Governor's Substance Use Disorders Task Force

Report

September 2018

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Acknowledgments

The Governor's Substance Use Disorders Task Force is grateful for the valuable input it received. Appointed members of the Task Force included:

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Additionally, the Task Force extends special thanks to the following staff of the Kansas Health Institute: Carlie Houchen, Analyst; Robert St. Peter, President and CEO; Kari Bruffett, Director of Policy; and Lisé White, Executive Assistant, for providing process facilitation, research support and report preparation under the Task Force's direction.

The Task Force would also like to thank Krista Machado, Project Manager, DCCCA for her research and other support, and members of the Kansas Prescription Drug and Opioid Advisory Committee for their work putting forward recommendations and information for the Task Force's consideration.

Lastly, the Task Force thanks the 86 individuals and organizations who submitted testimony to inform the Task Force.

Executive Summary

On March 1, 2018, Kansas Gov. Jeff Colyer signed Executive Order 18-09 to establish the Substance Use Disorders Task Force. The Task Force duties were to:

- Gather information regarding substance use disorder within the state of Kansas, particularly regarding the growing number of opioid and heroin overdoses in the state and the continued scourge of methamphetamine addiction;
- Evaluate and leverage existing resources, tools and initiatives already established in the Kansas healthcare continuum, notably the work and recommendations of the Kansas Prescription Drug and Opioid Advisory Committee;
- Investigate various response options, including distributing Naloxone to first responders, more comprehensively utilizing prescribing data and otherwise revising state policy as appropriate;
- Examine best practices for prevention, treatment and recovery of at-risk individuals through early detection and equation for patients;
- Advise and make recommendations to the governor; and
- Assist in implementing and executing a statewide response.

In establishing the Task Force, it was recognized that in 2016 alone, drug poisoning was a cause of death for over 300 Kansans.[1] Nearly a third of these deaths were attributed to methamphetamines.[2] Additionally, prescription medications were involved in over 80 percent of drug poisonings in Kansas from 2012 to 2016.[3] The Task Force's focus was on addressing substance use disorders, recognizing the multiple drugs contributing to state of addiction in Kansas.

The Task Force met approximately monthly from April to August 2018, and meetings were led by the Task Force chair, Dr. Greg Lakin, D.O., J.D., Chief Medical Officer, Kansas Department of Health and Environment (KDHE). Task force meetings were facilitated by the Kansas Health

Institute (KHI). Meetings focused on the five primary topic areas defined by the Kansas Prescription Drug and Opioid Advisory Committee and the focus of the Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan. These topics include: Provider Education, Prevention, Treatment & Recovery, Law Enforcement and Neonatal Abstinence Syndrome (NAS).

To view additional information about the Task Force, such as meeting minutes, public comments and other supporting materials, please visit preventoverdoseks.org.

This report includes a list of 34 high-priority, first action recommendations put forward by the Task Force (see *Figure 1*). The Task Force also considered or developed a number of other recommendations. While these recommendations were not prioritized at this time, the Task Force recognizes their merit and has included them in Appendix B (*page B-1*) and in each relevant section.

*Figure 1***. Substance Use Disorders Task Force Priority Recommendations**

Topic 1: **Provider Education**
PE1. Centralized Authority. Centralize Coordination of Substance Use Disorder Policy and Provider Education. The State of Kansas should create or identify a centralized authority to coordinate: (page 7) • Providing and raising awareness of educational opportunities – virtual and in person – on evidence-based practices associated with substance use disorder, addiction treatment and pain management; and • Continuing to develop and disseminate a comprehensive resource toolkit for prescribers.
PE2. Provider Training. Provide training and continuing education programs for healthcare professionals. Healthcare programs (e.g., M.D., N.P., P.A., A.P.R.N., Pharm.D., D.O., D.D.S.) should include in curricula additional education on opioid prescribing, addictions, medication-assisted treatment (MAT), pain management and risk identification. (page 8)
PE3. K-TRACS Education. Develop and disseminate materials on K-TRACS and CDC guidelines to healthcare providers and students. (page 10)
PE4. K-TRACS Utilization. Increase utilization of K-TRACS for surveillance and intervention. (page 11)

Figure 1. **Substance Use Disorders Task Force Priority Recommendations (continued)**

Topic 1: **Provider Education**
PE5. K-TRACS Registration. Require physicians and other clinicians authorized to prescribe medications subject to abuse as listed in K-TRACS and pharmacists authorized to dispense such medications be registered with K-TRACS. Strongly encourage and educate prescribers and pharmacists regarding utilization of K-TRACS when issuing or dispensing prescriptions of those medications as well as a periodic monitoring of all patients by prescribers. (page 12)
PE6. K-TRACS Funding. K-TRACS should be sustainably funded by the State General Fund after any available grant funding is exhausted. (page 13)
Topic 2: **Prevention**
Prev1. Promote Safety. Promote safe use, storage and disposal of prescription medications, including opioids, to prevent misuse and illicit acquisition and distribution. (page 16)
Prev2. **Disposal Sites.** Expand medication disposal sites in gap areas to ensure that there is a minimum of one medication disposal site in each Kansas county. (page 17)
Prev3. Awareness. Develop and disseminate educational materials for both professional and non-professional audiences on the issues of prescription drug, opioid, methamphetamines and other drug misuse, abuse, overdose and mitigation strategies. (page 18)
Prev4. Community Collaboration. Increase collaboration with community partners to enhance their capacity to develop and implement local-level prevention efforts for prescription drug, illicit opioid, methamphetamine and other drug misuse and overdose. (page 19)
Prev5. Data. Collect, analyze, use and disseminate surveillance data to inform prevention efforts and monitor trends in at-risk populations. (page 20)
Prev6. **Fund Prevention.** Establish and sustain permanent funding sources for primary, secondary and tertiary prevention associated with prescription drugs, opioids, alcohol, methamphetamines and other drug misuse for all ages. (page 21)
Prev7. **Survey Opt-Out.** Change legislation regarding public health and behavioral health state surveys (e.g., The Kansas Communities That Care Student Survey [KCTC] and the Youth Risk Behavior Surveillance System [YRBSS]) from an opt-in consent, to an informed opt-out consent to allow for meaningful data collection. (page 23)
Topic 3: **Treatment & Recovery**
TR1. Expand Medication-Assisted Treatment. Expand access and utilization of medication-assisted treatment (MAT). (page 26)

Figure 1. **Substance Use Disorders Task Force Priority Recommendations (continued)**

Topic 3: **Treatment & Recovery**
TR2. Buprenorphine Prescribers. Increase the number of buprenorphine-waivered prescribers practicing in Kansas and incentivize buprenorphine training for providers. (page 27)
TR3. Prior Authorizations. Remove prior authorization requirements for MAT. (page 28)
TR4. Needs Assessment. Conduct a statewide needs assessment to identify gaps in funding, access to substance use disorder (SUD) treatment providers and identify specific policies to effectively utilize and integrate existing SUD treatment resources. (page 29)
TR5. Opioid Addiction Project ECHO. Identify funding for Opioid Addiction Project ECHO telementoring. (page 29)
TR6. Service Integration. Adopt coding practices that allow for the integration of services across the continuum of care domains (e.g., primary care, substance use disorder and mental health) to provide more integrative services to clients with co-occurring conditions. (page 30)
TR7. SBIRT. Increase access to and utilization of Screening, Brief Intervention and Referral to Treatment (SBIRT) across health care provider disciplines by reimbursing appropriately trained and licensed professionals to provide this service across locations. (page 31)
TR8. Payment Reform. Support substance use disorder payment reform targeted to improve population health. (page 32)
TR9. Peer Support Reimbursement. Expand access to peer support services and increase Medicaid reimbursement rates for the services. (page 33)
TR10. Mental Health Parity. Review procedures for mental health parity laws to ensure compliance. (page 34)
TR11. IMD Waivers. Explore waiver of IMD exclusion for mental health and substance use disorder treatment and support current IMD exclusion waiver for residential services for substance use treatment. (page 35)
TR12. Treatment Navigator. Develop a statewide treatment navigator. (page 37)

Figure 1. **Substance Use Disorders Task Force Priority Recommendations (continued)**

Topic 3: **Treatment & Recovery**
TR13. KanCare. Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans. Expansion will improve access to needed healthcare services, including substance use disorder treatment, and reduce more costly treatment sought in hospital emergency departments. Data clearly show that states that have expanded Medicaid have improved access to all healthcare services, including SUD treatment; individuals stay in treatment longer; and chronic disease management and outcomes are improved. (page 37)
TR14. KCPC. Replace Kansas Placement Criteria Program (KCPC) with modern technology and data collection methods consistent with current and future electronic health records to prevent major systemic failure. (page 41)
TR15. Senate Bill 123. Assure adequate funding for 2003 Senate Bill 123 to allow for appropriate provision of medically necessary treatment services and allow for an expanded list of qualifying offenses. (page 41)
Topic 4: **Law Enforcement**
LE1. Community-Based Liaison. Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for those with SUD and co-occurring conditions. (page 45)
LE2. Benefits Reinstatement. Develop reinstatement policies or procedures to increase the ability of offenders to access Medicaid benefits upon release, such as suspending benefits rather than termination upon incarceration. (page 46)
LE3. Diversion Sobriety and Treatment. Expand pre-charge and post-charge diversion sobriety and treatment options for first-time, non-violent simple drug possession charges. (page 47)
LE4. Naloxone. Promote Naloxone education and use for first responders and pursue all available funding. (page 47)
Topic 5: **Neonatal Abstinence Syndrome**
NAS1. **Educate and Intervene.** Provide education, screening, intervention and support to substance-using women to reduce the number of infants born substance-exposed, while expanding coverage for family planning services, preconception services and a variety of contraceptives, including long-acting reversible contraceptives (LARCs). (page 50)

Figure 1. **Substance Use Disorders Task Force Priority Recommendations (continued)**

Topic 5: **Neonatal Abstinence Syndrome**
NAS2. Standardize Care. Provide education on best practices to reduce stigma and promote standardized care regarding NAS cases, develop a standardized reporting process for NAS cases across the state, and offer universal training and continuing education through the Vermont Oxford Network (VON) NAS Universal Training Program to Kansas birthing centers. (page 52)

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

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Introduction

In the United States, more than 63,000 people died from drug overdoses in 2016.[4] Millions more people experience substance use disorders.[5] Since 2012, more than 1,500 Kansans have died from opioid or heroin overdoses.[6] In 2016 alone, drug poisoning was an underlying cause of death for more than 300 people in Kansas with nearly a third of these poisonings attributed to methamphetamines.[7] Given this demonstrated need, Executive Order 18-09 established a task force to address substance use disorder. The Task Force duties were to:

- Gather information regarding substance use disorder within the state of Kansas, particularly regarding the growing number of opioid and heroin overdoses in the state and the continued scourge of methamphetamine addiction;
- Evaluate and leverage existing resources, tools and initiatives already established in the Kansas healthcare continuum, notably the work and recommendations of the Kansas Prescription Drug and Opioid Advisory Committee;
- Investigate various response options, including distributing Naloxone to first responders, more comprehensively utilizing prescribing data and otherwise revising state policy as appropriate;
- Examine best practices for prevention, treatment and recovery of at-risk individuals through early detection and equation for patients;
- Advise and make recommendations to the governor; and
- Assist in implementing and executing a statewide response.

Task Force Members

The Executive Order designated Task Force members or individuals responsible for appointing members. Additionally, the Executive Order named the Chief Medical Officer at the Kansas Department of Health and Environment as the chair of the Task Force. The Task force membership included the heads of the following agencies, or their designees:

- Kansas Attorney General
- Kansas Department of Health and Environment
- Kansas Department for Aging and Disability Services
- Kansas Department for Children and Families

- Kansas Department of Corrections
- Kansas State Board of Pharmacy
- Kansas State Board of Healing Arts
- Kansas State Board of Nursing
- Kansas Dental Board
- Kansas State Board of Emergency Medical Services
- Association of Community Mental Health Centers of Kansas
- Kansas Hospital Association
- Kansas Medical Society
- Kansas Association of Addiction Professionals
- Kansas Pharmacists Association

Additional members included:

- One pain management professional
- One hospice industry professional
- One representative of a Kansas nursing facility
- One representative of law enforcement
- One education professional

Lastly, each of the following were afforded the opportunity to appoint one member of the Task Force:

- Speaker of the House
- President of the Senate
- House Majority Leader
- Senate Majority Leader
- House Minority Leader
- Senate Minority Leader

Overview of Process

Per the Executive Order, the purpose of the recommendations included in this report is to advise the governor and legislature and should not be construed as official policies, positions or interpretation of laws, rules or regulations.

The role of the Kansas Health Institute (KHI) was to provide administrative and facilitation support to the Task Force as it developed and prioritized recommendations. KHI activities included preparing and publishing meeting agendas, meeting minutes and compilation and dissemination of public comment and other materials requested by the Task Force. KHI also ensured that the objectives of each meeting had been met and developed surveys to capture any outstanding items.

The Task Force met from April through August 2018. Throughout this time period, the Task Force met once per month with three meetings held in August, for a total of seven meetings. Each meeting focused on specific topic area(s) designated in the *Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan*. These topic areas included: Provider Education, Prevention, Treatment & Recovery, Law Enforcement and Neonatal Abstinence Syndrome (NAS).

Related to each topic, the Task Force prioritized the most critical strategies for discussion; heard background and context on that strategy from members of the *Kansas Prescription Drug and Opioid Advisory Committee*; revised recommendations to increase effectiveness or specify the mechanism for implementation; and characterized the anticipated effect of the recommendation. Within each topic recommendations are listed approximately by order of discussion, the order of presentation of each recommendation is not indicative of its priority. To view additional information about the Task Force, such as meeting minutes, public comments and other supporting materials, please visit preventoverdoseks.org.

See *Figure 2* (page 4) for a sample matrix that was used to characterize or describe each recommendation. Following the discussion and characterization of recommendations, the Task Force identified high-priority recommendations.

Figure 2. **Characterization Matrix of Recommendations**

Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☐ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☐ No ☐ What level of initial investment will be required? High ☐ Low☐ What level of ongoing investment will be required? High ☐ Low ☐ How many people would be affected? Large Number ☐ Small Number ☐ Would this recommendation avoid costs? Yes ☐ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Additional Issues

The Task Force recognized substance use disorders and the national opioid epidemic as an evolving and ongoing issue. With that in mind the Task Force wished to indicate that consideration of these and other emerging recommendations should be ongoing as communities and researchers across the country better understand how to address substance use disorders. In their meetings since April, the Task Force has primarily focused discussions on the following five topics: provider education, prevention, treatment and recovery, law enforcement and neonatal abstinence syndrome. Recognizing the importance of these topic areas, the Task Force raised the importance of further discussion on the following critical issues:

- Role of technology to support those with substance use disorders
    - Telehealth provision of substance use disorder treatment
    - Consideration of reimbursement and other issues related to the utilization of technology to increase access to substance use disorder treatment
- Additional audiences for prevention and education

    - Engagement with schools around substance use disorders
    - Early identification of substance use disorder among students
    - Student knowledge of risks involved with available substances
- Early childhood development and interventions
    - Addressing early-childhood traumas and adverse childhood experiences (ACEs) that can impact substance use later in life
- Prescription Drug Monitoring Programs (PDMPs)
    - Collaboration with other states to ensure interoperability of PDMPs
    - Partnering with Missouri in the development of a PDMP
    - Clarification between providers and pharmacists on the diagnosis information that can be made available
- Pain management
    - Mechanisms to ensure appropriate options for those with chronic pain
    - Access to multidisciplinary chronic pain management (e.g., Project ECHO, telehealth) as recommended in the *Joint Policy Statement of the Kansas Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Chronic Pain* [8]

Provider Education

Introduction: The Task Force recognized the role of health care providers in addressing substance use disorders – particularly regarding the misuse of prescription medications, such as opioids. The Task Force discussed mechanisms for coordinating opportunities for provider education, opportunities to support the increased utilization of K-TRACS – Kansas' prescription drug monitoring program — as well as removing barriers to comprehensive pain management. From these important discussions, the Task Force indicated that timely action is needed on the following priority recommendations.

Priority Recommendations:

- **PE1. Centralized Authority.** Centralize Coordination of Substance Use Disorder Policy and Provider Education. The State of Kansas should create or identify a centralized authority to coordinate:
    - Providing and raising awareness of educational opportunities – virtual and in person – on evidence-based practices associated with substance use disorder, addiction treatment and pain management; and
    - Continuing to develop and disseminate a comprehensive resource toolkit for prescribers.
- **PE2. Provider Training.** Provide training and continuing education programs for healthcare professionals. Healthcare programs (e.g., M.D., N.P., P.A., A.P.R.N., Pharm.D., D.O., D.D.S.) should include in curricula additional education on opioid prescribing, addictions, medication-assisted treatment (MAT), pain management and risk identification.
- **PE3. K-TRACS Education.** Develop and disseminate materials on K-TRACS and CDC Guidelines to healthcare providers and students.
- **PE4. K-TRACS Utilization.** Increase utilization of K-TRACS for surveillance and intervention.

- **PE5. K-TRACS Registration.** Require physicians and other clinicians authorized to prescribe medications subject to abuse as listed in K-TRACS and pharmacists authorized to dispense such medications be registered with K-TRACS. Strongly encourage and educate prescribers and pharmacists regarding utilization of K-TRACS when issuing or dispensing prescriptions of those medications as well as a periodic monitoring of all patients by prescribers.

- **K-TRACS Funding.** K-TRACS should be sustainably funded by the State General Fund after any available grant funding is exhausted.

PE1. Centralized Authority**.** Centralize Coordination of Substance Use Disorder Policy and Provider Education. The State of Kansas should create or identify a centralized authority to coordinate:

- Providing and raising awareness of educational opportunities – virtual and in person – on evidence-based practices associated with substance use disorder, addiction treatment and pain management; and

- Continuing to develop and disseminate a comprehensive resource toolkit for prescribers.

Background:

The Task Force discussed the value of a centralized authority to ensure coordination of substance use disorder policy and provider education. It was discussed that this position should have regular, direct access to the governor and top leadership and the authority to drive meaningful collaboration across agencies and departments. It was discussed that this position should have high visibility to contribute to continued public awareness of the issues related to substance use disorders. The Task Force discussed that this recommendation could reduce downstream direct and indirect costs, such as in patient and emergency department utilization, treatment costs, justice system interactions and lost productivity. The position could further increase efficiency via collaboration across agencies and departments to streamline coordination of efforts.

Figure 3. **Characterization Matrix for PE1. Centralized Authority**

PE1. Centralized Authority	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

PE2. Provider Training**.** Provide training and continuing education programs for healthcare professionals. Healthcare programs (e.g., M.D., N.P., P.A., A.P.R.N., Pharm.D., D.O., D.D.S.) should include in curricula additional education on opioid prescribing, addictions, medication-assisted treatment (MAT), pain management and risk identification.

Task Force also wanted to highlight the following key components of provider training:

- Provide education to health care providers on evidence-based multimodal pain management and discuss these treatment options with patients.
- Provide and support clinician education to utilize best practice (e.g., Clinically Aligned Pain Assessment [CAPA] tool) to assess patient function to determine appropriate prescribing decisions rather than utilize a pain scale alone.
- Educate providers to recognize evidence-based sex- and gender-based differences in pain and pain management.
- Provide education to health care providers on early-recognition of substance use or misuse.

Background:

The Task Force discussed the importance of educating health care professionals on opioid prescribing practices, addiction treatment, medication-assisted treatment (MAT), chronic pain management and risk identification. It was discussed that changing curricula in educational programs for healthcare professionals can be a time- and resource-intensive process. However, it was thought that the existing system of health care training programs, continuing medical education programs, licensing boards and Area Health Education Centers (AHECs) could facilitate efficient and effective delivery of educational opportunities.

Figure 4. **Characterization Matrix for PE2. Provider Training**

PE2. Provider Training	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☐ Long Term (3+ years) ☒ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☒ Low ☐ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

K-TRACS Recommendations:

The Task Force viewed K-TRACS – Kansas' prescription drug monitoring program (PDMP) – as playing a critical role in the state's response to increasing cases of substance use disorders. Given this, the Task Force made four recommendations related to K-TRACS with the intent of maximizing possible benefits from the resource.

K-TRACS monitors all controlled substances scheduled as II, III or IV, as well as other drugs of concern, with the goal of preventing misuse, abuse and diversion of controlled substances.[9] K-TRACS provides interoperability for prescribers and pharmacists to allow them to quickly and efficiently identify a patient's controlled-substance prescription history. This then allows the prescribers and dispensers the opportunity to make informed clinical decisions. The Task Force discussed strategies to support increased utilization of K-TRACS as well as strategies for long-term, sustainable funding of the program. These discussions are reflected in the recommendations, prioritized for timely action, below.

PE3. K-TRACS Education. Develop and disseminate materials on K-TRACS and the Centers for Disease Control and Prevention (CDC) prescribing guidelines for healthcare providers and students.

Background:

The Task Force discussed the relative low cost of developing and sharing materials with healthcare providers regarding the resource available to them in K-TRACS. It was similarly discussed that disseminating information to health care providers and students on the CDC's *Guidelines for Prescribing Opioids for Chronic Pain* would be a low cost, effective strategy. Clinical reminders offered in the CDC publication include: Opioids are not first-line or routine therapy for chronic pain; Establish and measure goals for pain and function; and Discuss benefits and risks and availability of non-opioid therapies with patients.[10] It was discussed that some grant funding for the development and dissemination of these resources may be available through the Data-Driven Prevention Initiative from the CDC. Further, the Kansas Board of Pharmacy (KBOP) indicated that additional grant funding for K-TRACS educational materials might become available.

Figure 5. **Characterization Matrix for PE3. K-TRACS Education**

PE3. K-TRACS Education	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☐ Long Term (3+ years) ☒ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☒ Low ☐ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

PE4. K-TRACS Utilization. Increase utilization of K-TRACS for surveillance and intervention.

Background:

The Task Force discussed the value of increased utilization of K-TRACS by healthcare providers. Additionally, members discussed that for controlled medications prescribed for long-term use, K-TRACS should be reviewed by prescribers approximately every three months during the care of their patient. Further, it was discussed that the K-TRACS Prescription Monitoring Program (PMP) Advisory Committee should continue to meet and review K-TRACS data no less than quarterly but should meet or assign a qualified licensed prescriber to review K-TRACS data monthly for areas of urgency or concern to bring to the committee for potential action on an emergent basis.

Figure 6. **Characterization Matrix for PE4. K-TRACS Utilization**

PE4. K-TRACS Utilization	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

PE5. K-TRACS Registration. Require physicians and other clinicians authorized to prescribe medications subject to abuse as listed in K-TRACS and pharmacists authorized to dispense such medications be registered with K-TRACS. Strongly encourage and educate prescribers and pharmacists regarding utilization of K-TRACS when issuing or dispensing prescriptions of those medications as well as a periodic monitoring of all patients by prescribers.

Background:

As a strategy to increase utilization of K-TRACS by healthcare providers, the Task Force made the recommendation to require registration in K-TRACS for all providers who write prescriptions for controlled substances, scheduled II through IV, and other drugs of concern. It was discussed that this allows for appropriate follow-up with a prescriber to occur if suspect activity is flagged in the system. Currently, there is not a consistent mechanism to ensure that contact information is available to communicate with prescribers when a question arises.

Figure 7. **Characterization Matrix for PE5. K-TRACS Registration**

PE5. K-TRACS Registration	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

PE6. K-TRACS Funding. K-TRACS should be sustainably funded by the State General Fund after any available grant funding is exhausted.

Background:

The Task Force discussed that K-TRACS is critical to efforts to reduce substance use disorders in the state. With this in mind, after due consideration, the Task Force made the recommendation that State General Funds (SGF) be used after any available grant funding for K-TRACS is expended. The cost to fund K-TRACS for fiscal year 2020 is estimated to be just under $1.0 million.[11]

Figure 8. **Characterization Matrix for PE6. K-TRACS Funding**

PE6. K-TRACS Funding	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☐ No ☒ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☐ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Non-Prioritized Recommendations:

In addition to the high priority recommendations listed above, the Task Force also developed or discussed the following recommendations for inclusion.

Figure 9. **Non-Prioritized Recommendations for Provider Education**

Recommendations
PE7. **Prescribing Support.** Expand support for electronic health records (EHR) decision support and K-TRACS integration.
PE8. Comprehensive Pain Management. Reimburse for evidence-based multidisciplinary and comprehensive pain management models (non-opioid/non-pharmacologic). Assess coverage barriers to pain management (including those in Medicaid related to over-the-counter medications).
PE9. **Provider Notification.** Notify providers when a patient has contact with law enforcement due to a K-TRACS referral.
PE10. **Coroner Letters.** Explore the feasibility of and consider a pilot program for coroners or medical examiners sending educational letters to prescribing providers upon their own patient's death from prescription drug or other illicit substance overdose.

Figure 9. **Non-Prioritized Recommendations for Provider Education (continued)**

Recommendations
PE11. Multidisciplinary Approach. Provide and support clinician education about effective evidence-based multidisciplinary approaches to and advances in acute and chronic pain management.
PE12. Provider MAT Training. Increase capacity and access to MAT in Kansas through provider training on medication-assisted treatment (MAT).

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Prevention

Prevention plays a key role in counteracting the increase of deaths related to drug poisonings. Related to prevention, the Task Force discussed expanded medication disposal sites and the sharing of educational materials on the dangers of prescription and other drug misuse. The Task Force also discussed opportunities for collaboration and data analysis and use in Kansas communities. From these discussions, the Task Force indicated the need for timely action on the following items:

<u>Priority Recommendations:</u>

- **Prev1. Promote Safety.** Promote safe use, storage and disposal of prescription medications, including opioids, to prevent misuse and illicit acquisition and distribution.
- **Prev2**. **Disposal Sites.** Expand medication disposal sites in gap areas to ensure that there is a minimum of one medication disposal site in each Kansas county.
- **Prev3. Awareness.** Develop and disseminate educational materials for both professional and non-professional audiences on the issues of prescription drug, opioid, methamphetamines and other drug misuse, abuse, overdose and mitigation strategies

- **Prev4. Community Collaboration.** Increase collaboration with community partners to enhance their capacity to develop and implement local-level prevention efforts for prescription drug, illicit opioid, methamphetamine and other drug misuse and overdose.
- **Prev5. Data.** Collect, analyze, use and disseminate surveillance data to inform prevention efforts and monitor trends in at-risk populations.
- **Prev6**. **Fund Prevention.** Establish and sustain permanent funding sources for primary, secondary and tertiary prevention associated with prescription drugs, opioids, alcohol, methamphetamines and other drug misuse for all ages.
- **Prev7**. **Survey Opt-Out.** Change legislation regarding public health and behavioral health state surveys (e.g., The Kansas Communities That Care Student Survey [KCTC] and the Youth Risk Behavior Surveillance System [YRBSS]) from an opt-in consent, to an informed opt-out consent to allow for meaningful data collection.

Prev1. Promote Safety**.** Promote safe use, storage and disposal of prescription medications, including opioids, to prevent misuse and illicit acquisition and distribution.

Background:

The Task Force discussed the continued need to promote the safe use, storage and disposal of prescription medications, such as opioids. It was discussed that with enhanced outreach and communication efforts this recommendation could positively affect a large number of Kansans at a low cost. This is the primary focus of the Kansas Partnership for Success 2015 Prescription Drug initiative that is currently funded through 2020.

Figure 10. **Characterization Matrix for Prev1. Promote Safety**

Prev1. Promote Safety	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Prev2. Disposal Sites**.** Expand medication disposal sites in gap areas to ensure that there is a minimum of one medication disposal site in each Kansas county.

Background:

The Task Force was interested to recommend that additional medication disposal sites be made available across the states, particularly in areas that currently may not have any safe disposal sites. It was discussed that some grant funds from Partnership for Success 2015 Prescription Drug Prevention Initiative, a program of the Substance Abuse and Mental Health Services Administration (SAMHSA), and from the SAMHSA State Targeted Response to the Opioid Crisis (STR) Grant funds, are currently available. The Task Force noted that grant funds may be term-limited, and it is unclear what additional or future funds might become available.

Figure 11. **Characterization Matrix for Prev2. Disposal Sites**

Prev2. Disposal Sites	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Prev3. Awareness**.** Develop and disseminate educational materials for both professional and non-professional audiences on the issues of prescription drug, opioid, methamphetamines and other drug misuse, abuse, overdose and mitigation strategies.

Background:

The Task Force discussed the importance of continued communication of educational materials for professional and community audiences on drug misuse, abuse, overdose and prevention strategies. With consideration of the specific drugs currently affecting a large number of Kansans, the Task Force made the recommendation that this information be made widely available regarding prescription drugs, other opioids and methamphetamines, among others. The Task Force anticipated that this recommendation would be inexpensive to implement and could positively impact a large number of people. Some grant funding to implement this recommendation may be available from the Prescription Drug Overdose: Data-Driven Prevention Initiative (DDPI) from the Centers for Disease Control and Prevention (CDC) (through 2019), Partnerships for Success 2015 Grant Prescription Drug Prevention Initiative (through 2020) and the State Targeted Response (STR) to the Opioid Crisis (through 2019). Additionally,

Kansas currently has an awareness campaign called, "It Only Takes a Little to Lose a Lot." This program is funded as part of the CDC's Rx Awareness Media Campaign.

*Figure 12***. Characterization Matrix for Prev3. Awareness**

Prev3. Awareness	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Prev4. Community Collaboration**.** Increase collaboration with community partners to enhance their capacity to develop and implement local-level prevention efforts for prescription drug, illicit opioid, methamphetamine and other drug misuse and overdose.

Background:

The Task Force discussed the value of collaboration with community partners to develop local-level prevention efforts. Additionally, the Task Force cited the recurring mention of collaboration in the public comments they received as an additional reason to consider this recommendation a high priority. It was thought that this recommendation could require a high investment as funding and access to data would be required across the state to build meaningful collaborations. The Task Force discussed that this recommendation could build on the mental health funding for schools that was authorized in the 2018 legislative session. Additionally, some grant funding from Partnership for Success, Data-Driven Prevention Initiative, State Targeted

Response to the Opioid Crisis and Centers for Disease Control and Prevention Public Health Crisis Funding are available and currently being utilized to begin work on this recommendation.

Figure 13. **Characterization Matrix for Prev4. Community Collaboration**

Prev4. Community Collaboration	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Prev5. Data**.** Collect, analyze, use and disseminate surveillance data to inform prevention efforts and monitor trends in at-risk populations

Background:

The Task Force repeatedly discussed the role and value of data in understanding substance use disorder. Utilization of data was thought to have a positive impact on a large number of people in a short time period. The Task Force also discussed the value of utilizing data from a variety of sources, such as emergency rooms, health care providers, treatment providers, mortality data, emergency medical services and criminal justice sources. It was projected that the level of funding required to implement this recommendation would be low as it would primarily require sustainable funding to support ongoing data analysis.

Figure 14. **Characterization Matrix for Prev5. Data**

Prev5. Data	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Prev6. Fund Prevention**.** Establish and sustain permanent funding sources for primary, secondary and tertiary prevention associated with prescription drugs, opioids, alcohol, methamphetamines and other drug misuse for all ages.

Background:

The Task Force noted the importance of sustained and permanent funding for prevention associated with prescription drugs, opioids, alcohol and methamphetamines. The Task Force also recommends the utilization of primary, secondary and tertiary prevention strategies to prevent negative health effects from ever occurring, screening to identify ill-effects early, and managing ongoing challenges associated with a diagnosed condition. For the sake of this recommendation, the Task Force considers the definitions of primary, secondary and tertiary prevention as:

- Primary Prevention – Intervening before health effects occur, through measures such as vaccinations, altering risky behaviors and banning substances known to be associated with a disease or health condition.[12]

- Secondary Prevention – Screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing.[13]

- Tertiary Prevention – Managing disease post diagnosis to slow or stop disease progression through measures such as chemotherapy, rehabilitation and screening for complications.[14]

Figure 15. **Characterization Matrix for Prev6. Fund Prevention**

Prev6. Fund Prevention	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☐ Long Term (3+ years) ☒ Is there an existing system in place to support the implementation of this recommendation? Yes ☐ No ☒ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☒ Low ☐ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Prev7. Survey Opt-Out**.** Change legislation regarding public health and behavioral health state surveys (e.g., The Kansas Communities That Care Student Survey [KCTC] and the Youth Risk Behavior Surveillance System [YRBSS]) from an opt-in consent, to an informed opt-out consent to allow for meaningful data collection.

Background:

Task force members discussed the value of accurate data that can be utilized to understand changes in consumption of controlled substances. Members discussed that these data are particularly important for understanding drug-use in youth. Given this, the Task Force pointed to the Kansas Communities That Care (KCTC) student survey as an opportunity to collect this valuable information. Currently, data from public health surveys can be of variable quality because of opt-in language. Changing the requirement on KCTC and other surveys to "opt-out" would increase the usability of that data source for understanding and preventing youth drug use. This recommendation was not characterized.

Non-Prioritized Recommendations:

In addition to the high priority recommendations developed related to each topic, the Task Force also developed or discussed additional recommendations for inclusion in this report. However, related to Prevention, there are no additional, non-prioritized recommendations at this time.

Treatment & Recovery

According to the U.S. Department of Health and Human Services, 11.5 million Americans misused prescription opioids and nearly one million Americans used heroin in 2016.[15] A large number of people who have a substance use disorder (SUD) need treatment and recovery services. The Task Force discussed opportunities and mechanisms to increase the number of services accessible to those with substance use disorders, as well as strategies to help additional individuals access treatment and recovery services.

Priority Recommendations:

- **TR1. Expand Medication-Assisted Treatment.** Expand access and utilization of medication-assisted treatment (MAT).
- **TR2**. **Buprenorphine Prescribers.** Increase the number of buprenorphine-waivered prescribers practicing in Kansas and incentivize buprenorphine training for providers.
- **TR3**. **Prior Authorizations.** Removing prior authorization requirements for medication-assisted treatment (MAT).
- **TR4. Needs Assessment.** Conduct a statewide needs assessment to identify gaps in funding, access to substance use disorder (SUD) treatment providers and identify specific policies to effectively utilize and integrate existing SUD treatment resources.
- **TR5. Opioid Addiction Project ECHO.** Identify funding for Opioid Addiction Project ECHO telementoring.
- **TR6. Service Integration.** Adopt coding practices that allow for the integration of evidence-based services across the continuum of care domains (e.g., primary care, substance use disorder and mental health) to provide more integrative services to clients with co-occurring conditions.

- **TR7. SBIRT.** Increase access to and utilization of Screening, Brief Intervention and Referral to Treatment (SBIRT) across health care provider disciplines by reimbursing appropriately trained and licensed professionals to provide this service across locations.
- **TR8. Payment Reform.** Support substance use disorders payment reform targeted to improve population health outcomes.
- **TR9. Peer Support Reimbursement.** Expand access to evidence-based peer support services and funding mechanisms to support these services.
- **TR10. Mental Health Parity.** Review procedures for mental health parity laws to ensure compliance.
- **TR11. IMD Waivers.** Explore waiver of IMD exclusion for mental health and substance use disorder treatment and support current IMD exclusion waiver for residential services for substance use treatment.
- **TR12. Treatment Navigator.** Develop a statewide treatment navigator.
- **TR13**. **KanCare.** Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans. Expansion will improve access to needed healthcare services, including substance use disorder treatment, and reduce more costly treatment sought in hospital emergency departments. Data clearly show that states that have expanded Medicaid have improved access to all healthcare services, including SUD treatment; individuals stay in treatment longer; and chronic disease management and outcomes are improved.
- **TR14**. **KCPC.** Replace Kansas Placement Criteria Program (KCPC) with modern technology and data collection methods consistent with current and future electronic health records to prevent major systemic failure.
- **TR15**. **Senate Bill 123.** Assure adequate funding for 2003 Senate Bill 123 treatment service and allow for it to address an expanded list of offenses.

TR1. Expand Medication-Assisted Treatment**.** Expand access and utilization of medication-assisted treatment (MAT).

Background:

The Task Force discussed medication-assisted treatment (MAT) as a best practice treatment for those with substance use disorders (SUD). As this is considered a best practice, the Task Force made the recommendation to expand opportunities for those with SUD to access this care. It was discussed that there is an existing network of providers who could facilitate access to MAT, but that there is not adequate support for this system of providers. The Task Force discussed that an additional challenge to the implementation of this recommendation is that in rural parts of the state access to MAT is limited. The Task Force discussed that expanded access to MAT could reduce costs and increase quality of life for Kansans recovering from SUD by reducing emergency department visits, reducing incarceration and increasing earnings potential, among others. Currently some opportunities for MAT are supported by grant funding such as the State Targeted Response to the Opioid Crisis from Substance Abuse and Mental Health Services Administration (SAMHSA).

*Figure 16***. Characterization Matrix for TR1. Expand MAT**

TR1. Expand MAT	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☐ No ☒ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☒ Low ☐ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR2. Buprenorphine Prescribers**.** Increase the number of buprenorphine-waivered prescribers practicing in Kansas and incentivize buprenorphine training for providers.

Background:

Buprenorphine is an opioid partial agonist and it is used in medication-assisted treatment (MAT) to help people quit or reduce their use of heroin or other opiates. Buprenorphine is the first medication used in MAT that can be prescribed in the office of a qualified physician.[16] The Task Force was interested to recommend that the number of physicians qualified to prescribe buprenorphine in Kansas increase so that patient access to this care could increase. Providers can become qualified to prescribe buprenorphine in any setting in which they are qualified to practice by qualifying for a physician waiver offered through the Substance Abuse and Mental Health Services Administration (SAMHSA). In order to become qualified for the physician waivers, physicians must complete eight hours of required training and complete an application for the waiver.[17] The training required for the waiver is offered free-of-charge. Some funds are currently available to support the increase in the number of buprenorphine-waivered prescribers in Kansas through the State Targeted Response (STR) to the Opioid Crisis.

*Figure 17***. Characterization Matrix for TR2. Buprenorphine Prescribers**

TR2. Buprenorphine Prescribers	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☐ No ☒ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR3. Prior Authorizations**.** Remove prior authorization requirements for medication-assisted treatment (MAT).

Background:

The Task Force discussed the removal of prior authorizations for medication-assisted treatment (MAT) as a key strategy to increase access to this care by those with substance use disorders (SUD). The group discussed the importance of eliminating prior authorization requirements for MAT from public and third-party health care payers. According to the Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan, the removal of prior authorization for MAT has been successfully implemented in other state Medicaid programs and by many commercial insurers.[18]

*Figure 18***. Characterization Matrix for TR3. Prior Authorizations**

TR3. Prior Authorizations	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☐ No ☒ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR4. Needs Assessment. Conduct a statewide needs assessment to identify gaps in funding, access to substance use disorder (SUD) treatment providers and identify specific policies to effectively utilize and integrate existing SUD treatment resources.

Background:

The Task Force discussed the need to understand with more precision the state of and gaps in treatment services around the state. The Task Force indicated interest in engaging with treatment providers to learn what is and is not available regarding substance use disorders and related conditions so that it could be better understood where additional services are needed. The Task Force recommended that this assessment be conducted, and the information made available publicly. This recommendation was not characterized.

TR5. Opioid Addiction Project ECHO**.** Identify funding for Opioid Addiction Project ECHO telementoring.

Background:

The Task Force recommended that funding be identified for Opioid Addiction Project ECHO (Extension for Community Healthcare Outcomes) telementoring as a strategy to increase access to care for substance use disorders (SUD) across the state and as a way to increase the knowledge of SUD treatment for providers across the state. It was discussed that much of the technical infrastructure is likely in place to facilitate the implementation of this recommendation. Task force members with previous experience with Project ECHO indicated that the initial investment required is low. Additionally, there is some limited grant funding available related to this recommendation through the State Targeted Response to the Opioid Crisis from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Figure 19. **Characterization Matrix for TR5. Opioid Addiction Project ECHO**

TR5. Opioid Addiction Project ECHO	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR6. Service Integration**.** Adopt coding practices that allow for the integration of services across the continuum of care domains (e.g., primary care, substance use disorder and mental health) to provide more integrative services to clients with co-occurring conditions.

Background:

The Task Force discussed that the adoption of coding practices to allow for integrated service delivery across domains is a broad recommendation that aims to move toward the best practice of whole-person care. Integrating services and coordinating across primary care and behavioral health care (e.g., mental health care and care for substance use disorders) allows for better service delivery for those with co-occurring conditions. It was discussed that the initial costs associated with this recommendation would be administrative as time must be invested to navigate integrated care codes.

Figure 20. **Characterization Matrix for TR6. Service Integration**

TR6. Service Integration	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☐ Moderate ☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR7. SBIRT**.** Increase access to and utilization of Screening, Brief Intervention and Referral to Treatment (SBIRT) across health care provider disciplines by reimbursing appropriately trained and licensed professionals to provide this service across locations.

Background:

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce and prevent abuse of alcohol and illicit drugs.[19] SBIRT was developed out of the identified need for community-based screening for health risk behaviors, such as substance use.[20] The Task Force discussed their interest in expanding the provider panel and locations from which this service can be billed. For example, the Task Force discussed the value of being able to bill for SBIRT in school settings. Currently SBIRT can be provided by practitioners to Medicaid-eligible Kansans if the practitioner is currently licensed, in good standing, as an approved professional type and has submitted proof of completion of SBIRT training to the Kansas Department for Aging and Disability Services (KDADS).[21] Eligible practitioners include licensed physicians, physician's assistants, nurse practitioners, psychiatrists, nurses, dentists or certified health educators, or psychologists, social workers, professional

counselors, marriage and family therapists or addiction counselors licensed by Kansas Behavioral Sciences Regulatory Board.[22]

Figure 21. **Characterization Matrix for TR7. SBIRT**

TR7. SBIRT.	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR8. Payment Reform**.** Support substance use disorders payment reform targeted to improve population health.

Background:

The Task Force discussed payment reform with the aim of improving population health as beneficial to those with substance use disorders. While the impact from implementing this recommendation would not be seen in the short-term, it was discussed as a strategy that could slow the growth of health care costs related to substance use disorders.

Figure 22. **Characterization Matrix for TR8. Payment Reform**

TR8. Payment Reform	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☐ Long Term (3+ years) ☒ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR9. Peer Support Reimbursement**.** Expand access to peer support services and increase Medicaid reimbursement rates for the service.

Background:

Peer support services are provided by individuals with a personal experience of substance use disorder who can serve as models for successful recovery after receiving treatment and progressing to a stage where they can manage their conditions.[23] Kansas has trained and certified peers since 2011. There are two levels of certification a Kansas Peer Mentor in Training (KPMT) and a Kansas Certified Peer Mentor (KCPM). A KCPM certification requires attendance at a multi-day training, completion of course materials, exam passage and an application for full-certification. Fully-certified KCPMs can provide up to 30 contact hours of peer support services each week and must have one hour of supervision for each 30 client contact hours. KPMT certified providers can have fewer client hours and require more supervision. Both KCPM and KPMT require a high school diploma or GED and at least one year of sustained recovery. Peer services are billable as group peer services and individual peer services under the Substance Abuse Prevention and Treatment (SAPT) Block Grant and Medicaid. In addition to the

certification of individuals, substance use disorder (SUD) programs must apply to the Kansas Department for Aging and Disability Services (KDADS) to have the service approved as billable modality.[24]

An evidence base supports the effectiveness of peer support services in reducing inpatient care and a variety of other recovery outcomes.[25] Currently, some peer support services are funded by the State Targeted Response to the Opioid Crisis from the Substance Abuse and Mental Health Services Administration (SAMHSA) through 2019. However, the Task Force discussed interest in expanding the availability of peer support services by increasing Medicaid reimbursement for the service. Similar recommendations related to peer support services were put forth by the Nursing Facilities for Mental Health Workgroup and the Mental Health Task Force reports.[26] [27]

Figure 23. **Characterization Matrix for TR9. Peer Support Reimbursement**

TR9. Peer Support Reimbursement	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☐ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR10. Mental Health Parity**.** Review procedures for mental health parity laws to ensure compliance.

Background:

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that prevents health plans and health insurers from imposing less-

favorable benefits for mental health or substance use disorder (SUD) than other medical benefits.[28] Task force members discussed that the implementation or enforcement of this federal law has been variable. Given this, Task Force members were interested to make a recommendation that procedures be reviewed to ensure compliance with mental health parity laws.

*Figure 24***. Characterization Matrix for TR10. Mental Health Parity**

TR10. Mental Health Parity	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR11. IMD Waivers**.** Explore waiver of IMD exclusion for mental health and substance use disorder treatment and support current IMD exclusion waiver for residential services for substance use treatment.

Background:

Under federal law, the Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients age 21-64 in mental health facilities with more than 16 beds. The Managed Care Final Rule, released in 2016, allows states to maintain eligibility for individuals enrolled in managed care during inpatient stays up to 15 days long if the admissions could be considered "in lieu of" services that would offset other

costs. However, many states, including Kansas, have asked the Centers for Medicare and Medicaid Services (CMS) to grant a broader waiver to allow covered services in IMDs.

SUD services often are grouped with mental health services in the interpretation of the IMD exclusion. In the KanCare Section 1115 demonstration special terms and conditions, certain residential SUD treatment levels of care are specifically authorized. The Task Force recommended the state ensure those services are continued while also seeking to waive the IMD exclusion as it applies currently to mental health treatment.

The Task Force discussed that more information would be needed to accurately describe the number of people who might be affected by this recommendation. Specifically, the Task Force indicated interest in knowing the current number of Kansans receiving SUD services in residential settings who retain Medicaid eligibility.

Figure 25. **Characterization Matrix for TR11. IMD Waivers**

TR11. IMD Waivers	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☐ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR12. Treatment Navigator**.** Develop a statewide treatment navigator.

Background:

The Task Force discussed the need for a statewide substance use disorder treatment navigator to be available. Currently, the Regional Alcohol and Drug Assessment Center (RADAC) has a navigator for those accessing care via public insurance options (e.g., Medicaid). Kansas also has a treatment referral line operated by ValueOptions that can be reached by calling 1-866-645-8216. The Task Force discussed the need to have a similar navigator for those who are uninsured or utilize a commercial insurer. The Task Force was interested for the treatment navigator to be modeled after best-practices established in other states and for it to be hosted by the Kansas Department for Aging and Disability Services.

*Figure 26***. Characterization Matrix for TR12. Treatment Navigator**

TR12. Treatment Navigator	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

TR13. KanCare**.** Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans. Expansion will improve access to needed healthcare services, including substance use disorder treatment, and reduce more costly treatment sought in hospital emergency departments. Data clearly show that states that have expanded Medicaid have improved access to all healthcare services, including SUD treatment;

individuals stay in treatment longer; and chronic disease management and outcomes are improved.

Background:

Throughout the development of recommendations, the Task Force discussed the need for funding for many of the strategies it viewed as beneficial to treating and preventing substance use disorder (SUD) in Kansas. A key strategy discussed for this funding was the expansion of Medicaid eligibility to 138 percent of the Federal Poverty Level, as allowable under federal law. The Task Force recognized the role of Kansas' Medicaid program, KanCare, in ensuring access to treatment for substance use disorder and other co-occurring conditions for low-income Kansans. Task Force members recognized that other states have expanded Medicaid and since received increased federal funding for care of critical medical conditions, including SUD, for low-income citizens.[29] Additionally, the Task Force discussed that Medicaid expansion can increase access to healthcare, and subsequently SUD treatment, for those with opioid-use disorders (OUD) by decreasing the rate of uninsurance in this population.[30] Task Force member Representative Elizabeth Bishop discussed a report on the Ohio Medicaid program that appears to show favorable outcomes for those with substance use disorders after Medicaid expansion.[31]

Recommendations from this Task Force were generally developed and put forward by consensus. However, a vote was held on this issue and a majority of the Task Force members present wished to make a recommendation for the full expansion of Medicaid to improve access to needed health care services, such as SUD treatment. Some present indicated their belief that a recommendation regarding Medicaid expansion was outside of the scope of the issues the Task Force was empowered to address. For this and other reasons, some indicated their opposition to including a recommendation for Medicaid expansion. Others present could not speak to the issue of expansion on behalf of the individuals or agencies they represented on this Task Force, so they abstained from voting. Recorded below is the vote of those Task Force members present on the inclusion of this recommendation for expansion of Medicaid. Some Task Force members wished to provide additional clarifications on their votes for this issue. Those clarifying statements are included with the recorded votes below.

The following ten Task Force members present voted in favor of including recommendation TR13. KanCare: *(listed alphabetically)*

- Elizabeth Bishop, Representative, Kansas Legislature, "*I voted to expand Medicaid in Kansas for the following reasons: 1) Substance use disorders constitute an enormous problem in Kansas communities, with serious overlays with the burgeoning foster care system, with mental health services, and with the criminal justice system. 2) Experience in other states shows that expansion reduces uninsurance, makes it easier to work, enhances family financial security, increases use of primary care over emergency departments, improves mental and physical health. In particular it made a positive difference in access to medications and behavioral health services for those with substance use disorders.*"
- Karen Braman, R.Ph., M.S., Senior Vice President Healthcare Strategy & Policy, Kansas Hospital Association
- Steve Denny, Chair, Kansas Association of Addiction Professionals
- Aaron Dunkel, Executive Director, Kansas Pharmacists Association
- Keith Rickard, M.S., L.C.P., M.B.A., Executive Director, The Guidance Center
- Jon Rosell, Ph.D., Executive Director, Kansas Medical Society
- Mark Rowe, M.S.W., President and CEO, Rivercross Hospice, LLC
- Les Sperling, CEO Emeritus, Central Kansas Foundation
- Kimberly Templeton, M.D., Board Member, Kansas State Board of Healing Arts
- Eric Voth, M.D., Vice President Primary Care, Stormont Vail Health

The following four Task Force members voted to exclude recommendation TR13. KanCare: *(listed alphabetically)*

- B. Lane Hemsley, Executive Director, Kansas Dental Board
- Joseph House, Paramedic, Executive Director, Kansas Board of Emergency Medical Services
- Greg Lakin, D.O., J.D., Task Force Chair, Chief Medical Officer, Kansas Department of Health and Environment, *"This issue is beyond the scope or expertise of this Task Force."*
- Joe Norwood, Secretary, Kansas Department of Corrections

Lastly, the following five Task Force members, or their designees, abstained from voting on this issue: *(listed alphabetically)*

- Alexandra Blasi, J.D., M.B.A., Executive Secretary, Kansas State Board of Pharmacy
- Sharon Kearse, M.S., Opioid Program Coordinator, Kansas Department of Aging & Disability Services
- Ed Klumpp, Chief of Police-Retired, Topeka Police Department, Kansas Sheriff's Association and Kansas Association of Chiefs of Police
- Tiffany Liesmann, Pharm.D., Staff Pharmacist, Blue Cross and Blue Shield of Kansas, *"To clarify my abstention, as a representative of BCBSKS, we understand the decision to expand Medicaid is complicated. We believe it is not our place as a commercial insurer to comment one way or the other*."
- Melissa Ward, on behalf of Gina Meier-Hummel, Secretary, Kansas Department for Children and Families

Oletha Faust Goudeau, Senator, Kansas Legislature, was not available at the time of this vote, but wished to make the following statement, "I would have voted yes. I also, believe that Medicaid Expansion in Kansas would benefit those seeking treatment for Substance Abuse."

This recommendation was not characterized.

TR14. KCPC**.** Replace Kansas Client Placement Criteria program (KCPC) with modern technology and data collection methods consistent with current and future electronic health records to prevent major systemic failure.

Background:

The Kansas Client Placement Criteria program is a system of the Kansas Department for Aging and Disability Services (KDADS) and is used to guide substance use disorder counselors as they work to determine whether or not a substance use disorder exists and the level of treatment that would best meet the identified needs.[32] The program began in the 1990s, and the Task Force discussed the need to update the technology supporting this program to prevent the system from failing and to allow for consistent data collection and data sharing with electronic health records.[33] This recommendation was not characterized.

TR15. Senate Bill 123**.** Assure adequate funding for 2003 Senate Bill 123 to allow for appropriate provision of medically necessary treatment services and allow for an expanded list of qualifying offenses.

Background:

K.S.A. 21-6824 (2003 SB 123) provides certified substance use disorder (SUD) treatment for offenders convicted of drug possession who are nonviolent with no prior convictions.[34] The goal of this program is to provide community intervention and treatment to reduce recidivism among those with SUD.[35] The Task Force recommended that Senate Bill 123 be funded to allow for an expanded level of clinically appropriate services to be provided. The Task Force discussed that it is considered a best practice to allow law enforcement to make referrals to services in a non-arrest setting and that connecting individuals to treatment earlier, when possible, reduces the potential downstream costs to the justice system.

Figure 27. **Characterization Matrix for TR15. Senate Bill 123**

TR15. Senate Bill 123	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☐ Long Term (3+ years) ☒ Is there an existing system in place to support the implementation of this recommendation? Yes ☐ No ☒ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☒ Low ☐ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Non-Prioritized Recommendations:

In addition to the high priority recommendations listed above, the Task Force also developed or discussed the following recommendations for inclusion.

Figure 28. **Non-Prioritized Recommendations for Treatment and Recovery**

Recommendations	Characterization
TR16. Medically Managed Withdrawal. Increase access to residential and medically managed withdrawal treatment services	• High impact will be observed in short-term. • No existing system in place. • High initial investment. • High ongoing investment. • Positive impact on a large number of people. • Avoid costs.

Figure 28. **Non-Prioritized Recommendations for Treatment and Recovery (continued)**

Recommendations	Characterization
TR17. Addiction Treatment. Create additional services for the treatment of addiction as well as any co-occurring mental health diagnoses	• High impact will be observed in short-term. • Existing system in place. • High initial investment. • High ongoing investment. • Positive impact on a large number of people. • Avoid costs.
TR18. **Sober Housing.** Study the efficacy of sober housing and strategies for success from other states including funding mechanisms.	• High impact will be observed in short-term. • No existing system in place. • High initial investment. • High ongoing investment. • Positive impact on a small number of people. • Avoid costs.
TR19. Workforce Development. Implement workforce development programs to increase capacity of addiction professions.	• High impact will be observed in long-term. • Existing system in place. • High initial investment. • Low ongoing investment. • Positive impact on a large number of people. • Avoid costs.

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Law Enforcement

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that about two-thirds of incarcerated individuals in the United States have a substance use disorder.[36] This indicates that a large number of justice-involved individuals likely would benefit from additional access to treatment and recovery resources and prevention efforts. The Task Force discussed the importance of considering treatment and other services as part of pre-release planning for those in Kansas correctional facilities or jails. Additionally, the group discussed opportunities for diversion programs to connect persons with law enforcement contact to treatment and recovery services. From these discussions, the Task Force indicated a need for timely action on the following items.

Priority Recommendations:

- **LE1. Community-Based Liaison.** Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for those with SUD and co-occurring conditions.
- **LE2. Benefits Reinstatement.** Develop reinstatement policies or procedures to increase the ability of offenders to access Medicaid benefits upon release, such as suspending benefits rather than termination upon incarceration.
- **LE3. Diversion Sobriety and Treatment.** Expand pre-charge and post-charge diversion sobriety and treatment options for first time, non-violent simple drug possession charges.
- **LE4. Naloxone.** Promote Naloxone education and use for first responders and pursue all available funding.

LE1. Community-Based Liaison**.** Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for those with substance use disorder and co-occurring conditions.

Background:

The Task Force discussed the need for a liaison to connect justice-involved individuals to treatment and community-based support services as a component of pre-release planning for those with substance use disorder and co-occurring conditions. In discussion, the Task Force emphasized the importance of an individual to facilitate connections to needed services. The Task Force also discussed the importance of making funding available to ensure that community-based services are available across the state. It was discussed that the baseline availability of these resources might be lower in rural areas, so additional investment might be needed to ensure that treatment services for substance use disorder and other community supports exist.

*Figure 29***. Characterization Matrix for LE1. Community-Based Liaison**

LE1. Community-Based Liaison	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☒ Low ☐ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

LE2. Benefits Reinstatement**.** Develop reinstatement policies or procedures to increase the ability of offenders to access Medicaid benefits upon release, such as suspending benefits rather than termination upon incarceration.

Background:

The Task Force discussed that it is a high priority to develop a policy or procedure by which offenders can suspend, rather than terminate, Medicaid benefits upon incarceration. Federal policy does not allow states to provide Medicaid coverage for health care services delivered to inmates, except for inpatient admissions of at least 24 hours outside the institution. Allowing suspension, rather than termination, of eligibility would allow those individuals access to needed care, such as treatment for substance use disorders (SUD), upon release. The Task Force recognized that efforts are underway to develop such policy but was interested to affirm the value of these efforts and the importance of seeing that policy development through to implementation.

*Figure 30***. Characterization Matrix for LE2. Benefits Reinstatement**

LE5. Benefits Reinstatement	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☐ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☐ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

LE3. Diversion Sobriety and Treatment**.** Expand pre-charge and post-charge diversion sobriety and treatment options for first time, non-violent simple drug possession charges.

Background:

The Task Force made the recommendation to expand pre- and post-charge diversion to sobriety and treatment opportunities for some non-violent offenders. It was discussed that earlier connection to treatment and other support services can prevent other, downstream costs to the justice system.

*Figure 31***. Characterization Matrix for LE3. Diversion Sobriety and Treatment**

LE3. Diversion Sobriety and Treatment	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

LE4. Naloxone**.** Promote Naloxone education and use for first responders and pursue all available funding. Consider creating a strategic statewide stockpile(s) of Naloxone able to be deployed as necessary with focused and "just-in-time" education.

Background:

The Task Force discussed the value in making Naloxone – a medication designed to reverse opioid overdose – more available across Kansas.[37] The Task Force was interested to increase the knowledge around the state of Naloxone delivery and the role its delivery can play in the

reversal of an overdose. As an additional strategy to increasing availability of the medication, the Task Force made the recommendation to pursue all available funding to make Naloxone available to first responders. Currently some funding is available through the State Targeted Response to the Opioid Crisis funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) through 2019. It also was discussed that the Kansas Bureau of Investigation (KBI) has a contract to support access to Naloxone for government entities at a reduced rate. The Task Force expressed interest in learning from strategies implemented in other states, such as group pricing agreements to ensure affordable access to the medication and availability of the medication in rural areas. It was discussed that in rural areas law enforcement officers often might be the first to arrive on the scene of an overdose, but that it can be challenging for law enforcement to properly store Naloxone nasal spray for irregular use as the medication must be maintained at room temperature (59° F to 77° F) and away from direct light.[38]

Figure 32. **Characterization Matrix for LE4. Naloxone**

LE4. Naloxone	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☐ What level of ongoing investment will be required? High ☒ Low ☐ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Non-Prioritized Recommendations:

In addition to the high priority recommendations listed above, the Task Force also developed or discussed the following recommendations for inclusion.

Figure 33. **Non-Prioritized Recommendations for Law Enforcement**

Recommendations	Characterization
LE5. Law Enforcement Referrals. Increase utilization and development of evidence-based substance use disorders (SUD) referral, as well as treatment and recovery services among persons with law enforcement contact (this includes securing funding to increase access to services for this population).	• High impact will be observed in long-term. • No existing system in place. • High initial investment. • High ongoing investment. • Positive impact on a large number of people. • Avoid costs.
LE6. Good Samaritan. Enact a 911 Good Samaritan Law. This law must be crafted to avoid unintentionally allowing persons to avoid prosecution for serious felony charges, especially when their actions directly involved providing illicit substance to the ill individual.	• High impact will be observed in short-term. • Existing system in place. • Low initial investment. • Low ongoing investment. • Positive impact on a small number of people.
LE7. Correctional Employees. Provide training in correctional facilities to allow employees to better recognize those with substance use disorders and other mental health needs and connect those with needs to available services.	• High impact will be observed in short-term. • Existing system in place. • High initial investment. • Low ongoing investment. • Avoid costs.

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Neonatal Abstinence Syndrome (NAS)

Neonatal Abstinence Syndrome (NAS) is a syndrome that occurs when a newborn infant withdraws from drugs to which he or she was exposed to *in utero*.[39] As more and more adults, including women of childbearing age, misuse prescription drugs or other substances, an increasing number of infants are born substance-exposed. The Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan states that Kansas saw a 900-percent increase in the incidence of NAS between the years 2000 and 2014.[40] Related to NAS the Task Force discussed the value of educating, screening and providing intervention and support to substance-using women by expanding coverage for family planning services. From these discussions, the Task Force indicated a need for timely action on the following items:

Priority Recommendations:

- **NAS1**. **Educate and Intervene.** Provide education, screening, intervention and support to substance-using women to reduce the number of infants born substance-exposed, while expanding coverage for family planning services, preconception services and a variety of contraceptives, including long-acting reversible contraceptives (LARCs).
- **NAS2. Standardize Care.** Provide education on best practices to reduce stigma and promote standardized care regarding Neonatal Abstinence Syndrome (NAS) cases, develop a standardized reporting process for NAS cases across the state and offer universal training and continuing education through the Vermont Oxford Network (VON) NAS Universal Training Program to Kansas birthing centers.

NAS1. Educate and Intervene**.** Provide education, screening, intervention and support to substance-using women to reduce the number of infants born substance-exposed, while expanding coverage for family planning services, preconception services and a variety of contraceptives, including long-acting reversible contraceptives (LARCs).

Background:

The Task Force discussed the importance of reducing the number of infants born substance-exposed. To reduce the number of infants who experience neonatal abstinence syndrome (NAS) the Task Force made recommendations to increase screening, education and interventions among women with substance use disorders and expand coverage for family planning services, preconception services and a variety of contraceptives, including long-acting reversible contraceptives (LARCs). Regarding LARCs, the Task Force expressed interest in modeling efforts after the Colorado Family Planning Initiative (CFPI). CFPI was an expanded family planning program that provided training and low- or no-cost LARCs to low-income women across the state.[41] The Task Force described this recommendation as one with the potential to reduce other costs, as care for patients with NAS is expensive.

Figure 34. **Characterization Matrix for NAS1. Educate and Intervene**

NAS1. Educate and Intervene	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☒ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☒ Low☐ What level of ongoing investment will be required? High ☒ Low ☐ How many people would be affected? Large Number ☐ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

NAS2. Standardize Care**.** Provide education on best practices to reduce stigma and promote standardized care regarding Neonatal Abstinence Syndrome (NAS) cases, develop a standardized reporting process for NAS cases across the state, and offer universal training and continuing education through the Vermont Oxford Network (VON) NAS Universal Training Program to Kansas birthing centers.

Background:

The Task Force was interested to reduce stigma, promote standardized care and improve case reporting for Neonatal Abstinence Syndrome (NAS) in Kansas. To accomplish this, the Task Force made the recommendation to provide education, such as the Vermont Oxford Network's (VON) NAS Universal Training Program to Kansas birthing centers. The VON program is designed for individuals, centers or health systems and includes online lessons for continuing education credits. The program also includes sample policies, procedures and guidelines for improving NAS care.[42] The Task Force discussed this recommendation as an opportunity to implement best practice care at a low cost, benefiting a large number of Kansans.

*Figure 35***. Characterization Matrix for NAS2. Standardize Care**

NAS2. Standardize Care	
Characterization	When do we expect to see a high impact? Immediate (1-2 years) ☐ Long Term (3+ years) ☐ Is there an existing system in place to support the implementation of this recommendation? Yes ☒ No ☐ What level of initial investment will be required? High ☐ Low☒ What level of ongoing investment will be required? High ☐ Low ☒ How many people would be affected? Large Number ☒ Small Number ☐ Would this recommendation avoid costs? Yes ☒ No ☐

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Non-Prioritized Recommendations:

In addition to the high priority recommendations listed above, the Task Force also developed or discussed the following recommendations for inclusion.

Figure 36. **Non-Prioritized Recommendations for Neonatal Abstinence Syndrome**

Recommendations	Characterization
NAS3. Women and Family Treatment Centers. Increase the number and capacity of designated women and family treatment centers across the state.	• High impact will be observed in long-term. • No existing system in place. • High initial investment. • Low ongoing investment. • Positive impact on a large number of people. • Avoid costs.
NAS4. MAT in Pregnancy. Increase access to medication-assisted treatment (MAT) for pregnant women.	• High impact will be observed in short-term. • Existing system in place. • High initial investment. • High ongoing investment. • Avoid costs.

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

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Appendix A: Glossary of Acronyms

Listed alphabetically.

ACEs: Adverse Childhood Experiences

AHEC: Area Health Education Center

BCBSKS: Blue Cross and Blue Shield of Kansas

CDC: The Centers for Disease Control and Prevention

CFK: Central Kansas Foundation

CFPI: Colorado Family Planning Initiative

CMS: Centers for Medicare and Medicaid Services

CPST: Community Psychiatric Support and Treatment

DCF: Kansas Department for Children and Families

DDPI: Prescription Drug Overdose: Data-Driven Prevention Initiative

GME: Graduate Medical Education

IMD: Institutions for Mental Diseases (a federal term under Medicaid)

K-TRACS: The Kansas prescription drug monitoring program (PDMP)

KAAP: Kansas Association of Addiction Professionals

KBI: Kansas Bureau of Investigation

KBOP: Kansas Board of Pharmacy

KCPM: Kansas Certified Peer Mentor

KCTC: Kansas Communities That Care Student Survey

KDADS: Kansas Department for Aging and Disability Services

KDHE: Kansas Department of Health and Environment

KDOC: Kansas Department of Corrections

KHA: Kansas Hospital Association

KHI: Kansas Health Institute

KMS: Kansas Medical Society

KPhA: Kansas Pharmacists Association

KPMT: Kansas Peer Mentor In-Training

KSAG: Kansas Attorney General's Office

KSBHA: Kansas Board of Healing Arts

LARCs: Long-Acting Reversible Contraceptives

MAT: Medication-Assisted Treatment

MHPAEA: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

MME: Morphine Milligram Equivalents

NAS: Neonatal Abstinence Syndrome

OUD: Opioid Use Disorder

PDMP: Prescription Drug Monitoring Program

PMP: Prescription Monitoring Program

Project ECHO: Extension for Community Healthcare Outcomes

SAMHSA: Substance Abuse and Mental Health Services Administration

SAPT: Substance Abuse Prevention and Treatment Block Grant

SBIRT: Screening, Brief Intervention and Referral to Treatment

SGF: State General Funds

STR: State Targeted Response to the Opioid Crisis

SUD: Substance Use Disorder

VON: Vermont Oxford Network

Appendix B: Non-Prioritized Recommendations

Non-Prioritized Recommendations:

In addition to the 34 high-priority recommendations put forward by the Task Force, the Task Force also developed or discussed the following recommendations for inclusion.

Figure B-1. **Non-Prioritized Recommendations for All Topics**

Provider Education	
Recommendations	**Characterization**
PE7. **Prescribing Support.** Expand support for electronic health records (EHR) decision support and K-TRACS integration.	• Not rated.
PE8. Comprehensive Pain Management. Reimburse for evidence-based multidisciplinary and comprehensive pain management models (non-opioid/non-pharmacologic). Assess coverage barriers to pain management (including those in Medicaid related to over-the-counter medications). Provide education to health care providers on evidence-based multimodal pain management and discuss these treatment options with patients.	• Not rated.

Figure B-1. **Non-Prioritized Recommendations for All Topics (continued)**

Provider Education	
Recommendations	**Characterization**
PE9. **Provider Notification.** Notify providers when a patient has contact with law enforcement due to a K-TRACS referral.	• Not rated.
PE10. **Coroner Letters.** Explore the feasibility of and consider a pilot program for coroners or medical examiners sending educational letters to prescribing providers upon their own patient's death from prescription drug or other illicit substance overdose.	• Not rated.
PE11. Multidisciplinary Approach. Provide and support clinician education about effective evidence-based multidisciplinary approaches to and advances in acute and chronic pain management.	• Not rated.
PE12. Provider MAT Training. Increase capacity and access to medication-assisted treatment (MAT) in Kansas through provider training on MAT.	• Not rated.

Figure B-1. **Non-Prioritized Recommendations for All Topics (continued)**

Prevention	
Recommendations	**Characterization**
None.	
Treatment and Recovery	
Recommendations	**Characterization**
TR16. Medically Managed Withdrawal. Increase access to residential and medically managed withdrawal treatment services	• High impact will be observed in short-term. • No existing system in place. • High initial investment. • High ongoing investment. • Positive impact on a large number of people. • Avoid costs.
TR17. Addiction Treatment. Create additional services for the treatment of addiction as well as any co-occurring mental health diagnoses	• High impact will be observed in short-term. • Existing system in place. • High initial investment. • High ongoing investment. • Positive impact on a large number of people. • Avoid costs.

Figure B-1. **Non-Prioritized Recommendations for All Topics (continued)**

Treatment and Recovery	
Recommendations	**Characterization**
TR18. **Sober Housing.** Study the efficacy of sober housing and strategies for success from other states including funding mechanisms.	• High impact will be observed in short-term. • No existing system in place. • High initial investment. • High ongoing investment. • Positive impact on a small number of people. • Avoid costs.
TR19. Workforce Development. Implement workforce development programs to increase capacity of addiction professions.	• High impact will be observed in long-term. • Existing system in place. • High initial investment. • Low ongoing investment. • Positive impact on a large number of people. • Avoid costs.

Figure B-1. **Non-Prioritized Recommendations for All Topics (continued)**

Law Enforcement	
Recommendations	**Characterization**
LE5. Law Enforcement Referrals. Increase utilization and development of evidence-based substance use disorders (SUD) referral, as well as, treatment and recovery services among persons with law enforcement contact (this includes securing funding to increase access to services for this population).	• High impact will be observed in long-term. • No existing system in place. • High initial investment. • High ongoing investment. • Positive impact on a large number of people. • Avoid costs.
LE6. Good Samaritan. Enact a 911 Good Samaritan Law. Enact a 911 Good Samaritan Law. This law must be crafted to avoid unintentionally allowing persons to avoid prosecution for serious felony charges, especially when their actions directly involved providing illicit substance to the ill individual.	• High impact will be observed in short-term. • Existing system in place. • Low initial investment. • Low ongoing investment. • Positive impact on a small number of people.
LE7. Correctional Employees. Provide training in correctional facilities to allow employees to better recognize those with substance use disorders and other mental health needs and connect those with needs to available services.	• High impact will be observed in short-term. • Existing system in place. • High initial investment. • Low ongoing investment. • Avoid costs.

Figure B-1. **Non-Prioritized Recommendations for All Topics (continued)**

Neonatal Abstinence Syndrome	
Recommendations	**Characterization**
NAS3. Women and Family Treatment Centers. Increase the number and capacity of designated women and family treatment centers across the state.	• High impact will be observed in long-term. • No existing system in place. • High initial investment. • Low ongoing investment. • Positive impact on a large number of people. • Avoid costs.
NAS4. MAT in Pregnancy. Increase access to medication-assisted treatment (MAT) for pregnant women.	• High impact will be observed in short-term. • Existing system in place. • High initial investment. • High ongoing investment. • Avoid costs.

Source: Report from the Governor's Substance Use Disorder Task Force, 2018.

Appendix C: Endnotes

[1] Governor Jeff Colyer. (March 2018). Executive Order 18-09: Task Force to Address Substance Use Disorders.

[2] Ibid.

[3] Kansas Department of Health and Environment: Kansas Injury Prevention Program. (2017). Kansas Trends in Drug Poisoning Deaths: Special emphasis report. Retrieved from http://www.preventoverdoseks.org/download/2017_KS_SER_Drug_Poisoning.pdf

[4] Centers for Disease Control and Prevention. (2017). Opioid Overdose. Retrieved from https://www.cdc.gov/drugoverdose/index.html

[5] Governor Jeff Colyer. (March 2018). Executive Order 18-09: Task Force to Address Substance Use Disorders.

[6] Ibid.

[7] Ibid.

[8] Kansas Board of Healing Arts, Kansas Board of Nursing and Kansas Board of Pharmacy. (2016). Joint Policy Statement of the Kansas Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Chronic Pain. Retrieved from https://pharmacy.ks.gov/docs/default-source/Guidance-Documents/joint-policy-statement-on-use-of-controlled-substances-and-for-the-treatment-of-chronic-pain.pdf?sfvrsn=0

[9] Kansas Prescription Drug and Opioid Advisory Committee. (2018). Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan.

[10] Centers for Disease Control and Prevention. (n.d.). Guidelines for Prescribing Opioids for Chronic Pain. Retrieved from https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

[11] Kansas State Board of Pharmacy. (July 2018). Testimony to the Task Force.

[12] Centers for Disease Control and Prevention. (n.d.). Picture of America: Prevention. Retrieved from https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

[13] Ibid.

[14] Ibid.

[15] United States Department of Health and Human Services. (2018). About the U.S. Opioid Epidemic. Retrieved from https://www.hhs.gov/opioids/about-the-epidemic/index.html#data

[16] Substance Abuse and Mental Health Services Administration (SAMHSA). (May 2016). Buprenorphine. Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

[17] Substance Abuse and Mental Health Services Administration (SAMHSA). (Jan 2018). Buprenorphine Waiver Management. Retrieved from https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

[18] Kansas Prescription Drug and Opioid Advisory Committee. (2018). Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan.

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