



Planning Guidance to Expand
Blueprint Community Health Teams with “Spoke Staffing”
For Treatment of Opioid Dependence

SCHEDULE

August 7, 2012	Planning Guidance Issued
September 21, 2012	Plans Due to DVHA/Blueprint
October 19, 2012	Final Plans Approved
Oct 22 – Dec 31, 2012	Staff Recruitment
Jan 1, 2013	Program & Funding Begin

System for Treating Opioid Dependence: “*Hub & Spoke*”

The Vermont Agency of Human Services issues these guidelines to support implementation of a comprehensive treatment system for Vermonters with opioid dependence. The planned system builds on the strengths of specialty addictions treatment programs, the local infrastructure of *Blueprint for Health* Community Health Teams and Patient Centered Medical Homes, and the valued physicians who prescribe buprenorphine statewide.

Most Vermonters who are treated for opioid dependence receive buprenorphine from primary or specialty practice physicians with limited coordinated access to other health, mental health, rehabilitation, or recovery services. A smaller number of Vermonters receive methadone and associated addictions treatment services in four specialty clinics. Waiting lists for methadone indicate insufficient treatment capacity in Vermont, and the number of providers willing to prescribe buprenorphine for new patients is declining. Furthermore, the current methadone clinics and Physicians who prescribe buprenorphine work in relative isolation from each other.

The public health care expenditures for patients receiving buprenorphine and methadone are quite high. In state fiscal year 2011, Vermont’s Medicaid program paid nearly \$45 million in health, addictions treatment, and mental health care claims for the 3,400 Vermonters who received methadone or buprenorphine maintenance treatment that year.

Three partnering entities - the Department of Vermont Health Access (Vermont Medicaid), the Division of Alcohol and Drug Abuse Programs within the Vermont Department of Health, and the Blueprint for Health - working in collaboration with local health, addictions, and mental health providers developed a program and cost model for a comprehensive and systemic response to treat opioid dependence. Grounded in the principles of Medication Assisted Therapy (MAT)¹, the *Blueprint*’s health care reform framework, and the Health Home concept in the Federal Affordable Care Act, the partners proposed the “*Hub and Spoke*” initiative.

A ***Hub*** is a regional specialty treatment center responsible for coordinating the care of individuals with complex addictions and co-occurring substance abuse and mental health conditions across the health and substance abuse treatment systems of care. In the case of medication assisted therapy (MAT) for opiate addiction, *Hubs* will initiate medication assisted treatments, provide care through the period of initial stabilization, coordinate referrals to ongoing care, and provide consultation and support to ongoing care. All methadone treatment is provided in *Hubs*. A subset of buprenorphine treatment also is

¹ Medication Assisted Therapy (MAT) is the use of medications (such as methadone and/or buprenorphine), in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

provided in *Hubs*, specifically for more clinically complex induction, prevention and treatment of relapse, and to provide support for tapering off MAT. Plans are underway to expand or create five (5) regional specialty addictions treatment centers in Northwest, Southwest, Southeast, Central and Northeast Vermont.

A *Spoke* is the ongoing care system comprised of a physician prescribing buprenorphine and the collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports and community services, and provide counseling, contingency management, care coordination and case management services. The plan is for all Vermont physicians who prescribe buprenorphine to become *Spokes*, with embedded nursing and clinical addictions / mental health counselors working in conjunction with the physician to form a Health Home² team. The new *Spoke* staffing will provide augmented counseling, health promotion, and care coordination services to current buprenorphine practices.

There are approximately 180 physicians prescribing buprenorphine, most of who practice in the following specialties:

- Psychiatry
- Family Practice
- Internal Medicine
- Obstetrics & Gynecology
- Pediatric Medicine

***Spoke* Concept**

The *Hub and Spoke* approach is built upon the statewide expansion of Advanced Primary Care Practices (APCP) also known as Patient Centered Medical Homes, supported by core *Blueprint for Health* Community Health Teams (CHT) and CHT extenders³. This model has allowed Vermont to establish a novel foundation for high quality primary care with embedded multidisciplinary support services, better coordination and transitions of care, and more seamless linkage among the multitude of partners from many disciplines.

As a public-private partnership, the *Blueprint* has existing CHTs comprised of nurse coordinators, clinician case managers, social workers and other professionals who extend the capacity of primary care practices to assess patients' needs, coordinate community-based support services, and provide multidisciplinary care. Effective teams are the basis

² Section 2703 of the Patient Protection and Affordable Care Act offers "State Option to Provide Health Homes for Enrollees with Chronic Conditions." The goal is to expand patient-centered medical homes to build linkages with other community and social supports, and to enhance coordination of medical and mental health / addictions care to meet the needs of people with multiple chronic conditions. The "Health Home model of service delivery encompasses all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions."

³ Community Health Team "extenders" include the Vermont Chronic Care Initiative staff focusing on the most expensive 5% of Medicaid beneficiaries; the SASH coordinators and wellness nurses serving at risk Medicare beneficiaries; and the *Spoke* staff serving patients receiving buprenorphine by qualified physicians.

for all of the quality improvements in the *Blueprint*, supported by payment reforms that provide patients and practices with unhindered access to CHTs, CHT extenders and self-management opportunities. Vermont will be building upon this medical home model to create enhanced Health Homes for individuals receiving MAT (see attached Guidance Letter to State Medicaid Directors on Health Homes).

Under the *Hub and Spoke* approach, each patient undergoing MAT will have an established medical home, a single MAT prescriber, a pharmacy home, access to existing *Blueprint* Community Health Teams (CHTs), and access to *Hub* or *Spoke* nurses and clinicians.

The five regional specialty addictions treatment centers (*Hubs*) will support the work of the *Spokes* in several ways. At the request of a *Spoke* team, the regional *Hub* will provide:

- ***Consultation services***, for example psychiatry, addictions medicine, expertise in managing co-occurring mental health conditions, and recovery supports.
- ***Comprehensive assessments and treatment recommendations***, such as differential diagnosis, assessment of need for medication assisted therapy versus other services, use of methadone or buprenorphine.
- ***Induction and stabilization services for initiation of buprenorphine***, especially for complex clinical presentations.
- ***Reassessment and treatment recommendations*** for individuals experiencing relapse.
- ***Support for tapering off maintenance medication***, including the provision of more intensive psycho-social supports.
- ***Support and consultation for recovery and rehabilitation services***, including assistance with designing individualized recovery plans and coordination with human services, housing, employment and other specialized services and supports.

Spoke Staffing

Building on the infrastructure of *Blueprint* Community Health Teams, the Department of Vermont Health Access (DVHA) will support the costs of one full-time equivalent nurse and one full-time equivalent clinician case manager for every 100 buprenorphine patients served.

The clinician case manager will be a licensed, Master's prepared social worker, counselor, or psychologist, ideally with specialty addictions experience. This staff – the nurse and clinician case manager - will be available to work directly with the PHYSICIANS prescribing buprenorphine, thereby forming the team-based care so important to the effective treatment for individuals with opioid dependence. The *Spoke* staff will be deployed to the prescribing practices based on local planning in a manner similar to that of the *Blueprint* Community Health Team staff.

The local *Blueprint* Administrative Entity will receive quarterly payments from DVHA to support *Spoke* staff costs, including salaries, benefits, and modest operating expenses. The payment mechanism will be similar to the current Medicaid payments for Community Health Team staff.

This payment approach eliminates the need for fee-for-service billing and patient co-pays, which often are barriers to services for patients with addiction and mental health conditions. Embedding the staff directly in the prescribing practices allows for more direct access to mental health and addiction services, promotes continuity of care, and supports the provision of multidisciplinary team care. Like the *Blueprint* Community Health Teams, the *Spoke* staff (the nurse and clinician case manager) are provided free of cost to patients receiving MAT, essentially as a “utility” to the practices and patients.

Spoke staffing will be provided to any PHYSICIAN who prescribes buprenorphine, regardless of specialization. The *Spoke* staffing (1 FTE nurse and 1 FTE clinician case manager for every 100 patients) will therefore be available to practices that may not participate in the *Blueprint* for Health (due to choice or practice specialty).

In the *Spoke* staffing model (1 FTE nurse and 1 FTE clinician case manager for every 100 patients), a provider who prescribes buprenorphine to an average monthly case load of 20 patients would receive a 20% FTE nurse and a 20% FTE clinician case manager to provide direct services to their patients. Similarly, if the provider prescribes to 50 patients, then two 50% FTE staff would be offered to the provider. A Health Services Area such as Rutland, which provides buprenorphine to an average monthly caseload of 215 patients, would receive funding for approximately four FTE nurses and clinicians to be shared among the six prescribing PHYSICIANS.

Participating PHYSICIANS will continue to bill as usual for their services, and the patients can access other health and treatment services in addition to those provided by the *Spoke* staff.

The local *Blueprint* Administrative Entity will convene the planning process, in collaboration with local buprenorphine prescribers, to develop the best approaches to recruiting, employing, preparing and placing the staff in practices. The *Hub and Spoke* model provides a funding framework for the provision of locally designed services. The participating providers and *Blueprint* Administrative Entities are encouraged to develop staffing arrangements that meet local needs and reflect the unique strengths of local organizations and practices.

The program is completely voluntary. Physicians who prescribe buprenorphine are strongly encouraged to participate and to work closely with the local *Blueprint* Administrative Entity to implement the best staffing approach for their individual practice within this planning framework.

Health Home Services

Section 2703 of the Patient Protection and Affordable Care Act offers “State Option to Provide Health Homes for Enrollees with Chronic Conditions.” The goal is to expand patient-centered medical homes to build linkages with other community and social supports, and to enhance coordination of medical and mental health / addictions care to meet the needs of people with multiple chronic conditions. The “Health Home model of service delivery encompasses all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions.”⁴

The Department of Vermont Health Access is pursuing a State Plan Amendment to create a Health Home for individuals with opioid dependence and who are at risk of additional chronic conditions. The *Hub and Spoke* program will offer the new Health Home services as part of this Medicaid State Plan Amendment. The Spoke staff will provide the following services, which are required Health Home activities under the Affordable Care Act:

Comprehensive Care Management: Activities undertaken to identify patients for Medication Assisted Therapy, conduct initial assessments, and formulate individual plans of care. Care Management also includes the activities related to managing and improving the care of the patient population across health, substance abuse and mental health treatment, and social service providers.

Care Coordination: The implementation of individual plans of care (with active patient involvement) through appropriate linkages, referrals, coordination and follow-up, as needed, to services and supports across treatment and human services settings and providers. The goal is to assure that all services are coordinated across provider settings, which may include medical, social, mental health, substance, corrections, educational, and vocational services.

Health Promotion: Activities that promote patient activation and empowerment for shared decision-making in treatment, support healthy behaviors, and support self-management of health, mental health, and substance abuse conditions. There is a strong emphasis on person-centered empowerment to promote self-management of chronic conditions.

Comprehensive Transitional Care: Care coordination services focused on streamlining the movement of patients from one treatment setting to another, between levels of care, and among health and specialty mental health / substance abuse service providers. The goal is to reduce hospital readmissions, facilitate the timely development of community placements, and coordinate sharing of necessary treatment information among providers. The key orientation is a shift from reactive responses to transitions to planned, seamless transitions of care.

⁴ Centers for Medicare and Medicaid Services Guidance Letter to State Medicaid Directors Re: Health Homes for Enrollees with Chronic Conditions, November 16th, 2010.

Individual and Family Support: Individual and family support services assist individuals to fully participate in treatment, reduce barriers to accessing care, support age and gender appropriate adult role functioning, and promote recovery.

Referral to Community and Social Support Services: Assistance for clients to obtain and maintain eligibility for formal supports and entitlements (e.g., health care, income support, housing, legal services) and to participate in informal resources to promote community participation and well-being.

Services Documentation

The *Spoke* staff will ensure proper documentation of all required Health Home activities and services in accordance with CMS requirements. Documentation will be entered in the practice clinical record and in a special module of the *Blueprint* Central Clinical Registry (that will be designed this fall). In addition, medical and clinical leaders will assist in the design of an addictions treatment measure set for the Central Clinical Registry that will be available to participating *Spoke* practices and *Hubs* for use by January 2013.

Learning Collaboratives and Training Opportunities

The Division of Alcohol and Drug Abuse Programs (ADAP) within the Vermont Department of Health, in partnership with DVHA and the *Blueprint*, will offer training and learning collaboratives throughout the next year to support program implementation and to assist in development of a skilled workforce. A clinical and medical leaders' group will be established and will help develop recommendations for training and learning opportunities. In addition, a group of leader-mentors will be organized to assist local practices and providers. Local planning leaders will receive timely announcements of training opportunities.

A team from Dartmouth in partnership with Vermont's medical and clinical leaders will organize three regional learning collaboratives regarding MAT. Buprenorphine providers will be invited to participate. Two collaboratives will focus on the best practices for buprenorphine treatment in primary care and specialty medical practices and will be organized geographically: one each in northwestern and southwestern Vermont. Each may involve four to ten practices. The third collaborative will focus on best practices for the relationship between a regional *Hub* and local *Spoke* teams. The *Blueprint for Health* practice facilitators will assist with the learning collaborative activities.

In a learning collaborative, clinical staff work together to redesign care processes and supporting office systems to become more patient focused, more efficient, and to improve patient care. Each practice participating in the learning collaborative will appoint a team to identify the targets for change, collect baseline data, implement process improvements, and measure the impact of the changes [essentially "Plan-Do-Study-Act (PDSA) cycles]. The participating practice teams will meet regularly with expert faculty to share information about their practice's progress and experience implementing changes.

Participation in the learning collaboratives is voluntary; each practice determines the focus of its work within the general topic area and is expected to work intensively to implement changes between learning sessions.

Planning & Implementation Timeframes

The *Hub and Spoke* comprehensive opioid treatment system will be implemented in two phases.

Phase 1. The first phase will begin on January 1, 2013, in the following counties:

- Bennington
- Rutland
- Addison
- Chittenden
- Franklin
- Grand Isle

There will be two (2) regional *Hubs*: the Chittenden Center in Burlington and the _____ in Rutland.

Phase 2. The second phase begins July 1, 2013, with the remaining counties and will include three (3) regional *Hubs*. The planning cycle for this phase begins with a Request for Proposals (RFP) for three regional *Hubs* (July 31, 2012) and continues in early 2013 to plan the *Spoke* staffing with participating providers.

Detailed Schedule for Phase 1

Timeframe	Activity
Aug 7, 2012	Planning Guidance Issued to: Bennington, Rutland, Chittenden, Addison, Franklin, Grand Isle
Aug 7 – Sep 14, 2012	Local planning meetings: DVHA/ <i>Blueprint</i> staff available to attend
Sep 21, 2012	Local plans due to DVHA/ <i>Blueprint</i>
Sep 21 – Oct 12, 2012	Meetings to finalize proposals if needed/requested
Oct 19, 2012	DVHA/ <i>Blueprint</i> approves plans, MOU(s) established
Oct 22 – Dec 31, 2012	Staff recruitment, hiring arrangements finalized
Jan 1, 2013	Program & payments begin; staff in place

Planning Guidance

Each *Blueprint* Health Services Area (HSA) Administrative Entity will be provided with a list of local buprenorphine prescribers and numbers of associated patients⁵ based on prescription claims data. This information is based on monthly Medicaid claims from July 1, 2011, through March, 2012. Based on this, an overall staffing estimate for the county is created.

HSA Administrative Entities are requested to use the following process and steps to develop and provide a written plan:

- (1) Please review the provider and recipient count information in the data provided and recommend any changes or identify issues for consideration. For example, the data are organized by county of the prescribing provider. As organizational affiliations and Health Services Areas (HSAs) do not follow county lines, you are requested to identify providers and their associated caseloads that would be better attributed to neighboring *Blueprint* HSAs. In addition, please assess the completeness of the information provided, since providers and caseload patterns change.

Identify any changes to participating providers and caseloads.

- (2) Convene planning processes with local physicians prescribing buprenorphine and local specialty addictions and mental health providers to develop preliminary staffing patterns. Please consider an array of employment and staffing options. For instance, some physicians may have associated nursing and counseling staff already working with them, in which case the practice may directly employ the *Spoke* staff. In some communities, the local Designated Agency or Preferred Substance Abuse Treatment Provider may be best able to recruit and provide clinical supervision for the Master's prepared, licensed, clinical case managers. Similarly, the nursing staff may be best employed through the *Blueprint* Administrative Entity or the local Federally Qualified Health Center.

Identify the *Spoke* staffing plan for each participating provider / practice.

Identify the hiring entities.

Describe the arrangements for clinical supervision.

Describe how the *Spoke* staff will be integrated into the physician practice.

⁵ No patient-identifying information is provided.

- (3) Identify and engage partners for primary care, pharmacy, vocational, and human services (including probation and parole). The overall goal is to create comprehensive and coordinated services for MAT patients. In addition, there are specific categories of expenditures that *Hub* and *Spoke* services can impact, such as duplicative lab tests, emergency room use for ambulatory care sensitive conditions, reduced inpatient days, and more targeted use of residential treatment services. In addition, *Hubs* and *Spokes* can improve the coordination and management of chronic health conditions in collaboration with primary care providers and *Blueprint* Community Health Teams, all of which can help reduce the growth in health care expenditures. CMS requires that designated Health Home providers meet the following standards:
- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered services;
 - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
 - Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
 - Coordinate and provide access to mental health and substance abuse services;
 - Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
 - Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
 - Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
 - Coordinate and provide access to long-term care supports and services;
 - Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
 - Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
 - Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Describe the comprehensive services network and how it will ensure CMS provider standards are met.
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- (4) Develop a recruiting strategy and training plan for *Spoke* staff. Participation in the planned learning collaboratives is strongly encouraged. In addition, identify other activities that will support the capacity of the participating network to provide comprehensive and coordinated care.

Describe the staff recruitment plan.

Describe the training and quality improvement activities planned or in progress.

Identify additional activities to support the network.

- (5) Develop inter- and intra-organizational agreements for staffing, clinical supervision, and support as needed to realize the local plan(s) including business associates agreements. Include commitments to participate in the documentation of staff time and clinical information in the *Blueprint* Central Clinical Registry, and provision of information needed for required quality reporting and evaluation (see *Health Home Evaluation* and *Health Home Quality Measures* below). Agreement to use the Registry as designed is necessary in order to receive funds to support the *Spoke* staffing. (We appreciate it is difficult for providers to commit to specific data until design of the activity tracker and measure set are completed.)

Provide copies of organizational agreements.

Provide an attestation of commitment to use the Central Clinical Registry for *Spoke* staff activity tracking and for care and clinical information.

Health Home Evaluation

Services provided to individuals with opiate addiction through the *Hub and Spoke* initiative should demonstrate an overall:

- Reduction in avoidable hospitalization utilization
- Reduction in avoidable ER utilization
- Improvement in the management of co-occurring chronic condition(s)
 - Provider perspective – Improvement in care integration, coordination and transitions
 - Use of electronic resources (e.g., use of DocSite, prescription monitoring service, etc.)
 - Retention of patients in MAT services
 - Patient perspective – Increase awareness of and actual patient empowerment and self-management of chronic condition(s)
 - Documentation of self-management goals and plans

- Participation in community self-management programs (e.g., Healthier Living Workshops, Fresh Start Tobacco Cessation, WRAP, etc.)
- Improvement and increase in the use of preventive services
- Reduction in substance abuse and other drug dependence

The Centers for Medicare and Medicaid Services (CMS) requires states to evaluate Health Homes using the above outcomes and also make this information available for a national evaluation.

Health Home Quality Measures

CMS requires participating Health Home providers to report quality measures to the state as a condition of receiving enhanced funding. The purpose of these measures is to capture information on clinical outcomes, experience of care outcomes, and quality of care outcomes specific to the provision of Health Home services. Measure reporting is to be done through the use of health information technology when appropriate and feasible. The core measures that CMS is requiring follow:

In addition to reporting on the CMS core set of Health Home quality measures, states are required to develop measureable goals for their Health Home model and interventions. For CMS, each quality measure should “feed the goals” and “tell the story of whether the goal was achieved” utilizing the core domains of:

- Quality of care
- Clinical outcomes
- Experience of care

At this time, AHS is considering including all CMS core quality measures as well as a subset of measures recommended by CMS for use with state-specific goals (below). Bidders should attest to their ability to collect these measures and enter appropriate documentation into the registry:

Proposed Quality Measures

Core Quality Measures	Other Quality Measures
<ul style="list-style-type: none"> • Adult BMI assessment • Admissions for Ambulatory Care Sensitive Conditions (ACSC) • Care Transition Record transmitted upon discharge to health care professional • Follow-up after hospitalization for mental illness • All cause readmission within 30 days of discharge 	<ul style="list-style-type: none"> • Alcohol misuse screening • Care Transition Record provided to and reviewed with patient upon discharge • Care transitions – medication reconciliation completed • ER visits • Tobacco cessation screening • HIV/AIDS • Home health hospital admits

<ul style="list-style-type: none"> • Clinical depression screening and follow-up plan • Initiation and engagement of alcohol and other drug dependence treatment 	<ul style="list-style-type: none"> • Age & gender appropriate health screenings (health maintenance measures set) • Treatment continuity in <i>Hub</i> and/or <i>Spoke</i> • Consistency of health insurance • Employment rate • Incarceration rate • Self management for any chronic condition (plan, goal, progress)
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Please provide your plan to:

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Attachments:

1. Summary of buprenorphine providers and recipient count by county – July 2011 – March 2012.
2. DVHA outreach letter to buprenorphine providers
3. CMS Guidance Letter to State Medicaid Directors Re: *Health Homes for Enrollees with Chronic Conditions*, November 16, 2010.