**Health Engagement Hubs – One Example of Low Barrier Models**

* Pilot until June 2025
* All-in-one location where people who use drugs can access a range of medical, harm reduction and social services. Piloting in a rural and urban site. It’s a result of community engagement processes most notably the state opioid and response goal 3 workgroup and Substance Use Services Recovery Advisory Committee
* Subject to availability of funds authority should develop payment structures for health engagement hubs by June 30th 2024. Authority shall
* Core components:
	+ Low-barrier substance use treatment, harm reduction and basic medical services for people who use drugs (primarily opioids and stimulants)
	+ Philosophy
		- Provide services where people who use drugs feel welcome and by people they trust
		- Offer services on a walk in basis, no appointments required
		- Clients are welcome to use any service at any time they feel ready
		- The goal is to engage and support, even if drug use continues “keep coming back”
		- Client-centered with a prescriber, nurse care manager, care navigator and mental health coordinator
	+ Services often include but are not limited to
		- Screening and referral for primary care, infectious diseases, substance use disorder treatment, mental health treatment, recovery supports
		- Screening and referrals for HIV, hepatitis C, sexually transmitted infections (particularly syphilis) vaccinations and other medical services
		- Minor wound care; triage and referral for more acute medical conditions
		- Medications for opioid use disorder.
		- Education to understand options and make informed, shared decisions about substance use and/or mental health treatment.
		- Care navigation to assess needs for other services (e.g., housing, employment, legal, recovery supports) and to help clients connect and stay engaged with these services.
		- Mental health screening and care coordination, either in-person or via telehealth options.
		- Medication management for common mental health conditions.
		- Behavioral health support approaches including incentives or Contingency Management.
		- Emotional support and brief harm reduction counseling in 1-1 sessions or small groups.
* Staffing model minimums
	+ Partial or full time APP (MD, DO, ARNP, PA) licensed in WA
	+ Partial or full time RN who can provide medication management, medical case management, care coordination, wound care, vaccine administration, community based outreach
	+ Partial or full time behavioral health staff qualified to assess and provide counseling and treatment recommendations for substance use and mental health diagnoses (e.g., LICSW, LMHC, SUDP)
	+ Partial or full time outreach and engagement staff (e.g., peer community health workers, recovery coaches)
	+ Prescriber to treat psychiatric and co-occurring disorders, experience prescribing MOUD
* Do not need to be OTPs but need to have dedicated partnerships to provide warm handoffs to OTPs for participants
* The health engagement hubs should prioritize communities disproportionately impacted by overdose, health issues, other harms related to drugs, including AIAN, Black/African American Communities, Latino/Hispanic Communities, people experiencing homelessness, impacted by criminal legal system
* Funding model:
	+ “The authority shall develop payment structures for health engagement hubs by June 30, 2024. Subject to the availability of funds appropriated for this purpose, and to the extent allowed under federal law, the authority shall direct medicaid managed care organizations to adopt a value-based bundled payment methodology in contracts with health engagement hubs and other opioid treatment providers. The authority shall not implement this requirement in managed care contracts unless expressly authorized by the legislature.”

Key Barriers for Health Engagement Hubs

* Workforce: salaries to support the staff for appropriate supplies and facilities to provide physical healthcare, reimbursement for provider visit doesn’t cover the amount of time providers need with each patient; lack of traditional prescribers providing MOUD so nowhere to transfer more stable patients
* Funds: investment in equipment and space to provide services; reimbursement model incents FFS – doesn’t allow flexibility in scheduling.
* Compounding inequities: co-occurring mental health and housing concerns, patients need more intensive case management; Lack of inpatient facilities: only 585 inpatient facilities in the country, not enough spots for those who need inpatient treatment

**Components of Low-barrier models**

Available and accessible:

* Same day/short time for medication start, without appointments.
* Telehealth and in-person services available

Flexible

* Counseling is always offered but never mandated; no treatment engagement conditions.
* Medication provided first visit if the patient chooses
* Urine drug screens are used to inform clinical care and does not impact access to MOUD
* Home initiation is offered, and various forms are offered.

Responsive

* Ongoing substance use/polysubstance use is allowed, and not automatically lead to discontinuation of treatment or reduction in medication dose
* MOUD is not used as contingency for continued SUD treatment
* Individualized treatment goals that are patient driven
* Peer services or nonclinical professionals with lived experience in recovery from SUD are available to support people on their recovery journey
* Providers work with patients and team to determine what services are needed to support growth

Collaborative

* Partner with other providers or community organizations to deliver the services needed, such as PCPs, mental health services, housing agencies, social services, transportation services, offices of employment, and peer support networks.
* Settings vary: services delivered in the community through trusted organizations (e.g., SSPs, addiction treatment programs, primary care clinic, BHA)

Engaged in Learning and Quality Improvement

* Adequate training and education of healthcare providers, staff members in low barrier care principles, evidence-based treatment practices, signs and symptoms of co-occurring disorders, recovery-oriented care, and harm reduction strategies are crucial to delivering effective care for people with SUDs.
* Can look like providing information, offeiring cultural competency training, encouraging continuing education and professional development opportunities,
* Collecting and analyzing data on treatment outcomes, client satisfaction, accessibility of services, using standardized tools and measures
* Incorporate feedback from clients, staff and community partners to identify strengths and weaknesses of low barrier care model
* Conduct regular reviews of clinical practices and policies to ensure alignment with latest research evidence and best practices in the field
* Continuous quality improvement culture

**Structure for Low Barrier Models**

Minimum staffing requirements for Low Barrier Care Models

* Prescriber (MD, DO, NP, PA, PharmD?)
* Partial or full time RN who can provide medication management, medical case management, care coordination, wound care, vaccine administration, community-based outreach
* Partial or full-time behavioral health staff qualified to assess and provide counseling and treatment recommendations for substance use and mental health diagnoses (e.g., LICSW, LMHC, SUDP)
* Partial or full-time outreach and engagement staff (e.g., peer community health workers, recovery coaches)
* Prescriber to treat psychiatric and co-occurring disorders with experience prescribing MOUD

Minimum services available

* Screening and referral for primary care, infectious diseases, substance use disorder treatment, mental health treatment, recovery supports
* Screening and referrals for HIV, hepatitis C, sexually transmitted infections (particularly syphilis) vaccinations and other medical services
* Minor wound care; triage and referral for more acute medical conditions
* Medications for opioid use disorder.
* Education to understand options and make informed, shared decisions about substance use and/or mental health treatment.
* Care navigation to assess needs for other services (e.g., housing, employment, legal, recovery supports) and to help clients connect and stay engaged with these services.
* Mental health screening and care coordination, either in-person or via telehealth options.
* Medication management for common mental health conditions.
* Behavioral health support approaches including incentives or Contingency Management.

Potential Settings – trusted locations for care (not an exhaustive list)

* Primary care including FQHCs
* SSPs
* Mobile vans
* BHAs
* Community pharmacies?

**Bree Guidelines –** potential edits are listed in red

Programs and Facilities

*Opioid use disorder treatment should be provided through a variety of models on multiple levels of care (e.g. office-based opioid treatment (OBOT) in medical or mental health clinics, jail-based care, opioid treatment program care, mobile care, home-based care, community-based organizations, care provided through telehealth). Our workgroup does not endorse a specific model but does strongly recommend adoption of evidence-based methods of treating patients that increase access for underserved populations. Low-barrier treatment models have been found to increase access to evidence-based treatment, reduce overdose and . We also support piloting innovative and promising treatment models along with formal evaluations measuring benefits, costs, and disadvantages. Seek assistance from mentors available from comparable clinics, professional societies such as American Society of Addiction Medicine (ASAM), American Academy of Addiction Psychiatry (AAAP), and the Providers’ Clinical Support System (PCSS), Telehealth programs such as UW Telepain, Project Echo, UW psych provider line, and to begin to offer office-based treatment with buprenorphine.*

* + Train your workforce in harm reduction principles and evidence-based best practices for treatment of OUD
	+ Provide staff with links to current, short guidelines regarding opioid use disorder (e.g., Substance Abuse and Mental Health Services Administration, National Institute on Drug Abuse).
	+ Distribute copies of language guidelines to be used when discussing substance use disorder, such as from here.
* **Treat adolescents and teens in accordance with MOUD best practices.**
	+ Medications for Opioid Use Disorder (MOUD) are the treatment of choice for adolescents. Primary care settings should be prepared to identify adolescents with OUD and start them on MOUD per clinical guidelines.
	+ Encourage involvement of Involve caregivers and/or members of adolescent’s social network, as appropriate, but do not turn away receiving treatment adolescents at age of consent. More information on specific treatment protocols for adolescents and teens is available [here.](http://adai.washington.edu/)
	+ Adolescents can receive quality care in primary care settings, but may benefit from treatment in specialized treatment facilities that provide multidimensional services. Develop a shared care plan with the patient and care team that is individualized to mee their needs.
	+ Screen for depression and suicide, educate about prevention, and offer treatment for blood borne pathogens, discuss contraceptive needs and sexually transmitted infections.
	+ Increase awareness about medications for opioid use disorder and facilitate engagement for both caregivers and patients.
* **Treat patients who are pregnant in accordance with best practices.** For more information see the Committee on Obstetric Practice and American Society of Addiction Medicine joint opinion [Opioid Use and Opioid Use Disorder in Pregnancy](https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy).
	+ Train pre- and perinatal care providers about opioid use disorder including how to recognize signs of opioid use disorder and how to facilitate safe and timely care.
	+ Engage patients who are pregnant in prenatal care in addition to opioid use disorder treatment. Identify emergent/urgent medical conditions that require immediate referral to clinical evaluation.
	+ Co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist.
	+ Perform routine verbal screening for substance use including use of prescribed or illicit opioids.
	+ After a positive screen for opioid use disorder, perform a medical examination and psychosocial assessment.
	+ Use urine drug testing in accordance with guidelines and to inform clinical care, not used punitively or resulting in withholding medication treatment.
	+ Use a supported referral to refer patients who are pregnant and physically dependent on opioids to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence. Initiate treatment with opioid replacement therapy as early as possible. Hospitalization during initiation may be advisable due to potential adverse events and/or need for close prenatal observation.
* **Prepare patient materials describing the risks and benefits of available opioid use disorder treatment options and train staff to talk to patients about how to select the best treatment option for them.**
	+ Staff should discuss risk of serious adverse events including risk of relapse and overdose death for withdrawal management and counseling alone, compared to the use of buprenorphine-naloxone, methadone, and naltrexone.
	+ Utilize a certified shared decision-making tool to guide discussion. Read more about the Health Care Authority’s work to certify patient decision aids here: [www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making](http://www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making).
	+ Distribute materials containing current, accepted language regarding substance use disorder.
* **Offer medications for opioid use disorder (MOUD) in primary care, behavioral health clinics/programs mental health clinics and hospitals (inpatient and emergency departments) in accordance with established guidelines such as from the American Society of Addiction Medicine.**
	+ Build expectations for prescribing buprenorphine into facility culture.
	+ Universally screen patients for OUD
* **Assess possible medication interactions, especially with benzodiazepines**. Treatment of opioid use disorder with medications should not be discouraged or delayed, but the risks of ongoing benzodiazepine use should be taken seriously and interventions guided accordingly. Follow guidelines of the American Association for the Treatment of Opioid Dependence here: [http://www.aatod.org/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs- otps/](http://www.aatod.org/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs-%20otps/)
* **Identify which patient comorbidities will be treated onsite, criteria, and partners for referrals.**
	+ Stabilize the patient and reduce harm as a first priority.
	+ Build relationships with collaborative providers including Opioid Treatment Programs to support providers with programs for patients needing a higher level of care.
	+ Assess patients for poly-drug use, physical health comorbidities, and mental health comorbidities but tailor additional care to the patient’s needs and wishes. Patients with opioid use disorder may have a variety of additional medical or behavioral health comorbidities requiring specific screening, diagnosis, treatment, and referral. Some patients may benefit from mental health or psychiatric treatment by well-trained providers providing therapy and/or appropriate medications. However, having onsite mental health care should not be a prerequisite to providing or receiving treatment for opioid use disorder, especially for patients who do not want or need additional mental health care. Facilitate access to appropriate level of care or external referral as needed.
* **Facilitate access to addiction consult services, either in person or through telephone**
* **Referral to appropriate levels of care**
	+ For patients with mental health issues, refer to treatment facilities conducting treatment by trained and licensed mental health providers, if needed and available.
	+ Include Opioid Treatment Programs as part of a referral system of care. Clinics may refer to an Opioid Treatment Program when the patient requires more intensive treatment, or when a patient wants methadone or daily dosing, additional counseling support, or assessment by an addiction medicine provider, if available.
	+ For patients with co-occuring stimulant use, refer to or offer contingency management services
* **Support patient involvement in other programs (e.g., peer support programs).**
	+ Support use of Employee Assistance Programs that may be able to provide support in accessing mental healthcare or care coordination services.

Health Plan Guidelines

* + **Support whole-person**. Develop a reimbursement structure that actively facilitates and encourages office-based buprenorphine prescribing for primary care practices. Develop reimbursement structures that support low-barrier models of care at various settings, including value-based contracts that allow for drop-in and flexible scheduling, remove all prior authorizations for MOUD, incent access to long-acting injectables and cover costs of harm reduction services in compliance with state and federal law. Payment, either by value-based care or fee-for-service, should cover reasonable and necessary costs, including the costs of nurse or comparable care and case managers who can oversee a group of patients, outreach and engagement staff, and behavioral health staff. ~~Consider alternative payment models for supportive, wrap-around care for patients with opioid use disorder.~~
		- Increase provider reimbursement for prescribing and managing MOUD treatment in line with specialty care rates~~.~~
	+ **Support use of medications for opioid use disorder as part of the treatment plan**. Prioritize prescription of MOUD and remove prior authorization.
		- Remove prior authorization for methadone, buprenorphine and naloxone for adults and patients who are pregnant and/or under the age of 18.
		- Remove prior authorization for higher doses of buprenorphine treatments that are more effective for patients using highly potent synthetic opioids like fentanyl in alignment with most updated guidance.[[1]](#endnote-1) Ensure any prior authorization processes do not limit same day access to MOUD.
		- Incentivize providers or facilities in areas without access to buprenorphine to begin and maintain office-based opioid treatment services.
		- Cover MOUD induction and management via telehealth (audio only and audio visual) in alignment with federal regulations at parity to in person induction and management costs
		- Reduce barriers such as co-pays to support appropriately timed (e.g., more frequent) personalized dosing.
		- Support Opioid Treatment Program reimbursement structures to cover the costs of effective care including treatment plans including buprenorphine, naltrexone, and telehealth.
		- Support Opioid Treatment Program reimbursement structures that facilitate use of both buprenorphine and telehealth.
		- Ensure that reimbursement programs do not prohibit patient access to medication treatment. Do not include time limits on use of MOUD (buprenorphine, methadone)
	+ **Reimburse provision of treatment for smoking cessation**. Individuals with opioid use disorder have very high rates of tobacco use. Patients who continue to smoke tobacco have higher all- cause mortality as well as higher opioid relapse rates.

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| Our workgroup endorses a “no wrong door” approach for patients wanting to access opioid use disorder treatment from a variety of settings. The following recommendations are meant to guide patients to appropriate opioid use disorder treatment. The goal for all settings is thatpatients receive the care they need at the time and in the setting of their choice, reduce illicit opioid use, and have no overdose events. |
|  | **Current State** | **Intermediate Steps** | **Optimal Care** |
| **Primary Care Setting – Large Integrated System** | * Patients with active opioid use disorder are not detected and not treated.
* If detected, providers may be uncertain as to next steps or may feel uncomfortable discussing opioid misuse.
* Some behavioral health integration may be present
 | * Primary care leadership support adding a service to treat opioid use disorder. For a summary of practice-based models see [Primary Care–Based Models for the Treatment of Opioid Use Disorder: A Scoping Review.](http://annals.org/aim/article/2589794/primary-care-based-models-treatment-opioid-use-disorder-scoping-review)
* Review AHRQ’s [Role of Low Threshold Treatment for Patients with OUD in Primary Care](https://integrationacademy.ahrq.gov/products/topic-briefs/oud-low-threshold-treatment)
* Primary care providers are incentivized by higher reimbursement to treat opioid use disorder and co-occurring conditions.
* Primary care leadership, providers and staff build relationships with surrounding facilities (OTPs, hospitals, behavioral health providers/clinics)
* Primary care providers and staff are trained:
	+ To diagnose opioid use disorder.
	+ On indications for buprenorphine, naltrexone, and methadone.
	+ On local behavioral health providers, Opioid Treatment Programs and how to provide supported referrals for patients.
	+ To use current, non-stigmatizing language regarding substance use disorders.
* The [Bree Collaborative behavioral health integration framework](http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf) and complementary models (e.g., [AIMS Center Collaborative Care](https://aims.uw.edu/collaborative-care)) are understood and that steps have been taken to integrate into care structures.
* Primary care teams and providers are introduced to ongoing training resources such as Providers’ Clinical Support System for opioid therapies
 | * Patients have access to all available treatments for OUD and behavioral health care and counseling as wanted and needed without mandatory requirements that constitute a barrier to care.
* Team-based care including include the ability to treat patients with buprenorphine or naltrexone and supported referral to opioid treatment programs.
* Patients are referred to other harm reduction, peer and other support services if not offered in house.
* Practices use a tracking system, such as a registry, to track and monitor progress toward treatment goals for patients with OUD
* Primary care teams are co-located with or have access to behavioral health specialty consultation through integrated behavioral health care.
* Practice offers same-day walk-in visits, direct phone access to the treatment team, and work with community organizations to fill gaps in care (transportation, childcare, food, housing, etc).
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| **Primary Care Setting – Independent/Rural Clinic** | * Patients with active opioid use disorder are not detected and not treated.
* If detected, providers may be uncertain as to next steps or may feel uncomfortable discussing opioid misuse.
* There may be a lack of availability at other levels of care for referral or consultation (OTPs, inpatient care, behavioral health consultation)
 | * Primary care leadership support adding a service to treat opioid use disorder. For a summary of practice-based models see [Primary Care–Based Models for the Treatment of Opioid Use Disorder: A Scoping Review.](http://annals.org/aim/article/2589794/primary-care-based-models-treatment-opioid-use-disorder-scoping-review)
* Review AHRQ’s [Role of Low Threshold Treatment for Patients with OUD in Primary Care](https://integrationacademy.ahrq.gov/products/topic-briefs/oud-low-threshold-treatment)
* Primary care providers are incentivized by higher reimbursement to treat opioid use disorder and co-occurring conditions.
* Primary care leadership, providers and staff build relationships with surrounding resources and seek out telehealth/telemedicine partnerships
* Primary care providers and staff are trained:
	+ To diagnose opioid use disorder.
	+ On indications for buprenorphine, naltrexone, and methadone.
	+ On local behavioral health providers, Opioid Treatment Programs and how to provide supported referrals for patients.
	+ To use current, non-stigmatizing language regarding substance use disorders.
* The [Bree Collaborative behavioral health integration framework](http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf) and complementary models (e.g., [AIMS Center Collaborative Care](https://aims.uw.edu/collaborative-care)) are understood and that steps have been taken to integrate into care structures.
* Primary care teams and providers are introduced to ongoing training resources such as Providers’ Clinical Support System for opioid therapies
 | * Patients have access to all available treatments for OUD and behavioral health care and counseling as wanted and needed without mandatory requirements that constitute a barrier to care.
* Team-based care including the ability to treat patients with buprenorphine or naltrexone and supported referral to opioid treatment programs.
* Patients are referred to other harm reduction, peer and other support services.
* Primary care teams have access to behavioral health specialty consultation through integrated behavioral health care.
* Practice offers same-day walk-in visits, direct phone access to the treatment team, and work with community organizations to fill gaps in care (transportation, childcare, food, housing, etc).
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1. [asam\_clinical\_considerations\_\_buprenorphine.212-(1).pdf](https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/advocacy/letters-and-comments/asam_clinical_considerations__buprenorphine.212-%281%29.pdf?sfvrsn=1d12567a_1) [↑](#endnote-ref-1)