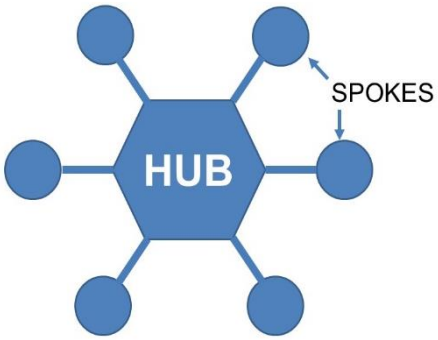
Wisconsin Hub and Spoke Health Homes

Supporting People with Opioid and other Substance Use Disorders

Background and Introduction

The 2019 Wisconsin Act 9 authorized the Department of Health Services (DHS) to pilot a Medicaid health home benefit for people with significant substance use disorders and who have co-morbid mental health and other health conditions. The proposed health home pilots will build on DHS efforts to develop a more integrated health care approach and to assure that people with substance use disorders (SUD) have quick access to the range of comprehensive addiction and mental health treatment, primary health care, and supports they need to assist their recovery.



A number of states have developed specialized "hub-and-spoke models" for treatment of opioid use disorders (OUD). The lead hub agency provides specialized SUD treatment and supports, including three forms of medication-assisted treatment, and takes responsibility for assessing and assuring the individual's overall behavioral health needs are met. The spokes in those other state models often provide office-based opioid treatment and health care services. In providing a hub-and-spoke model within the Medicaid health home benefit, these states have used the additional flexibility provided within the required health home services to provide important care management, health promotion services, and other supports. The model under discussion in this paper expands on the typical hub-and-spoke model by broadening the population of focus to include people with severe SUDs, not just people with OUDs.

The Medicaid health home benefit also builds off the "medical home model" because the enrolled individual is supported by team-based collaborative care and treatment that supports the person to meet their own identified health care goals across the spectrum of behavioral health and primary health care. At its core, it is designed to create a shift from an episodic acute care approach to a focus on ongoing integrated treatment and support. Primary health care systems often call this approach a "chronic care model," while specialty addiction treatment systems might refer to a similar shift as "recovery-oriented systems of care."

The Medicaid health home benefit itself does not include the payment for most Medicaid services, such as primary care office visits, addiction counseling, medications, or other Medicaid services. Those services are already defined in the Medicaid State Plan and are proposed in this pilot to be billed separately. However, the Wisconsin proposed health home model includes essential Medicaid services that must be available to the individual enrolled in the SUD health home either at the hub or the spoke.

DHS envisions the hub as an organization capable of rapidly serving individuals with complex substance use disorder treatment needs in order to stabilize and initiate treatment. In order to meet urgent needs of individuals with complex SUD, the hub must, at a minimum, provide

DRAFT

directly on-site or through telehealth, a core set of Medicaid benefits (in addition to the health home services). These include biopsychosocial assessments, physical health care assessments needed for initiation of medication-assisted treatment (MAT), on-site access to three forms of MAT, access to NARCAN, and access to the entire spectrum of addiction treatment services based on the appropriate level of care as determined by the application of the American Society of Addiction Medicine (ASAM) criteria.

DHS is interested in hearing from stakeholders and potential health home providers how they envision the required behavioral health services, the new health home benefit services, and primary health care can be coordinated across hubs and spokes.

The additional Medicaid health home benefit services are often not reimbursed in traditional primary health care settings, or through traditional outpatient substance use disorder treatment providers. Although county and tribal Comprehensive Community Services or targeted care management services may provide these services for some individuals, the additional activities reimbursed by the health home benefit can be the glue that allows a greater number of organizations involved in the health care system to coordinate, communicate, and jointly plan with the enrolled individuals across multiple care systems.

Vision Statement

Health homes will provide services through a hub-and-spoke model to promote seamless transitions of care from emergency rooms, jails or correctional facilities, or other sites where treatment might be initiated to specialized health homes. The health homes will offer evidence-based continuums of care to meet the needs of persons with severe or complex substance use disorders. This will occur by ensuring timely and proper follow-up care to ease the transition to long-term recovery services and supports.

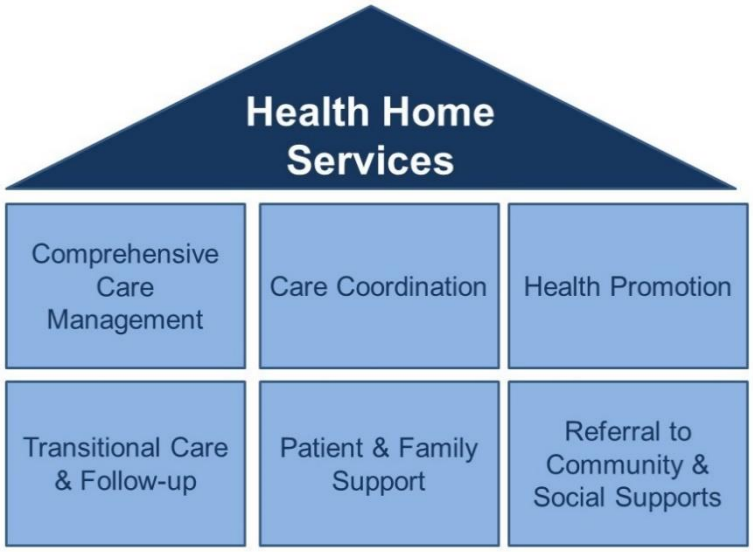
The target population will include Medicaid-eligible youth and adults who have severe substance use disorders (SUD) and are experiencing or at a high risk for chronic physical and mental health conditions. The health home will utilize person-centered and evidence-based services. The health home will support a person through their recovery journey by integrating addiction, behavioral health, and medical treatment and care coordination to proactively address chronic conditions throughout a person's recovery.

Please note: Individuals participating in services are referred as "persons" or "people." Specific agencies or systems of care may refer to the person as a client, patient, member, consumer, or enrolled individual, as appropriate.

DRAFT

Core Health Home Services

The Center for Medicare & Medicaid Services (CMS) requires that the health home benefit includes the following services: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, individual and family support, referral to community and social supports. These services may be provided across hubs or spokes. The DHS draft definitions for the Wisconsin hub-and-spoke health home concept are described below.



I. Comprehensive Care Management

Comprehensive Care Management involves identifying patients for treatment, conducting initial assessments, and formulating individual plans of care.

The health home will develop plans of care that include primary care, addiction and behavioral health care, and essential social services to address the needs of the whole person through a team-based care model. The person will communicate their preferences throughout the service delivery process to prioritize a person-centered approach to positive change. Care management will promote multidisciplinary treatment recommendations and planning by fostering consistent access to services and communication between providers. The person's preferences will be communicated throughout the service delivery process to prioritize a person-centered approach to positive behavior change. The hub will determine the complexity of the person's treatment needs, and assign and delegate care coordination activities to the hub or the spoke.

The initial assessment will include an immediate response to the person in need of services to promptly engage the individual in treatment. The emphasis of a trauma-sensitive and trauma-informed approach will be needed to facilitate engagement of the person in need of services. An emphasis on trauma recovery, assurances, and empowerment will facilitate successful engagement and interventions. Evidence-based practices, such as motivational interviewing, will occur during the initial screening and intake process. Based upon clinical judgment and following essential screenings and exams, immediate evidence-based interventions will be available, such as medication-assisted treatment (MAT), which often will begin prior to

completion of the full assessment. If this immediate engagement in treatment is necessary to stabilize the individual, it will be followed by a complete biopsychosocial assessment of physical, behavioral, and psychological status and social functioning, along with a physical exam. The hub should also have available on site a prescriber who can provide medications that can ease symptoms that often place individuals at risk, or can help with reducing the risk of overdose: naltrexone, acamprosate, gabapentin, and disulfiram would be appropriately used per clinical guidelines.

If immediate treatment is not required, the complete biopsychosocial assessment will occur before starting treatment. The comprehensive care plan will be developed jointly by the health home team and the person receiving services. The assessment will apply American Society of Addiction Medicine (ASAM) criteria to determine the appropriate level of care. The assessment will also include the need for specialized, evidence-based medical and psychological evaluations and treatments, and services for substance use disorder. The health home team will also promote participation by the person's family or preferred natural support network to address social and community issues that create barriers to treatment. Early engagement with the person will inform individualized approaches for the team to help the person achieve their self-identified goals. The person receiving services and the health home team will develop the comprehensive care plan. The care plan, developed with the person receiving services, will be based on the assessment and tailored to meet the person's needs and goals. Early engagement with the person will inform individualized approaches for the team to help the person achieve their goals. The person receiving services and their family, or self-identified support network, will be engaged to address social and community strengths and needs to prevent barriers to treatment.

Initial engagement will be individualized and promote patient safety and rapport-building through an acute care plan designed to manage a potential crisis. Harm reduction and MAT will be considered during the initial engagement with the person, as appropriate. The comprehensive care plan that follows will be based on the assessment and the active participation of the person. The care plan will be measurable, well-defined, clinically relevant, and monitored by members of the multi-disciplinary team. The needs identified during the assessment will be incorporated into the care plan and documented in an electronic format, such as an electronic medical record (EMR). The care plan will include goals, timeframes, the person's preferred natural support network, and the specific, evidence-based services the team will provide or arrange with the person. Health homes will demonstrate the availability of staff with the skills to successfully motivate and engage the person in planning their treatment.

Each health home will involve team members with clear roles and responsibilities that are specific to the person's needs. Health homes will identify and connect the various providers and specialists involved in the person's care to promote integrated health care, and identify the roles and communication protocols for the providers involved in a person's care on a need-to-know basis. The providers included in this treatment planning and communication process may include external partners, such as pain management clinics, managed care organizations, counties, tribes, and residential or hospital-based service providers.

Periodic reassessment, jointly with the individual, of the person's progress and outcomes will occur, including health status, quality of life, participation in services based on the person's care plan, satisfaction with services, and availability of community supports. Adjustments to the

treatment plan may be necessary, including moving from one setting of care to another, developing quality improvement activities to improve care, and linkages with long-term care services and supports. Reassessment will occur twice annually or more frequently, based on the intensity of treatment or changes in the person's goals and/or condition. Reassessments will include current information on the person's confidence and readiness for change, adherence to treatment, use of emergency services, and any identified barriers to recovery.

The health home will track each person's treatment, outcomes, and self-management goals using validated measurement tools identified by DHS. Specific services and outcomes will be reported to the health home for program validation and monitoring. Both the person's self-report and administrative data will be tracked and reported to monitor program integrity and to assure evidence-based practices are included in the course of treatment. Person-centered information and shared decision-making will drive the course of treatment, with periodic and systematic reporting of evidence-based interventions and outcome data.

The hub will monitor population health status and service use. The hub will work to identify and prioritize population-wide needs and trends, and promote and implement appropriate population-wide treatment guidelines and interventions. The hub will also take the lead role in collecting and reporting data for program certification.

II. Care Coordination

Care Coordination involves implementing the plan of care through appropriate linkages, referrals, coordination, and follow up across treatment and human service settings and providers.

Care coordination will implement the individualized comprehensive care plan to attain the individual's goals and improve chronic conditions. The care coordinator (i.e., social worker, care manager, etc.) will take the lead role facilitating linkages between team members who are responsible for different aspects of a person's care and treatment. Care coordination in a health home is designed to facilitate the delivery of appropriate person-centered services across all elements of the broader health care system and other service-delivery systems, including the management of integrated primary and specialty medical services, behavioral health services, and social, educational, vocational, and community services and supports to attain the goal of integrated, high-quality, cost-effective care resulting in improved outcomes. Components of care coordination include knowledge of (and respect for) the person's needs and preferences, resource management, advocacy, and communication between providers and family members. The care coordinator should be located at, or operate as a liaison to the hub, and follow the person for their long-term care and treatment. Care coordination services will be proactive and based on the person's individualized needs and preferences and have the capacity to engage the individual in their home and community. Care coordination may occur at the hub or be delegated to the spoke, based on individualized needs and preferences, as well as provider capacity at the spoke. The spoke may re-engage the hub if barriers to success emerge, or if the needs of the person exceed the spoke's capacity to support the person.

Health homes serving children and youth will place particular emphasis on coordination with primary care providers including medical homes, managed care organizations, and other involved agencies, such as schools, child protective services, juvenile justice, foster parents, or

other youth support networks. In collaboration with the youth receiving services, family and natural supports will be included and encouraged to participate in treatment planning and service coordination.

The health home team will ensure that all forms of MAT are readily available on a day-to-day basis for the treatment of people with opioid use disorder. Memorandums of understanding (MOUs) with opioid treatment programs (OTPs) and office-based opioid treatment (OBOT) may be required to ensure that all forms MAT are available on site through the health home service delivery system.

As the person proceeds through their recovery journey, they will work with the care coordinator and other health home team members, as appropriate, who will also assist the person with tasks such as updating recovery goals, developing wellness and recovery action plans, and solving problems directly related to recovery. These activities will involve holistic health and wellness strategies specific to the person, and be coordinated between the professionals in the person's system of care. Medical and mental health screenings and immunizations will be coordinated with the primary care or other appropriate providers.

III. Health Promotion

The health home team will work with each person to identify health promoting activities, screen

Health Promotion involves activities that activate and empower the individual's pursuit of healthy behaviors and self-management of health, mental health, and substance use disorder conditions.

for both medical and mental health conditions, and provide linkages for the person to access appropriate physical health care services, such as immunizations or dental care. Health promotion begins with the initial health home visit and continues during the development of a formal comprehensive care plan. In addition to substance use disorder treatment, the health home team will coordinate physical and mental health care services to promote a comprehensive and integrated approach to health and wellness. The health home team will talk with the person to assess the person's readiness for change and provide the person with the appropriate level of encouragement and support to engage in healthy behavior choices and/or lifestyle choices.

The health home team will also screen for past experience with trauma, as well as for health conditions that are critical for people with substance use disorders and often exist as co-occurring conditions, including HIV/AIDS, TB, and infectious hepatitis. The health home must ensure access to preventive and appropriate physical health care services, including the individual's primary care provider as part the health home team. In addition to substance use disorder treatment, the health home team will work with the person to coordinate physical and mental health care services in a comprehensive and integrated behavioral health approach to address each person's needs. All health home team members may contribute to developing goals related to health-promoting activities, with the designated care coordinator keeping documentation up to date for the person.

The health home will also provide health education to the person and their self-identified support systems regarding chronic conditions, prevention education, and promoting healthy lifestyle choices, such as:

- Smoking prevention and cessation.
- Stress reduction.
- Nutritional counseling.
- Obesity reduction and prevention.
- Engaging in regular physical activity.
- Disease-specific or chronic care management.
- Personal goal-setting for wellness and recovery.

Education may also focus on learning about the recovery cycle and individual trajectories toward wellness. This may involve creating agreements between the health home and people receiving services about their personal sobriety and wellness goals. This will include prevention education, including specific harm reduction options, based on the individual's substance use and risk factors.

At the population level, the health home team will use data to:

- Identify and prioritize particular areas of need with regard to health promotion.
- Research best practices and evidence-based interventions.
- Implement the activities in group and individual settings.
- Evaluate the effectiveness of the interventions and modify them accordingly.

Health homes working with children and youth will emphasize prevention health initiatives, including strategies to build residence and provide trauma-informed care, while actively involving parents and/or guardians, and other support networks. This will include identifying conditions contributing to risk due to family, physical, or social factors, and working with the youth to address these areas.

IV. Comprehensive Transitional Care/Follow Up

Comprehensive transitional care services streamline movement of patients from one treatment setting to another, between levels of care, and between health, substance abuse, and mental health service providers.

Transition care services focus on transitions from any long-term care facility, institution, or other out-of-home setting back to the community. Health home team members work closely with the person before and during a transition back to the community and share information with discharging organizations to prevent gaps in care that could result in re-admission or overdose. The health homes will increase the ability of people receiving services and family members to manage their care and live safely in the community, by shifting the focus from reactive care and treatment to proactive health promotion and self-management. Comprehensive transitional care focuses on streamlining movement of patients from one treatment setting to another, between levels of care, and between physical health and behavioral health treatment service providers.

Health homes will develop collaborative relationships with treatment providers and hospital ERs, discharge planners, managed care organizations, long-term care agencies, community corrections agents, residential treatment programs, county and tribal agencies, primary care and specialty mental health/substance use disorder treatment providers that provide day treatment, residential treatment, and psychosocial rehabilitation services. These activities include working with discharge planners to schedule follow-up appointments with primary or specialty care providers within seven days of discharge (or fewer if needed for MAT continuity), and working with the people receiving services to help facilitate attendance at scheduled appointments.

Engagement with all stakeholders in a person's transition will emphasize a trauma-sensitive and trauma-informed approach. The health home team will plan for potential escalation of symptomology or behaviors that may occur during transitions as a result of previous adverse experiences. An emphasis on trauma recovery, assurances, and empowerment will facilitate successful transitions.

Transitional care services will vary by the age of children and youth, and may include transitions to or from residential care facilities or foster care families. Among transitional-age youth, services will address the needs of participants and families as the individuals approach a shift into adult services and programs.

V. Individual and Family Support

Individual and family support services include activities related to advocating on the individual's behalf and engaging the individual's natural support network.

Individual and family supports may include any contacts the person identifies as instrumental in supporting their recovery. Services will include working with families based on agreements with the person in treatment; active community outreach to engage and support individuals by meeting people where they are in the community; assisting the person with their medication and treatment adherence; helping the family learn to support treatment monitoring in the home environment; addressing co-dependency challenges; and assisting the person to achieve personal goals and recovery outcomes.

While staffing patterns may vary by provider and location, health home teams must employ individuals with lived experience in substance use recovery, such as peer specialists or peer recovery coaches (certified or in training), or parent peer specialists.

A certified peer specialist is a professional who utilizes their personal lived experience of their journey in recovery from substance use disorders and co-occurring disorders to provide support to others and demonstrate that recovery is possible. Peer specialists support the person in their individual journey of recovery and wellness, which is often supported by networks of formal and informal services and supports. Peer specialists support many pathways to recovery and model hope. Natural supports and community-based groups with lived experience in substance use recovery may also support and mentor people in recovery from substance use disorders.

DRAFT

The health home providers will ensure that all communication and information shared with the person receiving services is culturally competent and respectful of the person's language and literacy, as well as their gender identity and preferred pronouns. Individual and family support services may be provided by any member of the health home team. Information must be communicated in a manner that is simple, clear, straightforward, and culturally appropriate.

The health home will regularly assess the person's readiness to address issues related to family relationships and dynamics. The health home team will work with the person to improve family relations or to re-engage family members who may have distanced themselves as the person progresses in treatment. Family-based therapy or family team meetings will be available to support those relationships to support the person's long-term health and recovery.

At the population level, services will include collecting and analyzing individual and family needs data. The health home will also develop individual and family support materials to further community awareness. Specialized individual support services may include training the person's support network on naloxone administration and other harm reduction strategies, as well as providing access to naloxone. Supports will be dynamic and flexible to build rapport and meet the safety needs of the person by including family and person's preferred support network when possible.

VI. Referral to Community and Social Support Services

Referral to community and social support services will connect the person to medical, behavioral, educational, community, and social support services to support their ongoing recovery.

Beginning with the initial assessment, the health home will assess needs related to financial strain, housing, food assistance, employment, transportation, and other resources. The health home will refer the person to community-based organizations and other key community stakeholders with the resources and services to support the person's health and well-being.

The health home will utilize motivational approaches to engage and retain people in person-centered recovery and wellness activities in the community. Referrals should be driven by the assessment process and the person's expressed requests, and noted on the person's care plan. The health home will designate staff to assist in coordinating and monitoring the following types of services:

- Benefit eligibility (disability, food share, etc.)
- Support to return to meaningful activity and/or work
- Subsidized or supportive housing
- Peer or family support
- Legal services as appropriate
- Others as appropriate

Appropriate referrals are driven by the assessment process and the person's expressed requests. Referrals will be noted on the person's care plan.

To create and recruit a robust network of resources, the health home will identify and partner with social service providers and community-based organizations. The health home will develop

cooperative agreements that allow monitoring of the person's participation in the community agency. The health home will provide training and technical assistance as needed regarding effective interventions for the population. Examples of potential partners include:

- Faith-based organizations
- Community mental health organizations
- Social integration opportunities including recovery centers
- Appropriate cultural support centers
- Mutual help groups (12-step groups, Smart Recovery, recovery support organizations, peer run respite programs, and warm lines)
- Housing assistance providers

Finally, the health home will also engage a specific subset of community partners (for example, community health workers, peer supports, support groups) to provide accessible group support to the population through partnerships and linkages.

DRAFT