" scores represent client functioning on date of assessment.

[3] "Flags" show individual deviations from facility averages on each scale that deserve special attention.

TWO WEEKS PRIOR TO THE END OF PROGRAM TCU ASSESSMENTS

Two weeks prior to the end of program, a final battery of TCU assessments will be administered by treatment staff to each inmate.

FINAL BATTERY OF ASSESSMENTS:

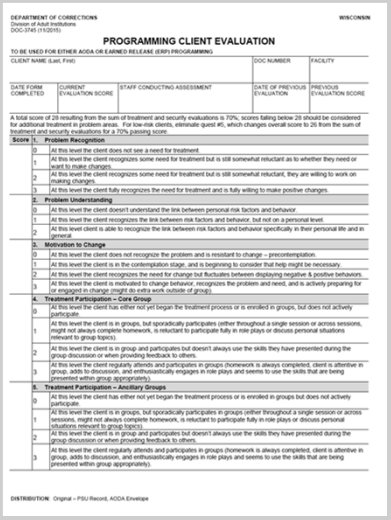
- TCU Treatment Needs and Motivation (TCU MOTForm)
- TCU Psychological Functioning (TCU PSYForm)
- TCU Criminal Thinking Scales (TCU CTSForm)
- TCU Treatment Engagement (TCU ENGForm)

PURPOSE:

- To compare the initial and final battery of TCU assessments and TCU Treatment Engagement.

CLIENT EVALUATION

- Each inmate is evaluated at midway and two weeks prior to the completion of the Residential Treatment Program
- Evaluation is completed by Treatment Provider(s) *(DOC-3745)* and security staff *(DOC-3746)*
- Treatment provider presents evaluations to inmates
  - Feedback may result in a treatment staffing and/or recommend Behavior Contract *(DOC-3741)* to address treatment needs and problem areas
  - A Behavior Contract can be used at any point in the program



DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3745 (11/2015)

WISCONSIN

PROGRAMMING CLIENT EVALUATION

TO BE USED FOR EITHER AODA OR EARNED RELEASE (ERP) PROGRAMMING

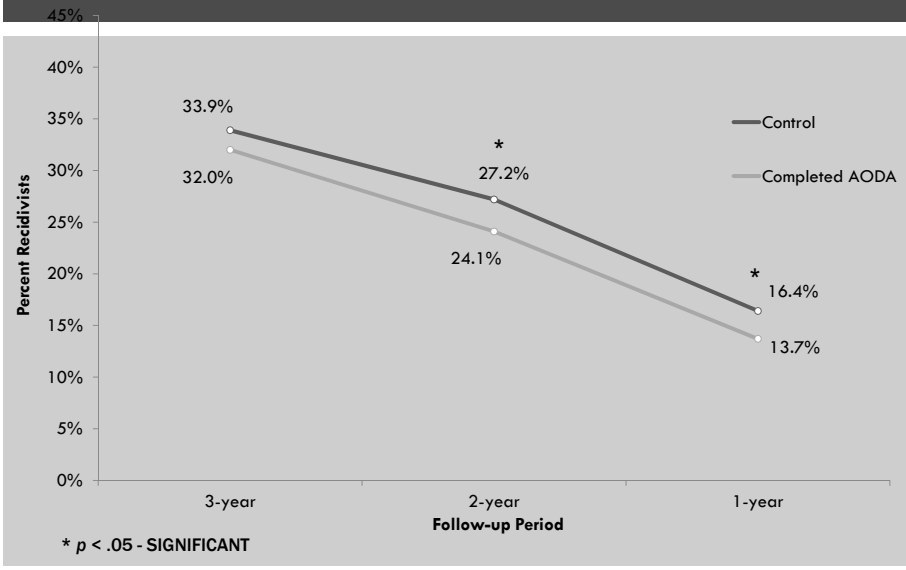
CLIENT NAME (Last, First)			DOC NUMBER	FACILITY
DATE FORM COMPLETED	CURRENT EVALUATION SCORE	STAFF CONDUCTING ASSESSMENT	DATE OF PREVIOUS EVALUATION	PREVIOUS EVALUATION SCORE

A total score of 28 resulting from the sum of treatment and security evaluations is 70%; scores falling below 28 should be considered for additional treatment in problem areas. For low-risk clients, eliminate guest #6, which changes overall score to 26 from the sum of treatment and security evaluations for a 70% passing score.

Score		
	1.	**Problem Recognition**
	0	At this level the client does not see a need for treatment.
	1	At this level the client recognizes some need for treatment but is still somewhat reluctant as to whether they need or want to make changes.
	2	At this level the client recognizes some need for treatment but is still somewhat reluctant, they are willing to work on making changes.
	3	At this level the client fully recognizes the need for treatment and is fully willing to make positive changes.
	2.	**Problem Understanding**
	0	At this level the client doesn't understand the link between personal risk factors and behavior.
	1	At this level the client recognizes the link between risk factors and behavior, but not on a personal level.
	2	At this level client is able to recognize the link between risk factors and behavior specifically in their personal life and in general.
	3.	**Motivation to Change**
	0	At this level the client does not recognize the problem and is resistant to change – precontemplation.
	1	At this level the client is in the contemplation stage, and is beginning to consider that help might be necessary.
	2	At this level the client recognizes the need for change but fluctuates between displaying negative & positive behaviors.
	3	At this level the client is motivated to change behavior, recognizes the problem and need, and is actively preparing for or engaged in change (might do extra work outside of group).
	4.	**Treatment Participation – Core Group**
	0	At this level the client has either not yet began the treatment process or is enrolled in groups, but does not actively participate.
	1	At this level the client is in groups, but sporadically participates (either throughout a single session or across sessions, might not always complete homework, is reluctant to participate fully in role plays or discuss personal situations relevant to group topics).
	2	At this level the client is in group and participates but doesn't always use the skills they have presented during the group discussion or when providing feedback to others.
	3	At this level the client regularly attends and participates in groups (homework is always completed, client is attentive in group, adds to discussion, and enthusiastically engages in role plays and seems to use the skills that are being presented within group appropriately).
	5.	**Treatment Participation – Ancillary Groups**
	0	At this level the client has either not yet began the treatment process or is enrolled in groups but does not actively participate.
	1	At this level the client is in groups, but sporadically participates in groups (either throughout a single session or across sessions, might not always complete homework, is reluctant to participate fully in role plays or discuss personal situations relevant to group topics).
	2	At this level the client is in group and participates but doesn't always use the skills they have presented during the group discussion or when providing feedback to others.
	3	At this level the client regularly attends and participates in groups (homework is always completed, client is attentive in group, adds to discussion, and enthusiastically engages in role plays and seems to use the skills that are being presented within group appropriately).

DISTRIBUTION: Original – PSU Record, AODA Envelope

AODA RESIDENTIAL RECIDIVISM
(2010-2013 RELEASE YEARS)



AODA RESIDENTIAL REINCARCERATION
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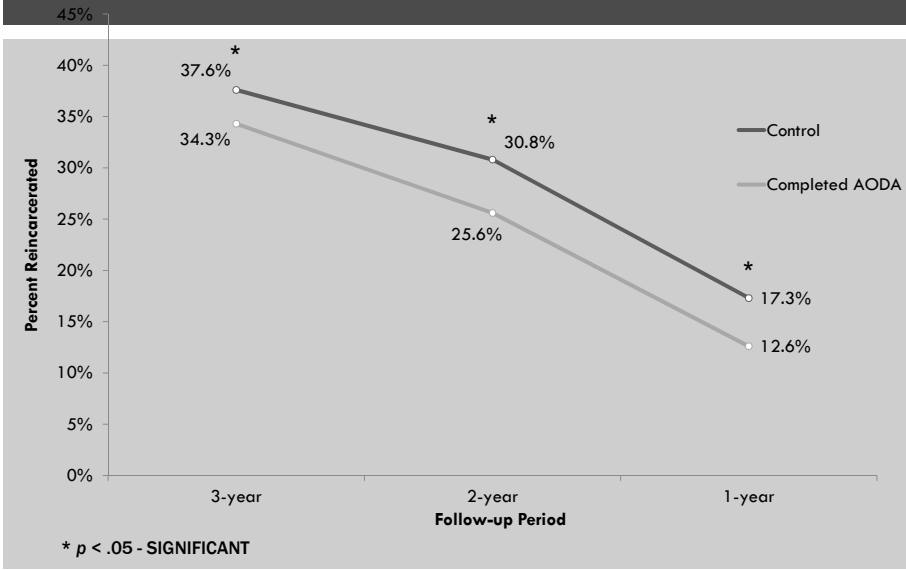
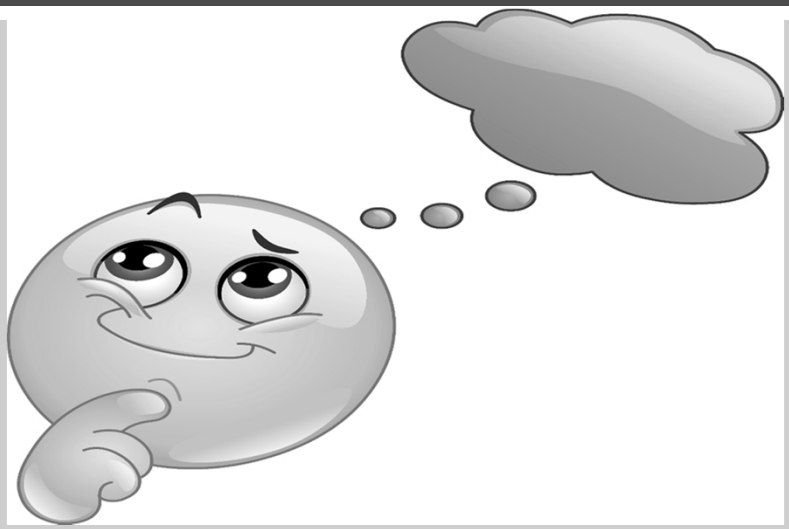


QUESTIONS?



Get 6 FREE CE Credits!

Help Your Behavioral Health Patients Quit Smoking

☑ Get FREE online training to learn how to bring smoking treatment into your behavioral health-care setting.

☑ Get 6 FREE CE credits from the University of Wisconsin School of Medicine and Public Health!

☑ Hear from experts who have successfully done it.

☑ Develop your own personalized plan.

Research shows patients are 25% more likely to quit their other addictions if they also recover from their addiction to tobacco. They also enjoy improved levels of anxiety, stress, and depression.

HelpUsQuit.org

UW Center for Tobacco Research and Intervention
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

WiNTiP
Wisconsin Nicotine Treatment Integration Project

Sponsored by the Wisconsin Department of Health Services

UW-CTRI
UNIVERSITY OF WISCONSIN
Center for Tobacco Research & Intervention

WiNTiP
Wisconsin Nicotine Treatment Integration Project

TRAINING FOR SYSTEMS CHANGE

"*ADDRESSING TOBACCO, OTHER SUBSTANCE USE, AND MENTAL HEALTH DISORDERS"*

SCAODA QUARTERLY MEETING
Presented by Amy Scora, UW-CTRI Outreach Specialist
David "Mac" Macmaster – WINTIP Managing Consultant
September 7th, 2018

Wisconsin Nicotine Treatment Integration Project

WiNTiP

2008 – 2018

UW-CTRI
Center for Tobacco Research & Intervention

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WiNTiP
Wisconsin Nicotine Treatment Integration Project

PRIMARY FUNDING
TOBACCO PREVENTION AND CONTROL PROGRAM
DIVISION OF PUBLIC HEALTH

ADDITIONAL FUNDING
BUREAU OF PREVENTION, TREATMENT AND RECOVERY DIVISION OF CARE AND TREATMENT

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3

WINTIP HAS ADVANCED ITS TOBACCO INTEGRATION MISSION WITH SCAODA SUPPORT FOR A DECADE

SCAODA UNANIMOUSLY APPROVED THE FIRST WINTIP MOTION TO ENCOURAGE POLICIES LEADING TO TOBACCO INTEGRATION INTO WISCONSIN'S AODA AND MENTAL HEALTH SERVICES

SCAODA ENDORSED THE WINTIP/UW-CTRI TOBACCO INTEGRATION GUIDELINES DEVELOPED TO PROVIDE A PATH TO TOBACCO INTEGRATED SYSTEMS AND PROGRAMS

SCAODA ADOPTED THE WINTIP/ UW-CTRI/ ITC TOBACCO EQUITY RESOLUTION RECOMMENDING RULE CHANGES THAT WOULD NO LONGER DENY WISCONSIN RESIDENTS WITH PRIMARY TOBACCO USE DISORDERS FROM EXISTING SUBSTANCE USE DISORDER SERVICES

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WiNTiP
Wisconsin Nicotine Treatment Integration Project

MISSION: WINTIP WAS CREATED AND FUNDED IN 2008 TO INTEGRATE EVIDENCE-BASED TOBACCO USE DISORDERS TREATMENT IN WISCONSIN ADDICTION AND MENTAL HEALTH SERVICES

PROBLEM IDENTIFICATION: TOBACCO USE DISORDERS ARE NOT BEING ADEQUATELY ADDRESSED AND TREATED IN BEHAVIORAL HEALTH TREATMENT SERVICES CONFIRMED BY PREVALENCE AND MORTALITY DATA

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WiNTiP
Wisconsin Nicotine Treatment Integration Project

MISSION: ADDRESS WISCONSIN'S TOBACCO TREATMENT GAP IN BEHAVIORAL HEALTH SERVICES

WINTIP FORMULA FOR TRANSFORMING A TOBACCO TOLERANT SUBSTANCE USE CULTURE AND SERVICES TO A TOBACCO FREE RECOVERY SYSTEM

"BUY-IN + TRAINING RESOURCES = TOBACCO INTEGRATION IMPLEMENTATION"

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UNPLEASANT REALITY

**** IN THE DECADE WINTIP HAS BEEN ADVANCING OUR TOBACCO INTEGRATION MISSION IT IS ESTIMATED MORE THAN 70,000 WISCONSIN RESIDENTS HAVE DIED FROM TOBACCO***

**** IT IS BELIEVED THAT APPROXIMATELY 40% OR MORE THAN 30,000 OF THESE DEATHS ARE INDIVIDUALS WITH OTHER SUBSTANCE USE AND MENTAL DISORDERS**

****WISCONSIN BURDEN OF TOBACCO REPORTS***

*****SMOKING CESSATION LEADERSHIP CENTER***

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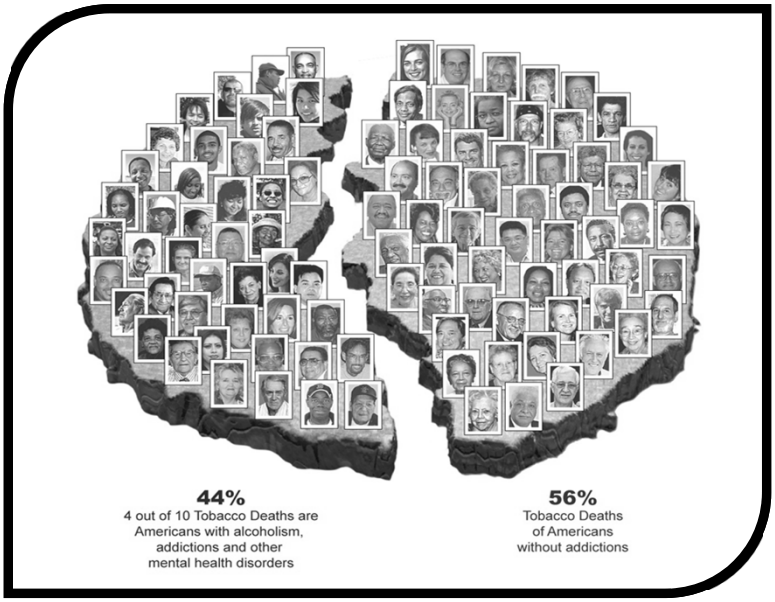

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PROPOSED SOLUTIONS

- Integrate evidence-based Tobacco Use Disorder treatment into Wisconsin's established substance use and mental health service system with measurable objectives to save 15% (4,500) of those predicted to die from tobacco caused and related diseases within 5 years of the tobacco integration implementation

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PROPOSED SOLUTIONS

- Assure that the Wisconsin scope of practice for behavioral health professionals includes evidence-based Tobacco Use Disorder interventions, treatment and recovery services as a requirement in rules, policies, procedures and practices for all professionals identified as providers in Wisconsin behavioral health services

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OFFER: WINTIP will visit behavioral health programs requesting technical assistance for beginning and continuing tobacco free programs and services

WINTIP provides a free assessment of the potential behavioral health programs have for beginning and successfully completing a tobacco-free integration program

WINTIP develops plans for tobacco integration utilizing proven methods for successful tobacco-free programs

UW-CTRI provides regional ongoing technical assistance for all Wisconsin behavioral health and medical programs

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WiNTiP
Wisconsin Nicotine Treatment Integration Project

LEARN HOW TO SUCCESSFULLY INTEGRATE TOBACCO USE DISORDER TREATMENT IN YOUR BEHAVIORAL HEALTH PROGRAM

Now With a Training Incentive

6 Free CEU'S

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Save lives of Wisconsin residents with substance use and mental health disorders from disease and death from tobacco by implementing tobacco-free treatment and recovery substance use and mental health programs

Here's How

WiNTiP/CTRI Free Online Training
Now With 6 Free CEU credits

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WiNTiP/CTRI Free Online Training
Now With 6 Free CEU credits

"Addressing Tobacco, Other Substance Use and Mental Health Disorders"

https://ce.icep.wisc.edu/tobacco-and-behavioral-health

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WiNTiP
Wisconsin Nicotine Treatment Integration Project

UW-CTRI CONTACT
Bruce Christiansen,
Senior Scientist
608-262-4087
bc1@ctri.wisc.edu

WINTIP CONTACT
David "Mac" Macmaster
608-393-1556
dmac1956@charter.net;
creativerep@mac.com

WISCONSIN NICOTINE TREATMENT INTEGRATION PROJECT

COORDINATED BY UW-CENTER FOR TOBACCO RESEARCH AND INTERVENTION, UW SCHOOL OF MEDICINE

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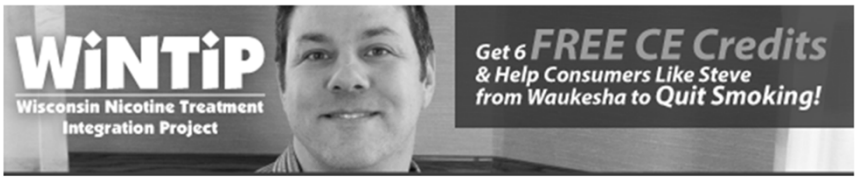

Online Training: Tobacco Integration for Behavioral Health Providers

https://ce.icep.wisc.edu/tobacco-and-behavioral-health

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OVERVIEW

Target Audience

- Practitioners who provide health care to people with mental illness/substance use disorders
- Program Directors and Quality Improvement staff

Learning Objectives

- Upon completion of this activity, learners will:
  1. Be able to articulate what constitutes as evidence-based tobacco dependence treatment
  2. Have developed a plan to integrate evidence-based tobacco dependence treatment and policy that is tailored to their setting
  3. Within one year of completion, have a tobacco policy in palace in their treatment setting and more evidence-based tobacco dependence treatment will be provided to patients

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FREE CE CREDITS

- Course 1: 3.5 hours
- Course 2: 2.5 hours

- Approved for CME (Continuing Medical Education)
- Approved for CNE (Contining Nursing Education)
- Approved for CEU (Continuing Education Units)

- The CEU credit letter indicates that the course was designed for CME, which will help some people submit to their boards for credit (PAs, for example)

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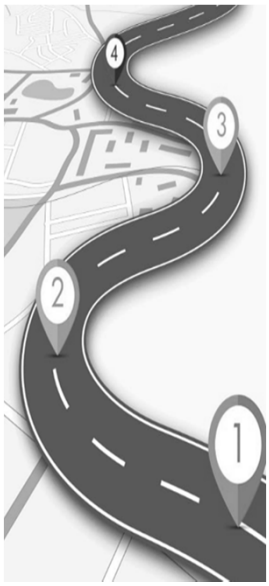
COURSE 1

1. What is tobacco integration? (required)
2. How integrated are you? (required)
3. The integration process (panel discussion)
4. Does setting make a difference? (panel discussion)
5. Enforcement (panel discussion)
6. How to help staff who use tobacco (panel discussion)



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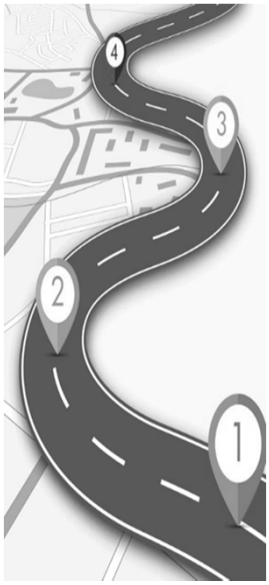
COURSE 2

1. What is evidence-based treatment? (presentation)
2. FDA-approved medications (presentation)
3. Evidence-based tobacco dependence treatment (panel discussion)
4. Building toward the future: Using the EHR (presentation)
5. The Wisconsin Tobacco Quit Line (WTQL) (presentation)
6. E-cigarettes (presentation)



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ADDITIONAL FEATURES

- Links to other resources
- Videos
- Tailored integration plan
  - Questions after each module that produce a personalized plan to guide tobacco treatment integration

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HOMEPAGE

TRAINING FOR SYSTEMS CHANGE: ADDRESSING TOBACCO AND BEHAVIORAL HEALTH

OVERVIEW | PROGRAM | FACULTY | ACCREDITATION | REGISTER/ENROLL

Title	Price	Status
Training for Systems Change: Addressing Tobacco and Behavioral Health	$0.00	Locked
Training for Systems Change: Addressing Tobacco and Behavioral Health - Course 1	$0.00	Locked
Training for Systems Change: Addressing Tobacco and Behavioral Health - Course 2	$0.00	Locked

PRICE
COST: $0.00

Please login or register to take this course.

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COURSE 1

intro questions

COMPLETE THE FOLLOWING BEFORE YOU BEGIN.

WHAT IS THE HIGHEST GRADE OR YEAR OF SCHOOL THAT YOU HAVE COMPLETED? *
- Grade 12 or GED (high school graduate)
- College Undergraduate
- Masters
- Doctorate
- Other

WHICH BEST DESCRIBES THE GENDER WITH WHICH YOU IDENTIFY?
Choose some options

WHAT BEST DESCRIBES YOUR WORK SETTING? *
- Substance abuse field
- Mental health field
- Both substance abuse and mental health
- Other type of patients/clients
- Non-clinical
- Other

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR PROFESSIONAL ROLE WITHIN BEHAVIORAL HEALTH CARE DELIVERY? *
- I provide direct patient care
- I work in administration
- I work in a support role
- I am an executive of the organization
- While I don't work in the Behavioral Health delivery directly, I work in an organization that participat health care or partners with organizations that provide behavioral health care such as government, ac charity, pharmaceutical, or supplier
- I don't work in the Behavioral Health care system or other participating/partnering organization
- Other

DOES YOUR TREATMENT PROGRAM TREAT: *
- Men
- Women
- Both
- Not Applicable

DOES YOUR TREATMENT PROGRAM TREAT: *
- Children (0-14)
- Adolescents (15-17)
- Adults (18+)

WHICH TYPE OF PATIENTS ARE SERVED? *
- Primarily Mental Health
- Primarily Substance Use Disorders (SUD)
- Both
- Not Applicable

WHAT LEVELS OF CARE ARE PROVIDED AT THIS LOCATION?
- Inpatient
- Outpatient
- Residential
- Other

DOES TREATMENT TAKE PLACE IN MORE THAN ONE BUILDING AT YOUR LOCATION? *
- Yes
- No
- Not Applicable

IS YOUR TREATMENT PROGRAM IN A BUILDING THAT HOUSES OTHER ORGANIZATIONS? *
- Yes
- No
- Not Applicable

HOW MANY EMPLOYEES DO YOU HAVE AT THIS LOCATION?

HOW MANY PATIENTS ARE SERVED ANNUALLY AT THIS LOCATION?

TRAINING FOR SYSTEMS CHANGE: ADDRESSING TOBACCO AND BEHAVIORAL HEALTH - COURSE 1

← RETURN TO PARENT HOME ← RETURN TO COURSE HOME

COURSE PROGRESS

- MODULE 1: WHAT IS TOBACCO INTEGRATION?
- POLICIES AND PROCEDURES FOR TOBACCO-FREE FACILITIES AND SERVICES
- MEASURING THE INTEGRATION OF TOBACCO POLICY AND TREATMENT INTO THE BEHAVIORAL HEALTH CARE DELIVERY SYSTEM: HOW ARE WE DOING?
- TOBACCO INTEGRATION SELF ASSESSMENT
- QUICK CHECK: WHAT IS TOBACCO INTEGRATION?
- MODULE 2: HOW INTEGRATED ARE YOU?
- QUICK CHECK: HOW INTEGRATED ARE YOU?
- MODULE 3: THE INTEGRATION PROCESS
- PANEL DISCUSSION: THE INTEGRATION PROCESS
- YOUR INTEGRATION PLAN
- QUICK CHECK: THE INTEGRATION PROCESS
- MODULE 4: DOES SETTING MAKE A DIFFERENCE?
- PANEL DISCUSSION: INTEGRATION DIFFERENCES

TRAINING FOR SYSTEMS CHANGE: ADDRESSING TOBACCO AND BEHAVIORAL HEALTH - COURSE 1

COURSE INSTRUCTIONS:

To receive continuing education credits, you will need to successfully complete course components. To do this, follow all the directions listed below.

1. Proceed to the activity by going to Course Progress > MODULE 1 > Start.
2. The course has six modules, each with multiple components accessible in the Course Progress column on the left.
   - Module 1 and Module 2 are required, and you will be prompted to complete these before moving on to the rest of the modules.
   - We recommend that you complete the other modules in order, but you are welcome to proceed in any order you see fit.
3. You are welcome to exit and come back to the course at any time. Your progress will be saved, and you can continue to complete more modules and components for credit.
4. The course is accredited for a maximum of 3.5 hours. If you choose to complete only a few modules or components, you may claim partial credit. Once you select the "Claim Credit" component on the left, you are indicating that you are done participating and would like to claim credit commensurate with the number of hours you spent in the course. *Once you claim your hours/credit you will not be able to participate further for credit.* You will be able to enter back into the course to review material.
5. Next, complete the Evaluation.
6. Your credit certificate will be available for you to download. A copy of this certificate will always be available to you at My account > My Activities.

There are no fees for participating in or receiving credit for this online educational activity. For information on applicability and acceptance of continuing education credit for this activity, please consult your professional licensing board. The activity is available to complete at your convenience through 06/11/2021. Credit will not be given after this date.

This activity is designed to be completed within the time designated; learners should claim only those credits that reflect the time actually spent in the activity.

If you do not wish to receive credit, you may review the material, but you are not required to complete assessments or claim credit.

TRAINING FOR SYSTEMS CHANGE: ADDRESSING TOBACCO AND BEHAVIORAL HEALTH - COURSE 1

MODULE 1: WHAT IS TOBACCO INTEGRATION?

← RETURN TO PARENT HOME ← RETURN TO COURSE HOME

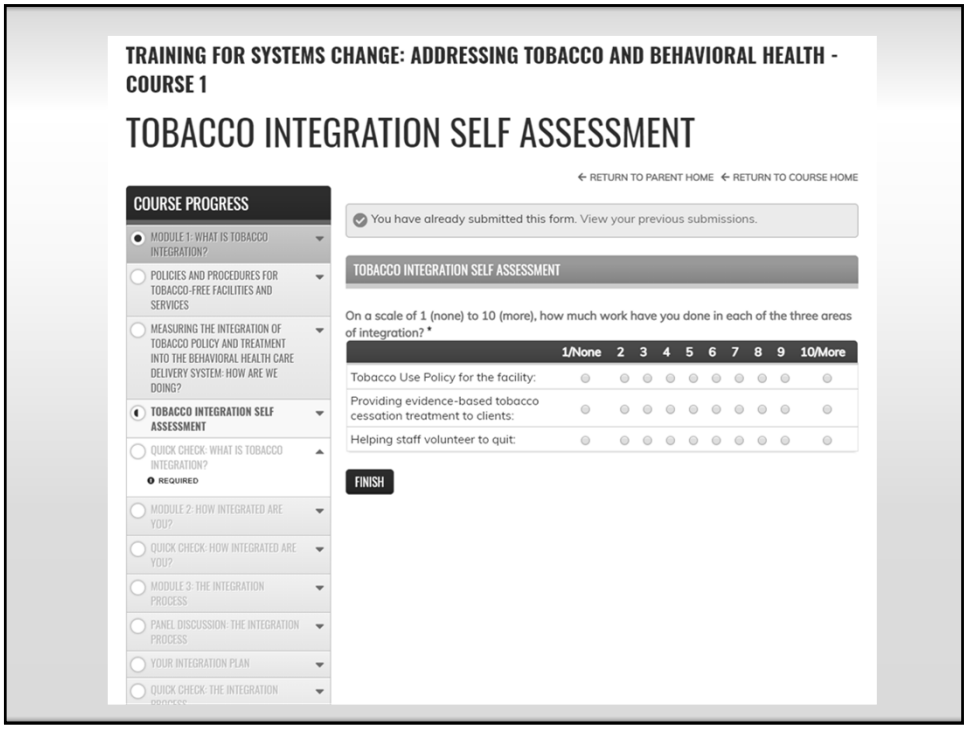
COURSE PROGRESS

- MODULE 1: WHAT IS TOBACCO INTEGRATION? — REQUIRED — REVIEW
- POLICIES AND PROCEDURES FOR TOBACCO-FREE FACILITIES AND SERVICES — OPTIONAL — START
- MEASURING THE INTEGRATION OF TOBACCO POLICY AND TREATMENT INTO THE BEHAVIORAL HEALTH CARE DELIVERY SYSTEM: HOW ARE WE DOING? — OPTIONAL — START
- TOBACCO INTEGRATION SELF ASSESSMENT — REQUIRED — START
- QUICK CHECK: WHAT IS TOBACCO INTEGRATION? — REQUIRED
- MODULE 2: HOW INTEGRATED ARE YOU? — REQUIRED
- QUICK CHECK: HOW INTEGRATED ARE YOU? — REQUIRED
- MODULE 3: THE INTEGRATION PROCESS — OPTIONAL

MODULE 1: WHAT IS TOBACCO INTEGRATION?

Please watch the following 5 minute video to learn about the need for a common understanding and clear definition of Tobacco Integration.

Bruce Christiansen, PhD
Senior Scientist
Center for Tobacco Research and Intervention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TOBACCO INTEGRATION SELF ASSESSMENT
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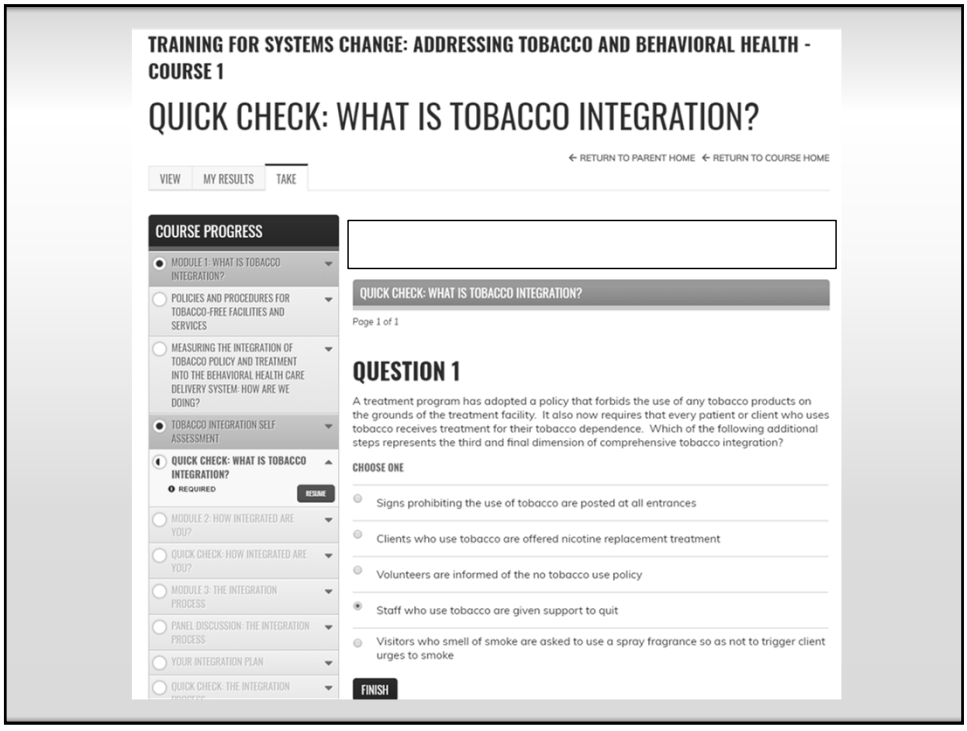
QUICK CHECK: HOW INTEGRATED ARE YOU?
MODULE 3: THE INTEGRATION PROCESS
PANEL DISCUSSION: THE INTEGRATION PROCESS
YOUR INTEGRATION PLAN
QUICK CHECK: THE INTEGRATION
You have already submitted this form. View your previous submissions.
TOBACCO INTEGRATION SELF ASSESSMENT
On a scale of 1 (none) to 10 (more), how much work have you done in each of the three areas of integration? *
1/None 2 3 4 5 6 7 8 9 10/More
Tobacco Use Policy for the facility:
Providing evidence-based tobacco cessation treatment to clients:
Helping staff volunteer to quit:
FINISH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QUICK CHECK: WHAT IS TOBACCO INTEGRATION?
← RETURN TO PARENT HOME ← RETURN TO COURSE HOME
VIEW MY RESULTS TAKE
COURSE PROGRESS
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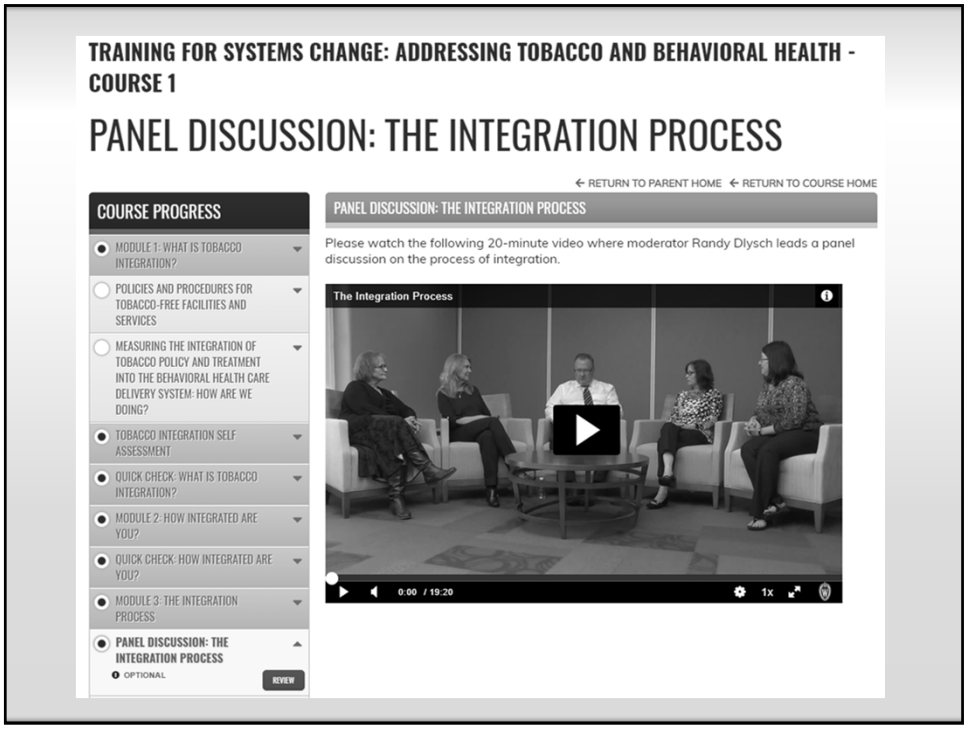
MODULE 3: THE INTEGRATION PROCESS
PANEL DISCUSSION: THE INTEGRATION PROCESS
YOUR INTEGRATION PLAN
QUICK CHECK: THE INTEGRATION
QUICK CHECK: WHAT IS TOBACCO INTEGRATION?
Page 1 of 1
QUESTION 1
A treatment program has adopted a policy that forbids the use of any tobacco products on the grounds of the treatment facility. It also now requires that every patient or client who uses tobacco receives treatment for their tobacco dependence. Which of the following additional steps represents the third and final dimension of comprehensive tobacco integration?
CHOOSE ONE
Signs prohibiting the use of tobacco are posted at all entrances
Clients who use tobacco are offered nicotine replacement treatment
Volunteers are informed of the no tobacco use policy
Staff who use tobacco are given support to quit
Visitors who smell of smoke are asked to use a spray fragrance so as not to trigger client urges to smoke
FINISH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PANEL DISCUSSION: THE INTEGRATION PROCESS
← RETURN TO PARENT HOME ← RETURN TO COURSE HOME
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MODULE 3: THE INTEGRATION PROCESS
PANEL DISCUSSION: THE INTEGRATION PROCESS
OPTIONAL
REVIEW
PANEL DISCUSSION: THE INTEGRATION PROCESS
Please watch the following 20-minute video where moderator Randy Dlysch leads a panel discussion on the process of integration.
The Integration Process
0:00 / 19:20
1x


uw-ctri
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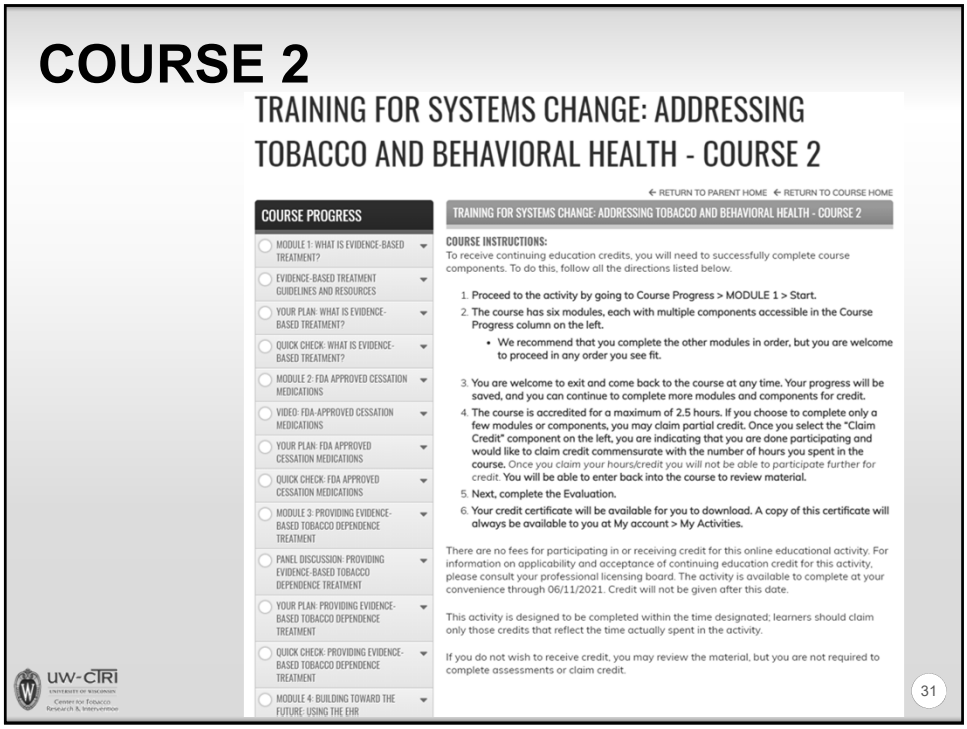
COURSE 2


TRAINING FOR SYSTEMS CHANGE: ADDRESSING TOBACCO AND BEHAVIORAL HEALTH - COURSE 2
← RETURN TO PARENT HOME ← RETURN TO COURSE HOME
COURSE PROGRESS
MODULE 1: WHAT IS EVIDENCE-BASED TREATMENT?
EVIDENCE-BASED TREATMENT GUIDELINES AND RESOURCES
YOUR PLAN: WHAT IS EVIDENCE-BASED TREATMENT?
QUICK CHECK: WHAT IS EVIDENCE-BASED TREATMENT?
MODULE 2: FDA APPROVED CESSATION MEDICATIONS
VIDEO: FDA-APPROVED CESSATION MEDICATIONS
YOUR PLAN: FDA APPROVED CESSATION MEDICATIONS
QUICK CHECK: FDA APPROVED CESSATION MEDICATIONS
MODULE 3: PROVIDING EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT
PANEL DISCUSSION: PROVIDING EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT
YOUR PLAN: PROVIDING EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT
QUICK CHECK: PROVIDING EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT
MODULE 4: BUILDING TOWARD THE FUTURE: USING THE EHR
TRAINING FOR SYSTEMS CHANGE: ADDRESSING TOBACCO AND BEHAVIORAL HEALTH - COURSE 2
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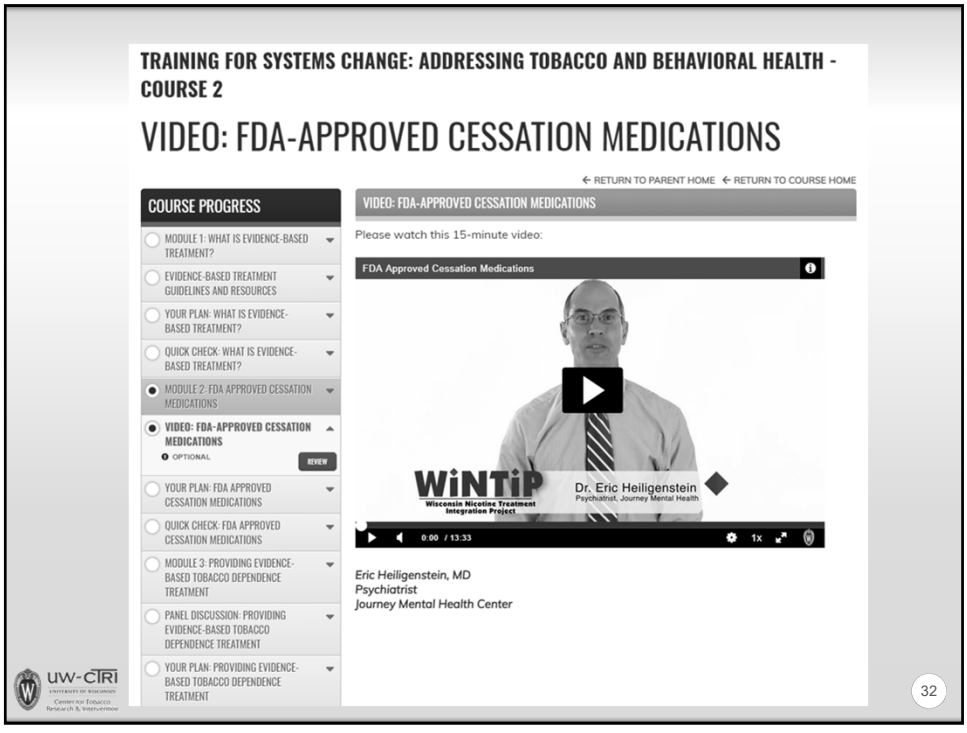
TRAINING FOR SYSTEMS CHANGE: ADDRESSING TOBACCO AND BEHAVIORAL HEALTH - COURSE 2
VIDEO: FDA-APPROVED CESSATION MEDICATIONS
← RETURN TO PARENT HOME ← RETURN TO COURSE HOME
COURSE PROGRESS
MODULE 1: WHAT IS EVIDENCE-BASED TREATMENT?
EVIDENCE-BASED TREATMENT GUIDELINES AND RESOURCES
YOUR PLAN: WHAT IS EVIDENCE-BASED TREATMENT?
QUICK CHECK: WHAT IS EVIDENCE-BASED TREATMENT?
MODULE 2: FDA APPROVED CESSATION MEDICATIONS
VIDEO: FDA-APPROVED CESSATION MEDICATIONS
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REVIEW
YOUR PLAN: FDA APPROVED CESSATION MEDICATIONS
QUICK CHECK: FDA APPROVED CESSATION MEDICATIONS
MODULE 3: PROVIDING EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT
PANEL DISCUSSION: PROVIDING EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT
YOUR PLAN: PROVIDING EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT
VIDEO: FDA-APPROVED CESSATION MEDICATIONS
Please watch this 15-minute video:
FDA Approved Cessation Medications
WiNTiP
Wisconsin Nicotine Treatment Integration Project
Dr. Eric Heiligenstein
Psychiatrist, Journey Mental Health
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Eric Heiligenstein, MD
Psychiatrist
Journey Mental Health Center
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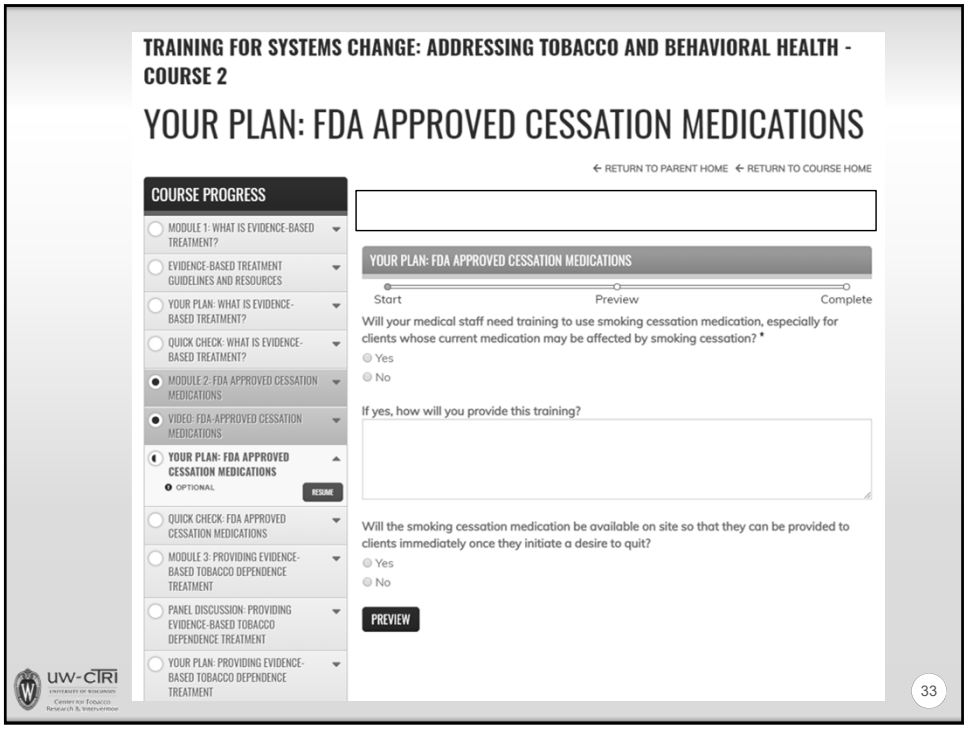
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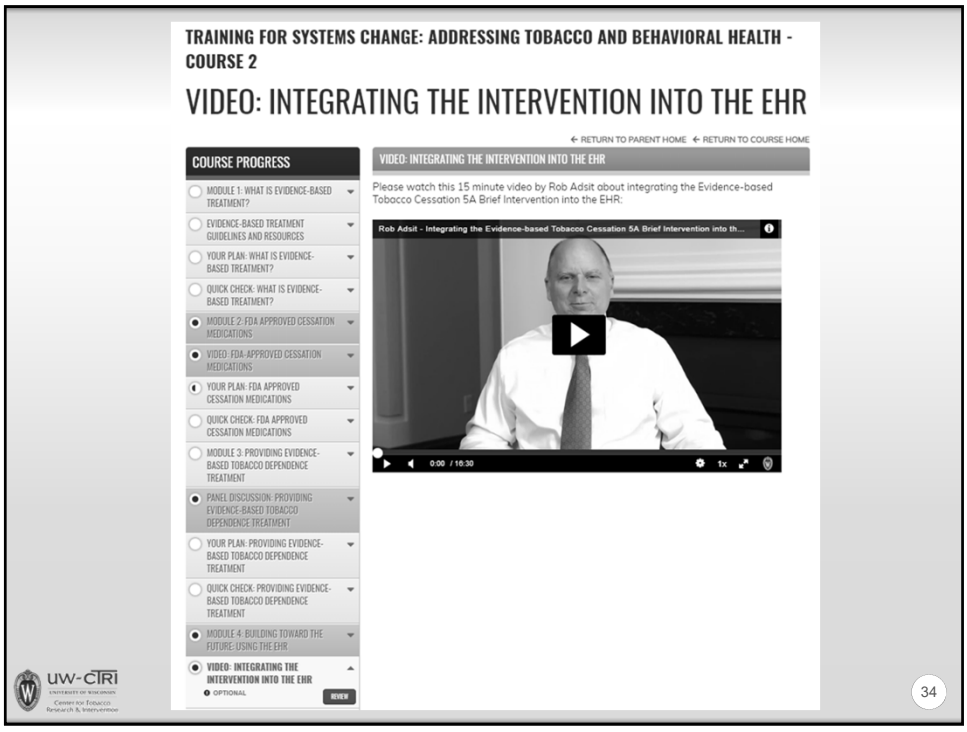
YOUR PLAN: PROVIDING EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT
YOUR PLAN: FDA APPROVED CESSATION MEDICATIONS
Start
Preview
Complete
Will your medical staff need training to use smoking cessation medication, especially for clients whose current medication may be affected by smoking cessation? *
Yes
No
If yes, how will you provide this training?
Will the smoking cessation medication be available on site so that they can be provided to clients immediately once they initiate a desire to quit?
Yes
No
PREVIEW
UW-CTRI
33


TRAINING FOR SYSTEMS CHANGE: ADDRESSING TOBACCO AND BEHAVIORAL HEALTH - COURSE 2
VIDEO: INTEGRATING THE INTERVENTION INTO THE EHR
← RETURN TO PARENT HOME ← RETURN TO COURSE HOME
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MODULE 4: BUILDING TOWARD THE FUTURE: USING THE EHR
VIDEO: INTEGRATING THE INTERVENTION INTO THE EHR
OPTIONAL
REVIEW
VIDEO: INTEGRATING THE INTERVENTION INTO THE EHR
Please watch this 15 minute video by Rob Adsit about integrating the Evidence-based Tobacco Cessation 5A Brief Intervention into the EHR:
Rob Adsit - Integrating the Evidence-based Tobacco Cessation 5A Brief Intervention into th...
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UW-CTRI
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UTILIZATION STATS

- 209 have enrolled in Course 1
  - 63 have claimed credit
- 152 people have enrolled in Course 2
  - 36 have claimed credit
- Broad reach:
  - 33 states in the U.S.
  - Portugal

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CONSUMERS: Help Us Quit Smoking

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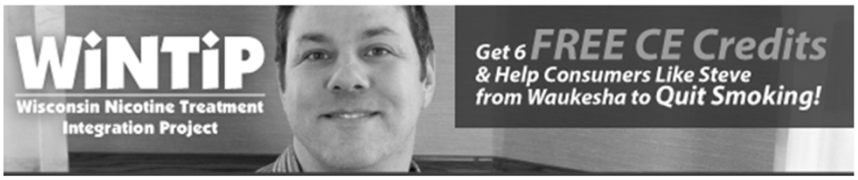

Online Training: Tobacco Integration for Behavioral Health Providers

https://ce.icep.wisc.edu/tobacco-and-behavioral-health

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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 19 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 19 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

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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:

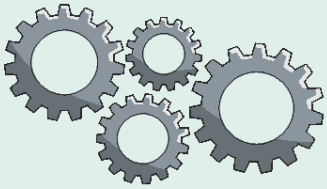
- **Timely:** Ensures that capacity exists to meet treatment demands through the availability of facilities, providers, and services. A timely system ensures that all services and levels of care recommended by the ASAM guidelines[9] are geographically distributed across the state according to need. To 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

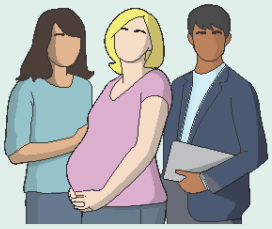
An effective and comprehensive treatment system requires several foundational elements to ensure access to high-quality and evidence-based care. Pew has categorized its recommendations into four areas: treatment system transformation, substance use disorder workforce, coverage and reimbursement, and 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

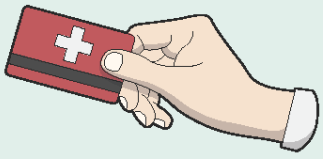
Treatment system transformation Models and approaches that affect the delivery of care in states



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

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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

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

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:

- 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

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

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 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 19 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)
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)

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

Date	City	Group	Recruited	Participated	Demographics
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)
1/16/2018	Milwaukee, WI	In recovery	7	6	Male (3) Female (3) African American (1) White (4) Hispanic (1) Age Range (32-61)

Date	City	Group	Recruited	Participated	Demographics
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)

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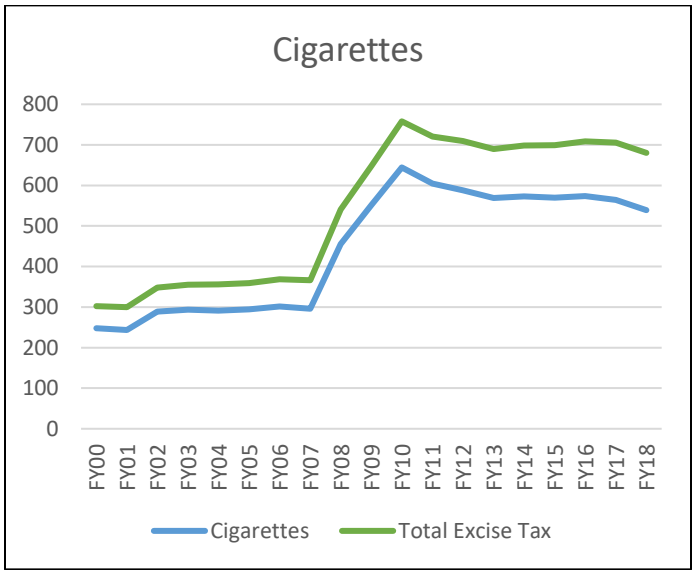
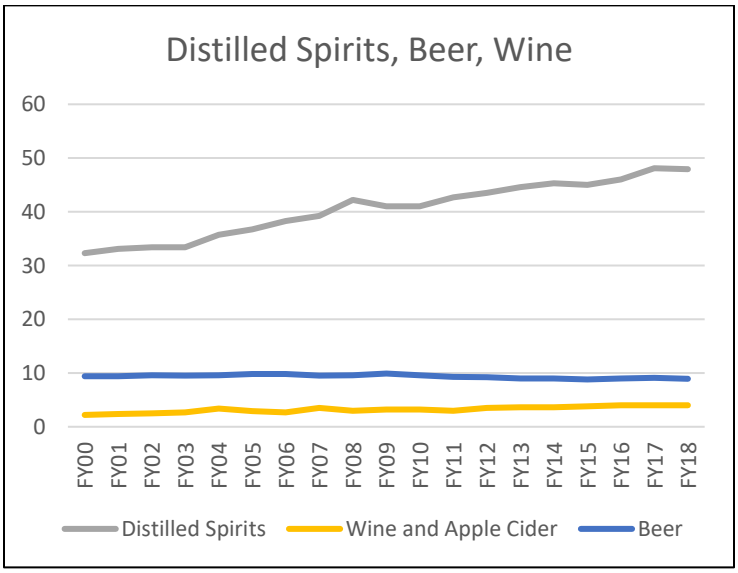
Historical Excise Tax Collections FY00 – FY18

Excise Tax Collections And Percent Change FY00 - FY18
($ Millions)

FY	Cigarettes	Tobacco Products	Distilled Spirits	Wine and Apple Cider	Beer	Total Excise Tax
FY00	247.6	10.3	32.3	2.2	9.4	301.9
FY01	243.5	11.4	33.1	2.4	9.4	299.8
FY02	288.8	13.9	33.4	2.5	9.6	348.3
FY03	293.7	15.5	33.4	2.7	9.5	354.8
FY04	291.3	16.1	35.7	3.4	9.6	356.1
FY05	294.3	15.8	36.7	2.9	9.8	359.4
FY06	301.5	16.4	38.3	2.7	9.8	368.7
FY07	296.1	17.5	39.2	3.5	9.5	365.8
FY08	455.7	29.7	42.2	3	9.6	540.3
FY09	551.3	42.2	41	3.2	9.9	647.6
FY10	644.3	59.9	41	3.2	9.6	757.9
FY11	604.6	60.9	42.7	3	9.3	720.6
FY12	587.8	65.5	43.5	3.5	9.2	709.5
FY13	569.2	63	44.6	3.6	9	689.5
FY14	573	67.7	45.3	3.6	9	698.6
FY15	569.5	71.9	45	3.8	8.8	699.1
FY16	573.4	76.1	46	4	9	708.5
FY17	564.2	80.3	48.1	4	9.1	705.7
FY18	539.1	80.2	47.9	4	8.9	680.1
Cumulative % Change	217.73%	778.64%	148.30%	181.82%	-5.31%	225.27%





Prepared by Matt Sweeney, Administrative Policy Advisor, Wisconsin Department of Revenue
608-267-1262, matthew1.sweeney@wisconsin.gov

Wisconsin Department of Revenue

RALLY for RECOVERY 2018

SATURDAY, SEPTEMBER 22
WISCONSIN STATE CAPITOL
11a.m.-2p.m.
OUTSIDE, STATE STREET SIDE

JOSEPH GREEN is a spoken word artist, educator, motivational speaker and a believer in transformation.

"Strength built, lessons learned, and a way to pay it forward."

WISCONSIN VOICES FOR RECOVERY

EVENT ACTIVITIES

- Open Mic – Poetry, Live Performances
- Recovery Speakers and Family Members
- Narcan Trainings and Kit Giveaways
- Recovery Coaching Tent and On-site Support
- Kids Area – Face Painting, Balloons
- Purple Communications, Inc. – Offering ASL Services for Individuals with Hearing Impairments
- Resource Fair with Recovery Resources from across Wisconsin
- Free Ian's Pizza
- Wisconsin Dells Wilderness Resort Weekend Giveaway!
- Ho-Chunk Nation Drumming Circle
- UW-Marching Band

Community RESILIENCE: RECOVERING Together

HELIOS RECOVERY

Friends of Recovery, Inc.

STOP HEROIN NOW stopheroinnow.org

apricity

CONNECTIONS COUNSELING LLC together we recover

Tellurian Recovery Begins Here

WISCONSIN DEPARTMENT of HEALTH SERVICES

Great Lakes (HHS Region 5) ATTC Addiction Technology Transfer Center Network Funded by Substance Abuse and Mental Health Services Administration

Department of Family Medicine and Community Health UNIVERSITY OF WISCONSIN SCHOOL OF MEDICINE AND PUBLIC HEALTH

Recovery Foundation

JUST Listen just-listen.org

FRIDAY, OCTOBER 5, 2018

OCTOBER 5, 2018

Gateway Technical College, Racine Campus Conference Center

Addiction and recovery throughout the lifespan

FEATURED TOPICS INCLUDE:

- > Adverse childhood experiences
- > Teaching resilience to teens
- > Addressing the opioid epidemic
- > Substance use and the elderly

CEUs available

Registration open through
October 3, 2018 for $119
Reduced rate for multiple registrations

More information and registration
are available at gtc.edu/help-hope

Conference hosted by Gateway Technical College
Hope Council on AODA – Community Impact Programs, Inc.
Equal opportunity/access/employer & educator

GATEWAY TECHNICAL COLLEGE

3520 30th Ave.
Kenosha, WI 53143

2018 Substance Use Disorder Training Sessions and Conferences

(Prevention Focus)

September 7, 2018 SCAODA Meeting

September 2018 Activities

CHANGING THE CONVERATION ON OPIOIDS

September 11-12, 2018, at the Kalahari Resort --

Free training for county health departments, tribal health clinics, and members of community-based substance abuse prevention coalitions. The Department of Health Services (DHS) is offering a FREE two-day training by national experts in the field of data visualization and communication.

Join us as we bring together experts from Evergreen Data and Frameworks Institute to:

- Learn tools and techniques for presenting data effectively.
- Understand how to frame messages to inspire community action.

Register:https://wihiv.wisc.edu/events.aspx?event_id=qGG5J6QlEwaGsdBTmM7Vk5GXfJ4z0p1G663hgg==

REJUVENATING TRIBAL COMMUNITIES CONFERENCE

September 11-12, 2018 at the Potawatomi Hotel & Casino, Milwaukee, WI --

This event is open to all tribes in Wisconsin and surrounding counties, ICW Family Support Workers and other individuals that work with tribal families. Topics will include: Indigenous psychology, wellness courts, drug identification, prescription drug and heroin epidemic, and so much more.

Register: https://www.fcpotawatomi.com/event/rejuvenating-tribal-communities-conference-2018/?instance_id=3038

October 2018 Activities

HMONG AMERICAN COMMUNITY CERTIFCATE PROGRAM

This is a five-part series in the Fall of 2018. Dates for this series are as follows from 8:30 a.m. – 2:30 p.m., October 6, 13 and 27th, and November 3 and 10th.

For more information: https://diversity.edgewood.edu/Hmong-Community-Certificate-Program

WISCONSIN ALCOHOL POLICY SEMINAR

October 10, 2018 at the Kalahari Conference Center --

This year's theme, ***Creating a Positive Alcohol Environment,*** offers two general sessions and 16 workshops of practical guidance and ideas you can implement to improve the community alcohol environment. All attendees receive a bound volume with the handouts for all sessions and excerpts from relevant publications as a permanent reference.

More information, the full schedule of workshops and online registration is at: http://bit.ly/2018AlcoholPolicy

WISCONSIN SUMMIT ON OPIOIDS AND METH – Department of Justice
October 23-24, 2018 at the Hyatt Regency Milwaukee in Milwaukee, WI --
The Summit will highlight the good work of our Wisconsin anti-drug coalitions and introduce best practices from around the country for protecting our most vulnerable neighbors. Attendees will have the option to select from over 40 programs as they work with other professionals to address this national epidemic.
Register: https://northcentralhidta.org/EBForms.aspx?EBID=904&EBType=MR

FAITH-BASED SUMMITS ON OPIOIDS
October 29 in Milwaukee, October 30 in De Pere, and October 31 in Rice Lake --
Join the Wisconsin Department of Health Services to learn how faith-based groups, organizations, and individuals can help end Wisconsin's opioid crisis by supporting prevention, intervention, treatment, and recovery activities. These free faith-based summits are open to all faith-based groups, organizations, and individuals regardless of your location.
For more information please contact: Mary.Haralampopoulos@dhs.wisconsin.gov or at 608.267.3783.

2018 Substance Use Disorder Training Sessions and Conferences

(Treatment and Recovery Focus)

September 7, 2018 SCAODA Meeting

September:

Opioids Misuse: Increasing Access to Transportation in Rural Communities Workshop
Sponsored by the U.S. Department of Agriculture, and Federal Transit Administration
September 20, 2018 at West Virginia School of Osteopathic Medicine, 9:30 am to 1:00 pm
Livestream is available
The lack of reliable transportation is often noted as a barrier to care in rural communities. Rural residents have fewer rural public transportation options which makes it more challenging for them to access addiction treatment facilities or services. The workshop will cover the resources and options available to communities to help. For further information, contact Betty-Ann Bryce of the USDA, Rural Development Program, at 202/720-9634, or visit https://www.usda.gov/topics/opioids .

22nd Annual Crisis Intervention Conference
September 20-21, 2018 at Kalahari Resort & Convention Center in Wisconsin Dells
https://www.uwsp.edu/conted/ConfWrkShp/Pages/Crisis/default.aspx

American Society of Addiction Medicine (ASAM) Conference – Wisconsin Chapter,
September 27-29, 2018 in Madison, WI
http://www.wisam-asam.com/

October:

2018 Annual National Association for Alcoholism and Drug Abuse Counselors (NAADAC) Conference "Shoot for the Stars"
October 5-9, 2018 in Houston, Texas, at the Westin Galleria
Registration will open on February 12th!
The three-day Annual Conference will take place on October 6-8, 2018. In addition, attendees may register to attend full-day pre-conference sessions on October 5, 2018, full-day post-conference sessions on October 9, and/or a two-day U.S. Department of Transportation - Substance Abuse Professional (SAP) Qualification/Re-Qualification training on October 9 & 10.
https://www.naadac.org/2018annualconference

Mental Health and Substance Use Recovery Training Conference (14th Annual)
Wednesday-Thursday, October 17-18, 2018
Kalahari Resort and Convention Center at Wisconsin Dells
https://www.uwsp.edu/conted/ConfWrkShp/Pages/MHSA/default.aspx

SCAODA 2018-19 Meeting Dates

September 7, 2018
December 7, 2018
March 1, 2019 (tentative)
June 7, 2019 (tentative)
September 13, 2019 (tentative)
December 13, 2019 (tentative)

American Family Insurance Conference Center
6000 American Parkway
Madison, WI
A-Building, South Café in the Training Center

BY-LAWS
of the
State of Wisconsin
State Council on Alcohol and Other Drug Abuse
As Approved
June 6, 2008
Amended 9-10-10, 9-9-11, 12-13-13, 12-12-14

<please note: lines underlined below are taken directly from statute.>

ARTICLE I

Purpose and Responsibilities

Section 1. Authority

The council is created in the office of the governor pursuant to sec. 14.017 (2), Wis. Stats. Its responsibilities are specified under sec. 14.24, Wis. Stats.

Section 2. Purpose

The purpose of the state council on alcohol and other drug abuse is to enhance the quality of life of Wisconsin citizens by preventing alcohol, tobacco and other drug abuse and its consequences through prevention, treatment, recovery, and enforcement and control activities by:

a. Supporting, promoting and encouraging the implementation of a system of alcohol, tobacco and other drug abuse services that are evidence-based, gender and culturally competent, population specific, and that ensure equal and barrier-free access;

b. Supporting the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with a special emphasis on underage use; and

c. Supporting and encouraging recovery in communities by reducing discrimination, barriers and promoting healthy lifestyles.

Section 3. Responsibilities

The state council on alcohol and other drug abuse shall:

a. Provide leadership and coordination regarding alcohol and other drug abuse issues confronting the state.

b. Meet at least once every 3 months.

c. By June 30, 1994, and by June 30 every 4 years thereafter, develop a comprehensive state plan for alcohol and other drug abuse programs. The state plan shall include all of the following:

   i. Goals, for the time period covered by the plan, for the state alcohol and other drug abuse services system.

   ii. To achieve the goals in par. (a), a delineation of objectives, which the council shall review annually and, if necessary, revise.

   iii. An analysis of how currently existing alcohol and other drug abuse programs will further the goals and objectives of the state plan and which programs should be created, revised or eliminated to achieve the goals and objectives of the state plan.

d. Each biennium, after introduction into the legislature but prior to passage of the biennial state budget bill, review and make recommendations to the governor, the legislature and state agencies, as defined in s. 20.001 (1), regarding the plans, budgets and operations of all state alcohol and other drug abuse programs. The council also recommends legislation, and provides input on state alcohol, tobacco and other drug abuse budget initiatives.

e. Provide the legislature with a considered opinion under s. 13.098.

f. Coordinate and review efforts and expenditures by state agencies to prevent and control alcohol and other drug abuse and make recommendations to the agencies that are consistent with policy priorities established in the state plan developed under sub. (3).

g. Clarify responsibility among state agencies for various alcohol and other drug abuse prevention and control programs, and direct cooperation between state agencies.

h. Each biennium, select alcohol and other drug abuse programs to be evaluated for their effectiveness, direct agencies to complete the evaluations, review and comment on the proposed evaluations and analyze the results for incorporation into new or improved alcohol and other drug abuse programming.

i. Publicize the problems associated with abuse of alcohol and other drugs and the efforts to prevent and control the abuse. Issue reports to educate people about the dangers of alcohol, tobacco and other drug abuse.

j. Form committees and sub-committees for consideration of policies or programs, including but not limited to, legislation, funding and standards of care, for persons of all ages, ethnicities, sexual orientation, disabilities, and religions to address alcohol, tobacco and other drug abuse problems.

ARTICLE II

Membership

Section 1. Authority

Membership is in accordance with section 14.017(2), Wis. Stats.

Section 2. Members

2.1 The 22-member council includes six members with a professional, research or personal interest in alcohol, tobacco and other drug abuse problems, appointed for four-year terms, and one of them must be a consumer representing the public. It was created by chapter 384, laws of 1969, as the drug abuse control commission. Chapter 219, laws of 1971, changed its name to the council on drug abuse and placed the council in the executive office. It was renamed the council on alcohol and other drug abuse by chapter 370, laws of 1975, and the state council on alcohol and other drug abuse by chapter 221, laws of 1979. In 1993, Act 210 created the state council on alcohol and other drug abuse, incorporating the citizen's council on alcohol and other drug abuse, and expanding the state council and other drug abuse's membership and duties. The state council on alcohol and other drug abuse's appointments, composition and duties are prescribed in sections 15.09 (1)(a), 14.017 (2), and 14.24 of the statutes, respectively.

The council strives to have statewide geographic representation, which includes urban and rural populated areas, to have representation from varied stakeholder groups, and shall be a diverse group with respect to age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief, or affiliation, or military participation.

2.2 There is created in the office of the governor a state council on alcohol and other drug abuse consisting of the governor, the attorney general, the state superintendent of public instruction, the secretary of health services, the commissioner of insurance, the secretary of corrections, the secretary of transportation and the chairperson of the pharmacy examining board, or their designees; a representative of the controlled substances board; a representative of any governor's committee or commission created under subch. I of ch. 14 to study law enforcement issues; 6 members, one of whom is a consumer representing the public at large, with demonstrated professional, research or personal interest in alcohol and other drug abuse problems, appointed for 4-year terms; a representative of an organization or agency which is a direct provider of services to alcoholics and other drug abusers; a member of the Wisconsin County Human Service Association, Inc., who is nominated by that association; and 2 members of each house of the legislature, representing the majority party and the minority party in each house, chosen as are the members of standing committees in their respective houses. Section 15.09 applies to the council.

2.3 Selection of Members

From Wis. Stats. 15.09 (1)(a); Unless otherwise provided by law, the governor shall appoint the members of councils for terms prescribed by law. Except as provided in par. (b), fixed terms shall expire on July 1 and shall, if the term is for an even number of years, expire in an odd-numbered year.

2.4 Ex-Officio Members

a. Ex-officio members may be appointed by a majority vote of the council to serve on the council, special task forces, technical subcommittees and standing committees. Other agencies may be included but the following agencies shall be represented through ex-officio membership: The Wisconsin Departments of: Revenue, Work Force Development, Safety and Professional Services, Veteran Affairs and Children and Families, the Wisconsin Technical Colleges System and the University of Wisconsin System.

b. Ex-officio members of the council may participate in the discussions of the council, special task forces, technical subcommittees, and standing committees except that the chairperson may limit their participation as necessary to allow full participation by appointed members of the council subject to the appeal of the ruling of the chairperson.

c. An ex-officio member shall be allowed to sit with the council and participate in discussions of agenda items, but shall not be allowed to vote on any matter coming before the council or any committee of the council, or to make any motion regarding any matter before the council.

d. An ex-officio member may not be elected as an officer of the council.

e. An ex-officio member shall observe all rules, regulations and policies applicable to statutory members of the council, and any other conditions, restrictions or requirements established or directed by vote of a majority of the statutory members of the council

2.5 Selection of Officers

Unless otherwise provided by law, at its first meeting in each year the council shall elect a chairperson, vice-chairperson and secretary from among its members. Any officer may be reelected for successive terms. For any council created under the general authority of s. 15.04 (1) (c), the constitutional officer or secretary heading the department or the chief executive officer of the independent agency in which such council is created shall designate an employee of the department or independent agency to serve as secretary of the council and to be a voting member thereof.

2.6 Terms of Voting Members

a. Voting members shall remain on the council until the effective date of their resignation, term limit or removal by the governor, or until their successors are named and appointed by the governor.

b. Letter of resignation shall be sent to the governor and council chairperson.

c. Each voting member or designee of the council is entitled to one vote.

2.7 Code of Ethics

All members of the council are bound by the codes of ethics for public officials, Chapter 19, Wis. Stats., except that they are not required to file a statement of economic interest. Ex-officio members are not required to file an oath of office. As soon as reasonably possible after appointment or commencement of a conflicting interest and before

voting on any grant, members shall reveal any actual or potential conflict of interest. Chapter 19.46 of Wisconsin State Statutes states that no state public official may take any official action substantially affecting a matter in which the official, a member of his or her immediate family, or an organization with which the official is associated has a substantial financial interest or use his or her office or position in a way that produces or assists in the production of a substantial benefit, direct or indirect, for the official, one or more members of the official's immediate family either separately or together, or an organization with which the official is associated.

2.8 Nondiscrimination

The council will not discriminate because of age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief, or affiliation, or military participation.

2.9 Nomination Process for Appointed Members and Officers

As per Article II, Section 2.1, the governor is required to appoint six citizen members. In addition, the council elects the chairperson, vice-chairperson and secretary, annually. The council will follow this process when making recommendations to the governor concerning appointments and nominating a slate of officers:

a. The council, along with the office of the governor and department staff, will monitor when council terms will expire. It will also monitor the composition of the council with respect to the factors specified in Article II, Section 2.1.

b. The vice-chairperson of the council shall convene a nominating committee and appoint a chairperson of that committee as needed to coordinate the process for all appointments to the council as outlined in Article II, Section 2 and annually put forth a slate of officers as identified in Article II Sections 3.1, 3.2 and 3.3. The Council Chairperson may ask for nominations from the floor to bring forth nominations in addition to the slate of officers brought forth by the nominating committee. The nominating committee shall make recommendations to the council regarding nominations and appointments prior to the September council meeting and have such other duties as assigned by the council.

c. The nominating committee of the council, with support of bureau staff, will publicize upcoming vacancies, ensuring that publicity includes interested and underrepresented groups, including

alcohol, tobacco and other drug abuse agencies, alcohol, tobacco and other drug abuse stakeholder groups, consumers, and providers of all ethnic groups. Publicity materials will clearly state that council appointments are made by the governor. Materials will also state that the governor normally considers the council's recommendations in making council appointments.

d. While any person may apply directly to the governor according to the procedures of that office, all applicants will be asked to provide application materials to the council as well. Bureau staff will make contact with the office of the governor as necessary to keep the committee informed regarding applicants, including those that may have failed to inform the committee of their application.

e. Applicants shall provide a letter of interest or cover letter, along with a resume and any other materials requested by the office of the governor. The nominating committee, in consultation with department staff, may request additional materials. The nominating committee, with support of bureau staff, will collect application materials from nominees, including nominees applying directly to the governor. The nominating committee or staff will acknowledge each application, advising the applicant regarding any missing materials requested by the nominating committee. The nominating committee or staff will review each application to ensure that all required nomination papers have been completed.

f. The nominating committee may establish questions to identify barriers to attendance and other factors related to ability to perform the function of a member of the state council on alcohol and other drug abuse and to identify any accommodations necessary to overcome potential barriers to full participation by applicants. The nominating committee may interview applicants or designate members and/or staff to call applicants. Each applicant shall be asked the standard questions established by the committee.

g. The nominating committee shall report to the full council regarding its review of application materials and interviews. The report shall include the full roster of applicants as well as the committee's recommendations for appointment.

h. The council shall promptly act upon the report of the nominating committee. Council action shall be in the form of its recommendation to the governor. Department staff shall convey the council's recommendation to the office of the governor.

2.10 Removal from Office

The Governor may remove appointed members from the council. The council may recommend removal but the Governor makes the final decision regarding removal.

Section 3. Officers

3.1 Chairperson

The chairperson is the presiding officer and is responsible for carrying out the council's business including that motions passed be acted upon in an orderly and expeditious manner and assuring that the rights of the members are recognized. The chairperson may appoint a designee to preside at a meeting if the vice-chairperson is unable to preside in their absence. The chairperson is also responsible for organizing the work of the council through its committee structure, scheduling council meetings and setting the agenda. The chairperson may serve as an ex-officio member of each council committee. The chairperson shall represent the positions of the council before the legislature, governor and other public and private organizations, unless such responsibilities are specifically delegated to others by the council or chairperson. The agenda is the responsibility of the chairperson, who may consult with the executive committee or other council members as necessary.

3.2 Vice-Chairperson

The vice-chairperson shall preside in the absence of the chairperson and shall automatically succeed to the chair should it become vacant through resignation or removal of the chairperson until a new chairperson is elected. The vice-chairperson shall also serve as the council representative on the governor's committee for people with disabilities (GCPD). If unable to attend GCPD meetings, the vice-chairperson's designee shall represent the council.

3.3 Secretary

The secretary is a member of the executive Committee as per Article IV, Section 5. The secretary is also responsible for carrying out the functions related to attendance requirements as per Article III, Section 6.

3.4 Vacancies

In the event a vacancy occurs among the Officers (Chairperson, Vice-Chairperson, or Secretary) of the State Council on Alcohol and Other

Drug Abuse, the following procedure should be followed: In the event of a vacancy of the Chairperson, the Vice-Chairperson assumes the responsibility of Chairperson until such time as new Officers are elected according to the procedures outlined in the By-Laws. In the event of a vacancy of the Vice-Chairperson, the Secretary assumes the responsibility of the Vice-Chairperson until such time as new Officers are elected according to the procedures outlined in the By-Laws. In the event of a vacancy of the Secretary, the Chairperson shall appoint a replacement from the statutory membership until such time as new Officers are elected according to the procedures outlined in the By-Laws.

ARTICLE III

Council Meetings

Section 1. Council Year

The council year shall begin at the same time as the state fiscal year, July 1.

Section 2. Meetings

2.1 Regular and special meetings

Regular meetings shall be held at least four times per year at dates and times to be determined by the council. Special meetings may be called by the chairperson or shall be called by the chairperson upon the written request of three members of the council.

2.3 Notice of meetings

The council chairperson shall give a minimum of seven days written notice for all council meetings. An agenda shall accompany all meeting notices. Public notice shall be given in advance of all meetings as required by Wisconsin's Open Meetings Law. If a meeting date is changed, sufficient notice shall be given to the public.

2.3 Quorum

A simple majority (51%) of the membership qualified to vote shall constitute a quorum to transact business.

Section 3. Public Participation

Consistent with the Wisconsin Open Meetings law, meetings are open and accessible to the public.

Section 4. Conduct of Meetings

4.1 Meetings shall be conducted in accordance with the latest revision of Robert's Rules of Order, unless they are contrary to council by-laws or federal or state statutes, policies or procedures.

Section 5. Agendas

5.1 Agendas shall include approval of minutes from prior meetings, any action items recommended by a committee, an opportunity for public comment, and other appropriate matters.

5.2 Requests for items to be included on the agenda shall be submitted to the chairperson two weeks prior to the meeting.

Section 6. Attendance Requirements

6.1 All council members and committee members are expected to attend all meetings of the council or the respective committees. Attendance means presence in the room for more than half of the meeting.

6.2 Council or committee members who are sick, hospitalized or who have some other important reason for not attending should notify the secretary or the secretary's designee or committee staff person or chairperson at least a week before the meeting. If that is not possible, notice should be given as soon as possible.

6.3 Any statutory members or designees of the council or committee who has two unexcused absences from meetings within any twelve month period will be contacted by the secretary of the council or committee chair to discuss the reasons for absence and whether the member will be able to continue serving. Appointed members who do not believe that they can continue should tender their resignation in writing to the secretary of the council or committee chair. Any council member resignations will be announced by the chairperson and forwarded by written notice to the Governor of the need for a new appointment. The replacement member would fulfill he resigned member’s term.

Section 7. Staff Services

The division of mental health and substance abuse services shall provide staff services. Staff services shall include: record of attendance and prepare minutes of meetings; prepare draft agendas; arrange meeting rooms; prepare correspondence for signature of the chairperson; offer information and assistance to council committees;

analyze pending legislation and current policy and program issues; prepare special reports, and other materials pertinent to council business.

Section 8. Reimbursement of Council and Committee Members

According to Section 15.09 of Wisconsin Statutes: Members of a council shall not be compensated for their services, but, except as otherwise provided in this subsection, members of councils created by statute shall be reimbursed for their actual and necessary expenses incurred in the performance of their duties, such reimbursement in the case of an elective or appointive officer or employee of this state who represents an agency as a member of a council to be paid by the agency which pays his or her salary.

ARTICLE IV

Committees

Section 1. Committee Structure

1.1 There shall be an executive committee as provided below. The executive committee is a standing committee of the council.

1.2 The council may establish other standing committees and subcommittees as necessary or convenient to conduct its business. Of the standing committees established by the state council on alcohol and other drug abuse, at least one shall have a focus on issues related to the prevention of alcohol, tobacco and other drug abuse, at least one shall have a focus on issues related to cultural diversity, at least one shall have a focus on issues related to the intervention and treatment of alcohol, tobacco and other drug abuse, and at least one shall have a focus on issues related to the planning and funding of alcohol and other drug abuse services. Subcommittees are a subset of a standing committee. Subcommittees are standing committees, which by another name is a permanent committee. Standing committees meet on a regular or irregular basis dependent upon their enabling act, and retain any power or oversight claims originally given them until subsequent official actions of the council (changes to law or by-laws) disbands the committee. Of the standing subcommittees established by the state council on alcohol and other drug abuse, at least one shall have a focus on children youth and families and is a subcommittee of the intervention and treatment committee, at least one shall have a focus on cultural competency and is a subcommittee of the cultural diversity committee, and at least one shall have a focus on epidemiology and is a subcommittee of the prevention committee.

Ad-hoc committees are established to accomplish a particular task and are to be temporary, with the charge being well-defined and linked to SCAODA's strategic plan, not to exceed duration of twelve calendar months. Ad-hoc committees are formed by standing committee chairs. Ad-hoc committees must report their progress at the meeting of their standing committee. Ad-hoc committees can be granted extensions by the standing committee chair.

It is the intent of this section that:

- There should be periodic review of the structure and progress of the work of the committees, subcommittees and ad-hoc committees.
- If the officers have concerns about the work of the standing committees, subcommittees or ad-hoc committees, they could convene an executive committee meeting to discuss options, "for the good of the order."
- The intent of this group is to recommend that ad-hoc committees be time-limited (recommend one year) and the committee chair determines if the work should go forward beyond the original charge.
- The charge should be well-defined and linked to SCAODA's strategic plan.
- The committee chairs should be primarily responsible for creating and disbanding ad-hoc groups.
- The committee chairs should be responsible for monitoring the work and duration of the work in coordination with SCAODA.

1.3 Committees may determine their own schedules subject to direction from the full council.

Section 2. Composition of Committees

2.1 Council committees may include members of the public as well as council members.

2.2 The council chairperson may appoint a chairperson who must be a member of the council, for each committee. The council chairperson, with the advice of the committee chairperson may appoint other committee members.

2.3 Committees may designate subcommittees including ad hoc committees, as necessary or convenient subject to limitation by the full council.

2.4 A council member shall not chair more than one committee.

2.5 A committee chairperson's term shall not exceed the length of their appointment or four years whichever comes first. With the majority vote of the council, a chairperson may be reappointed.

Section 3. Requirements for all Committees

3.1 A motion or resolution creating a committee shall designate the mission and duties of the committee. The council may also specify considerations for the chairperson to follow in appointing committee chairpersons and members and such other matters as appropriate.

3.2 All committee members are expected to attend all meetings of the committee. Attendance means presence in the room for more than half of the meeting.

3.3 Any committee may authorize participation by telephone conference or similar medium that allows for simultaneous communication between members as permitted by law.

3.4 Committee members who are sick, hospitalized or who have some other important reason for not attending should notify the chairperson or the chairperson's designee at least a week before the meeting. If that is not possible, notice should be given as soon as possible.

3.5 Any committee member who has two unexcused absences within a twelve month period will be contacted by the committee chairperson to discuss the reasons for absence and whether the member will be able to continue serving. Members who do not believe that they can continue should tender their resignation in writing to the committee chairperson. Any resignations will be announced to the council chairperson and to the committee.

3.6 The committee chairperson may remove committee members, other than executive committee members, after notice of proposed removal to and an opportunity to be heard by the member consistently with this process.

Section 4. Requirements for Committee Chairpersons

The chairperson of each committee is responsible for:

a. Ensuring that the by-laws and every applicable directive of the council are followed by the committee as indicated in Chapters 15.09, 14.017 and 14.24 of Wisconsin Statutes;

b. Ensuring that recommendations of the committee are conveyed to the full council;

c. Submitting meeting minutes in the approved format to the council; and

d. Coordinating work with other committees where items could be of mutual interest.

Section 5. Executive Committee

5.1 The executive committee shall be comprised of at least three members, including the council chairperson, vice-chairperson and secretary.

5.2 The executive committee will have the following responsibilities:

a. Provide policy direction to and periodically evaluate the performance of the council and its activities relating to direction from the division of mental health and substance abuse services.

b. Meet at the request of the chairperson as needed;

c. Provide for an annual review of the by-laws;

d. Act on behalf of the council when a rapid response is required, provided that any such action is reported to the council at its next meeting for discussion and ratification; and

e. Other duties designated by the council.

5.3 Rapid Response

The executive committee may act on behalf of the full council only under the following circumstances:

a. When specifically authorized by the council;

b. When action is needed to implement a position already taken by the council;

c. Except when limited by the council, the executive committee may act upon the recommendation of a committee, other than the executive committee, if such action is necessary before a council meeting may reasonably be convened, provided that if more than one committee has made differing recommendations concerning the subject, the executive committee may not act except to request further study of the subject; or

d. Except when limited by the council, the executive committee, by unanimous consent, may take such other action as it deems

necessary before a council meeting may reasonably be convened.

ARTICLE V

Amendments

The by-laws may be amended, or new by-laws adopted, after thirty days written notice to council members by a two-thirds vote of the full council membership present at a regularly scheduled meeting.