

Department of Vermont Health Access Blueprint for Health

Spoke Implementation Guide and Toolkit

Updated 5/13/21

Spoke Providers, Practice Staff and Blueprint Program Managers,

We created this guide and toolkit in order to further support the robust Medication Assisted Treatment work you are conducting throughout the state. Thank you for your daily commitment to improving quality of life for Vermonters.

If you have any feedback on the guide and toolkit, please let us know. We hope you find this information helpful.

Sincerely,

The Blueprint for Health Central Office

For questions, comments, or concerns, please [contact us](#).

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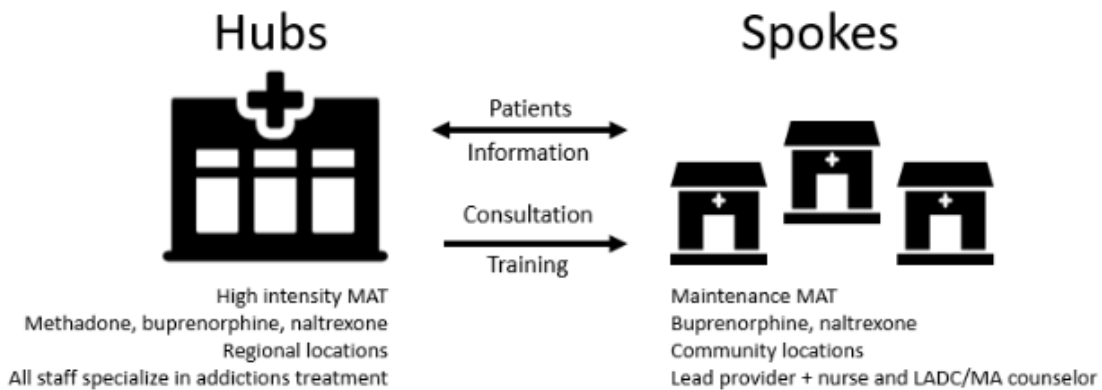
Program Description

Hub and Spoke: Vermont's Opioid Use Disorder Treatment System

Hub and Spoke is Vermont's system of Medication Assisted Treatment, supporting people in recovery from opioid use disorder. Nine Regional Hubs offer daily support for patients with complex addictions. At over 75 local Spokes, doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general healthcare and wellness services. This framework efficiently deploys opioid use disorder expertise and helps expand access to opioid use disorder treatment for Vermonters.

Medication Assisted Treatment: The Evidence-Based Approach to Opioid Use Disorder

Medication Assisted Treatment (MAT) uses medication such as methadone and buprenorphine, as part of a comprehensive opioid use disorder treatment program that includes counseling. Medication Assisted Treatment is not the only treatment for opioid use disorder, but it is the most effective treatment for most people. It is supported by the American Medical Association, the American Academy of Addiction Psychiatry, and the American Society of Addiction Medicine. Federal regulations designate two settings where Medication Assisted Treatment can take place, Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) settings. Vermont takes this structure as a starting point and strengthens and connects the elements.



Hubs Offer Intensive Treatment for Complex Addictions

Hubs are Opioid Treatment Programs, with expanded services and strong connections to area Spokes. There are currently 9 Hubs in Vermont. Each Hub is the source for its area's most intensive opioid use disorder treatment options, provided by highly experienced staff.

- Hubs offer the treatment intensity and staff expertise that some people require at the beginning of their recovery, at points during their recovery, or all throughout their recovery.
- Hubs provide daily medication and therapeutic support.
- Patients receiving buprenorphine or vivitrol may move back and forth between Hub and Spoke settings over time, as their treatment needs change.
- Hubs offer all elements of Medication Assisted Treatment, including assessment, medication dispensing, individual and group counseling, and more.
- Additional Health Home supports are made available at Hubs through the Hub & Spoke staffing and payment model. These include case management, care coordination, management of transitions of care, family support services, health promotion, and referral to community services.
- In addition to treating their own patients, Hub staff offer trainings and consultation to the Spoke providers.

Where are the Hubs located?

Health Service Area	Practice Name	Address	City
Barre	Central VT Addiction Medicine Hub	300 Granger Road	Berlin
Brattleboro	Habit OpCo	16 Town Crier Drive	Brattleboro
Brattleboro	Habit OpCo	254 N Plainfield Road	West Lebanon, NH
Burlington	Howard Center	75 San Remo Drive	South Burlington
Newport	BAART Behavioral Health Services	475 Union Street	Newport
Rutland	Rutland Regional Medical Center	160 Allen Street	Rutland
St. Albans	BAART Behavioral Health Services	242 South Main St	St. Albans
St. Johnsbury	BAART Behavioral Health Services	445 Portland Street	St. Johnsbury

Spokes Provide Ongoing Treatment in Community Settings

Spokes are Office Based Opioid Treatment settings, located in communities across Vermont. At many Spokes, addictions care is integrated into general medical care, like treatment for other chronic diseases.

- The Spokes are mostly primary care or family medicine practices, and include obstetrics and gynecology practices, specialty outpatient addictions programs, and practices specializing in chronic pain.
- Prescribers in Spoke settings are physicians, nurse practitioners, and physician's assistants federally waived to prescribe buprenorphine. They may also provide oral naltrexone or injectable Vivitrol.
- People with less complex needs may begin their treatment at a Spoke, other patients transition to a Spoke after beginning recovery in a Hub.
- Spoke care teams include one nurse and one licensed mental health or addictions counselor per 100 patients. These Spoke staff provide specialized nursing, counseling and care management to support patients in recovery, this staff assures team-based care and helps primary care providers balance MAT patient care with the needs of their full patient panel.

State Oversight, Supplemental Funding, Quality and Measurement Support

- The Hub & Spoke concept was first introduced by John Brooklyn, MD and the model was designed and operationalized by the State of Vermont through the Blueprint for Health, the Department of Vermont Health Access, and the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs.
- The State of Vermont pays for Hub and Spoke services via Medicaid. The Hub programs bill a monthly bundled rate, and the Blueprint distributes funds to support Spoke staffing through its existing Community Health Team payment infrastructure.
- The State of Vermont provides oversight for the program, helping communities monitor treatment needs, waitlist length, average time to treatment, and program performance.
- The Blueprint for Health provides each Vermont community with a data profile showing Hub & Spoke patient demographic data and key program measures, to support data-driven quality improvement.

Evidence of Program Impact

- Access to treatment has grown since program inception, with more than 6000 people now participating.

- The Blueprint for Health uses claims and clinical data to evaluate program impact and program costs. The Blueprint is working with other state agencies to incorporate additional data, such as Corrections data, into its evaluation.
- A peer-reviewed article published in the journal *Substance Abuse Treatment* showed that health care costs for Vermonters in Medication Assisted Treatment were lower than for Vermonters with opioid addiction not in Medication Assisted Treatment, even when including the substantial treatment costs. The article is available [here](#).
- An evaluation by Dr. Richard Rawson shows significant positive impact from the point of view of Hub & Spoke patients and their families. Dr. Rawson's report also provides an in-depth description of the Hub & Spoke model of care including regional variation. It is available [here](#).

MAT Single Point of Contact for Each Health Service Area

Barre Health Service Area

Evan Smith, MAT Supervisor
CVMC MAT Program
(802) 371-4875

Bennington Health Service Area

Todd Salvesvold, Community Health Team
Manager
Southwestern Vermont Health Care
(802) 440-4234

Brattleboro Health Service Area

Kurt White, Senior Director of Ambulatory
Services
Brattleboro Retreat
(802) 258-4388

Burlington Health Service Area

Kara Cooley, Case Management and Social Work
Supervisor, Community Health Team
UVM Health Network
(802) 847-8929 or kara.cooley@uvmhealth.org

Middlebury Health Service Area

Sylvie Choiniere, Blueprint Program Manager
Porter Medical Center, Addison County
(802) 382-3406

Morrisville Health Service Area

Meagan DeWitt, MAT Program Manager
Lamoille Health Partners
(802) 851-8822

Randolph Health Service Area

Susan Therrien, Spoke Nurse
Randolph Area MAT Team
Gifford Health Care
(802) 728-2687

Rutland Health Service Area

Katelyn Fitzgerald, MAT Care Coordinator
West Ridge Center
(802) 786-1497

Springfield Health Service Area

Brook Sherwood, Spoke Nurse
Springfield Medical Care Systems
(802) 463-2739

St. Albans Health Service Area

Denise Smith, Blueprint Program Manager
Northwestern Medical Center
(802) 355-0694

St. Johnsbury/Newport Health Service Areas

Jason Goguen, Regional Director of Operations
BAART Programs
(802) 748-6166

Windsor Health Service Area

Jill Lord, Director of Community Health
Mt. Ascutney Hospital and Health Center
(802) 674-7224

Expectations of Spoke Practices

All Spoke practices must utilize and implement the following:

- Integrate Spoke staffing as part of the Community Health Team.
- Regular communication and collaboration with their regional Blueprint Program Manager, especially if a Spoke practices is new.
- Participate in Learning Collaboratives, training events, and other educational and networking opportunities.
- Full implementation and documentation of the required Health Home Services (HHS) and Health Home Measures (HHM).
- Strong referral pathways to Hubs.
- If a primary care site, build a network of referral pathways for when specialty care is needed.
- If a specialty care site, build a network of referral pathways for when primary care is needed.
- If your local Emergency Department is conducting Rapid Access to Medication (RAM) inductions, a collaboration on referral pathways as appropriate.

Expectations of Blueprint Central Staff and Program Managers

All Blueprint Central Staff and Program Managers support Spoke practices with the following:

- Organization and delivery of training and learning events.
- Flow of Medicaid funding consistent with active caseloads for Spoke staffing.
- Data and analytics. The latest Hub & Spoke profiles can be found [here](#).
- Assistance in hiring and organizing Spoke staff in each participating practice.
- Seeking to support technical assistance needs of the practices.
- Quality Improvement (QI) facilitation to implement new workflows.

Becoming a MAT Prescriber

1. Apply for a Practitioner Waiver through SAMHSA. Online requests, training requirements, and patient limit information can be found [here](#).
2. Rules Governing Medication-Assisted Therapy for Opioid Dependence for Office-Based Opioid Treatment (OBOT) Providers Prescribing Buprenorphine and Opioid Treatment Providers (OTP) State Regulations can be found [here](#).
3. Vermont Board of Medical Practice: Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office can be found [here](#).

What Requires Prior Authorization (PA)?

Key items to be aware of:

- A detailed overview on Spoke medications can be found on the Preferred Drug List (PDL) [here](#).
 - The link contains criteria for Sublocade and Vivitrol approval as well as buprenorphine (mono).
 - Suboxone brand film is preferred and covered without PA. The maximum daily dose that does not require PA is 16mg/day. PA is required for over 16mg/day.
 - All strengths of Suboxone tablets require PA.
 - The maximum days' supply for Suboxone is 14 days.
- Prior Authorization Request Form for Spokes can be found [here](#).

Department of Vermont Health Access Buprenorphine Practice Guidelines

Please see the full pdf version [here](#).

Health Home Measures

Health Home Quality Measures

CMS requires that Health Homes select from established HEDIS (Healthcare Effectiveness Data and Information Set) and other standardized measures to measure outcomes and quality.

These measures include claims-based measures and “hybrid” measures. The hybrid measures require information from clinical records; as such need to be documented in the clinical records system. of each Hub program and Spoke practice.

Hybrid Quality Measures

The following Health Home Measures include information from both claims and the clinical record.

We ask that Blueprint Project Managers, participating Spoke practices, and HUBs to design methods to capture this information in current EMR / Registry systems.

1. **Self- Management for any chronic condition (including opiate dependence)**

Numerator: Number of Health home participants who have care plans that address self-management.

Denominator: Health home participants

2. **Adult Body Mass Index (BMI)**

Numerator: Body mass index documented during the measurement year for health home participants ages 18 to 74.

Denominator: Health home participants ages 18 to 74 who had an outpatient visit.

If outside parameters, percent with documented follow-up plan.

3. **Screening for Clinical Depression and Follow-Up Plan – Percent screened for clinical depression using standardized tool with follow up documentation**

Numerator: Total number of health home participants aged 18 years and older who were screened for clinical depression using a standardized tool and have follow-up documentation.

Denominator: All health home participants aged 18 years and older screened for clinical depression using a standardized tool.

4. **Alcohol Misuse Screening – Annual screening with AUDIT-C and documentation**

Numerator: Health home participants screened annually for alcohol misuse with the 3-item Alcohol Use Disorders Identification Test (AUDIT-C) with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in medical record.

Denominator: All health home participants eligible for alcohol misuse screening.

5. **Tobacco Cessation Screening – Receipt of advice to quit smoking**

Numerator: Health home participants using tobacco who, within the past year, received advice to quit.

Denominator: All health home participants using tobacco.

6. **Tobacco Cessation Screening – Receipt of information on smoking cessation medications**

Numerator: Health home participants screened for tobacco use within the past year, whose practitioner recommended or discussed smoking cessation medications.

Denominator: All health home participants during the year.

7. **Care Transitions – Transition Records – receipt of transition record at time of discharge with specified elements**

Numerator: Health home participants or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge.

Denominator: All health home participants discharged from an inpatient facility to home/self-care or any other site of care.

8. **Controlling High Blood Pressure – Percentage with adequately controlled hypertension during the year.**

Numerator: Number of Health Home participants with hypertension who's most recent representative blood pressure during the year was less than 140/90.

Denominator: All health home participants ages 18-85 with hypertension.

Claims-Based Measures

There are additional standardized Health Home measures that are reported from Claims data. DVHA will generate these on behalf of Hub and Spoke Providers. The following Health Home Measures will be reported by DVHA based solely on claims.

1. **Ambulatory Care-Sensitive Condition Admission**
2. **Follow-Up After Hospitalization for Mental Illness**
3. **All Cause Readmission**
4. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
5. **Preventable Ambulatory Claims Sensitive Condition Admission to Emergency Departments**
6. **All Cause Emergency Department Visits**
7. **Age and gender appropriate health screenings (breast and cervical cancer)**

Health Home Services

Medicaid beneficiaries receiving Medication Assisted Treatment for opioid addiction are now eligible for the following services. The services are detailed in the Affordable Care Act (ACA) and are designed to parallel the types of services and supports available in primary care patient centered medical homes. Vermont's Medicaid State Plan Amendment for the Hub and Spoke initiative offers these six Health Home services.

Documentation

Minimum requirement is an “**auditable record**” of at least one health home service per patient each month.” CMS is not requiring services reports. These services must be documented in the clinical record of each Hub program and Spoke practice. The services follow:

Comprehensive Care Management

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

Health Home Staff providing Comprehensive Care Management: Spoke Nurse and Spoke Clinician Care Manager; Hub Health Home Program Director, Hub supervising MD, Hub RN Supervisor, Hub Consulting Psychiatrist.

Specific activities include but are not limited to:

- Identification of gaps in care for MAT patients and organizing systemic responses to address these gaps.
- Identification of potential MAT patients via referrals, prior authorizations, VCCI risk stratification, claims and utilization data, judicial referrals for treatment, and outreach to patients lost to contact.
- Assessment of preliminary service needs; treatment plan development; including client goals.
- Assignment of health team roles and responsibilities.
- Developing treatment guidelines and protocols for health teams to use in specific practice settings (primary care, specialty care) for transitions of care, identified health conditions (e.g.,

opioid dependence with depression or chronic pain), and prevention and management of substance relapse.

- Developing protocols for health home staff to use in collaborating with community partners on behalf of beneficiaries including: housing, vocational services, peer recovery supports, mental health treatment, and economic and health insurance benefits.
- Monitor MAT patient's health status, treatment progress, service use to improve care and address gaps in care.
- Develop and use data to assess use of care guidelines in practice settings, patient outcomes, and patient experience of care.
- Design and implement quality improvement activities to improve the provision of care (learning collaborative, PDSA cycles).

Care Coordination

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 Home Staff providing Care Coordination: Spoke Nurse and Spoke Clinician Care Manager, the Hub Supervising MD, the Hub MA Addictions Counselors, the Hub MA Clinician Case Managers.

Specific activities include but are not limited to:

- Appointment scheduling, outreach to support attendance at scheduled treatment and human services appointments.
- Conducting referrals and follow-up monitoring, participating in discharge planning from hospital, residential, and corrections.
- Communicating with other providers and family members.
- Monitoring treatment progress and implementation of the individual care plan.
- Case management necessary for individuals to access medical, social, vocational, educational, substance abuse and/or mental health treatment supports, and community-based recovery services.

- Coordinating with other providers to monitor individuals' health status and participation in treatment.
- Assessing medication adherence and calculating medication possession rates.
- Identification of all medications being prescribed, communication with prescribers, and medication reconciliation.
- Access to and assistance in maintaining safe and affordable housing.
- Conducting outreach to family members and significant others in order to maintain individual's connection to services and expand their social network.

Health Promotion

Activities that promote patient activation and empowerment for shared decision-making in treatment, healthy behaviors, and self-management of health, mental health, and substance abuse conditions.

Health Home staffs providing Health Promotion Activities are the Spoke Nurse and Spoke Clinician Care Manager, and the Hub MA Addictions Counselors and the MA Clinician Case Managers.

Specific activities include but are not limited to:

- Providing health education specific to a patient's chronic conditions; including medication management.
- Providing of health education specific to opioid dependence and treatment options.
- Identifying health and life goals and development of self-management plans with the patient.
- Motivational interviewing and other behavioral techniques to engage patients in healthy lifestyles and reduce substance abuse.
- Supports for management of chronic pain and depression.
- Supports for smoking cessation and reduction of use of alcohol and other drugs.
- Providing health promoting lifestyle interventions including but not limited to nutritional counseling, obesity reduction, and increasing physical activity.
- Development of health information materials for patient and family education specific to MAT and common co-occurring conditions.
- Providing support to develop skills for emotional regulation and parenting skills.
- Providing support for improving social networks.

Comprehensive Transitional Care

Care coordination focused on planned, seamless transitions of care through streamlining the movement of patients from one treatment setting to another, between levels of care, and between health and specialty MH/SA service providers. Goals are to reduce hospital readmissions, facilitate timely development of community placements, and coordinate the sharing of necessary treatment information among providers.

Health Home Staff providing Transitional: Spoke Nurse, Spoke Clinician Care Manager, the Hub Health Home Director, the Hub Supervising MD, the Hub RN Supervisor, and the Hub MA Clinician Case Managers.

Specific activities include but are not limited to:

- Developing and maintaining collaborative relationships between health home providers and other entities such as hospital emergency departments, hospital discharge departments, corrections, probation and parole, residential treatment programs, primary care providers, and specialty MH/SA treatment services.
- Developing and implementing referral protocols including standardized clinical treatment information on electronic and paper CCD.
- Developing and using data to identify MAT clients with patterns of frequent ER, hospital, or other relapse-related services utilization and planning systemic changes to reduce use of acute care services.

Individual and Family Support

Assisting individuals to fully participate in treatment, reducing barriers to access to care, supporting age and gender appropriate adult role functioning, and promoting recovery.

Health Home Staff providing Individual and Family Support: Spoke Nurse, Spoke Licensed Clinician Case Manager, the Hub Supervising MD, the Hub MA Addictions Counselors, and the Hub MA Clinician Case Managers.

Specific services include but are not limited to:

- Advocacy.
- Assessing individual and family strengths and needs.
- Providing outreach and supportive counseling to key caregivers.

- Providing information about services and formal and informal resources, and education about health conditions and recommended treatments.
- Providing assistance with navigating the health and human services systems.
- Providing assistance with obtaining and adhering to prescribed treatments including medications.
- Facilitating participation in ongoing development and revisions to individual plan of care.

The Hub Supervising MD specifically assists with patient education about health conditions and recommended treatments and facilitating ongoing revisions to individual plans of care.

Referral to Community & Social Support Services

Assisting clients 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.

Health Home Staff providing Referral to Community Services: Spoke Nurse, Spoke Licensed Clinician Case Manager, the Hub MA Addictions Counselors, and the Hub MA Clinician Case Managers.

Specific services include but are not limited to:

- Developing and maintaining up-to-date local information about formal and informal resources beyond those covered in the Medicaid plan, including peer and community-based programs.
- Assisting and supporting access to community resources based on individual patient needs and goals.
- Assisting patients obtain and maintain eligibility for income support, health insurance, housing subsidies, food assistance.
- Providing information and supporting participation in vocational and employment services to promote economic self-sufficiency.

Spoke Staffing: An Overview

Spoke RN	Spoke Counselor
<ul style="list-style-type: none"> • Assures patient has active relationship with PCP • Coordinates and provides access to high quality health care services according to evidence-based clinical practice guidelines. Examples of health care issues that might be addressed: <ul style="list-style-type: none"> ○ Prevention of infectious diseases <ul style="list-style-type: none"> ▪ HIV/Aids ▪ Tuberculosis ▪ STDs ▪ Hepatitis C • Additional indications for RN assessment, planning, intervention and evaluation: <ul style="list-style-type: none"> ○ Pregnancy/Pre-natal Care ○ Parenting Skills ○ Tobacco use/Cessation ○ Co-occurring Mental Illnesses ○ Dental Health ○ Chronic illnesses: HTN, Diabetes, Obesity, CAD, Chronic Pain, Depression ○ Nutrition ○ Personal Hygiene • <u>Health Home Services:</u> <ul style="list-style-type: none"> ○ Comprehensive Care Management ○ Care Coordination ○ Health Promotion ○ Comprehensive Transitional Care <ul style="list-style-type: none"> ▪ ER Utilization ▪ Hospital Re-admission ○ Individual/Family Support ○ Referral to Community Services ○ Referral to Community Health Team • <u>HEDIS Measures (To be required):</u> <ul style="list-style-type: none"> ○ Self-management Skills ○ Body Mass Index ○ Health Screenings ○ Tobacco Cessation Screening ○ Care Transition ○ HTN Control 	<ul style="list-style-type: none"> • Must be either a licensed Social Worker, Mental Health Counselor, Marriage and Family Counselor, Psychologist, or other related Masters prepared and licensure recognized professional in Vermont. • Provides initial cognitive/behavioral risk assessments • Observes, describes, evaluates, and interprets behavior as it relates to substance abuse • Constructs with client an action plan based on client needs • Counsels and works with patient to modify harmful, addictive behaviors/lifestyle • Facilitates and supports the client’s choice of strategies that maintain treatment progress and prevent relapse • Conducts home visits as needed • <u>Health Home Services:</u> <ul style="list-style-type: none"> ○ Comprehensive Case Management ○ Care coordination ○ Individual/Family Support ○ Referral to Community Services (such as transportation, housing, parenting supports, job skills) • <u>HEDIS Measure (To be required):</u> <ul style="list-style-type: none"> ○ Self-management Skills ○ Depression Screening ○ Care Transition

In summary: RN and Counselor bring distinct and unique skills to the SPOKE milieu. These skills are complimentary to each other and as a result create an interdisciplinary team that has the potential to engage the patient in an effective holistic treatment plan. *See Appendix 1 for sample job descriptions.*

Spoke Staff: Waiver of Credentials

The calculation for the Per Member Per Month (PMPM) cost for Spoke staff is based on the annual estimated salary, fringe, and a little of the operational expense for a fully credentialed and experienced RN and a licensed Masters-prepared counselor. To the extent that the Blueprint utilizes Medicaid funds for a less credentialed Spoke staff in the role, it undermines the justification of the set PMPM payment. Therefore, the Blueprint will only approve less credentialed Spoke staff as an exception, and not the standard. However, there are situations that may come up (i.e. medical leave, staffing shortages, etc.) wherein certain instances the credentialing requirements can be waived for a limited period of time. This staffing exception requires specific authorization from the Blueprint Executive Director.

To waive Spoke staff credentialing, a request must be made in writing by the Blueprint Program Manager (to be mailed, not emailed) to the Blueprint Executive Director. The request should address the following:

- Why there is a request to hire or employ someone with a lower credential?
- What is the timeframe for employing the person of lower credential? Additionally, when will the organization hire someone else that meets the job requirements? For example, did the candidate under consideration just graduate and needs time to become licensed? There must be an indicated plan that this individual will receive sufficient clinical hours and supervision in order to obtain licensure. The timeframe for less credentialed employment cannot be longer than two years. If the individual is not licensed in the set timeframe, Blueprint Medicaid funds can no longer be used to support that salary line.
- A summary of the candidate's work and education experience, and why the Blueprint Program Manager thinks he or she would be an appropriate hire.
- The candidate's resume and/or curriculum vitae (CV).

The Blueprint Executive Director will respond to the request in writing (to be mailed, not emailed).

Medicaid Spoke Staff Payment Process

The “Hub & Spoke”

Three partnering entities - the Blueprint for Health, the Department of Vermont Health Access (DVHA), and the Vermont Department of Health (VDH) Division of Alcohol and Drug Abuse Programs (ADAP) - in collaboration with local health, addictions, and mental health providers have implemented a statewide treatment program. Grounded in the principles of Medication Assisted Treatment¹, the Blueprint’s health care reform framework, and the Health Home concept in the Federal Affordable Care Act, the partners have created the Care Alliance for Opioid Treatment, known as the Hub & Spoke initiative. This initiative:

- *Expands access to Methadone treatment* by opening new methadone programs in underserved regions and supports providers to serve all clinically appropriate patients
- *Enhances Methadone treatment programs (Hubs)* by augmenting the programming to include Health Home Services to link with the primary care and community services, provide buprenorphine for clinically complex patients, offer Vivitrol, and provide consultation support to primary care and specialists prescribing buprenorphine
- *Embeds new clinical staff (a nurse and a Master’s prepared, licensed clinician) in physician practices that prescribe buprenorphine or Vivitrol (Spokes)* through the Blueprint Community Health Teams to provide Health Home services, including clinical and care coordination supports to individuals receiving buprenorphine

Under the Hub & 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, and access to Hub or Spoke nurses and clinicians.

Spokes and the Blueprint for Health

The most common Spoke practice settings are:

- Primary care
- Obstetrics and gynecology
- Psychiatry
- Specialty outpatient addictions programs
- Practices specializing in the management of chronic pain

¹ Medication Assisted Treatment (MAT), the use of medications, in combination with counseling and behavioral therapies, is a successful treatment approach and is well supported in the addictions treatment literature. The two primary medications used in conjunction with counseling and support services to treat opioid dependence are methadone and buprenorphine. MAT is considered a long-term treatment, meaning individuals may remain on medication indefinitely, akin to insulin use among people with diabetes.

As part of the Blueprint for Health Community Health Teams (CHTs), a Registered Nurse and a Licensed Counselor are hired for every 100 Medicaid beneficiaries who are prescribed buprenorphine or Vivitrol for opioid addiction. Medicaid supports this Spoke staff through the local Blueprint infrastructure as a capacity-based payment, thus eliminating 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 CHTs, Spoke staff (a nurse and clinician case manager) are provided free of cost to patients receiving MAT, essentially as a “utility” to the practices and patients.

As of September 30, 2019, there were 68.5 FTE Spoke Staff in over 75 different treatment settings.

Payment Process for Spoke Staffing

Spoke payments are based on the average monthly number of unique patients in each Health Service Area (HSA) for whom Medicaid paid a Buprenorphine or Vivitrol pharmacy claim during the most recent three-month period. This is designed to reflect the active caseload for each provider and for the region. The pharmacy claims include information that identifies the provider, the patient, and the medication prescribed. The total number of unique patients served is rounded to next increment of 25 to arrive at a total count in the region for staffing purposes. For example, a count of 167 patients in active treatment is rounded to 175 for the staffing model. This allows staff to be hired and deployed increments of .25% Full Time Equivalent (FTE).

The patient counts for each Health Service Area (HSA) are calculated quarterly and the Blueprint provides Medicaid with that calculation based on the staffing cost model below. Medicaid makes the payments to the lead administrative agent in each Blueprint Health Service Area as part of the Medicaid Blueprint Community Health Team payment every quarter. The Blueprint Program Director in each HSA is responsible for organizing both the Community Health Team staff and the Spoke Staffing on behalf of the practices and programs in the region.

The prescribers bill evaluation and management codes for seeing patients and the pharmacy claims are also billed as usual. Spoke staff do not bill for their services as their salaries are supported by the Community Health Team payments. See below for the staffing cost models.

Spoke Staffing Scale Model: (100 patients)		
Staffing	Annual FTE cost	
1 FTE RN Care Manager	\$85,000	\$85,000
1 FTE Clinician Case Manager	\$55,000	\$55,000
Total Annual Salary		\$140,000
35% fringe benefits		\$49,000
Total Annual Personnel Costs		\$189,000
Operating		\$ 7,500
Total Estimated Annual Costs per 100 patients		\$196,500 (\$1,965 per patient)
		\$163.75 PPM

Vermont Hub & Spoke: Policy on “Pass-Through” Funding for Spoke Staff

Background

The Blueprint/Department of Vermont Health Access make monthly payments to 13 Administrative Entities (usually the local hospital) to support Medicaid’s portion of the Community Health Team (CHT), the Spoke Staff of the Hub and Spoke system of care, and for the Women’s Health Initiative (WHI) Social Workers. The local administrative entity, under the direction of the Blueprint Program Manager, is responsible for hiring and supervising the CHT, WHI, and Spoke Staff in collaboration with participating providers. The intention is to build integrated teams in each local Health Service Area that can address medical, mental health and substance abuse conditions, as well as social determinants of health risk factors. The staffing ratios for each program (CHT, Spoke, & WHI) often result in shared staff between participating providers.

The Administrative entity may, at the discretion of the Blueprint Program Manager, create an agreement to “pass-through” funds to a participating provider organization that becomes the hiring entity for Spoke, CHT or WHI staff.

The purpose of this policy is to outline the criteria and requirements for “Pass-Thru” funding for Spoke staffing.

Hub & Spoke System of Care

The Hub and Spoke System of Care for opioid use disorder (OUD) is designed to create an integrated system between the two settings where Medication Assisted Treatment (MAT) is provided and to coordinate the MAT treatment settings with the broader health and human services systems. The two MAT settings are: “Opioid Treatment Programs (OTPs)” where medications are *dispensed* and patients can be seen daily and “Office-Based Opioid Treatment (OBOT)” practices where medications are *prescribed* and patients are seen less frequently.

The OTPs in Vermont are called “Hubs” and these are addictions specialty programs best suited for patients who are experiencing a more severe course of addiction and/or who are best treated with methadone. The OBOTs in Vermont are called “Spokes” and these may be primary care medical practices, Ob-Gyn, outpatient psychiatry, or outpatient addictions treatment programs. Although patients may be seen as frequently a three times a week, many patients are seen monthly in Spoke settings. As such, the Spokes may serve patients with specific needs (for example pregnancy or co-occurring health conditions) and/or who are relatively stable in recovery.

The Hub & Spoke system of care is supported by a Health Home State Medicaid Plan Amendment that provides categorical eligibility for Health Home services for Medicaid members with OUD. Every Medicaid Member with OUD must be provided with at least one health home service monthly. The Health Home services are detailed in the Hub & Spoke Implementation guide. An additional requirement of the Health Home is that the Blueprint must report on the Medicaid Adult Core Measures for members receiving MAT. These are also detailed in the Hub & Spoke Implementation Guide.

Local System of Care

The expectation is that the patients move between Hubs and Spokes based on their clinical needs. In addition, the Hubs are expected to provide consultation support to the Spoke practices and to rapidly admit unstable patients referred from Spokes. In turn, as patients who receive Buprenorphine related products at Hubs stabilize, they are expected to be referred to Spokes for ongoing care. Each Medicaid

Member receiving MAT is also expected to have an identified Primary Care Provider with whom care is coordinated.

Each local Health Services Area is responsible for organizing a system to triage access to both the Hub and Spoke services based on matching the clinical needs and preferences of patients to the area settings.

The Payments

The Spoke Staff payments are based on the number of unique Medicaid members with pharmacy claims for Buprenorphine or Vivitrol products paid by Medicaid. The payments are recalculated each quarter based on the most recent three months of claims. The pharmacy claims show the unique member and associated provider allowing the Blueprint to establish a staffing ratio and associated funding amount for each Health Services Area. The staffing ratio is 1 FTE RN and 1 FTE Master's Licensed Clinician per 100 Medicaid members with pharmacy claims for MAT. This results in a total funding amount and FTE staffing expectation for each Health Services Area. The current PMPM is \$163.75.

DVHA/Blueprint will reduce the quarterly funding amount in the event of staff vacancies. The Blueprint Program Manager may request additional funding at the beginning of each quarter for planned expansions of caseload.

Policy on Pass through Payments

- I. The decision about Pass Through payments is the sole discretion of the Blueprint Program Manager in collaboration with the Blueprint Administrative Entity.
- II. The accountability for the funding, staffing levels and credentials, Health Home program requirements, and development of the integrated local system of care rests with the Blueprint Program Manager and Administrative Entity.

Criteria for Pass through Funding

1. The provider(s) must be enrolled in the Vermont Medicaid Program and all providers in good standing with relevant licensing, professional boards, and with the Vermont Medical Practice Board. In addition, provider(s) must have the XDEA waiver for MAT and practice within the caseload limitations of their waiver.
2. The provider(s) must demonstrate referral agreements with area Hubs, primary care, and specialty practices as appropriate for the provision of MAT and primary care for every Medicaid member. This includes ability to work with the local systems of care, demonstrated capability to assess and refer to appropriate levels of care.
3. The provider(s) or designee must participate in the Health Services Area access to MAT triage system.
4. The provider(s) must have appropriate human resource systems to support interdisciplinary staffing. This includes recruitment procedures, job descriptions for nurse and licensed clinician, qualifying credentials, performance review process, and clinical and administrative supervision of Spoke Staff.
5. The provider must demonstrate a clinical records system capable of documenting and reporting health home services.
6. The provider must demonstrate clinical records system capable of documenting and reporting health home measure results.
7. The provider(s) must demonstrate experience in the provision of MAT.

8. The provider(s) must agree to reports as requested by the Blueprint Program Manager and Administrative Entity.

9. A provider or specialty practice will consult with the Blueprint Program Manager on proposed staff hires.

10. The allocation of past through staffing dollars is based on the overall needs of the HSAs and the PCP or Specialty practice's existing resources, workflows, capability to integrate MAT staff into the facility.

Appendix 1: Sample Job Descriptions

Mt. Ascutney Hospital and Health Center

“Spoke” RN JOB DESCRIPTION

POSITION SUMMARY

A qualified Registered Nurse will offer the health home services of comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support and referral to community for patients receiving Buprenorphine and Vivitrol.

QUALIFICATIONS

BSN preferred.

Demonstrated ability in community planning, counseling, advocacy and outreach skills.

This high visibility position requires that the incumbent has excellent interpersonal skills, deals effectively with change, and is capable of implementing a new community initiative in an organized and collaborative way. Incumbent represents the hospital in its mission to improve the lives we serve through work on health promotion and disease prevention for patients receiving Buprenorphine and Methadone.

RELATIONSHIPS

Supervision received: Reports to Mt. Ascutney Hospital and Health Center Community Health/Blueprint Program Manager, and in partnership with specialty providers/prescribers of Morphine and Buprenorphine.

Supervises – None

Other relationships – Community Health Team, PATCH, SASH, Interagency Care Management Team, MAHHC Patient Centered Medical Home staff.

STATEMENT OF DUTIES

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.

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.

WORK RESPONSIBILITIES

- 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.

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 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

MAT "Spoke" Counselor JOB DESCRIPTION

POSITION SUMMARY

A qualified LADC or Licensed medical Social Worker or licensed psychotherapist in an allied mental health field, will offer the health home services of comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support and referral to community for patients receiving Buprenorphine and Vivitrol.

QUALIFICATIONS

MA with LICSW or LADAC or licensed psychotherapist in an allied mental health field.

Demonstrated ability in community planning, counseling, advocacy and outreach skills.

This high visibility position requires that the incumbent has excellent interpersonal skills, deals effectively with change, and is capable of implementing a new community initiative in an organized and collaborative way. Incumbent represents the hospital in its mission to improve the lives we serve through work on health promotion and disease prevention for patients receiving Buprenorphine and Vivitrol.

RELATIONSHIPS

Supervision received: Reports to Mt. Ascutney Hospital and Health Center Director of Community Health/Blueprint Program Manager, and works in partnership providers/prescribers of Vivitrol and Buprenorphine.

Supervises – None

Other relationships – Community Health Team, PATCH, SASH, Interagency Care Management Team, MAHHC Patient Centered Medical Home staff.

STATEMENT OF DUTIES

Comprehensive Care Management: Activities undertaken to identify patients for Medication Assisted Therapy, conduct initial assessments, and formulate individual plans of care. Care management includes direct provision of psychotherapy and/or substance use disorder counseling. 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.

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.

WORK RESPONSIBILITIES

- 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;
- Provide appropriate counseling and psychotherapy
- Lead therapeutic groups

- 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.

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

Northwestern Medical Center
MAT RN Care Coordination Job Description

Job Summary

The Registered Nurse Care Coordinator is located in offices of physicians prescribing Buprenorphine and is responsible for coordinating the care of patients receiving Medication Assisted Therapy (MAT) for opioid addiction.

Adheres to hospital policies and procedures including but not limited to safety, fire, disaster plans, and infection control.

Prerequisites

Education: Graduate of Accredited School of Nursing with Bachelors Degree in Nursing; Masters of Nursing or other relevant Masters degree preferred.

Prior Experience: Five years of clinical nursing experience required. Experience in mental health settings or substance treatment program highly preferred. Prior experience in a physician practice or case management highly preferred.

Required Licenses/Certification: Valid Vermont State Registered Nurse License required. Case Management certification preferred. Valid Driver's License and Automobile Insurance required.

Required Skills, Knowledge and Abilities:

Excellent communication and collaboration skills.

Proven critical thinking and problem solving skills.

Ability to establish a therapeutic relationship with patients and support resources (family or friends).

Strong organizational skills with ability to manage numerous cases effectively.

Strong team building skills and aptitude for integration in health homes.

Ability to effectively use Microsoft Office suite of products, Web-based applications for assessing and managing addiction, multiple physician electronic medical records, patient registries, and the hospital information system, Meditech.

Ability to provide self-management support.

Skilled at process and clinical outcomes improvement using Clinical Microsystems or other quality improvement methodologies, including tracking and reporting measures.

Ability to travel to various locations daily.

Reliable transportation required.

Relationships

Reports To: Project Manager for the Vermont Blueprint for Health.

Other Contacts: Physicians, nurses, care coordinators, substance abuse and mental health professionals, support staff, patients, family, other support resources, community resource personnel.

Job Duties

Health Home Services / Activities: Team with a Clinical Care Coordinator, to provide health home services to a panel of 100 MAT patients (per Full-Time Equivalent of care coordination). Minimum requirement is an “auditable record of at least one health home service per patient each month.” Establish mapping for the six health home services in each clinical record system that the MAT team can use. The services follow:

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

Specific activities include:

Identification of potential MAT patients via referrals, prior authorizations, VT Chronic Care Initiative (VCCI) risk stratification, claims and utilization data, judicial referrals for treatment, and outreach to patients lost to contact.

Assessment of preliminary services needs; treatment plan development; including client goals.

Assignment of health team roles and responsibilities.

Developing treatment guidelines and protocols for health teams to use in specific practice settings (primary care, specialty care) for transitions of care, identified health conditions (e.g., opioid dependence with depression or chronic pain), and prevention and management of substance relapse.

Monitor MAT patient’s health status, treatment progress, service use to improve care and address gaps in care.

Develop and use data to assess use of care guidelines in practice settings, patient outcomes, and patient experience of care.

Design and implement quality improvement activities to improve the provision of care (learning collaborative, PDSA cycles).

Care Coordination: 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.

Specific activities include:

Appointment scheduling, outreach to support attendance at scheduled treatment and human services appointments.

Conducting referrals and follow-up monitoring, participating in discharge planning from hospital, residential, and corrections.

Communicating with other providers and family members.

Monitoring treatment progress and implementation of the individual care plan.

Case management necessary for individuals to access medical, social, vocational, educational, substance abuse and/or mental health treatment supports, and community-based recovery services.

Coordinating with other providers to monitor individuals' health status and participation in treatment.

Assessing medication adherence and calculating medication possession rates.

Identification of all medications being prescribed, communication with prescribers, and medication reconciliation.

Access to and assistance in maintaining safe and affordable housing.

Conducting outreach to family members and significant others in order to maintain individual's connection to services and expand their social network.

Health Promotion: Activities that promote patient activation and empowerment for shared decision-making in treatment, healthy behaviors, and self-management of health, mental health, and substance abuse conditions.

Specific activities include but are not limited to:

Providing health education specific to a patient's chronic conditions.

Providing of health education specific to opioid dependence and treatment options.

Identifying health and life goals and development of self-management plans with the patient.

Motivational interviewing and other behavioral techniques to engage patients in healthy lifestyles and reduce substance abuse.

Supports for management of chronic pain.

Supports for smoking cessation and reduction of use of alcohol and other drugs.

Providing health promoting lifestyle interventions including but not limited to nutritional counseling, obesity reduction, and increasing physical activity.

Providing support to develop skills for emotional regulation and parenting skills.

Providing support for improving social networks.

Comprehensive Transitional Care: Care coordination focused on planned, seamless transitions of care through streamlining the movement of patients from one treatment setting to another, between levels of care, and between health and specialty MH/SA service providers. Goals are to reduce hospital

readmissions, facilitate timely development of community placements, and coordinate the sharing of necessary treatment information among providers.

Specific activities include:

Developing and maintaining collaborative relationships between health home providers and other entities such as hospital emergency departments, hospital discharge departments, corrections, probation and parole, residential treatment programs, primary care providers, and specialty Mental Health/Substance Abuse treatment services.

Developing and implementing referral protocols including standardized clinical treatment information on electronic and paper Continuity of Care Documents (CCD).

Developing and using data to identify MAT clients with patterns of frequent ER, hospital, or other relapse-related services utilization and planning systemic changes to reduce use of acute care services.

Individual and Family Support: Assisting individuals to fully participate in treatment, reducing barriers to access to care, supporting age and gender appropriate adult role functioning, and promoting recovery.

Specific services include:

Advocacy.

Assessing individual and family strengths and needs.

Providing outreach and supportive counseling to key caregivers.

Providing information about services and formal and informal resources, and education about health conditions and recommended treatments.

Providing assistance with navigating the health and human services systems.

Providing assistance with obtaining and adhering to prescribed treatments including medications.

Facilitating participation in ongoing development and revisions to individual plan of care.

Referral to Community & Social Support Services: Assisting clients 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.

Specific services include but are not limited to:

Developing and maintaining up-to-date local information about formal and informal resources beyond those covered in the Medicaid plan, including peer and community-based programs.

Assisting and supporting access to community resources based on individual patient needs and goals.

Assisting patients obtain and maintain eligibility for income support, health insurance, housing subsidies, and food assistance.

Providing information and supporting participation in vocational and employment services to promote economic self-sufficiency.

Health Home Quality Measures: Tracking and reporting Health Home Quality Measures. The program requires that Health Homes select from established HEDIS measures to measure outcomes and quality.

Following is the subset of required measures that need to be generated from the clinical chart as they are the only available consistent source of clinical data.

Measure 1: Self- Management for any chronic condition (including opiate dependence)

Numerator: % Health home participants who have care plans that address self-management.

Denominator: Health home participants

Measure 2: Adult Body Mass Index (BMI)

Numerator: Body mass index documented during the measurement year for health home participants ages 18 to 74.

Denominator: Health home participants ages 18 to 74 who had an outpatient visit.

If outside parameters, percent with documented follow-up plan.

Measure 3: Age and gender appropriate health screenings

Numerator: Health home participants with timely receipt of age and gender appropriate health screenings (e.g., breast cancer screening, cervical cancer screening and colorectal cancer screening).

Denominator: Health home participants eligible for screening (i.e., age and gender appropriate).

(Health screenings may include, for example, breast cancer, cervical cancer and colorectal cancer.)

Measure 4: Screening for Clinical Depression and Follow-Up Plan – Percent screened for clinical depression using standardized tool with follow up documentation

Numerator: Total number of health home participants aged 18 years and older who were screened for clinical depression using a standardized tool and have follow-up documentation.

MAT Clinical Care Coordinator Job Description

Job Summary

The Clinical Care Coordinator is located in offices of physicians prescribing Buprenorphine and is responsible for coordinating the care of patients receiving Medication Assisted Therapy (MAT) for opioid addiction.

Adheres to *[organization's]* policies and procedures including but not limited to safety, fire, disaster plans, and infection control.

Prerequisites

Education: Licensed health care professional with mental health experience (MSW; LCSW; RN; CNS; ARNP); Registered Mental Health Professional (MHP); Counselor (MA; MFT); clinical psychologist (PhD).

Prior Experience: Five years of clinical experience required. Experience in mental health settings or substance treatment program required. Prior experience in a physician practice or case management highly preferred.

Required Licenses/Certification: Valid Vermont State Registered Nurse License required. Case Management certification preferred. Valid Driver's License and Automobile Insurance required.

Required Skills, Knowledge and Abilities:

Excellent communication skills.

Demonstrated ability to collaborate effectively in a team setting.

Proven critical thinking and problem-solving skills.

Ability to establish a therapeutic relationship with patients and support resources (family or friends).

Ability to work with clients by telephone or in person.

Strong organizational skills with ability to manage numerous cases effectively.

Strong team building skills and ability for to integrate in health homes.

Comfort with the pace of primary care.

Experience with screening and assessment for common mental / substance use disorders.

Working knowledge of differential diagnosis of common mental / substance use disorders.

Working knowledge of evidence-based psychosocial treatments for common mental disorders.

Familiarity with brief, structured counseling techniques (e.g., Motivational Interviewing, Behavioral Activation).

Basic knowledge of psychopharmacology for common mental disorders.

Ability to provide self-management support.

Skilled at process and clinical outcomes improvement using Clinical Microsystems or other quality improvement methodologies, including tracking and reporting measures.

Ability to effectively use Microsoft Office suite of products, Web-based applications for assessing and managing addiction, multiple physician electronic medical records, patient registries, and the hospital information system, Meditech.

Ability to travel to various locations daily.

Reliable transportation required.

Relationships

Reports To: ***Project Manager for the Vermont Blueprint for Health*** [Insert direct supervisor].

Other Contacts: Physicians, nurses, care coordinators, substance abuse and mental health professionals, support staff, patients, family, other support resources, community resource personnel.

Job Duties

Health Home Services / Activities: Team with a Registered Nurse Care Coordinator, to provide health home services to a panel of 100 MAT patients (per Full-Time Equivalent of care coordination). Minimum requirement is an “auditable record of at least one health home service per patient each month.” Establish mapping for the six health home services in each clinical record system that the MAT team can use. The services follow:

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

Specific activities include:

Identification of potential MAT patients via referrals, prior authorizations, VT Chronic Care Initiative (VCCI) risk stratification, claims and utilization data, judicial referrals for treatment, and outreach to patients lost to contact.

Assessment of preliminary service needs; treatment plan development; including client goals.

Assignment of health team roles and responsibilities.

Developing treatment guidelines and protocols for health teams to use in specific practice settings (primary care, specialty care) for transitions of care, identified health conditions (e.g., opioid dependence with depression or chronic pain), and prevention and management of substance relapse.

Monitor MAT patient’s health status, treatment progress, service use to improve care and address gaps in care.

Develop and use data to assess use of care guidelines in practice settings, patient outcomes, and patient experience of care.

Design and implement quality improvement activities to improve the provision of care (learning collaborative, PDSA cycles).

Care Coordination: 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.

Specific activities include:

Appointment scheduling, outreach to support attendance at scheduled treatment and human services appointments.

Conducting referrals and follow-up monitoring, participating in discharge planning from hospital, residential, and corrections.

Communicating with other providers and family members.

Monitoring treatment progress and implementation of the individual care plan.

Case management necessary for individuals to access medical, social, vocational, educational, substance abuse and/or mental health treatment supports, and community-based recovery services.

Coordinating with other providers to monitor individuals' health status and participation in treatment.

Assessing medication adherence and calculating medication possession rates.

Identification of all medications being prescribed, communication with prescribers, and medication reconciliation.

Access to and assistance in maintaining safe and affordable housing.

Conducting outreach to family members and significant others in order to maintain individual's connection to services and expand their social network.

Health Promotion: Activities that promote patient activation and empowerment for shared decision-making in treatment, healthy behaviors, and self-management of health, mental health, and substance abuse conditions.

Specific activities include but are not limited to:

Providing health education specific to a patient's chronic conditions.

Providing of health education specific to opioid dependence and treatment options.

Identifying health and life goals and development of self-management plans with the patient.

Motivational interviewing and other behavioral techniques to engage patients in healthy lifestyles and reduce substance abuse.

Supports for management of chronic pain.

Supports for smoking cessation and reduction of use of alcohol and other drugs.

Providing health promoting lifestyle interventions including but not limited to nutritional counseling, obesity reduction, and increasing physical activity.

Providing support to develop skills for emotional regulation and parenting skills.

Providing support for improving social networks.

Comprehensive Transitional Care: Care coordination focused on planned, seamless transitions of care through streamlining the movement of patients from one treatment setting to another, between levels of care, and between health and specialty MH/SA service providers. Goals are to reduce hospital readmissions, facilitate timely development of community placements, and coordinate the sharing of necessary treatment information among providers.

Specific activities include:

Developing and maintaining collaborative relationships between health home providers and other entities such as hospital emergency departments, hospital discharge departments, corrections, probation and parole, residential treatment programs, primary care providers, and specialty Mental Health/Substance Abuse treatment services.

Developing and implementing referral protocols including standardized clinical treatment information on electronic and paper Continuity of Care Documents (CCD).

Developing and using data to identify MAT clients with patterns of frequent ER, hospital, or other relapse-related services utilization and planning systemic changes to reduce use of acute care services.

Individual and Family Support: Assisting individuals to fully participate in treatment, reducing barriers to access to care, supporting age and gender appropriate adult role functioning, and promoting recovery.

Specific services include:

Advocacy.

Assessing individual and family strengths and needs.

Providing outreach and supportive counseling to key caregivers.

Providing information about services and formal and informal resources, and education about health conditions and recommended treatments.

Providing assistance with navigating the health and human services systems.

Providing assistance with obtaining and adhering to prescribed treatments including medications.

Facilitating participation in ongoing development and revisions to individual plan of care.

Referral to Community & Social Support Services: Assisting clients 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.

Specific services include but are not limited to:

Developing and maintaining up-to-date local information about formal and informal resources beyond those covered in the Medicaid plan, including peer and community-based programs.

Assisting and supporting access to community resources based on individual patient needs and goals.

Assisting patients obtain and maintain eligibility for income support, health insurance, housing subsidies, and food assistance.

Providing information and supporting participation in vocational and employment services to promote economic self-sufficiency.

Health Home Quality Measures: In collaboration with the RN Care Coordinator, tracking and reporting Health Home Quality Measures. The program requires that Health Homes select from established HEDIS measures to measure outcomes and quality.

Following is the subset of required measures that need to be generated from the clinical chart as they are the only available consistent source of clinical data.

Measure 1: Self- Management for any chronic condition (including opiate dependence)

Numerator: % Health home participants who have care plans that address self-management.

Denominator: Health home participants

Measure 2: Adult Body Mass Index (BMI)

Numerator: Body mass index documented during the measurement year for health home participants ages 18 to 74.

Denominator: Health home participants ages 18 to 74 who had an outpatient visit.

If outside parameters, percent with documented follow-up plan.

Measure 3: Age and gender appropriate health screenings

Numerator: Health home participants with timely receipt of age and gender appropriate health screenings (e.g., breast cancer screening, cervical cancer screening and colorectal cancer screening).

Denominator: Health home participants eligible for screening (i.e., age and gender appropriate).

(Health screenings may include, for example, breast cancer, cervical cancer and colorectal cancer.)

Measure 4: Screening for Clinical Depression and Follow-Up Plan – Percent screened for clinical depression using standardized tool with follow up documentation

Numerator: Total number of health home participants aged 18 years and older who were screened for clinical depression using a standardized tool and have follow-up documentation.

Denominator: All health home participants aged 18 years and older screened for clinical depression using a standardized tool.

Measure 5: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Numerator: Adolescent (aged 13 – 17) and adult (aged 18 and older) health home participants with initiation of alcohol/other drug treatment through inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.

Denominator: Adolescent (aged 13-17) and adult (aged 18 and older) health home participants with new episode of alcohol/other drug during intake period and a total rate. Total rate is the sum of the two numerators divided by the sum of the two denominators.

Measure 6: Alcohol Misuse Screening – Annual screening with AUDIT-C and documentation

Numerator: Health home participants screened annually for alcohol misuse with the 3-item Alcohol Use Disorders Identification Test (AUDIT-C) with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in medical record.

Denominator: All health home participants eligible for alcohol misuse screening.

Measure 7: Tobacco Cessation Screening – Receipt of advice to quit smoking

Numerator: Health home participants using tobacco who, within the past year, received advice to quit.

Denominator: All health home participants using tobacco.

Measure 8: Tobacco Cessation Screening – Receipt of information on smoking cessation medications

Numerator: Health home participants using tobacco, within the past year, whose practitioner recommended or discussed smoking cessation medications.

Denominator: All health home participants using tobacco.

Measure 9: Care Transition – Transition Record Transmitted to Health Care Professional

Numerator: Health home participants for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Denominator: All health home participants discharged from an inpatient facility to home/self-care or any other site of care.

Measure 10: Care Transitions – Transition Records – receipt of transition record at time of discharge with specified elements

Numerator: Health home participants or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge.

Denominator: All health home participants discharged from an inpatient facility to home/self-care or any other site of care.

Measure 11: Care Transitions – Receipt of reconciled medication list

Numerator: All health home participants, regardless of age, or their caregiver(s) who received a reconciled medication list at the time of discharge.

Denominator: All health home participants, regardless of age, discharged from an inpatient facility to home/self-care or any other site of care.

Appendix 2: Windsor Staffing Agreement Sample

GREEN MOUNTAIN FAMILY MEDICINE OF WRJ AND MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

Agreement for Spoke Staffing in Medication Assisted Therapy (MAT) Program

This Agreement for spoke staffing ("Agreement") is made and entered into as of the 25th day of February 2014, by and between Mt. Ascutney Hospital and Health Center (the "Hospital") and Green Mountain Family Medicine of WRJ (The Practice), jointly and severally, for the purpose of providing professional counseling and nursing services to the practice upon and for the conditions, obligations and terms set forth herein.

1. **Spoke Staffing Services to be Provided by Hospital.** The Hospital shall provide one (1) duly licensed registered nurses ("RN") and one duly licensed counselor to provide spoke staffing services for the amount of time that correlates with the number of eligible patients of the practice. Such service shall be provided during the term of this Agreement. The service to be provided shall include, but not be limited to, the following:
 - a. Provide quality driven, cost-effective, culturally appropriate, and person and family centered health home services.
 - b. Coordinate and provide access to high quality healthcare services informed by evidence-based clinical practice guidelines.
 - c. Coordinate and provide access to preventative and health promotion services, including prevention of mental illness and substance use disorders.
 - d. Coordinate and provide access to mental health and substance abuse services.
 - e. 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 and discharge planning and facilitating transfer from a pediatric to an adult system of healthcare.
 - f. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
 - g. Coordinate and provide access to long term care supports and services.
 - h. Coordinate and provide access to individual and family supports, including referral to community, social support and recovery services.
 - i. Develop a patient-centered care plan for each individual that coordinates and integrates all of his or her clinical and nonclinical healthcare related needs and services.
 - j. Demonstrate the capacity to use health information technology to link services, facilitate communication among team members and between the health team and the individual and family caregivers, and provide feedback to practices, as feasible and appropriate.

- k. 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.
2. **Obligations of Practice.** The practice shall provide the following services to the RN and counselor so he/she may perform the services described in Section 1 above.
 - a. Provide reasonable physical space and facilities.
 - b. Provide reasonable medical and non-medical supplies.
 - c. Identify and provide an administrator of the practice who is responsible for integrating the RN and counselor for the practice.
 - d. Provide access to medical records for documentation of care.
 - e. Clinical oversight and supervision of MAT staff.
 3. **Compensation.** The compensation for the registered nurse and licensed counselor will be paid for by Mt. Ascutney Hospital and Health Center through a grant from the State of Vermont, Department of Health Access, Vermont Blueprint for Health.
 4. **Term.** This Agreement shall have a term of six (6) months beginning February 2014 and terminating on August 31, 2014. This Agreement shall automatically renew for additional consecutive one (1) year terms unless either party notifies the other in writing at least ninety (90) days prior to the end of the then current term of its intent not to renew.
 5. **Insurance.** The practice shall provide general liability insurance that is to be effective in circumstances or matters where they are liable or responsible; wholly or partially for the damage suffered. The Hospital shall indemnify, defend, and hold harmless the Practice from any and all acts of its employees as a result of their actions in the performance of this contract. The Hospital shall carry and pay for all statutory insurance required, including workers compensation insurance in accordance with state limits. The Hospital shall carry and pay for general liability insurance, and medical malpractice insurance to cover the acts of its employees and/or agents in the performance of this contract.
 6. **Amendment/Assignment.** This Agreement may not be changed, modified, amended or assigned by a party without the express written consent of the other party.
 7. **Notices.** Notices required hereunder shall be delivered in person or sent by certified mail, postage prepaid, return receipt requested, to the following addresses:

"Practice

Vanessa a Brown – Practice Manager
Green Mountain Family Medicine of WRJ
Office of John M. Severinghaus, M.D.
212 Holiday Drive, Suite 4
White River Junction, VT 05001

"Hospital"

Jill Lord, RN, Director of Patient Care Services
Mt. Ascutney Hospital and Health Center
289 County Road
Windsor, VT 05089

8. **Confidentiality of Records.** The Hospital and counselor shall maintain as private and confidential all individual student health care records created as a result of services provided under this Agreement. The Hospital shall disclose such records, and the contents thereof, only to the relevant patient or legal guardians, except as otherwise provided in this Agreement. The Hospital, and counselor shall not disclose such records, or the contents thereof, to any other individual, including but not limited to officials of the practice without the express prior written consent of a patient or legal guardian of the individual patient whose records are at issue, or as required by law.
9. **Severability.** If any part, term or provision of this Agreement is adjudged by any court of competent jurisdiction or any arbitrator or administrative agency to be illegal or in conflict with any applicable law or regulation, such invalidity shall not affect the validity and enforceability of the remaining provisions of this Agreement.
10. **Entire Agreement.** This Agreement contains the entire agreement of the parties with respect to the subject matter hereof. Any and all prior agreements, promises, inducements, negotiations or representations not expressly set forth in this Agreement are superseded hereby and are void and of no force and effect.
11. **Governing Law.** This Agreement shall be construed and interpreted in accordance with the laws of the State of Vermont.
12. **Waiver.** The waiver by a party of a breach of or a default under any term or provision of this Agreement by the other party shall not operate or be construed as a waiver of any substantive breach or default under the same or any other term or provision of this Agreement by that party.
13. **Status of RN and Counselor.** It is understood and agreed by the parties to this Agreement that the RN and counselor is an employee of the Hospital and will provide services to the practice as independent contractors pursuant to this Agreement. The RN and counselor is not an employee of the practice and nothing herein shall be construed to establish any other relationship between the parties. The parties also understand and agree that the Hospital shall determine the specific individuals who will serve as the RN and counselor.

Appendix 3: Gifford MOU Sample

This Memorandum of Understanding is entered into by and between Gifford Medical Center, Randolph Health Service Area Administrative Entity and Clara Martin Center, pertaining to Blueprint grant funding.

A. Hub and Spoke Medication Assisted Treatment

The Agency of Human Services is collaborating with the community providers to create a coordinated, systematic response to the complex issues of opioid and other addictions in Vermont. Medication Assisted Treatment (MAT) is the use of medication, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance abuse disorders.

MAT staff will provide comprehensive care management to patients receiving MAT, including CMS Health Home measures and standards. The MAT staff will document their activities in the medical record and participate in evaluation of the initiative.

DVHA/Medicaid will provide financing for MAT staff through the Health Service Area (HSA) Community Health Team (CHT) funding mechanisms. There will be no patient co-payments or fees for these services, to assure barrier-free access to these services for patients and providers.

B. Blueprint Hub and Spoke Medication Assisted Treatment Staffing

MAT staffing for the Health Service Area is determined quarterly based on the total number of Medicaid patients attributed to a participating physician prescribing buprenorphine. Attribution of patients is determined quarterly by Medicaid based on prescription claims for the previous quarter. The grant funding provides for 1.0 FTE RN Case Manager and 1.0 FTE Mental Health/Substance Abuse Case Manager for every 100 Medicaid buprenorphine patients. Attribution is rounded up to the next 25 patients. Staffing at participating practices is based on the distribution of the Medicaid buprenorphine patients: FTE is rounded to the nearest 0.1.

C. Blueprint Hub and Spoke Payments

**Any alteration of the MAT staff financing by DVHA/Medicaid or Blueprint for Health may result in a decrease or increase in payments to the Hub and Spoke practices.*

** Any additional participating buprenorphine prescribers may require a change in the calculation of staffing and payments*

MAT payments to the Health Service Area are determined quarterly based on

- a. Total number of Medicaid patients attributed to a participating physician prescribing buprenorphine, and
- b. FTE of *Spoke* staffing in place in the practices.

The funds are then allocated to the *Spoke* practices based on the percentage of the total HSA attributed patients.

Category	Calculation	Invoice	Recalculated
RN Case Manager	% of HSA total MAT patients	Monthly	Quarterly
Licensed Clinician			
Operating Expenses	% of HSA total MAT patients	Monthly	Annually with new grant year; or when a new buprenorphine provider is added

D. Invoice and Payments

The Project Manager will calculate the MAT funds allotted to each practice based on the percentage of the total MAT attributed patients. The practice will invoice the HSA entity via the project manager for the MAT funds monthly, to include RN Case Manager, Licensed Mental Health/Substance Abuse Case Manager, and operating expenses. Documentation of the operating expenses must accompany the invoice. Unused operating expenses funds may be carried over to subsequent months within the grant year.

The HSA entity will release the MAT funds to the practices when it has received the monthly MAT payments from Medicaid. Funds are received by the last day of the month, with MAT funds released to the practices by the last day of the following month. The practices will be notified by the Project Manager, in writing, of any delay in receipt of funds.

E. Health Home Services and Quality Measures

In accordance with the Blueprint for Health *Hub and Spoke* Planning Guidance, the practice staff will provide the following services, which are required Health Home activities under the Affordable Care Act. Each *Spoke* patient will receive at least one (1) Health Home service each month.

1. **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.
2. **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.
3. **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.
4. **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.

5. **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.
6. **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

The Centers for Medicare and Medicaid Services (CMS) requires participating Health Home providers to report quality measures to the state as a condition of receiving enhanced funding. CMS and Vermont quality measures Core and Vermont measures for the Health Home are:

1. Adult BMI Assessment
2. ACSC Admission
3. Care Transition – record transmitted to health care professional
4. Follow-up after hospitalization for mental illness
5. All cause readmission
6. Clinical depression screening and follow-up plan
7. Initiation & engagement of alcohol and other drug dependence treatment
8. Controlling high blood pressure
9. ACSC/Preventable ED visits
10. All cause ED visits
11. Self-management for any chronic condition
12. Age & gender appropriate health screening:
 - a. Breast cancer
 - b. Cervical cancer
 - c. Colorectal cancer
13. Alcohol misuse screening- Annual screening with AUDIT-C & documentation
14. Tobacco cessation screening & receipt of advice to quit smoking
15. Receipt of care transition record at time of discharge

CMS requires states to evaluate Health Homes using the above outcomes and also make this information available for a national evaluation.

F. Documentation and Reports

The *Spoke* staff will ensure proper documentation of all required Health Home activities and services in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements. Documentation will be entered in the practice clinical record or other auditable record. Documentation must be available to auditors if requested.

The *Spoke* staff will submit reports of *Spoke* activities to the Blueprint Project Manager as requested by Blueprint.

G. Participation in Learning Communities

MAT *Spoke* providers and staff will participate in Learning Communities, including but not limited to,

1. HSA multidisciplinary team meetings
2. VT *Spoke* Learning Community
3. MAT Learning Collaboratives (suggested)

H. Grant Amendments

The State of Vermont, Department of Vermont Health Access writes the grant for administering the Vermont Blueprint Integrated Health System and distributes the grant to the Health Service Area Administrative Entity. All participating HSA practices will be given a copy of the state-defined Grant for review & comment.

Appendix 4: Treatment Agreement for Buprenorphine Clients

Community Health Centers of Burlington Sample

**Office Based Medication Assisted Therapy (MAT)
Treatment Agreement for Buprenorphine Clients**

FOR USE IN the MEDICAL HOME

Patient Name: _____ DOB: _____ MRN: _____

In order to ensure the quality of your care and to increase success in recovery, we ask you to agree to the following treatment agreement/compliance form.

Please read carefully and fill in the blanks and/or initial.

1. I agree to have a working telephone and keep providers updated with any changes. My current phone number is: _____.
2. I authorize release of information and agree to sign all necessary releases to ensure collaboration of care with all physician and/or counselors involved in my treatment: _____.
3. In order to promote a therapeutic relationship, we (care team members and patient) agree to treat each other with mutual respect and in the appropriate manner _____.
4. I agree to use a single pharmacy for all controlled substances, including buprenorphine. My current pharmacy is: _____.
5. I agree to use a single physician to prescribe my medication assisted therapy (MAT): _____.
6. I understand that prescription (buprenorphine) refills are **my** responsibility. I agree to give **at least 48 hour notice** for needed refills, taking holidays and weekends into consideration: _____.
7. I agree to take my medications as the doctor and other treatment staff have instructed and not to alter the way I take my medication without first consulting the doctor: _____.
8. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree to keep my medication in a lock box/lock bag/safe. Lost medications will be addressed by the treatment team who will review the situation and come up with a treatment plan: _____.
9. I agree to maintain and if needed revise a treatment plan with my primary care provider and that the plan is shared with my physician(s) and any other providers that are pertinent to my recovery. The purpose of this is to ensure that all parties are working in collaboration to provide the best treatment possible: _____.

10. I agree to attend, and be on time for, my appointments with both my provider and primary care medication assisted treatment team as determined by my treatment plan _____.
11. I understand that compliance with all of my medication is expected, unless a change is made by my prescribing physician. If a change is made, my prescribing physician and I will notify the other professionals involved with my care: _____.
12. I agree to inform all of my professional providers about any of the following:
 - a. Relapse: _____.
 - b. Any change in prescription or use: _____.
 - c. Any change in prescribing physician or PCP: _____.
13. I understand that Urine Drug Testing (UDS) will be conducted randomly, observed and the results will be shared with the appropriate professionals in my care. I agree to provide a urine sample within 24 hours of being called: _____.
14. I agree to random film/pill counts within 24 hours of being called: _____.
15. I agree to not eat any foods or bakery items that contain **poppy seeds**. I agree to not use any **mouth wash or cough syrup** containing alcohol as these can result in positive drug screens: _____.
16. I understand the following indicates non-compliance with the MAT program:
 - a. Failure to provide a urine drug screen at physician/MAT Team request: _____.
 - b. Presence of non-prescribed substances in urine screens: _____.
 - c. Abnormal temperature range of urine drug screen: _____.
 - d. Falsification of a urine drug screen: _____.
 - e. Failure to attend medical and counseling appointments: _____.
 - f. Arriving to appointments under the influence of drugs or alcohol: _____.
 - g. Diverting medication: _____.
17. I understand that buprenorphine will be present on my medication list and “opioid use disorder” will be present on my problem list in the UVM Medical Center electronic medical record _____.
18. I understand that medication alone is not sufficient treatment for my disease. Counseling requirements will be at the discretion of the MAT Team, including the prescribing doctor: _____.

I understand that non-compliance will be discussed with my physician and clinical team and may result in a change of treatment plan, a behavioral contract, or a possible discharge from the MAT program: _____.

Patient Name (please print): _____ **Date:** _____

Patient Signature: _____

MAT Team Signature and title: _____

Primary Care Provider Signature and title: _____

Date of Transition to PCP: _____

BUPRENORPHINE TREATMENT AGREEMENT

Name: _____

Date of Birth: _____

I am requesting that my doctor provide buprenorphine treatment for my opioid use disorder. My provider is under no obligation to prescribe these medications for me. This decision is based on the professional judgment of my provider to improve my ability to participate in work and social activities. I have made this decision after fully discussing the risk benefits of controlled medications as well as other treatment options. I understand that these medications have potential risks, the most significant being:

Physical Dependence: Abrupt stopping of the drug will lead to withdrawal syndrome characterized by abdominal cramping, diarrhea, ‘goose flesh’ and anxiety. Psychological dependence or addiction which means it is possible that stopping the drug will cause me to miss it or crave it. Overdose of controlled substance can lead to respiratory arrest and death. Mental changes may result in confusion, changes in thinking abilities and problems with coordination and balance. I will use caution and common sense before operating equipment or motor vehicle. Other possible side effects include: nausea, constipation, sleepiness, decreased appetite, problems urinating, sexual difficulties and depression.

I freely and voluntarily agree to accept this treatment agreement as follows, and I understand that I will be provided controlled medication only if I follow these regulations:

APPOINTMENTS

I agree to keep, and be on time to all of my scheduled appointments with the doctor and any other members of the treatment team staff. _____

I am responsible for scheduling my follow up visits at the end of my appointments and I will do this during my check out. I am responsible for arranging my transportation needs. _____

I will come to my scheduled appointment prepared to submit a urine or blood sample to assess the effect of the controlled medication and compliance to my treatment plan. _____

BEHAVIOR/CONDUCT

I agree to conduct myself in a courteous manner in the physician’s or clinic’s office. _____

I agree not to deal, steal or conduct any other illegal or disruptive activities in or in the vicinity of the doctor’s office. _____

I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff may choose not to see me and I will not be given any medication until my scheduled appointment. _____

MEDICATION

I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal. _____

I understand that the use of Suboxone by someone who is addicted to opioids could cause them to experience severe withdrawal. _____

I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine/naloxone (Suboxone) with other medications, especially benzodiazepines (such as Valium, Xanax, Ativan, Klonopin), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that deaths have been reported in persons mixing buprenorphine with benzodiazepines. _____

I also understand that I should not drink alcohol while taking this medication as the combination could produce excessive sedation or impaired thinking or other medically dangerous events. _____

I agree to take my medication as the doctor has instructed, and not to alter the way I take my medication without first consulting the doctor. _____

PRESCRIPTIONS/REFILLS

I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reason for such a loss. _____

I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit. _____

I agree my prescriber MAY require me to commit to, i.e., “lock-in,” to one pharmacy for filling my buprenorphine prescription. _____

My Pharmacy Name & Location: _____

OTHER

I understand that medication alone is not sufficient treatment for my disease and I agree to participate in the recommended patient education and relapse prevention program to assist me in my treatment. _____

I understand that I may be called in at any time for a mandatory random drug urine screen and/or pill count as determined by my provider. I understand I must provide a phone number where I can be reached. I understand that I must come in within 24 hours. _____

I agree to comply if my doctor refers me to see another health care provider for evaluation and treatment of related and other medical conditions. Not complying with my doctor’s recommendations could result in a breach of this agreement. _____

I agree to sign release of information for all medical providers I see to ensure coordination of care and avoid prescriptions that may be contraindicated. _____

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including Vermont’s Board of Pharmacy in the investigation of any possible misuse, sale or other diversion of my medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. _____

I understand that my Suboxone treatment may be discontinued and I may be discharged from the clinic if I violate this agreement. _____

Any violation of this agreement will result in a discontinuation of Suboxone treatment, and may result in discharge from the clinic. Law enforcement officials may be contacted if my violation involves an illegal act. _____

I understand I must provide a phone number where I can be reached and I am responsible for updating this number if it should change. _____

I have read this document, understand it, and have had all questions answered satisfactorily. I agree to all conditions of this agreement.

I have been provided a copy of this agreement to keep.

Patient's Name

Patient's Signature

Date

I certify that I have explained this agreement including the risk and benefits and answered any questions for the above signed individual.

Provider's Signature

Date

Appendix 5: Sample Letter for Patients of New Spoke Practices

Central Vermont Medical Center

Dear _____:

I am writing to let you know that our office will be participating in an initiative that allows us to offer you more comprehensive care related to your treatment. As part of this initiative, we will have additional treatment team staff members on site, and our office will be working closely with the team to develop your individual treatment plan and also to identify any additional services or supports that may be needed.

You are currently being treated for an opioid use disorder with Medication Assisted Therapy that includes a prescription for buprenorphine. The framework for this new initiative consists of best practices for care, which include counseling and other social supports.

In the coming weeks you can expect to hear from (insert Spoke Team members' names), members of our treatment team who will be collaborating with me in the delivery of your health care. If you are contacted by a member of our team, it is my expectation that you actively participate with them as they assist with care coordination. They will be providing support and assistance by:

- Completing treatment assessment questionnaires.
- Scheduling appointments to update/sign releases that will allow us to coordinate care with outside counselors.
- Fielding questions about how the treatment team can help you to remain or become “stable.”
- Determining what, if any additional supports you may need.
- Conducting random calls for a pill/strip count or urine screen.
- Completing monthly “check-ins” via phone or in person.
- Providing counseling as determined by your treatment plan, or if you are struggling with cravings, relapse or other life stressors.

Our goal is to support you in your treatment, and provide you with the best care possible. Please let me know if you have any additional questions.

Thank you,

PCP

Appendix 6: Spoke Information for Front Desk Staff

Gifford Medical Center

Medication Assisted Treatment (MAT) Team:

List of MAT Team Staff Members

The MAT team can be reached at _____ (phone number). If a team member is not available, voicemail will be checked daily. The MAT team is comprised of _____ (insert practice name) staff members and will speak with patients as if they are calling from your practice and/or working with Dr. _____. They will be using _____ (insert EMR) for charting and telephone encounters, and will document all patient interactions. The MAT team will be reaching out to Dr. _____ patients to introduce themselves and provide an overview of their role. They will schedule visits with Dr. _____ using a new MAT visit type. They will then mail the patient a letter with more details about the supports they can offer.

Talking points and info for patients:

Dr. _____ is taking part in a new statewide initiative for doctors who prescribe buprenorphine (Suboxone). As part of that initiative we now have additional practice staff members who will be able to offer more comprehensive care related to your treatment. We will be working closely on your individual treatment plan, and will work to identify and provide you with any additional supports that may be needed. The framework for this new initiative consists of best practices for care, which include counseling and other social supports. All of Dr. _____'s Suboxone patients will be taking part in this new treatment model.

FAQs

1. What if I don't need/want additional support?

Because Dr. _____ is taking part in this program, we will be working with all of his Suboxone patients. If Dr. _____ feels you don't need additional support, the team's contact will likely be minimal. However, there will be some initial paperwork to complete, and you will need to see at least one member of the team monthly. The monthly contact can coincide with your visit with Dr. _____.

2. I haven't done anything wrong, why am I being punished?

This program is not intended to be punitive. The team is here to offer comprehensive support to you and Dr. _____.

3. What kind of supports does the team offer?

We can help with a variety of things. If you need counseling, if there are medical concerns that you would like to address, transportation needs, etc. Our goal is to provide the best care possible and to ensure that you have all the supports necessary for a positive treatment outcome.

4. I don't have time for this. What are my choices?

The MAT team may be able to complete some initial paperwork over the phone if that would be more convenient for you. I can have a member of the MAT team call you back and review your options in detail.