DENVER HEALTH CAM ACADEMY

DENVER HEALTH CENTER FOR ADDICTION MEDICINE

UTILIZING A HUB AND SPOKE MODEL TO ADVANCE OPIOID TREATMENT AND CARE IN COLORADO: *A PRACTICAL TOOLKIT*

NCHA North Colorado Health Alliance

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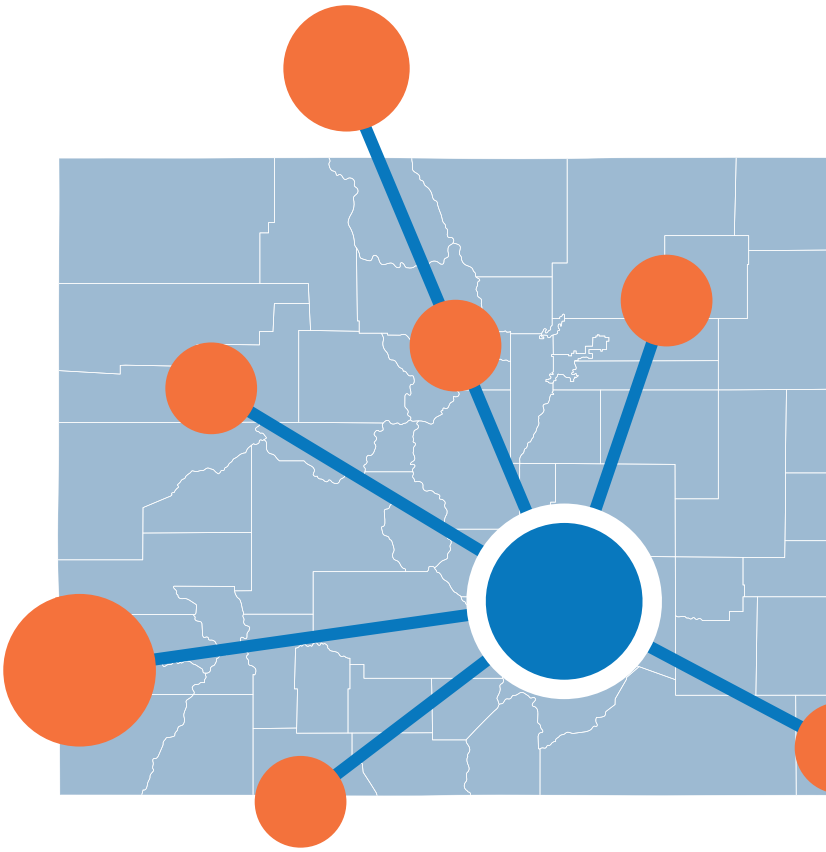
SECTION 1: INTRODUCTION

The purpose of this toolkit is to provide an evidence-based framework to expand opioid use disorder (OUD) treatment access and care coordination across Colorado. The Hub and Spoke model is an innovative system of care. It focuses on building a network of expertise, referral resources, and care coordination among substance use disorder treatment programs, correctional facilities, and other healthcare and social services organizations. Building on the Hub and Spoke model and the experience of the North Colorado Health Alliance and Denver Health, this toolkit aims to provide key implementation considerations for using this model within organizations, counties, and regions.



The Hub and Spoke model offers a structured and evidence-based approach to integrating specialized addiction treatment with primary and community-based care.

The Colorado Attorney General's Office provides funding for the Colorado Opioid Model to Advance Treatment (CO-MAT) project through the Opioid Abatement Innovation Share. The goal of the CO-MAT project is to help Colorado counties and organizations expand opioid treatment and care coordination. For more information, please visit our website: https://www.denverptc.org/co-mat/.

The CO-MAT project is led by the Center for Addiction Medicine (CAM) Academy at Denver Health. The CAM Academy is the training and education arm of Denver Health's Center for Addiction Medicine, dedicated to enhancing the well-being of individuals and communities by addressing addiction medicine-related challenges through education, training, technical assistance, and capacity building.

1.1 Who is This Toolkit For?

This toolkit is for anyone working along the continuum of care for individuals with OUD, as well as those who play a broader role in supporting the systems that make effective treatment possible. Whether you are directly providing services or shaping the policies, funding, and partnerships that support recovery, this resource is for you. Addressing OUD requires a coordinated and community-centered approach, with a commitment to achieving health equity and ending health disparities. By bringing together practical tools, examples, and insights from the field, this toolkit supports anyone invested in creating or strengthening systems of care. These Hub and Spoke models rely on collaboration across sectors and settings, and this resource is designed to help those efforts, regardless of your role in the treatment ecosystem.

This toolkit will provide ideas and outline the key components of the model; however, what is most important is starting small, utilizing existing resources, and then building upon them as you can.

1.2 How To Use This Toolkit?

This toolkit is divided into sections, each of which is a key component of a Hub and Spoke model. Resources, staffing, and infrastructure will vary across organizations, making it impossible to offer a one-size-fits-all strategy for implementation. Rather than prescribing a rigid formula, this toolkit outlines high-level activities and considerations that are essential for sustainability and impact, providing a flexible framework that can be adapted to fit different settings and contexts. The action items presented in this toolkit are not always completed sequentially; you might start in various places based on your organization's unique needs. Throughout the toolkit, several elements are included to help guide your implementation efforts. See Table 1 for a guide to each component.

Table 1: Toolkit Components

Tip Box		Practical advice or key takeaways to support application.
Case Study		Real world examples that illustrate how strategies are applied.
Checklist		Activities that guide implementation.
Resources		Connects readers to additional information, resources, or external websites for further exploration. Website changes may result in broken links over time. If you encounter a broken link and need assistance locating a resource, please contact us at CAMAcademy@dhha.org

Table 2: Acronym List	
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
CAM	Denver Health's Center for Addiction Medicine
CEO	Chief Executive Officer
CMS	Centers for Medicare & Medicaid Services
CO-MAT	Colorado's Opioid Model to Advance Treatment
COSLAW	Colorado Opioid Synergy for Larimer and Weld Counties
DUA	Data Use Agreement
ED	Emergency Department
EO	Executive Officer
IRT	Intensive Residential Treatment
KPI	Key Performance Indicator
LCJ	Larimer County Jail
MAT	Medication-Assisted Treatment
MOU	Memorandum of Understanding
MOUD	Medication for Opioid Use Disorder
NCHA	North Colorado Health Alliance
NIDA	National Institute on Drug Abuse
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
ROAC	Regional Opioid Abatement Council
ROI	Release of Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SOR	State Opioid Response
SUD	Substance Use Disorder

Tip: MOUD, MAT, or OAT? Medications are effective treatments that can help people manage their opioid use disorder (OUD) and other SUDs. There are a few acronyms that are commonly used when describing medications as part of a treatment plan: MOUD (medications for opioid use disorder), MAT (medication-assisted treatment), or OAT (opioid agonist therapy). While this toolkit includes all three, especially when referencing literature or evidence-based practices, it will primarily use the acronym MOUD, as this term refers exclusively to treatments for OUD.

1.3 Colorado Environment: Why Now?

Colorado is at a pivotal moment in addressing the opioid crisis. From legislative advancements to Medicaid expansion, the policy environment has evolved to support access to treatment, recovery pathways, and system-wide collaboration. This section provides a brief snapshot of the shifting landscape and explains how this model could address gaps in Colorado.

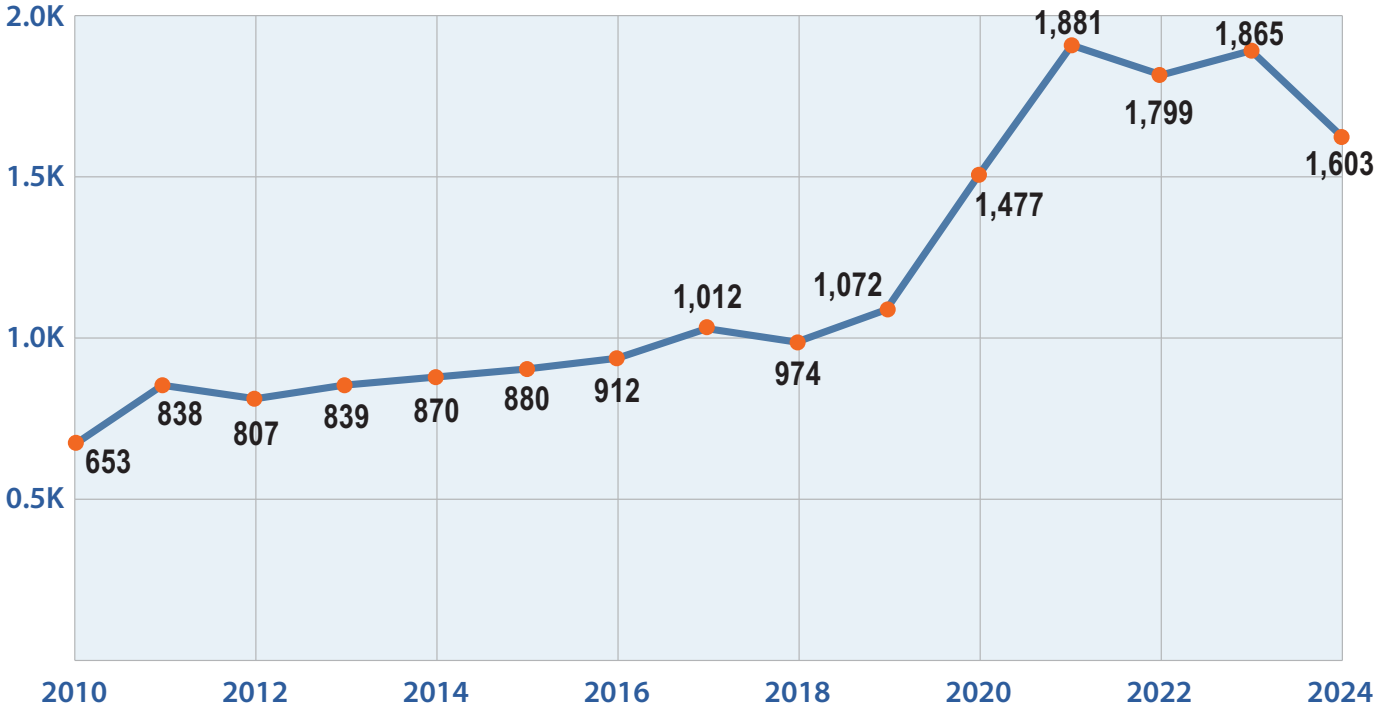
State Landscape

- **Overdose Crisis:** Since 2000, opioid overdose deaths have continued to increase, with a 69% increase from 2020 to 2021. The highest number of opioid overdose deaths was reported in 2023, with 1,273 deaths.[1] In 2024, we experienced the first reported decline in deaths, and we are hopeful that this trend will continue.[2]
- **Estimated Need:** More than 1 in 5 Coloradans (22.41%) is estimated to have a substance use disorder (SUD)—the highest prevalence among all U.S. states, surpassed only by the District of Columbia at 23.73%.[3] Despite this high need, access to treatment remains limited, particularly in rural areas and among justice-involved populations, who face persistent barriers such as provider shortages, transportation constraints, and stigma.[4]

People with SUDs are also significantly overrepresented in correctional facilities. Research from the National Institute on Drug Abuse (NIDA) estimates that 65% of incarcerated individuals have an active SUD, and an additional 20% were under the influence of drugs or alcohol when they committed their offense.[5]

Figure 1: Number of Drug Overdose Deaths in Colorado 2010-2024

Age: All, Sex: All, Ethnicity, All, Race: All, Marital status: All, Veteran status, All



Source: Colorado Center for Health and Environmental Data, 2025

Recent Legislation Supporting OUD Treatment in Colorado

House Bill 22-1326 Fentanyl Accountability and Prevention: This comprehensive legislation combines criminal justice reforms with public health strategies, raising penalties for fentanyl distribution while expanding access to prevention, treatment, and harm reduction services. The bill supports naloxone distribution, public education campaigns, and the legalization of fentanyl test strips. A critical provision requires all county jails to offer at least one FDA-approved medication for opioid use disorder (MOUD) and to develop reentry plans ensuring continuity of care. These provisions not only support treatment during incarceration but also recognize the importance of what happens after release. Individuals leaving incarceration are at extremely high risk of overdose, particularly in the first couple of weeks. Ensuring post-release connections to outpatient treatment, Medicaid coverage, and recovery supports is essential to saving lives. Hub and Spoke models that include correctional facilities as either Hubs or Spokes can help close this gap and create seamless transitions to community-based care. The law further encourages jails to coordinate with community providers, helping to establish jail-based programs as part of a larger regional network of care.[6]

Case Study: Jail-Based MOUD Program in Action

Larimer County Jail (LCJ) launched a program in 2018, partnering with its jail healthcare provider, regional behavioral health provider SummitStone Health Partners, and the North Colorado Health Alliance to offer medication-assisted treatment (MAT) continuation and initiation/induction, as well as reentry care coordination.

- The jail began continuing MOUD for individuals already receiving treatment in the community who become incarcerated.
- The jail initiated MOUD for eligible individuals during incarceration based on screening.
- MOUD services were integrated with mental health and substance use counseling.
- Jail staff were trained in substance use, trauma-informed care, and naloxone administration.
- Peer support specialists were embedded in jail programming to provide support during incarceration, re-entry planning, and once patients are released to support linkage to ongoing engagement in treatment within the community.
- Reentry planning included ongoing MOUD outpatient care, naloxone education and distribution, Medicaid reactivation, and harm reduction kits. Planning also included individual assessments of needs to support recovery capital development, which is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery. From these assessments, connections were created to housing, employment support, transportation, food security, and other essential services.

Outcomes after Implementation:

- Increased post-release treatment engagement.
- Improved collaboration between justice and community health systems.
- Reduced withdrawal-related incidents and medical emergencies in custody.

This program demonstrates how legislation, such as HB 22-1326,[7] can be translated into sustainable, system-wide improvements. To view the Larimer County Jail MAT Program clinical workflow, click here.

Medicaid 1115 Demonstration Waiver: The Medicaid 1115 Demonstration Waiver expands Medicaid coverage to address critical health-related social needs and improve access to care for individuals with complex needs. This includes services for individuals with SUDs, those transitioning from state correctional facilities, and people experiencing serious mental illness or serious emotional disturbance. Approved by the Centers for Medicare & Medicaid Services (CMS) on January 13, 2025, Amendments #1 and #2 authorize Colorado to provide pre-release services for individuals leaving correctional care, reimburse for medically necessary acute inpatient and residential stays in Institutes for Mental Disease, and offer housing services such as pre-tenancy support, housing navigation, rent and utility assistance for up to six months, and one-time moving costs. The expanded waiver also supports nutrition services, including pantry stocking, medically tailored meals, and nutrition counseling and education. Additionally, it enables longer treatment stays when medically necessary for individuals experiencing behavioral health challenges.[8] The Medicaid 1115 Demonstration Waiver will commence for the Department of Corrections in the Summer of 2025, with County Jail Systems tentatively scheduled to go live in the Summer of 2026.

Together, these legislative actions create a policy environment that not only supports but requires cross-sector collaboration. As the landscape of OUD treatment evolves, continued agility among providers, policymakers, and partners will be critical in navigating shifting best practices, funding streams, and public needs. If you do not reside in Colorado, consider what legislative actions impact people with SUDs in your state.

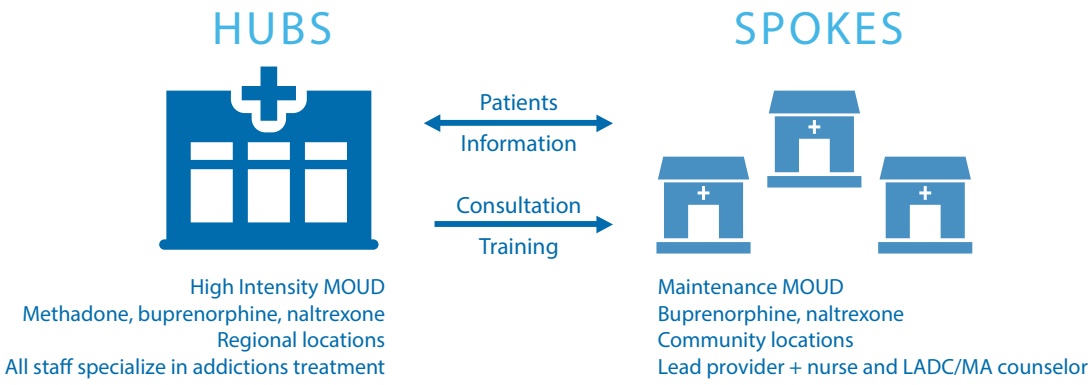
SECTION 2: INTRODUCTION TO THE HUB AND SPOKE MODEL

The Hub and Spoke model offers a structured and evidence-based approach to integrating specialized addiction treatment with primary and community-based care. The model was designed to increase access to care, enhance care coordination, and improve treatment outcomes. It is particularly effective in supporting patients through different stages of recovery, as it promotes patients receiving the most effective level of addiction treatment at various points in the healthcare and justice systems.

2.1 Model Origins: Vermont

The Hub and Spoke model was first implemented statewide in Vermont in response to the escalating opioid crisis. When a Vermont Senate bill was passed in 2000, allowing methadone treatment, a waiting list quickly developed, with a delay for the state's opioid treatment programs growing to almost two years.[9] The limited access to treatment options and fragmented care systems catalyzed change. The state recognized the need for a specialized clinic that could induct patients onto buprenorphine before transferring them to office-based opioid treatment. Vermont's solution was to create a coordinated, system-wide model of care that aligned with the state's Blueprint for Health. After receiving approval from the CMS for its 2013 State Plan Amendment, Vermont converted its existing Medicaid Assistance Team services system into a Hub and Spoke system.[10]

Figure 2: Vermont's Hub and Spoke System



Source: Hub and Spoke | Blueprint for Health. (2025). Blueprint for Health.

Under Vermont's system:

- Hubs, or opioid treatment programs (OTPs), provide intensive care and more complex treatment. As licensed OTPs that are subject to federal regulations, Hubs may dispense methadone in addition to other forms of MOUD. Each regional Hub also supports its area's Spokes.[10]

- Spokes are waivered primary care providers that offer integrated OUD treatment and may prescribe buprenorphine and administer naltrexone. Spoke providers also include family practitioners, internists, psychiatrists, obstetricians, and pediatricians in Federally Qualified Health Centers, private group practices, hospital-owned practices, and solo practices.[9]

Vermont's Hub and Spoke model became a national benchmark for OTP due to its successes:

- By the end of 2014, Vermont's treatment per-capita grew from 3.76 people treated per 1,000 to 10.56 per 1000.[9]
- Since 2013, overall healthcare costs, including the cost of opioid agonist therapy, dropped by 7% to 10%, for a projected estimated $6.7 million statewide savings. One report from the Vermont Department of Health[11] showed that emergency department (ED) visits fell by 89%.
- In July of 2018, Vermont passed Act 176 (S.166), which mandated the provision of MAT for inmates. In February 2019, 16% of all inmates were on medication-assisted treatment (MAT), and by November, 47% of the nearly 1,500 previously incarcerated individuals were receiving MAT.[12]
- From June 2018 through May 2019, there was a 23% increase in the number of buprenorphine-waivered prescribers.
- In 2018, overdose deaths in Chittenden County, Vermont's largest county, dropped by 50%.

The success in Vermont inspired other states, including California and Washington, to adapt the model to their healthcare systems. Click on the states below to read about their Hub and Spoke models.

California

Washington

2.2 Defining Hubs and Spokes

Hubs can also be primary care offices or other settings that have expertise with care coordination or MOUD. Across the country, Spokes are also emerging in settings such as jails, emergency departments, drug courts, and community-based recovery organizations. Here are the key characteristics of Hubs and Spokes.

Key Characteristics of Hubs:[13]

- Traditional Hubs provide comprehensive addiction treatment, including settings with MOUD expertise. Hubs can also include behavioral health assessment, referral networks, and treatment centers that may not have access to methadone.
- Hubs may have clinicians with training and experience in delivering MOUD, as well as staff physicians, nurses, advanced practice nurses, and counselors who provide intensive specialty care addiction treatment.
- Patients are inducted and stabilized on buprenorphine or methadone.
- Emerging models demonstrate that the Hub definition can be expanded to include centralized and comprehensive care coordination sites as Hubs. These care coordination sites can serve as a single point of entry to a larger network of providers.
- Hubs often build the capacity of Spokes to deliver MAT and other care coordination services through training and consultation, thereby expanding the reach of OUD treatment within the system.

Key Characteristics of Spokes:

- Spokes are satellite partner sites that offer care coordination, limited treatment options, and actively refer patients to Hubs.[14]
- Spokes can be primary care settings, staffed by one or more buprenorphine prescribers, that offer medication-assisted treatment but would not provide maintenance of methadone. Spokes may refer patients who need specialized treatment or maintenance of methadone to a Hub.[13]
- Spokes provide ongoing care coordination services in the community, and can include harm reduction agencies, community-based organizations, school-based health centers, correctional settings, and pharmacies.

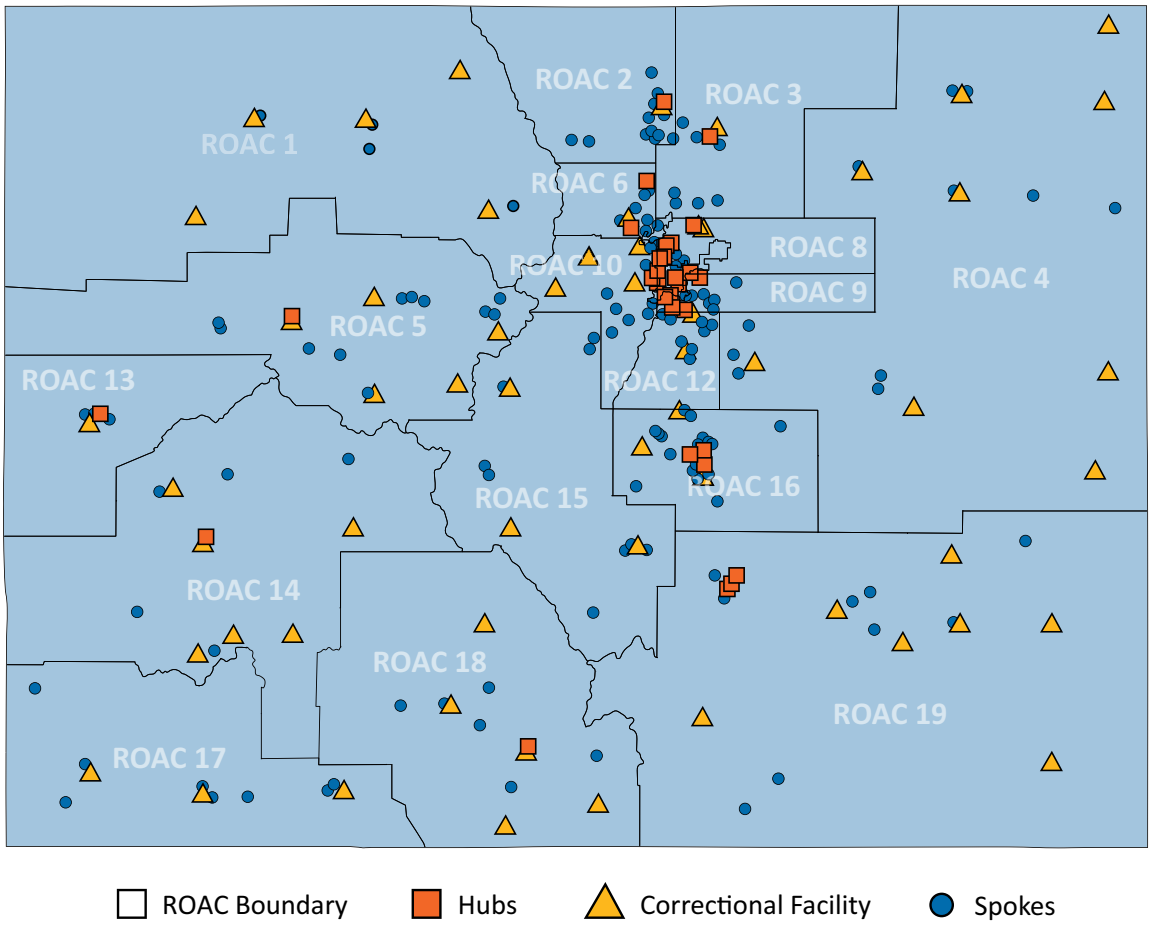
Tip: Start Small: Although the models and case studies referenced throughout this toolkit include expansive Hub and Spoke networks, remember that this work begins with just one connection. Any time you create a linkage between a site that provides addiction treatment or MOUD expertise and a site that offers care coordination, you are building a Hub and Spoke model.

2.3 The Need for Hub and Spoke Care

Patients with OUD face many challenges in seeking treatment. Challenges can include being uninsured or underinsured, unintegrated SUD treatment, geographic disparities in medication and therapeutic access, stigma, abstinence-only programming, and insufficient educational opportunities for providers.[14] Proximity to an OTP, or the availability of buprenorphine prescribers accepting new patients, also poses challenges.[15]

In 2024, the CAM Academy contracted with the Colorado Health Institute (CHI) to compile and interpret publicly available data on OUD, overdose rates, treatment, access measures, the workforce, and other indicators to understand the challenges for a Hub and Spoke model. Together with CHI, **the CAM Academy published a report** that highlighted Colorado data, as well as data from each of the state's Regional Opioid Abatement Councils (ROACs) in 2025. Profiles were created at the county level and then at the regional level, following the regions within Colorado's ROACs. The data highlighted disparities in access to care, with most traditional Hubs (methadone providers) located on the Front Range, the most populated area of the state.

Figure 3: Colorado ROAC Profile Findings



Source: The Colorado Opioid Model to Advance Treatment Project Report

For this project, Spokes were defined as facilities that refer patients to a Hub and include all facilities licensed in Colorado to provide behavioral health treatment. When examining the distribution of Spokes across Colorado, 91% of counties have a Spoke, while 9% have no Spoke. Counties with no Spokes include two urban (Clear Creek and Gilpin), one rural (Ouray), and three frontier counties (Hinsdale, Mineral, and San Juan). While every ROAC region in Colorado has a Spoke, density varies significantly by region:

- ROAC 11, which covers only Denver County, has 68.6 Spokes per 100 square miles.
- ROAC 1, which includes Grand, Jackson, Moffat, Rio Blanco, and Routt Counties, has 0.1 Spokes per 100 square miles.

For the CO-MAT project, Hubs are defined as opioid treatment programs that are licensed by the state to provide methadone. In Colorado, we found there are a total of **42 Hubs and 735 Spokes.** Most Hubs are in the most populated areas of our state. However, this means that beyond the Front Range, many counties lack access to a Hub.

Almost a quarter (22%, 14 of 64 counties) of Colorado counties have traditional Hubs as defined by being an OTP. Among these counties, 71% are in urban counties (Adams, Arapahoe, Boulder, Denver, El Paso, Jefferson, Larimer, Mesa, Pueblo, Weld) and 29% are in rural counties (Alamosa, Garfield, Montrose, Prowers).

These profiles are a helpful way to understand where gaps exist in the opioid care continuum geographically and can help target resources more effectively. Consider what data you have available that could help you determine geographic disparities in your model.

2.4 Benefits of the Hub and Spoke Model

A Hub and Spoke model for OUD can have transformative impacts on patients, organizations, and healthcare systems.

Table 3: Hub and Spoke Benefits to Patient, Organizations, and Systems

Benefits for Patients	Benefits for Organizations and Systems
• **Access to Care:** Creates an integrated network treatment setting, enabling more patients to access treatment wherever they enter the system. Patients are more rapidly connected to treatment and recovery services that best meet their needs.	• **Decreasing Overdose Mortality:** For individuals with OUD, untreated individuals have a 2.56 times higher risk of all-cause death, and an 8.10 times higher risk of overdose death compared to those receiving MAT. By making MAT services more accessible, we can reduce the number of overdose deaths in our state.[17]

Benefits for Patients	Benefits for Organizations and Systems
• **Continuity of Care:** Maintains continuity of care by integrating specialized addiction treatment services (Hubs) with ongoing community-based care (Spokes), allowing patients to receive the right level of support over time. • **Integrated and Holistic Support:** Encompasses comprehensive services, including medication management, behavioral health support or counseling, peer support, and care coordination, all of which are essential for long-term recovery. • **Trauma Informed Care:** Well-positioned to provide trauma informed care by supporting patient-centered treatment that emphasizes safety, trust, and empowerment. • **Co-location of Services:** Rural areas consistently face challenges in accessing MAT services, including limited clinic locations, restricted clinic hours, and transportation difficulties. In some studies, these accessibility barriers significantly outweighed emotional barriers, such as stigma or a lack of support.[16]	• **Expanded Rural Care:** Approximately 60% of the U.S. counties with the highest rates of OUD are in rural areas. Rural areas also experience shortages of qualified addiction medicine specialists. By building partnerships and expanding telehealth services through a network, access and outcomes can be improved for rural counties.[18] • **Justice System Linkages:** By connecting jails and probation services to healthcare networks, the model can reduce recidivism and decrease the likelihood of reentry into the justice system for justice-involved populations. Community re-entry is a high-risk period when many individuals "fall through the cracks" between systems. These issues are magnified for black, indigenous, and other people of color (BIPOC), as persistent systemic racism is inextricably linked with arrest and incarceration rates, access to effective services, and health and mortality outcomes.[19] The rate of opioid overdose is markedly elevated after prison release, particularly in the first two weeks; justice-involved individuals are up to 40 times more likely to die of a drug overdose during this time.[20] A single study in Washington state did find that justice-involved individuals might be 129 times more likely to die of a drug overdose in the first two weeks.[21] • **Insights into Health Disparities:** As Hub and Spoke models coordinate to expand access to treatment, disparities in access, retention, and outcomes —such as those related to race, rurality, insurance status, or incarceration history —become more visible through systemic tracking and analysis. • **Socioeconomic Improvements:** Within the NCHA Hub and Spoke model, which will be explained in detail below, socioeconomic factors and quality of life improved over time. The percentage of members who are employed part- or full-time rose from 27% to 45%. Housing situations also significantly improved, with 60% of members being housed at intake and 82% being housed six months later. With this, members' ratings of their quality of life also increased; at intake, 51% of members rated their quality of life as good or very good, compared to 75% six months later.

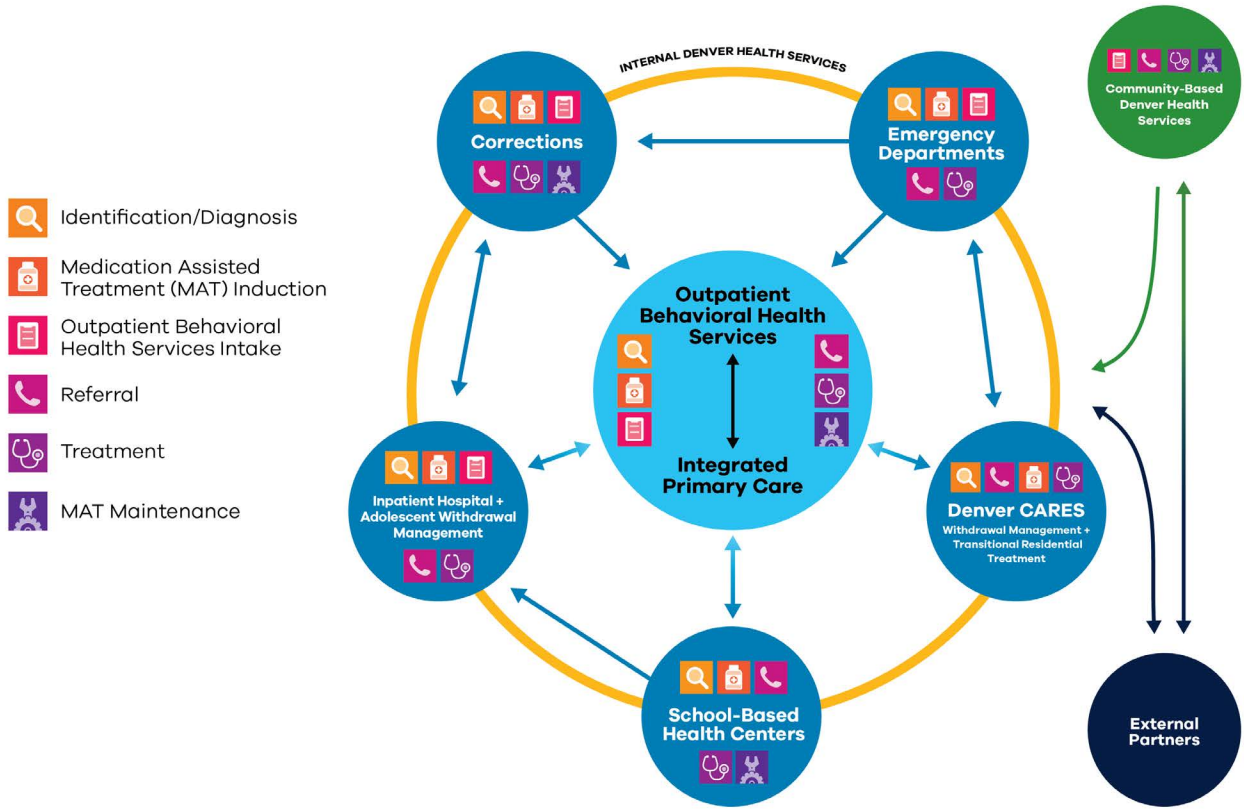
2.5 Overview of Two Unique Colorado Hub and Spoke Models

To illustrate the flexibility and scalability of the model, this toolkit will highlight two examples from Colorado: Denver Health and Hospital Authority's Center for Addiction Medicine and the North Colorado Health Alliance's CO-SLAW project. We will provide an overview of these models here and revisit them throughout the toolkit.

Denver Health: An Urban, Safety-Net, Integrated Health System in Denver, Colorado

Since 1860, Denver Health has served as the public safety net health system for residents of Denver, Colorado. As an integrated health system, Denver Health offers a 525-bed hospital, an Adult Level One Trauma Center, primary care services, school-based health centers, urgent care centers, paramedic and public health divisions, and correctional care health services. Denver Health cares for the needs of special populations, including those facing poverty and/or homelessness, refugees, non-English speakers, and minorities. In 2022, Denver Health cared for nearly 270,000 of Denver's most vulnerable residents: more than 60% of Denver Health patients identify as members of racial and ethnic minoritized groups, and 70% live below the 200% federal poverty level.[22]

Figure 4: The Center for Addiction Medicine at Denver Health



Source: The Center for Addiction Medicine at Denver Health

Denver Health created its Center for Addiction Medicine (CAM) in 2018. The CAM brings together Denver Health's robust range of opioid treatment services within a Hub and Spoke model that integrates resources and clinical expertise, providing a seamless, confidential, and supportive journey for patients. Delivering on the "no wrong door" approach, patients who misuse opioids and present to any Denver Health setting, whether it be a clinic, medical provider, or emergency facility, are rapidly connected to treatment and recovery services that best meet their needs.

The CAM now includes two Hubs, the specialty Behavioral Health department (which consists of an OTP) and the integrated primary care clinics across the city. The Spokes include the ED, Psychiatric Emergency Services, hospital medicine and adolescent withdrawal management, correctional care, Denver CARES withdrawal management and transitional residential treatment, Denver Recovery Group, Behavioral Health Group, Sobriety House, and other community partners.

In 2024, the CAM reached nearly 21,000 individuals with substance treatment services across the Denver Health system. As noted in the CAM's 2024 annual report, other highlights include:

- Upwards of 70,000 substance-related visits.
- A quarter (25%) of patients treated were persons experiencing homelessness.
- Most patients were male (63%), and over half (55%) were people of color.
- Half (50%) of patients were between the ages of 25-44 years.
- Most patients were insured with Medicaid (58%).

More information about Denver Health's CAM can be found here.

CO-SLAW: Colorado Opioid Synergy–Larimer and Weld

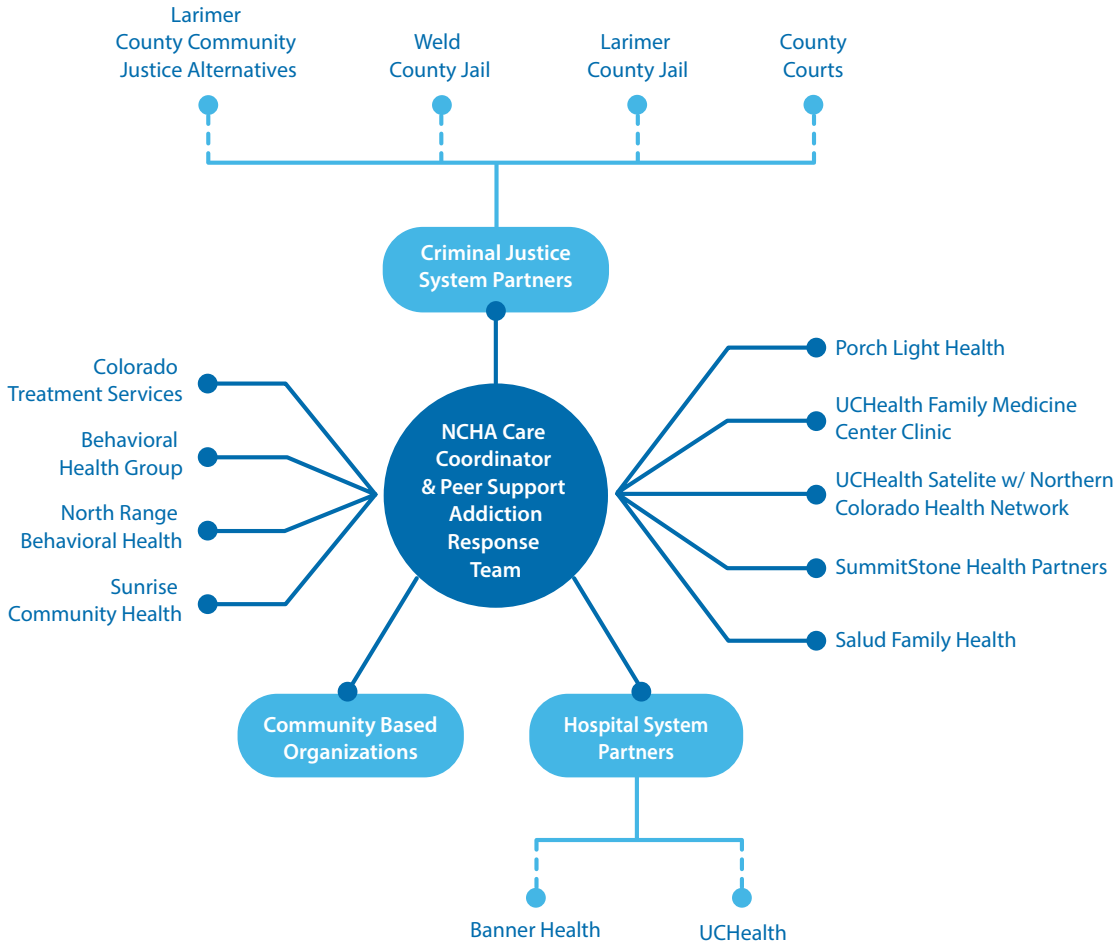
Community partners across Larimer and Weld counties recognized the devastating impacts of the opioid epidemic in their region and came together to address it. The Northern Colorado Collaborative for Addiction and Recovery Support (NOCO-CAReS) was launched as a community network to bring together collaborators, including those in behavioral health, criminal justice, and law enforcement, primary care and hospital systems, policymakers, and community members impacted by the opioid epidemic, to find solutions.

The group did an informal needs assessment and developed a strategic plan that identified four focus areas:

- Prevent misuse and optimize the use of opioids.
- Identify misuse of opioids and provide early intervention.
- Improve treatment and enable recovery for people with opioid use disorders.
- Reduce harm caused by opioid use and misuse.

Launched in 2018, the Colorado Opioid Synergy – Larimer and Weld (CO-SLAW) is a network of eight treatment providers and transitions of care sites, including criminal justice and hospital systems, served by a team of integrated care coordinators who facilitate members' access to and retention in substance use treatment across the network. CO-SLAW developed a "Virtual Hub" of care coordination that pairs members with a care coordinator as they move within the network of care providers. This model further demonstrates that a Hub doesn't have to be an OTP, if they can facilitate assessment, treatment, and coordination across a system of care.

Figure 5: The CO-SLAW Care Coordination Network



CO-SLAW met or exceeded its goals and objectives; some highlights of the success of the project include:[23]

- As of September 30, 2021, CO-SLAW has enrolled and provided MAT to 336 members.
- The project established a 1-800 telephone number, which is staffed 24 hours a day, 7 days a week, 365 days a year.
- A total of 1,064 adults (169 in year 1; 405 in year 2; and 490 in year 3) received MAT in Larimer County Jail (LCJ).

For more information about the CO-SLAW project, visit their website or read their report here.

SECTION 3: PLANNING AND READINESS ASSESSMENT

Planning and Readiness Checklist:

- ☑ Assess and Prioritize Community Needs
- ☑ Draft Project Goals
- ☑ Determine Internal Capacity
- ☑ Build an Informational Brief
- ☑ Identify Key Partners and Engagement Strategies
- ☑ Build a Leadership Team

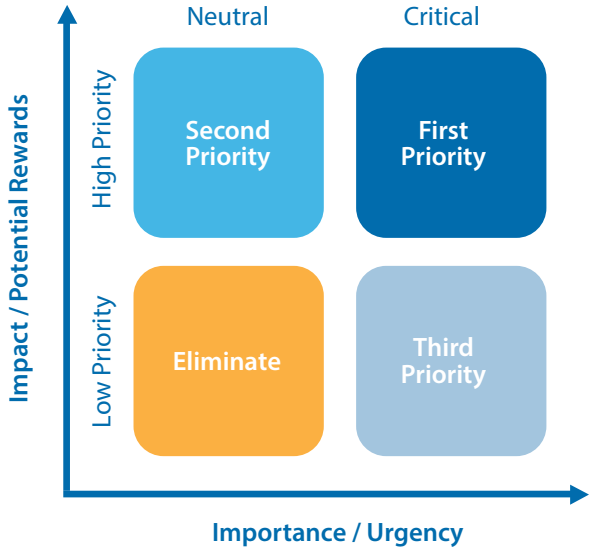
3.1 Assess Community Needs

To best focus resources to expand OUD treatment and care coordination, data points, such as increases in overdose death rates and extensive miles to treatment, could highlight prioritized areas for resource expansion. Even if establishing a Hub is not the goal of the region or county, improving communication, coordination, and collaboration between Spokes could ensure more comprehensive care coordination services for people with OUD. To assess your community's need for treatment and care coordination, several options exist.

- Collaborate with local public health agencies on their community health assessment to ensure questions are included about opportunities to improve OUD treatment and linkage to care coordination services.
- Collaborate with your ROAC to determine which regional surveys have been conducted, identify any available data, and explore how to collaborate to acquire additional information as needed.
- Utilize ROAC community advisory boards that include people with lived expertise with OUD to determine what treatment and care coordination gaps exist.
- Utilize the perspectives of the workforce serving people with OUD, such as peer support specialists, certified addiction technicians or specialists, and licensed addiction counselors, to identify service gaps and unmet needs.
- Establish or utilize an existing Steering Committee or Board composed of healthcare, public health, correctional facilities, and community-based organizations to gather input on how to support more effective partnerships and collaborative services for people with OUD.
- Use available data to monitor trends in OUD that might be lagging indicators of where gaps exist and what communities might be experiencing disparities.

After needs are identified, if there are numerous needs, consider prioritizing them using a tool such as a prioritization matrix that considers urgency, importance, value, and level of effort. Prioritizing needs will determine the key areas of focus for your Hub and Spoke model and potential expansion opportunities with time. This can be done with the community during a meeting. To the right is a picture of a prioritization matrix; the axis can be drawn on easel paper, and sticky notes can represent the needs. The result will help identify the priorities to focus on within the Hub and Spoke framework, expanding treatment and care coordination for people with OUD.

Figure 6: Prioritization Matrix



Draft Project Goals

After identifying what the Hub and Spoke model can address, you can start drafting project goals. Evidence-based goals could include:

- Expansion of MOUD services into surrounding communities or via telehealth.
- Expansion of primary care providers using buprenorphine and addiction medicine expertise in underserved areas through training, consultation, or mentoring with the Hub.
- Improvements in the referral, treatment, and retention of people with OUD in care.
- Expanding wrap-around services, such as social services for people with OUD through Spokes.
- Enhanced communication and data sharing between the Hub and Spokes for coordinated care.

Determine Internal Capacity

As you build this initiative and its purpose, it will be critical to identify and engage champions or a host organization to lead the efforts within your organization, county, or region. Champions are anyone who can support and advocate for the project's success. Champions should have a high level of influence and enthusiasm for the project and be considered key partners. Champions can be used to gather input on the initial project goals and plans, and then invited to share their needs based on their role or experience. Champions can also be engaged to speak to the value of the initiative for their program or department, building more support and awareness for the project. Champions in organizations, departments, or the community can be engaged on the Advisory Committee or throughout the project as a partner.

Any champions working on the initiative will need to have organizational support, as it is likely to be unfunded initially. Identifying how champions will support this initiative, estimate the time commitment, and understanding the value added will be crucial for these conversations. Champions can be identified as staff who have established expertise in addiction medicine, program administration, community engagement, or care coordination. Champions could also be individuals with decision-making authority who can lead organizational change initiatives, or individuals who demonstrate passion and engagement in serving people with OUD, inspiring others.

Tip: Engage champions who are:

- SMEs in addiction medicine, behavioral health, care coordination, or community engagement
- Program administrators who understand how to build sustainable programs
- Decision-makers
- Passionate that can inspire others

In addition to champions, it might be helpful to identify a host organization. This organization could apply for funding, host meetings of an advisory board or steering committee, help identify key partners, and raise awareness in the community for the prioritized needs. Consider whether you or your team are emerging as key leaders and ask that your organization host the initiative indefinitely or for a defined period.

Build an Informational Brief

As you start to engage champions and gain organizational support, build an informational brief to describe the problem, the needs, and how advancing OUD treatment and care coordination using the Hub and Spoke model will align with the organizational and/or network's mission and values. The informational brief can guide conversations as you meet individually with leaders and champions or present at existing meetings to engage leadership. Be sure to develop what your asks are for each individual or group you are meeting with. Is it their support, dedicated staff time for program and protocol development, assistance in mobilizing community partners, or time for strategic planning to implement a Hub and Spoke model? You can use these steps to guide your talking points on an informational brief and for meetings:

- **Articulate the Vision:** What is the purpose of the Hub and Spoke model? What are the initial goals (often these are refined throughout program development)? What are the short-term and long-term benefits of this model?

- **Alignment and Benefits:** How will this model align with your organization's mission and values? What benefits will it bring?
- **Present Evidence:** What data does your organization have on people with OUDs (overdose visits, clinical visits, treatment, or referrals)? Utilize some of the existing data from our state's overdose dashboard in this document. This can also include the evidence for the Hub and Spoke model from this toolkit.
- **Describe Funding:** Is there any funding? How will the project aim to get funding support? If no funding is available, can you demonstrate cost savings with these activities?

A helpful tool to utilize with champions as you begin to make your case for a Hub and Spoke initiative will be to conduct a SWOT analysis. A SWOT analysis will help you identify any internal strengths (S), internal weaknesses (W), external opportunities (O), and external threats (T) for your project. This will help ensure as you continue to engage in strategic planning for your key priorities based on needs, you build upon strengths and opportunities, and plan to address weaknesses and threats.

Figure 7: SWOT Analysis

3.2 Identify Key Partners and Engagement Strategies

Engaging partners early in the planning will ensure you are creating a shared vision and representing partner priorities. There is ample evidence that partner engagement benefits population health improvements. A partner is defined as an individual or group who is responsible for or affected by health and healthcare-related decisions.[24]

Table 4: Partner Categories *Adapted from Petovic and Colleagues*[26]

Partner Category	Description	Examples
Patients, patient caregivers, patient advocates/organizations	Those with lived expertise with the condition of interest or who care for or advocate on behalf of those with lived expertise	• People with OUD • Caregivers and other supports for people with OUD
Program Managers	Managers/directors who plan, lead, oversee, or deliver any program that provides public health, community services, or clinical care (e.g. budgeting, hiring, staffing, organizing, coordinating, reporting)	• May be health care providers but are not on the front-line delivering health care related to the program of interest, such as a person overseeing an immunization program but not delivering vaccinations
Providers	Persons and their professional associations who provide health care in a professional capacity and allowed by regulatory bodies to provide a health care service	• Advanced practice providers, clinical pharmacists, dentists, nurses, optometrists, physicians, physician assistants, physiotherapists, psychologists
Policymakers	Individuals, organizations and entities that craft public or private policy (on health) at any level of government	• Regulators • Health departments ministries
Payers of Health Research	Individuals and organizations that fund research projects, such as government funders, industry funders, foundations	• National health research funding agency • Philanthropic foundations
Payers/Purchasers of Health Services	Individuals, organizations and entities that pay for health services	• Public health systems • Private insurers
Public	Individuals in the general population of a defined geographic area excluding patients, caregivers, and health professionals living or working with the condition of interest	• Member of the public with no specific experience with the intervention or condition on which the guideline is focused

Partner engagement is a process that involves identifying, analyzing, planning, and implementing actions to influence partners. It involves various levels of interaction to ensure you understand their needs, keep them informed, and collaborate to achieve your goals. Partner engagement also ensures the needs, assets, and concerns of affected communities are included, promotes trust in the community, strengthens communication, and encourages the development of interventions that are tailored, non-duplicative, and sustainable.[25]

1. **Identify Partners:** Partners might be departments within your organization or external partners such as public health, health officials, ROACs, healthcare agencies, etc. A partner engagement plan is a tool that can help you track key organizations or partners involved in serving people with OUD, as well as other organizations that serve key communities impacted by OUD. This plan also helps you track the level of partners involvement and maintain transparent communication throughout your project. Begin drafting a list of known partners and ask your champions to share any additional partners they are aware of.

Tip: Partner Considerations: As you create a partners list, it might be helpful to consider the following factors as you identify and invite partners for a partnership:

- Ability and willingness to represent and advocate for your project
- Commitment and time capacity
- Communication skills and preferences
- Conflicts of interest
- Expertise and/or experience
- Organizational mission and values, and commitment to inclusivity
- Training, support, and funding needs

2. **Analyze Partners:** Include a column in your plan to collect information on their needs, expectations, influence, and desired level of engagement. This can be done through a survey or individual meetings.

Table 5: Four Levels of Partner Engagement[26]

Communication	Partners receive communication but have no contributing role.
Consultation	Partners provide their views, thoughts, or experiences, but without a commitment that all their input will be utilized.
Collaboration	Partners are engaged and influence the project.
Coproduction	Partners are equal members and have a key role in decision-making, serving on a governing body such as an advisory committee.

3. **Plan Engagement:** This includes developing a communication plan that defines how communication will be delivered, the frequency and type of communication, and the desired outcome of the communication. This plan will include emails, partner meetings, reports, and other communication modalities identified.
4. **Engagement Activities:** This involves maintaining and adjusting the communication plan, continually seeking feedback, and ensuring improvements or concerns are addressed. This also means your partners engagement plan is a living document that should be reviewed and revisited regularly over time.

3.3 Build a Leadership Team

Determining a leadership structure for your project ensures you have transparency and accountability. Leadership could include a governing body with decision-making authority, such as a steering committee. Your leadership structure may also include two rotating co-chair positions, which facilitate meetings, have decision-making authority, and serve as the primary project managers. It will be essential to define key leadership roles, their responsibilities, and the decision-making authority of each, as well as the process for seeking approval for key decisions from partners or governing bodies. For these types of shared decisions, having a basic understanding of consensus-building techniques will help you reach agreement and is key to the success of a project. Consensus building is an effort to meet the interests of all partners.

Case Study: Denver Health's Leadership Structure

Denver Health's Hub and Spoke Model is a Chief Executive Officer (CEO) supported initiative. The CEO approved organization-wide efforts dedicated to de-siloing and creating this model. The Chief Operating Officer also serves as an executive sponsor to create awareness and assist with problem-solving as needed. Denver Health recognized the need and value in having our Privacy Officer serve as a key leader to inform data sharing and to ensure regulatory requirements are adhered to (CFR-42 Part 2).

To manage the administrative needs of the Center for Addiction Medicine, Denver Health established an Administrative Director to lead efforts and serve as the primary point of accountability for the Hub and Spoke Model. The CAM Medical Director provides a portion of their time to inform and support these efforts. Across Denver Health, clinical leaders from each department or program that serves as a Spoke participate in developing standardized workflows and quality improvement efforts, and they also serve as champions, communicating processes and expectations to staff about the Hub and Spoke model.

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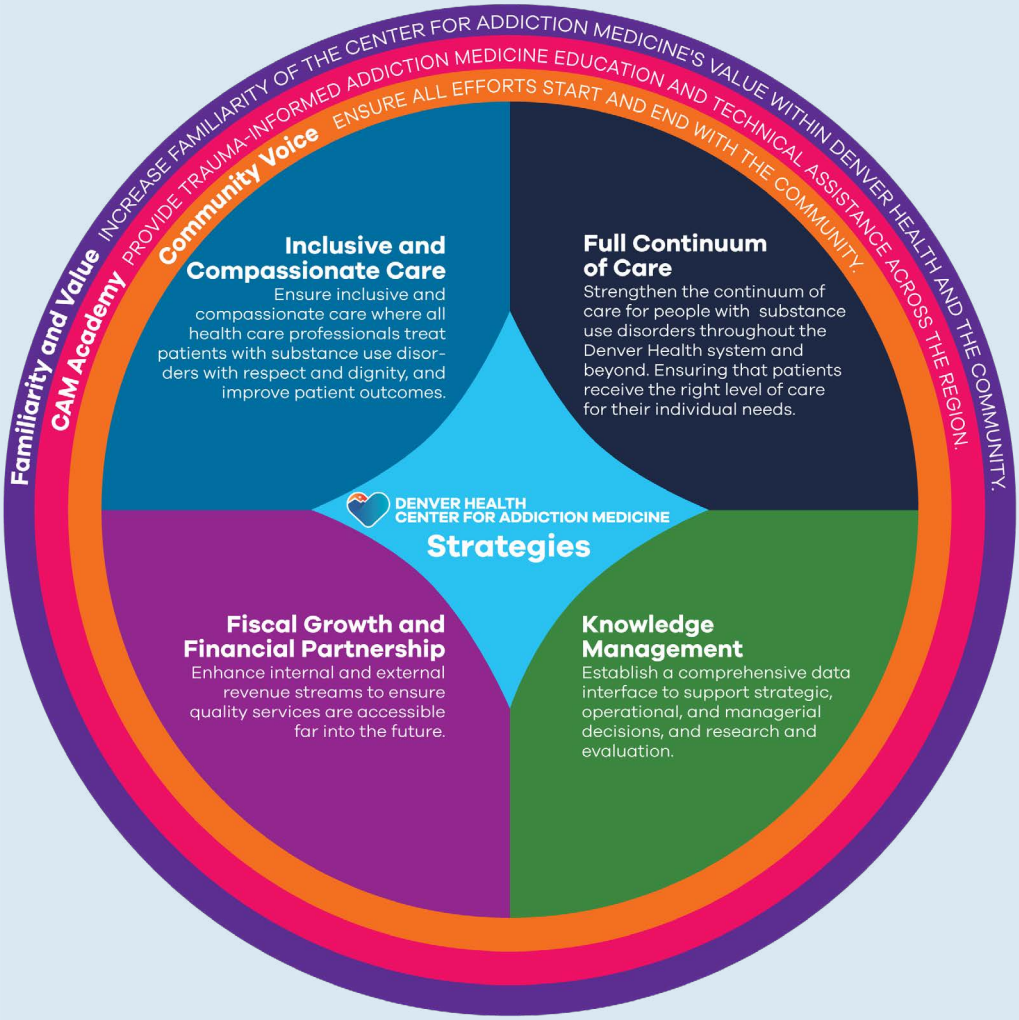
The CAM also has several workgroups that execute and plan the five-year strategic plan captured in the Figure below. The Knowledge Management team is composed of Data Scientists who are 100% supported by the CAM and build tools for the electronic health record, analyze and report on data to show outcomes of the model efforts, such as referrals and linkage to care across the care continuum.

Figure 8: CAM Strategic Focus Area Structure



Case Study: CO-SLAW: Colorado Opioid Synergy–Larimer and Weld Leadership Structure

CO-SLAW's Hub and Spoke model across Larimer and Weld counties is supported by the NCHA's Chief Executive Officer (CEO), who approves of efforts dedicated to de-siloing and increasing access to care coordination and treatment. The Director of Addiction Response manages staff, grants, community partnerships, workflows, expansion, contracts, and agreements. An Assistant Medical Director supports providers with clinical consultation on prescribing practices, informs clinical workflows, and supports clinical efforts of the model. Both positions are NCHA staff, and NCHA serves as the host organization.

Beyond the core leadership, clinical leaders from each Spoke participate in building out standardized workflows and quality improvement efforts, communicate processes and expectations to frontline staff as champions. They also provide legal consultation about data privacy needs for the model. More recently, the focus on the leadership structure has shifted to support regional expansion with the following additional leadership positions. A Deputy Executive Officer continues to support and oversee key aspects of the Hub and Spoke, contracts, agreements, and workflow revisions. A Program Manager supports community partnership development, staff, data management, workflows, and outcomes.

And finally, the Addiction Response Team Supervisors, Peer Recovery Supervisor, two Care Coordination Supervisors, and a Team Lead for northeastern Colorado oversee day-to-day efforts, staffing, and communication.

In this section, we have covered how to assess community needs, determine internal capacity, identify key partners and engagement strategies, and consider building a leadership team. Now you are ready to start designing the Hub and Spoke model that is tailored and responsive to your community's needs.

SECTION 4: DESIGNING THE HUB AND SPOKE MODEL

Designing the Hub and Spoke Model Checklist:

- ☑ Identify Hubs
- ☑ Develop Spokes and Referral Pathways
- ☑ Develop Written Agreements
- ☑ Document Processes and Workflows
- ☑ Monitor, Evaluate, and Make Improvements
- ☑ Train Staff

Now that you have gathered your data and identified prioritized community needs, it is time to start designing a Hub and Spoke model. This section will review the milestones for designing your Hub and Spoke model. These steps are not meant to be sequential, and you might start in different places based on the resources available to you. We also recommend starting small by building one connection between two Spokes or a Hub and a Spoke, refining it, and then working on another linkage in a stepwise fashion. The iterative process of the first Hub and Spoke connection will allow you to identify successes and challenges that can inform future growth. If you have the resources to build the entire model, you can use this section to determine the milestones that will create a robust network to meet your community's needs. Your organizational, community, or regional assets should guide you on where to start and how to build on your strengths. As always, the CAM Academy is here to provide consultation and technical assistance as you develop your model.

4.1 Identify Hubs

In this step, you will identify and define your Hub, including the expertise it encompasses, the services it offers, the geographic reach of care, and its staffing model. If the Hub is established in providing addiction medicine, you will work closely with the Hub to determine services, gaps, and referral pathways. If the Hub is newly formed or aspiring to serve as a Hub, it will be essential to assess its current state and identify the necessary interventions needed to serve as a Hub. Hubs should ensure that addiction medicine expertise is extended throughout the entire staff, not just one provider, so that everyone who encounters the patient takes a trauma and addiction-informed approach with every patient. As previously described, Hubs can move beyond the traditional definition of a clinical site with addiction expertise to be a care coordination Hub providing assessment and linking to treatment and care coordination needs. Organizational leadership will need to take an active role to ensure the Hub meets the project goals and serves as a model for the community. Hubs often build the capacity of Spokes to deliver MAT and other care coordination services through training and consultation, thereby expanding the reach of OUD treatment within the system.

The Hub plays a crucial role in medical and behavioral assessment, as well as care coordination with other treatment providers. The Hub may have access to medications for OUD, including naloxone, buprenorphine, and naltrexone, to enable patients and their care team to determine the best-suited medicines for each patient. Or Hubs may work in a system of treatment providers and refer patients to providers based on patient preferences and needs. Additionally, Hubs should strive to provide comprehensive services, including assessments, counseling, and behavioral health therapies. Larimer and Weld County's CO-SLAW model emphasizes the pivotal role of embedded care coordinators, utilizing standardized screening tools as a foundation to develop individualized treatment plans focused on connection and engagement in care. Utilizing an expanded definition, a Hub may be any trusted community agency with the capacity for assessment, treatment, and referral. Examples of Hubs in local Colorado communities include hospitals (such as Lincoln Health in Lincoln), Federally Qualified Health Centers (like Valley-Wide Health in Alamosa), and Behavioral Health Providers (like Health Solutions in Pueblo).

Hubs have connections to other services, including insurance navigation, crisis services, emergency benefits assistance, mutual aid organizations, and other community-based services. In some cases, a robust community-based organization that does not provide direct clinical care may also serve as an alternative Hub for linking individuals to services, including medical treatment. Below are considerations for conceptualizing traditional Hubs or alternative Hubs based on your program's needs and capacity.

Table 6: Hub Considerations

	Traditional Hub	Alternative Hub
Type	Opioid Treatment Program	Behavioral Health Agency FQHC Emergency Department Hospital Community-Based Organization
Services	Methadone dispensing Buprenorphine dispensing Buprenorphine prescription Counseling	Buprenorphine prescription Linkage and transitions of care Additional services based on type: Medical care, Behavioral care, counseling, insurance navigation, housing and financial assistance
Models of Care Coordination	Traditional case manager	Peer case manager Nurse care manager Social worker case manager Medicaid health home

4.2 Develop Spokes and Referral Pathways

To develop Spokes, you can identify existing linkages to care coordination services and review the prioritized community needs to determine what new linkage systems might be required. Spokes may include treatment providers, such as primary care practices and behavioral health providers, as well as non-clinical service providers, including recovery communities, sober living homes, mutual aid organizations, peer counselors, and other social service providers. Consistent evidence across a broad spectrum of medical and behavioral health conditions, from diabetes and hypertension to depression and SUD, has demonstrated the value of care coordination on enrollment into care, treatment engagement, and clinical outcomes.[27] Spokes can be organizations that identify OUD, such as an ED or primary care provider, or organizations that offer additional support services, such as social service providers.

Once you have defined your Spokes, you can determine the specific services offered across the Hub and Spoke model. These referral pathways include the staff who will make referrals by service types, communication between sites (including data sharing agreements), and feedback mechanisms. Hubs can provide ongoing training and support to Spokes to ensure they offer high-quality and coordinated care. As you consider Spokes, you may want to assess Spoke density. For example, if you have Spokes in population-dense areas, it will be necessary to understand capacity. If Spokes are near capacity, increasing Spoke density for similar services may be needed to ensure that Spoke services can be provided to meet the population density.

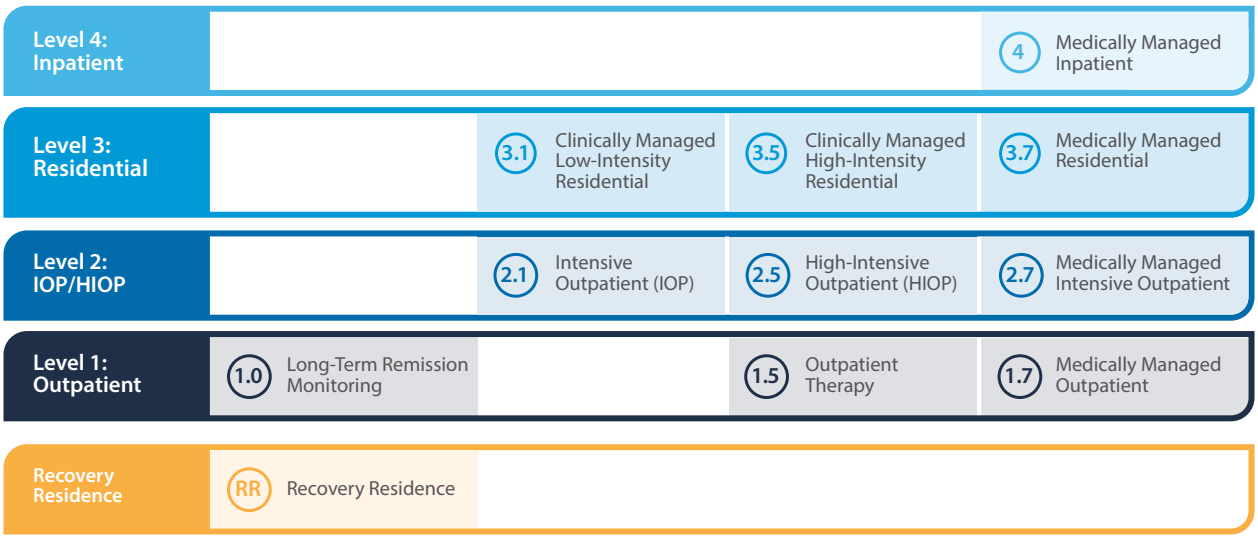
To measure Spoke density, consider the following:

- Number of Spokes per 100,000 population by county or defined region. Calculate by dividing Spokes by county population or region population and multiplying by 100,000.
- Number of Spokes per square mile in the county or region. Calculate by dividing the number of Spokes by the county or region area in square miles and multiplying by 100.

Tip: Consider Telehealth: A note about telehealth providers: expanded telehealth flexibilities during the COVID-19 pandemic provided a natural experiment to study engagement and retention. In one cohort study of Medicaid patients initiating buprenorphine in Kentucky and Ohio, telemedicine initiation was associated with greater odds of 90-day retention compared with in-person care. It was not associated with an increased risk of overdose. In January 2025, the DEA announced three new rules to make the COVID-19 telehealth flexibilities permanent. Telehealth providers may be attractive partners for regions without a local care provider offering medications for opioid use disorder treatment.

The American Society of Addiction Medicine (ASAM) defines treatment for SUDs into four broad levels of care. These levels ensure patients receive the appropriate intensity of services based on their needs. The levels range from early intervention to medically managed intensive inpatient care. Each level is characterized by both the specific services it provides and its staffing model. In Colorado, the Behavioral Health Administration licenses these facilities based on these levels, which provide a framework for defining the levels of care that might be found in your network of Spokes.

Figure 9: ASAM Criteria Continuum



Source: American Society of Addiction Medicine Levels of Care Criteria

4.3 Develop Written Agreements

After determining the organizations that will build a Hub and Spoke model, the next step is to formally clarify the functional aspects and objectives of the partnership. Written agreements, such as a Memorandum of Understanding (MOU), Data Use Agreement (DUA), and Release of Information (ROI), are often necessary to foster mutual alignment, comply with relevant privacy laws, and maintain a trauma-responsive environment for individuals with SUD. Every partnership will have unique facilitators and constraints. For personalized technical assistance or support in determining which agreements would benefit your Hub and Spoke network, please get in touch with CAMAcademy@dhha.org.

Tip: A Note About Privacy: Privacy laws protect patients' sensitive personal and medical information, which can help foster trust between individuals and their healthcare providers. Maintaining confidentiality ensures that patients feel safe in seeking care and disclosing the necessary information for accurate diagnosis and effective treatment. For over 50 years, federal laws have protected the confidentiality of people seeking treatment for SUD. In February of 2024, SAMHSA released a final rule revising the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2 (Part 2). This final rule aims to ensure that individuals seeking SUD treatment are not deterred by fear of stigma or potential negative consequences, such as discrimination or legal repercussions. Part 2 applies to records maintained by programs that provide or assist with SUD treatment, education, prevention, training, rehabilitation, or research, and are federally funded or assisted. Click here to view an example of Denver Health's Release of Information. For more information, please review the Legal Action Center's 42 CFR Part 2 fundamentals resource.

To formalize a Hub and Spoke partnership through an agreement, organizations should engage in the following steps:

- Identify the purpose and scope of the collaboration.
- Determine what agreements are necessary based on the shared work, organizational requirements, and other considerations (MOU, DUA, ROI).
- Draft documents that describe roles and responsibilities.
- Review, finalize, and sign.
- Implement and monitor.

This toolkit will explore each of these steps in further detail.

Identify the Purpose and Scope of the Collaboration: To determine the scope of a collaboration, organizations should ask questions that clarify goals, roles, resources, limitations, and expectations. As we discussed earlier, we suggest starting small with one connection between Spokes or a Hub and a Spoke initially. This will help you learn what formal agreements are needed. To help get the conversation started, here are some key areas that should be explored:

- **Goals and Purpose:** What are we trying to achieve together? How does this collaboration align with each organization's mission and priorities? Who are the communities we aim to serve?
- **Roles and Responsibilities:** What specific roles will each partner play? Who will be responsible for leadership, coordination, and decision-making? How will accountability be ensured across organizations?

- **Activities and Services:** What services will be included in the collaboration? How are we delivering services (i.e., integrating care, conducting outreach, or referring between organizations)? Who will be eligible?
- **Timeline and Duration:** Is it a short-term project, a pilot program, or a long-term partnership? What key milestones or deadlines should we establish?
- **Data Sharing and Confidentiality:** What patient data will be shared? What data privacy standards apply to us? What agreements will be needed (MOU, DUA, ROI; see below for more details)?
- **Funding and Resources:** What financial, human, or material resources will each organization contribute? Are we seeking grants together?
- **Communication and Decision Making:** How will we communicate and share updates? Who are the main points of contact? What is our process for making joint decisions?
- **Evaluation and Outcomes:** How will we measure success? What data will be tracked and by whom? How will we report outcomes?

Determine what Agreements are Necessary: A foundational agreement is often an MOU, which is a formal, legally binding agreement that outlines the roles, responsibilities, and expectations of each participating organization. An MOU will help ensure there is mutual understanding and strategic alignment in how patients will be referred, treated, and monitored across the network. MOUs can also clarify communication protocols, data sharing practices, and compliance with privacy regulations. They are essential tools in building trust and transparency, ensuring that all partners contribute to a unified vision for patient outcomes.

Tip: Memorandums of Understanding (MOU): An MOU can be a powerful tool for supporting trauma-informed care. Individuals with SUD can have complex histories of trauma, and fragmented or inconsistent care can lead to feelings of disempowerment or vulnerability. By outlining clear referral protocols—such as sharing substance use histories or ASAM levels—MOUs reduce the need for patients to retell their stories repeatedly. This can help minimize the risk of re-traumatization and ensure that organizations maintain a commitment to patient-centered care.

For some partnerships, a DUA may also be necessary, particularly if organizations will be sharing patient-level data rather than aggregate data. A DUA might be for a single project, or a master DUA can be utilized for ongoing data partnerships in a system of care. DUAs will detail how data will be shared, protected, and utilized between parties. An MOU and a DUA are often complementary; MOUs establish the framework for the partnership, and DUAs cover specifics of data exchange. For partnerships where Part 2 Privacy Laws apply, a release of information will also be required. CFR42 Part 2 requires written patient consent for disclosures, and the consent form must be specific about the information being shared and with whom it is being shared.

Table 7: Key Differences Between an MOU and DUA

	MOU	DUA
Purpose	MOUs are agreements between two or more entities who intend to collaborate on activities.	A DUA is a contract between the entity that owns access to a data source, typically a dataset or database, and a secondary entity that will receive the data, or a subset of it, for reuse.
Scope	MOUs establish a framework for collaboration, which can include outlining the objectives, scope, and responsibilities of each party.	DUAs inform data users of their limitations on uses and disclosures, and obligations to safeguard the data as required by law, policy, or practice.
Content Examples	• Purpose and objectives of partnership • Roles and responsibilities • Scope of work • Communication guidelines • Duration and termination guidelines	• Restricting access to the shared data • Requiring that any research dissemination include citation of the data and its originating entity • Requiring that data files are destroyed at the completion of research period • Restrictions on data use for commercial purposes
Similar Alternative Agreements to Consider	• Memorandum of Commitment • Care Compact	• Business Use Agreement • Business Associate Agreement

Draft Your Documents: When drafting your documents, we recommend that legal counsel from both organizations be involved to ensure compliance with HIPAA, state-specific healthcare laws, and organizational policies. Documents should clearly outline the expectations of each partner and provide details on what information will be shared, how it will be shared, the frequency of sharing, accountability measures, and communication expectations. If you are focusing on one connection in your network, **a standard template** can be customized for your partnership.

If you are designing a network or if a network is your goal, consider creating a universal umbrella or master agreement that is general enough to cover multiple efforts; this will eliminate the need to create a unique agreement for each project or iteration. This can include a universal network MOU, DUA, etc. Within this type of system, it is also a best

practice to establish a **network ROI,** rather than a separate ROI for each agency. NCHA established a **Care Compact** where multiple agencies coordinated to reduce organizational and patient administrative burden.

We recommend that drafted documents also include what personal health information (PHI) will be shared in a referral between sites. To facilitate a trauma-responsive process for patients, referrals should consist of (at a minimum):

- Patient's name
- Patient's date of birth
- Patient's contact information
- Referral to the location
- Referral from the location
- Date of referral

A best practice is to include referral elements beyond the basic information listed above. In addition to the demographic information, consider building into your referral process the following questions:

- Primary SUD
- Secondary SUD (if applicable)
- Confirmation that the patient's phone number was confirmed or updated
- Whether the patient was inducted (i.e., started medications for a SUD)
- Pregnancy status
- Whether the patient has mental health comorbidities
- Patient's preferred treatment location

Linkage and retention data should be considered when building agreements across organizations. In creating a data agreement, we recommend including the following linkage and retention data elements in what is shared:

- **Linkage data**: Indicate whether the patient appeared for the referral and which services were provided. At a minimum, this can be a yes/no question on whether the patient was successfully linked to care.
- **Outreach data:** If a patient doesn't initially link to care, organizations should share outreach efforts that occur and outcomes of those efforts.
- **Retention data:** Consider sharing the duration of patient retention in programming and whether the patient has been lost to care. Although this can be challenging to track, it enables potential collaboration in outreach efforts. Suggested time frames are 30, 90, and/or 365 days. Retention rates can show whether treatment programs are meeting the needs of patients, identify when and why people fall out of care, and reveal disparities or structural barriers that affect different populations. As organizations seek funding opportunities, retention data can also help demonstrate a program's performance and sustainability. For many grants, it is a required metric.

Review, Finalize, and Sign: In addition to legal counsel and compliance review, it's also important to share the documents with internal partners whose collaboration will be impacted. This may include program managers, clinicians, administrative staff, or IT teams, depending on the nature of the agreement. All partners should agree on final revisions and confirm that the expectations and new processes are realistic and aligned. To ensure it remains a living document, partners should establish a process for reviewing and updating the MOU on an annual basis or as circumstances evolve.

Implement and Monitor: Organizations must implement and monitor any agreements that they have established. Each organization should designate a lead contact or liaison to coordinate communication, address issues, and track progress. The agreements should be shared with any relevant staff so that they understand their roles, responsibilities, and ways to collaborate with the partnering agency. This might include time to provide training orientation if the partnership introduces a new workflow, referral pathway, or data practice. Schedule regular and ongoing partner meetings – initially monthly at the start of the partnership, then quarterly once the partnership is well-established – to review progress, discuss challenges, and adjust agreements as needed. Partnerships should use performance metrics when meeting to assess if the collaboration is meeting its goals. Share stories or outcome data that show the value of the partnership, as recognizing success will build trust and momentum.

Document Workflows and Processes

Workflows standardize how care is delivered across systems by creating structure, consistency, and accountability in patient interactions and treatment processes. A workflow defines how patients move between programs or organizations. Within the Hub and Spoke model, it visually documents the steps staff must follow when identifying, assessing, referring, and following up with individuals affected by SUD. Workflows help ensure consistency in care by reducing variability, eliminating guesswork, and incorporating essential steps—such as obtaining consent or completing documentation—into every patient encounter. For example, a workflow might guide healthcare staff in emergency departments on how to connect patients to SUD services by evaluating key considerations such as whether the patient is actively in withdrawal, requires medical admission, or has other factors affecting their care. Denver Health's Center for Addiction Medicine's ED workflow can be **found here**.

Workflows often exist alongside policies and protocols:

- Policies establish clear expectations that guide staff behavior, ensure legal and ethical compliance, and promote equitable, patient-centered care. They may be developed at the organizational or program level and are designed to protect both patients and providers. By addressing issues such as stigma, confidentiality, and privacy, policies help create a safe and supportive environment for individuals seeking treatment. For instance, a policy might require that all patients identified as needing SUD treatment be offered a referral within 48 hours of assessment.

- Protocols support clinical and operational decision-making by providing evidence-based, detailed instructions on how specific treatments or interventions should be delivered. Usually developed at the program level, protocols promote consistency in care quality and outcomes. A typical example would be a protocol requiring that patients experiencing opioid withdrawal be assessed for immediate access to MAT, ensuring timely and appropriate care.

Workflows, policies, and protocols can exist independently or be combined into one document. We have included two examples for your reference from Denver Health Center for Addiction Medicine: ED to Outpatient Behavioral Health Services (link on page 37) and **Outpatient Behavioral Health Services to Community Health Services**. The Colorado Consortium for Prescription Drug Use has developed the **Withdrawal Management Pathways** that exemplify workflows based on substance type. Finally, **NCHA has this clinical pathway and workflow** for MAT in the Larimer County Jail.

To create an effective workflow, it's important to understand who will be involved in the process and how information, responsibilities, and decisions move between the Hubs and Spokes. To design an effective workflow, we recommend that you include the following activities in your approach:

- Identify key participants.
- Map the current process and the ideal state.
- Create a visual representation.
- Pilot the workflow.

The participants in the workflow process might be different from the partners who were involved in conversations about establishing partnerships or the partners involved in data agreements. Creating a workflow will require input from a well-rounded team. It will be important to have a diversity of perspectives in the room, as leaders with decision-making power might not fully understand a process, including its barriers, the ways that frontline staff members do. The team should include members involved in all steps of the process to ensure that every step is accurately represented. Because of the nature of the Hub and Spoke model, it is also recommended to have someone involved who can bring a regulatory perspective.

Tip: Workflow Perspectives: When assembling your workflow team, consider how to include the perspective of a peer support specialist, patient, or family member with lived expertise. This can help ensure your model remains patient-centered, accessible, and trauma-responsive.

Table 8: Staff Roles to Consider when Creating Workflows

Category	Examples of roles:	Perspective they can bring:
Healthcare Providers	• Primary Care Providers • Addiction Medicine specialists • Behavioral Health Clinicians • Nurse and Care Coordinators	• Delivery of treatment and follow-up • Whole-person care • Treatment adherence
Healthcare Administrative Staff	• Practice/Clinic Manager • Patient Access Specialist (e.g., registration, scheduling) • Medical Billing and Coding Specialist	• Resource allocation • Staffing • Patient experience
Community Based Organizations (CBOs)	• Harm Reduction Specialists • Peer Recovery Coaches • Peer Support Specialists	• Lived expertise • Patient experience • Social determinants of health
Policy Makers and Regulators	• ROAC leaders • Behavioral Health Administration or Regulators	• Policy • Reduction of barriers • Compliance • Data support • Funding guidance • Coordination

Process Mapping:

Process mapping is a technique to illustrate how a process functions from start to finish visually. The goal in creating a process map is to have a comprehensive document that shows who does what (roles/responsibilities), when (steps), and how they do it (supporting resources). Process maps can help clarify roles, expedite clinical decisions, build contingency plans, and turn big ideas, like creating a Hub and Spoke model, into actionable steps.

To begin developing your process map, you'll first need to determine whether an existing process can be adapted to fit your Hub and Spoke model or if a new process must be created. If a process is in place, mapping it allows you to identify which elements can be modified or expanded to move your workflow from the current state to a future, ideal state. If no process exists, process mapping is still possible—it will simply require more emphasis on design and definitions rather than documentation. In this case, you'll focus on outlining your ideal workflow based on *anticipated* needs, rather than using current state data to make improvements.

In either case, start by having your team members write down every step in the process; the focus at this point is not on the order, but ensuring that every step is represented. A well-constructed process map will contain the following elements:

Tip: Process Mapping: Use sticky notes to create your process map. Sticky notes allow you to write down every activity in the process (one idea per sticky note) and move them around as needed when finalizing the order.

- **A "Start" and "End" to the Process:** Establishing a clear starting point helps scope the process and ensures that everyone understands when and how the workflow is initiated. An endpoint provides clarity on the desired outcome and signals when the process is considered complete. Clearly defining the boundaries of the process will help prevent confusion, duplication of responsibilities, and gaps in responsibilities.
- **All Process Steps:** When creating a **current state** process map, try to document all the steps that occur between the defined start and end points, precisely as they happen in practice. This includes capturing every action, decision point, and patient handoff, even if some steps are inefficient, redundant, or not in an ideal sequence. This level of detail provides a clear foundation for identifying areas for improvement and designing a more effective future state workflow. **If no current process exists**, the approach shifts from documentation to design. In this case, you'll build a draft process map based on anticipated needs, best practices, and input from key partners. Start by defining the desired outcome, then work backward to identify the steps. Engaging front-line staff and end users in this design phase is critical to ensure the new process is realistic and efficient.
- **Roles and Responsibilities:** A process map should clearly outline the roles and responsibilities associated with each step in the workflow. Identifying who is accountable for specific actions ensures clarity, reduces confusion, and supports smooth handoffs throughout the process. It's important to use general role titles—such as "Care Coordinator" or "Charge Nurse"—rather than individual names. This approach promotes sustainability and adaptability, allowing the process to remain relevant even as staffing changes occur.

In addition to the elements above, process maps can also incorporate organizational policies and protocols. While these are optional additions, having them in one document can streamline decision-making and expectations for staff.

Case Study: Denver Health and UCHealth Emergency Departments: EDs are often the first and only contacts with the medical system for underserved populations and, therefore, represent a vital setting to deploy evidence-based MOUD interventions and provide an "on demand" access point for underserved patients seeking help. Initiating MOUD before ED discharge or providing a prescription for the medication increases engagement in addiction treatment and significantly improves patient outcomes.

Both Denver Health and University of Colorado Hospital EDs provide 24/7/365 support to patients with OUD in withdrawal who want to initiate MOUD and link to next day ongoing care.

Denver Health's MED ED MOUD Initiation Workflow Diagram shows an example of a workflow that incorporates protocols for various medications and specialty populations (i.e. pregnant patients) within the unique ED Spoke setting.

The UCH ED has over 15 community opioid treatment program partners who receive patient referrals for follow-up care. Patients who are inducted on MOUD in Denver Health's ED are prioritized for next-day care at Denver Health's Outpatient Behavioral Health Services (OBHS); however, patients can choose to link to whichever outpatient treatment facility of their choice.

In 2024 alone, the UCH ED identified 2,910 patients with at least one risk factor for OUD, engaged 490 patients in OUD treatment with linkage to outpatient community partners, and provided naloxone to 3,464 people. Similarly, Denver Health's ED identified 1,643 patients with OUD, inducted 474 patients on MOUD treatment, successfully linked 167 patients to Denver Health outpatient treatment, and provided 1,202 patients with naloxone.

Create a Visual Representation:

With all actions and decisions arranged in a draft sequence, the next step is to turn the notes into an electronic document; we recommend using either a flowchart or standard work.

Tip: Document Your Workflow: Before transcribing notes into a digital format, take a photograph of the workflow to document its initial structure. Then, determine what software will be used to create a final flowchart. Some programs, like Microsoft Visio, are designed explicitly for diagramming. If Visio is not an option, other programs, such as PowerPoint or even Google Slides, can also be used.

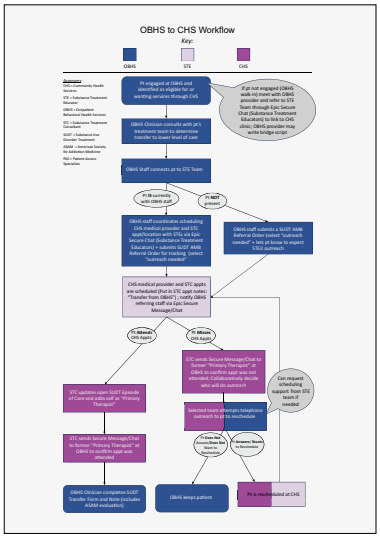
In a formal process map, different shapes represent different types of steps. For example, rectangles are used for process steps, and diamonds are used for decision points. See Figure 10 for a guide to the most used shapes. Each step of the process should be mapped using the appropriate shape and placed in sequence to display a logical flow. Arrows should be used between each shape to highlight the flow of the process, including any loops, branching decisions, or parallel paths.

Figure 10: Flowchart Symbols

Symbol	Name	Function
	Start/end	An oval represents a start or end point
	Arrows	A line is a connector that shows relationships between the representative shapes
	Process	A rectangle represents a process
	Decision	A diamond indicates a decision

Credits: smartdraw

Figure 11: Sample



Click here to view the full-size version of this Denver Health workflow

Processes can also be documented through standard work. Standard work is a core concept in quality improvement, referring to the most efficient and safest way to complete a task. As a comprehensive document, standard work outlines every step in a process to make the process precise and repeatable with no variability. Review your documents to check that there are no disconnected steps and that all decision branches have an endpoint. The participants who provided input on the initial design should also review the documents for accuracy.

Pilot the Workflow:

Piloting ensures a real-world application to reveal gaps, inefficiencies, or points of confusion that were not anticipated in the brainstorming stage. Because of these unforeseen gaps, piloting the workflow is an essential step before fully launching a new process. By piloting the workflow, partners can test the process in a controlled environment to identify and correct any issues early. This will help reduce the risk of errors or rework. Team members can offer practical insights based on their experiences that may not have been considered during the initial design. This feedback can lead to refinements in the flowchart, making it more intuitive and user-friendly, which in turn improves compliance and overall effectiveness.

In some instances, piloting allows an organization to bring in a patient's perspective on the new process. While there might be organizational requirements or regulatory steps that cannot be changed in a workflow, some process steps, such as when an intake is completed, e.g., at the patient's bedside or via telehealth after release, can be qualitatively evaluated. This qualitative analysis can help ensure that the process is sensitive to the needs and experiences of patients with OUD, supporting trauma-informed care. Best practices for incorporating a patient's perspective include having responses be anonymous or confidential, utilizing a consent form, offering incentives, and using an Institutional Review Board if the focus of feedback is research instead of quality improvement.

Case Study: Using Patient Feedback to Inform a Workflow Between Denver Health and Sobriety House

Sobriety House is a state-licensed substance use treatment center that offers Intensive Residential Treatment (IRT) for SUD. Denver Health partnered with Sobriety House for a pilot collaboration aimed at improving the quality of Denver's MAT system of care for community members with OUD and deep tissue infections by integrating medical support into IRT. This project integrated medical support for People Who Inject Drugs with OUD who require extended parenteral antibiotic therapy with intensive residential substance use disorder treatment. All patients enrolled in the program were eligible for a qualitative interview where they could share their satisfaction with the partnership. An example of the qualitative customer satisfaction interview is available here.

4.4 Monitor, Evaluate, and Continuous Improvement

Medical providers, including health systems and public health departments, often struggle with selecting relevant data and performance metrics to measure success. Systems, including payers and governmental entities, may take the "more is better" approach, requesting excessive data reporting that adds little value or influence on treatment and funding decisions. Communities building Hub and Spoke models should select a limited number of leading and lagging indicators based on their goals. Engaging project partners, champions, and the Hub and Spoke sites during this process will ensure you set realistic and valuable measures.

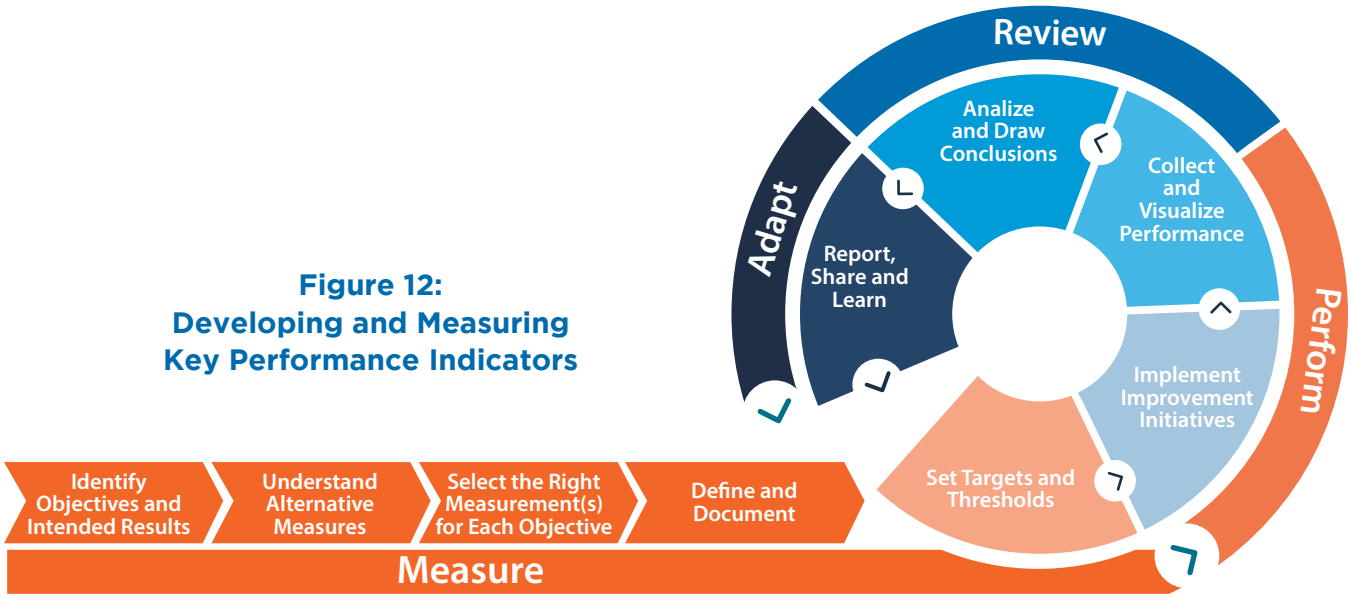
Establishing key performance indicators will help track the model's effectiveness and identify areas for continuous improvement. Key performance indicators (KPIs) are quantifiable measures of progress toward project goals, providing focus for strategic and operational improvement, creating an analytical basis for key decision-making, and helping to direct attention and resources toward what matters most. When using KPIs, targets (the desired level of performance) are used to track progress against the target.

Table 9: Types of KPIs

Leading indicators	Predict future performance. Help anticipate trends and potential barriers.
Lagging indicators	Reflect past outcomes and results. Confirm trends.

Programs should focus on five to seven key measures to determine the success of your project. Other measures that may not be ranked in the top five to seven can become outcome metrics, which we will discuss later in this section. The Balanced Scorecard Institute's Measure-Perform-Review-Adapt framework is a practical and evidence-based approach for developing and implementing KPI's. The graphic below summarizes the process of developing measures, measuring performance, identifying improvements, reviewing data, and adapting the model as needed.

Figure 12:
Developing and Measuring Key Performance Indicators



Source: Harlow, J. (2022, June 22). *How to Develop KPIs/Performance Measures.*

Once you have identified your KPIs, determine the frequency at which you report these measures to your partners and staff. Creating meaningful visuals enables deeper interpretation for enhanced decision making. Visualizing performance over time will also reveal any trends. Regional dashboards that provide timely reporting on actionable and local measures can be of significant assistance to regions building Hub and Spoke models. Examples of metrics tracked by the Washington State Hub and Spoke model[28] include MOUD type, treatment setting, and Hub type at the initial Hub/Spoke visit, number of outpatient services in their first enrollment month, and six-month outcomes, including MOUD continuity, ED utilization, hospitalization, and intensive SUD treatment. However, given the technical capacity needed and the expense of developing and maintaining

dashboards, consider tracking a limited number of the most relevant and locally reported metrics. For example, the agencies may initially report de-identified or aggregate data on referrals initiated and completed between partner agencies.

Implementing a robust quality improvement structure is crucial to sustainability. Beyond individual agency efforts, quality improvement initiatives might involve all partners, including treatment providers and patients, to maintain and improve the care continuum. Quality improvement can be achieved through adding capacity to an existing service, introducing new services, or enhancing service delivery. Partner meetings should include a review of data, identification of improvement priorities based on positive impact and harm avoidance, and implementation of strategies based on the Plan-Do-Study-Act (PDSA) framework.

Tip: Recovery Ecosystem Map: A wealth of publicly available county-level data is also available to the public to help assist reporting and to identify trends and correlations. For example, the Recovery Ecosystem Index Map produced by NORC at the University of Chicago, provides county-level data for years 2022-2024 on the "recovery ecosystem" that include locations of substance use disorder treatment facilities and proximity to medications for opioid use disorder, drug overdose and mortality data, sociodemographic, economic, and housing data. This map provides county ratings for substance use disorder treatment and the continuum of substance use disorder support, with comparisons to overall state and national data.

Case Study: CO-SLAW Outcome Metrics:
The NCHA Addiction Recovery Team's COSLAW project illustrates this in their choice of a specific and measurable 5-year primary project goal to increase MAT provision to 600 individuals with opioid use disorder. Lagging outcome metrics included increasing capacity, collaboration, and communication, supporting this lagging outcome measure. Process leading metrics included establishing a regional MAT care coordination center of excellence. Important secondary goals for the project include decreasing mental health symptoms and substance use, increasing employment and housing, and creating a perception of helpful and professional care coordinator staff among patients. Process goals included staff hiring and training milestones, community outreach and education, and the measurement of referrals to behavioral healthcare support these secondary goals.

In addition to KPIs, process and outcome measures related to your project's evolution will help monitor key aspects of implementation. Often, the overarching goals of Hub and Spoke models are to decrease the harms related to substance use, which may include fatal and non-fatal overdoses, hospitalizations, and ED visits, criminal justice involvement, and homelessness. Process measures help to clarify approaches and reduce variability in service implementation and delivery. For an example of outcome metrics for the OUD continuum of care, see **this example from Denver Health's CAM.**

Table 10: Types of Measures

Process measures	Specific steps taken in a process that led to a particular outcome metric. Focus on steps, activities, or procedures within a process. Process measures help ensure the program is being implemented correctly.
Process measure examples	# of partners meetings, # of standardized trainings, # specialized trainings, # of Hubs, # of Spokes, # and type of referral pathways, # of DUA's, # MOU's, # and type of staff in model
Outcome measures	High level outcome. Measure the results or impact of a program on the intended target. They determine whether the program met its goals.
Outcome measure examples	# of new patients screened, # of positive screens for OUD, # of patients on MOUD, # and type of referrals, #/% of referrals that linked to care, #/% of patients linked to care that were retained or completing MOUD, # of ED discharges, # of days between diagnosis and starting treatment

For a deeper dive into metrics for consideration, the Johns Hopkins Bloomberg School of Public Health maintains a database of indicators for monitoring opioid litigation spending. The **Opioid Settlement Principles Resource and Indicators** spreadsheet includes over 100 measures that support the nine core abatement strategies. Each metric is linked to a key performance question and data logic that can help ground clinical reasoning and is identified along the opioid overdose prevention continuum (primary prevention, harm reduction, treatment, recovery).

Table 11: Representative Metrics for Hub and Spoke Model Consideration

Metric	Opioid Abatement Strategy Targeted
Proportion of people who remained engaged in buprenorphine treatment for a 6-month (180 day) time period	Increase MOUD use, fund warm handoff programs and recovery services
Number of adolescents and adults who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-treatment within 14 days of diagnosis	Increase MOUD use, fund warm handoff programs and recovery services
Number peer support/peer navigators employed by an organization or department	Treatment & support during pregnancy and post-partum, fund warm handoff programs and recovery services
Number of people with opioid use disorder who received buprenorphine or methadone treatment within 14 days following release from a jail or prison	Increase MOUD use, fund warm handoff programs and recovery services, improve care for OUD in criminal justice system
Number of families who receive specific social supports, which could include case management, childcare, transportation, employment assistance, family housing and family-centered treatment, support groups, referral services, and peer counselors	Treatment & support during pregnancy and post-partum, expand services for neonatal abstinence withdrawal syndrome, fund warm handoff programs and recovery services, enrich prevention strategies

Train Staff

Comprehensive training will be necessary to ensure that all staff understand their roles, the Hub and Spoke model's goals, referral pathways, evaluation, and monitoring processes, and feel confident in addressing any challenges that may arise. Standardized training can be used to ensure that all staff receive a consistent message about project goals, scope, and the model. These trainings should also include information on referral pathways so that all staff understand the structure, services, and staffing of the Hub and Spoke model. Finally, standardized training should encompass all program metrics, ensuring that all staff understand what the project is measuring and what the targets are.

Tip: Broaden Standardized Training: Standardized training may include de-escalation techniques, pathways to recovery, various treatment modalities, trauma responsive care, motivational interviewing, and shared decision-making processes.

Then, specialized training based on staff role or organization type (Hub or Spoke) will be needed to ensure staff understand their responsibilities, how to escalate patient needs, and the data that they are responsible for monitoring. Specialized training will also review protocols and policies around services in which staff are involved. For example, social workers or care coordinators will need different training than clinical prescribers based on the type of care they provide.

As the training is initially rolled out, identify how new staff will continue to be trained. Will standardized and specialized training content be a part of new employee orientation or included in job descriptions? How will ongoing training be provided, such as monthly in-services or annual training? Training could be delivered as sessions within existing meetings or more formally by bringing all staff together and closing the organization for a few hours. For ongoing training, determine how to assess training needs across sites, which may consist of topics to refine skills through case studies or address new issues based on emerging needs. For staff who will pursue additional credentials on the job, such as peer support specialists, certified addiction counselors, or technicians, consider how they will complete the required training and certification requirements during work hours. Carve out time for completion of training and to gain the supervised hours required.

SECTION 5: FOUNDATIONAL CONCEPTS IN OPIOID USE DISORDER TREATMENT AND CARE

This section covers foundational concepts to consider throughout all stages of implementing a Hub and Spoke model. This section will include language considerations and guidance on incorporating harm reduction principles throughout the model.

5.1 Words Matter: Reducing Stigma Through Language

Language shapes how we think, how we treat others, and how systems respond to people. In the context of Hub and Spoke design, where care is coordinated across jails, community partners, providers, and peer networks, language plays a significant role in shaping these systems. Language can be used to build trust, reduce stigma, and enhance engagement across every point of care.

Stigmatizing language—like "addict" or "abuser"—can reinforce negative stereotypes and discourage people from seeking treatment. For individuals navigating criminal-legal systems or receiving care in correctional or clinical settings, language that blames or dehumanizes can be especially harmful. It can contribute to shame, mistrust, and disengagement from services.

Person-first language promotes dignity, hope, and connection. Saying "person with opioid use disorder" rather than "addict" signals that OUD is a treatable health condition and not a moral failure. When we shift the way we talk about substance use, we also shift how systems treat people.

Language in Action

At Denver Health's Center for Addiction Medicine, we launched a campaign called Words Matter to support internal culture change around language and stigma. We created a guide with preferred terms, held team presentations featuring real stories from individuals with lived expertise, and invited staff to commit to inclusive language through a pledge. We also utilized data tools to measure the shift in language in clinical notes and communications after the campaign.

Table 12: Denver Health's Words Matter Guide (Simplified)

Use This...	Instead of This...	Why It Matters
Substance Use Disorder (SUD)	Drug abuse, drug problem, drug habit,	Medicalizes the condition and removes blame.
Has an (X) use disorder	Addicted to (X)	Person-first language
Person with Opioid Use Disorder (OUD)	Addict, junkie, druggie, abuser	Person-first language
Testing negative for (X) Testing positive for (X)	Clean drug screen Dirty drug screen	Neutral and objective; avoids shaming terms and terms that are associated with a person's cleanliness.
Substance-free Abstinent from (X)	Clean, clean from (X)	Neutral and objective language. See above recommendation to avoid "clean".

Consider how language shows up:

- How do staff talk about patients?
- What words appear in documentation or case notes?
- Are all partners aligned in using non-stigmatizing, person-first language?

Taking small, intentional steps—such as adopting a shared language guide or training staff on stigma-reducing communication—can help build more welcoming, trauma-responsive systems. To learn more about Denver Health's campaign and access the Words Matter Language Guide and use it as a reference or training tool, please visit Denver Health's **Words Matter** website.

5.2. Opioid Use Disorder Treatment Options

This section is not intended to offer clinical guidance on prescribing or diagnosis. Instead, its goal is to expand readers' understanding of what *Medication for Opioid Use Disorder (MOUD)* is, and how treatment options can shape a Hub and Spoke model. A key takeaway from Colorado's CO-MAT efforts is that methadone clinics alone do not define a "Hub." Flexibility and adaptability is critical.

Table 13: Overview of MOUD Options[29]

Medication	How It Works	Who Can Provide It	Where It's Offered	How It's Administered
Methadone[30]	Full opioid agonist prevents symptoms of withdrawal and reduces cravings.	SAMHSA-certified opioid treatment programs (OTPs) only.	Specialized clinics (often Hubs), mobile OTP units	Oral tablet or liquid, administered daily under supervision at an OTP. Take-home doses are allowed gradually based on clinical stability and federal/state regulations.
Buprenorphine[31] (Suboxone, Subutex, Sublocade, etc.)	Partial agonist lowers the risk of use and overdose.	Any clinical prescriber with a DEA registration. Can also be administered at SAMHSA-certified OTPs.	Primary care, SUD clinics, jail clinics, telehealth	Sublingual film or tablet (daily); buprenorphine extended release injection
Naltrexone[32] (oral or extended-release injectable as Vivitrol)	Opioid antagonist blocks opioid effects. Also used to treat Alcohol Use Disorder (AUD).	All licensed clinical prescribers (MD, PA, NP, etc.)	Primary care, outpatient treatment centers, jails	Oral tablet (naltrexone oral, daily); monthly intramuscular injection (naltrexone extended release injection Vivitrol)

5.3 Naloxone, Overdose Prevention, and the Role of Harm Reduction

Opioid overdose is preventable, and in any Hub and Spoke model, overdose prevention must be a core component of care. Whether you're operating in a jail, clinic, or community-based setting, strategies like naloxone distribution, staff training, and harm reduction partnerships are essential for saving lives and keeping people engaged in care.

Naloxone: The First Line of Defense

Naloxone (commonly known by the brand name Narcan) is a fast-acting medication that reverses opioid overdose. It is safe, easy to administer, and has no potential for misuse (National Institute on Drug Abuse, 2022).[33] With the recent FDA approval of over-the-counter Narcan nasal spray, it's more accessible than ever, but availability alone isn't enough. Jails, treatment programs, and community partners must actively distribute naloxone, train staff and participants on how to use it, and integrate overdose response planning into their workflows.

Harm Reduction: Principles and Practice in Overdose Prevention

Harm reduction is more than a strategy—it's a philosophy of care rooted in dignity, compassion, and pragmatism. SAMHSA emphasizes that rather than requiring abstinence as a precondition for support, harm reduction meets people where they are, recognizing that small changes can be the first step toward greater health and stability. To read about Colorado's public health harm reduction legislation, click here.

Principles of Harm Reduction: Hawk et. al (2017) outline six core principles of harm reduction to guide providers in delivering compassionate, patient-centered care.[34]

- Humanism: Every person deserves respect, regardless of their stage in the recovery journey. Harm reduction starts from a place of nonjudgment and empathy.
- Pragmatism: Substance use exists; harm reduction accepts this reality and focuses on reducing associated risks rather than ignoring or condemning the behavior.
- Autonomy: People who use substances are the experts in their own lives. Harm reduction supports informed choice and self-determination.
- Incrementalism: Any positive change—such as safer use, fewer overdoses, or simply utilizing a syringe exchange—is progress.
- Empowerment: Harm reduction builds on individuals' strengths and emphasizes their right to health and well-being.

Harm Reduction in Action: When these principles are put into practice, they translate into concrete, life-saving interventions:[30]

- Naloxone distribution through community outreach, vending machines, and transitional housing ensures overdose reversal medication is accessible where and when it's needed most.
- Peer-led engagement builds trust by leveraging the lived expertise of people who have used substances and navigated recovery. Peer support specialists often serve as a bridge between harm reduction and formal treatment systems.
- Fentanyl test strips and other drug-checking tools provide people with vital information about their substances, helping them make safer decisions.
- Syringe access programs prevent the transmission of infectious diseases like HIV and Hepatitis C and serve as an entry point to other services.
- Harm reduction kits may include sterile syringes, safer smoking supplies, fentanyl test strips, naloxone, wound care items, condoms, and educational materials. These kits reduce risk and open the door to conversations about treatment and health.

Why This Matters in Hub and Spoke Models: Incorporating harm reduction into your network improves health outcomes without requiring readiness for treatment as a prerequisite. These approaches:

- Reduce fatal and nonfatal overdoses
- Decrease disease transmission
- Increase treatment referrals and retention
- Promote equity and culturally responsive care
- Foster safety and engagement within justice-involved and marginalized communities

By integrating harm reduction principles and services (including harm reduction kits, peer support, and low-barrier naloxone access) into your Hub and Spoke model, you're creating a trauma-responsive and patient-centered system that strengthens individual and *community* health.

SECTION 6: CONCLUSION

Thank you for taking the time to engage with this toolkit and for your ongoing dedication to supporting individuals, families, and communities affected by OUD. Implementing a Hub and Spoke model is not a small task—it requires vision, collaboration, and the willingness to challenge traditional systems of care to build something more responsive, connected, and sustainable. Whether you are just beginning this work or refining an existing model, your commitment to improving outcomes through coordinated, person-centered care is both needed and commendable.

Change doesn't happen overnight, and challenges will inevitably arise. But know that your work matters. Every step you take to enhance coordination, reduce gaps, and center the voices of those most impacted brings us closer to a system that truly supports recovery and well-being. We encourage you to continue learning, adapting, and leading in this field, as we will.

We hope this toolkit has provided practical insights, usable tools, and a solid foundation for planning, partnership building, and implementation. While every community and organization will have unique needs, the principles outlined here can guide efforts across a wide range of settings. If you would like technical assistance as you embark on this journey, the CAM Academy is here to support. Please get in touch with us at CAMAcademy@dhha.org.

Thank you again for your time, energy, and dedication. Together, we can build systems of care that treat OUD and holistically support individuals on their path to recovery.

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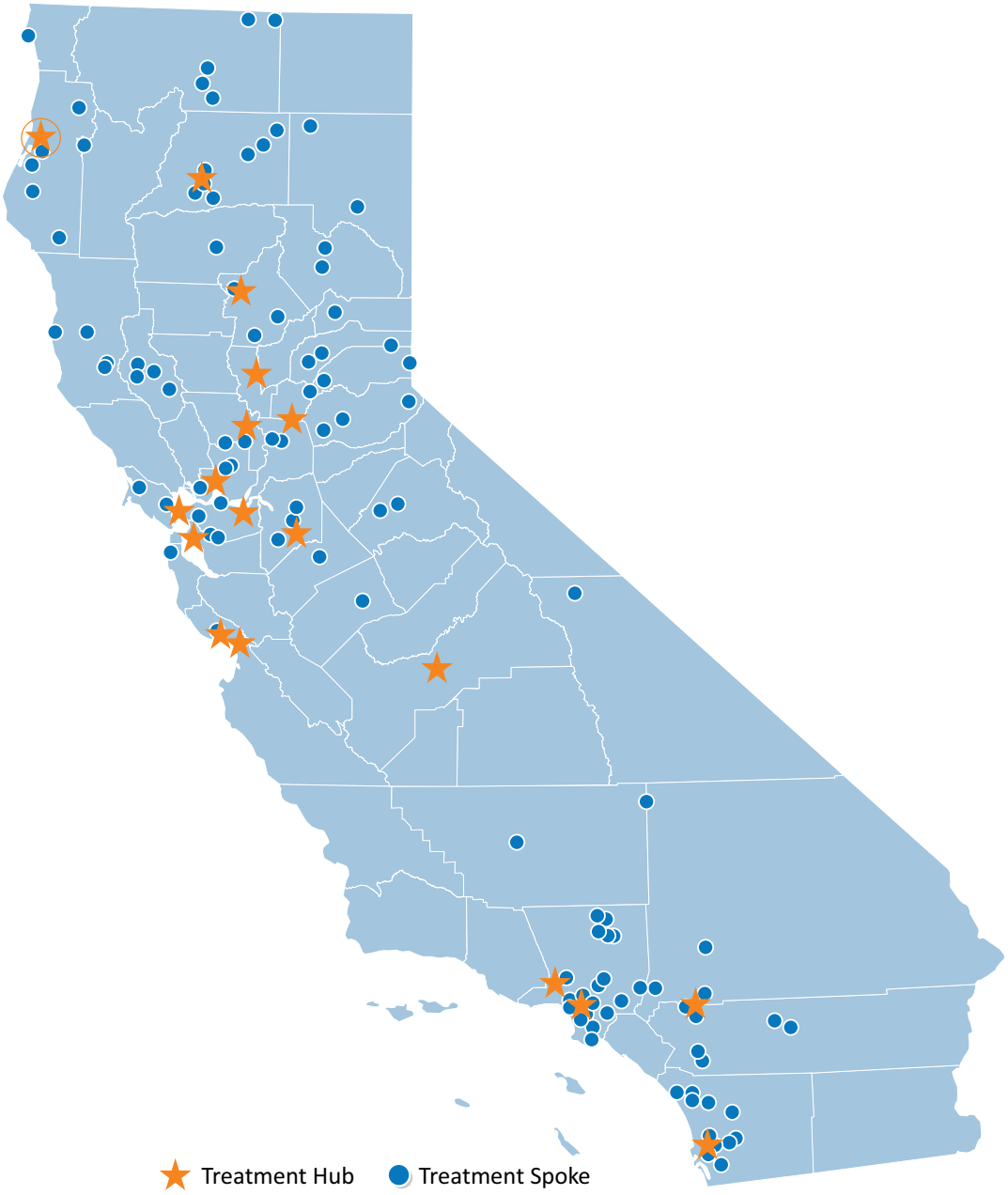
APPENDIX A: CALIFORNIA'S HUB AND SPOKE SYSTEM[a,b]

California funded a Hub and Spoke system through its State Opioid Response (SOR) IV grant program. The system was modeled after Vermont's framework; it utilizes Hubs as OTPS with experts in opioid use disorder, and Spokes as sites that provide ongoing care and maintenance. While the system's overarching goal is to increase access to OUD prevention, treatment, and recovery for all Californians, organizations that actively provide culturally competent and non-stigmatized care to individuals and communities at the highest risk of overdose were given priority funding in the project.

Figure 13: California's Hub Hub and Spoke System



Source: UCLA Integrated Substance Use and Addiction Programs. 2020.

California's Hub and Spoke System SOR IV program was built to accomplish six goals:

- Increase access and uptake of MAT services and evidence-based SUD treatment services in marginalized populations and communities with disproportionately high overdose death rates.
- Enhance MAT provider infrastructure, including access to appropriate telehealth services, community educational outreach, peer recovery support specialists, harm reduction programming, and expanded service hours.
- Enhance patient-centered care and broaden the concept of the patient population from the individual to include family and friends, thereby maximizing recovery capital, supporting family resilience, and destigmatizing treatment.
- Increase referrals and communication between Hubs and Spokes and strengthen regional relationships within the network through effective case management, thereby minimizing patient care fragmentation and improving patient retention and long-term recovery.
- Increase the number of buprenorphine prescribers, prescriptions, and successful prescriptions.
- Maximize patient Medi-Cal timely enrollment, billing, and other program sustainability practices, including collaborative partnerships with local service providers for essential auxiliary care and the use of state-certified Medi-Cal reimbursable peer recovery support specialists.

In addition to these goals, the Hub and Spoke System also supports harm reduction programming, programming for family members and transitional youth in coordination with family-focused services, implementation of innovative models to serve unhoused individuals and those re-entering the community following incarceration, and collaboration with county behavioral health care agencies, State Opioid Treatment Authorities, and other OUD/SUD providers that are required to offer MAT or immediate referrals to MAT to decrease MAT access barriers.

The University of California, Los Angeles Integrated Substance Abuse Programs evaluated the California Hub and Spoke System over its first three years and noted promising results[c]:

- The program expanded threefold to include 174 Spokes and 18 Hubs. Nearly one-third (28.5%) of Spokes were in rural areas.

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[a] Miele, G. M., Caton, L., Freese, T. E., McGovern, M., Darfler, K., Antonini, V. P., ... & Rawson, R. (2020). Implementation of the Hub and Spoke model for opioid use disorders in California: Rationale, design and anticipated impact. *Journal of substance abuse treatment*, 108, 20-25.

[b] California Department of Health Care Services (DHCS) Community Services Division. (2025, March 23). About Us - *The California Hub and Spoke System*. The California Hub and Spoke System. https://caHubandSpoke.com/about-us/

[c] Darfler, K., Santos, A., Gregorio, L., Vazquez, E., Bass, B., Joshi, V., Antonini, V., Hall, E., Teruya, C., Sandoval, J., Urada, D. (2020). California State Targeted Response to the Opioid Crisis: Final Evaluation Report. Los Angeles, CA: UCLA Integrated Substance Abuse Programs. https://courses.denverptc.org/resource.php?id=594

- Between Hubs and Spokes, 34,595 new patients started MAT (methadone, buprenorphine, or extended-release naltrexone).
- Spokes saw a 146% increase in the number of patients starting buprenorphine each month over baseline (pre-Hub and Spoke), with Hubs having 8.5 times the number of new buprenorphine patients.
- Most patients (93.4%) who completed both treatment initiation and follow-up interviews were still in treatment after 90 days.

Please click here to return to the toolkit.

APPENDIX B: WASHINGTON STATE'S HUB AND SPOKE SYSTEM

The Washington State Hub and Spoke model is a part of the 21st Century Cures Act to address the opioid epidemic. As described by the Washington State Healthcare Authority,[a] it is designed to create a coordinated, systematic response to the complex issues of opioid use disorder among populations on Medicaid and who qualify as low-income.

The Washington State model expanded upon Vermont's initial definition of what types of settings can serve as a treatment Hub. In Washington's model, any organization with MOUD expertise and capacity can serve as a Hub; this has allowed three networks to utilize primary care offices as Hubs. As in other states, Washington State Hubs identify, collaborate with, and subcontract to Spoke sites to provide integrated care, regardless of how individuals enter the system. Spokes are facilities that provide OUD treatment, behavioral health treatment, primary healthcare services, wraparound services, and referrals.

Each Hub and Spoke network is staffed with nurse care managers and care navigators to reduce barriers for individuals seeking services by helping them navigate the system and assisting prescribing practitioners in managing the increased number of patients.

The Washington Hub and Spoke model was built to accomplish the following goals:

- Increase the number of patients receiving MOUD by growing capacity in a variety of settings.
- Enhance the integrated care that patients receive.
- Improve retention rates for enrollees.
- Decrease drug and alcohol use.
- Decrease overdoses.
- Reduce adverse outcomes related to OUD.

The Washington State Hub and Spoke Model employed a flexible approach that integrated primary care and substance use treatment programs, as well as outreach, referral, and social service organizations, with a nurse care manager. Hubs could be any program that had the required expertise and capacity to lead their network in medication for OUD, including all three FDA-approved medications. Six Hub and Spoke networks were funded, with an average of eight unique agencies and multiple sites. Approximately 150 prescribers are in these networks (25 on average). Notable outcomes and lessons learned include:[b]

- In the first 18 months, nearly 5,000 people were inducted into OUD medication treatment: 73% on buprenorphine, 19% on methadone, and 9% on naltrexone.

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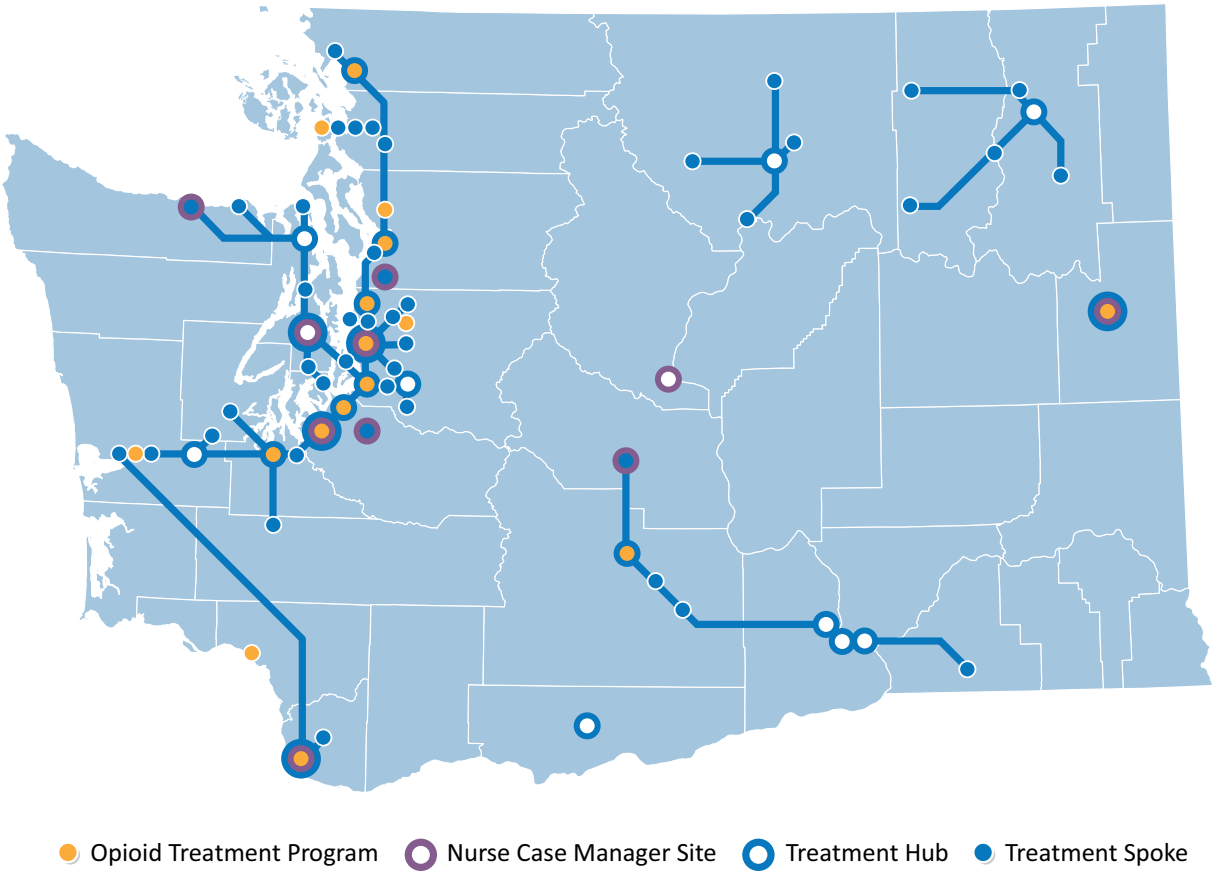
[a] Weed, L., & Barker, L. (2024). *Opioid Treatment Network Hub and Spoke Projects*. Washington State Healthcare Authority. https://www.hca.wa.gov/assets/program/fact-sheet-Hub-Spoke.pdf

[b] Reif, S., Brolin, M. F., Stewart, M. T., Fuchs, T. J., Speaker, E., & Mazel, S. B. (2020). The Washington State Hub and Spoke Model to increase access to medication treatment for opioid use disorders. *Journal of substance abuse treatment*, 108, 33-39.

- Only 24% of participants remained in MOUD treatment for at least six months. Initiation on MOUD was the only metric that sites reported; retention reporting was not a required metric.
- In the patients receiving buprenorphine, the number of outpatient services in the first month was strongly correlated with improved outcomes. Two outpatient services were associated with an increased likelihood of six-month MOUD continuity. Four or more outpatient services were associated with reduced ED and hospital utilization.
- Patients at FQHC or public health settings had higher odds of MOUD continuity than SUD treatment settings. The researchers believe this demonstrates that FQHCs and public health settings may be more skilled at treating the whole person. Additionally, people may prefer to receive MOUD in settings where other health needs are being met.

Figure 14: Washington State Hub and Spoke Map



Source: Washington State Hub and Spoke project. (2025). Washington State Health Care Authority.

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