Community Behavioral Health

City of Philadelphia

Distilling Solutions

Clinical Practice Guidance for Alcohol Use Disorder

Thursday February 25, 2021
12:00 p.m. – 1:30 p.m.

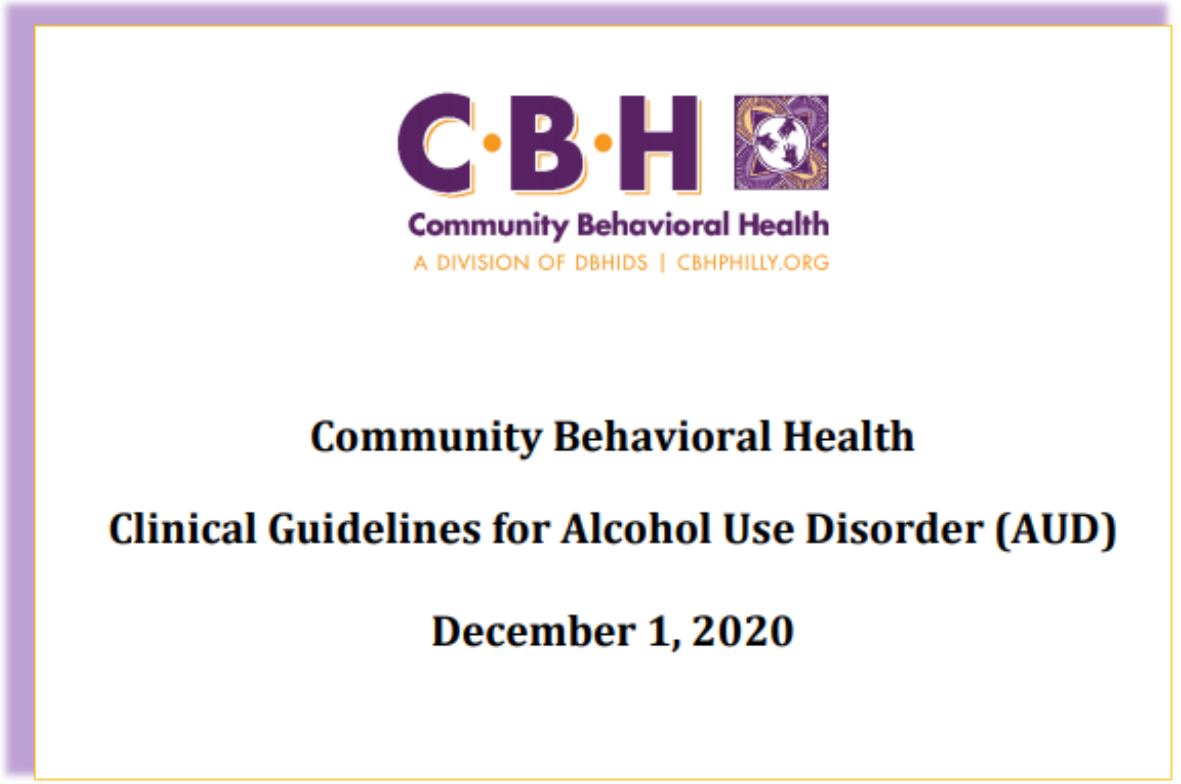
Welcome

Meeting Agenda

Background AUD CPG Context Outline	Dr. Robin Hanson, DO, CPHQ CBH Medical Director of Quality
Medications for the Treatment of Alcohol Use Disorder	Dr. Maryem Hussein, MD, PhD Addiction Psychiatry Fellow University of Pennsylvania
Accessing Treatment for AUD	Orfelina Feliz Payne Director of CBH Member Services
Questions/Feedback Please use Q&A	Erin Maloney Moderator

Please complete the follow-up survey!

Materials You May Find Useful for This Webinar


C·B·H
Community Behavioral Health
A DIVISION OF DBHIDS | CBHPHILLY.ORG

Community Behavioral Health

Clinical Guidelines for Alcohol Use Disorder (AUD)

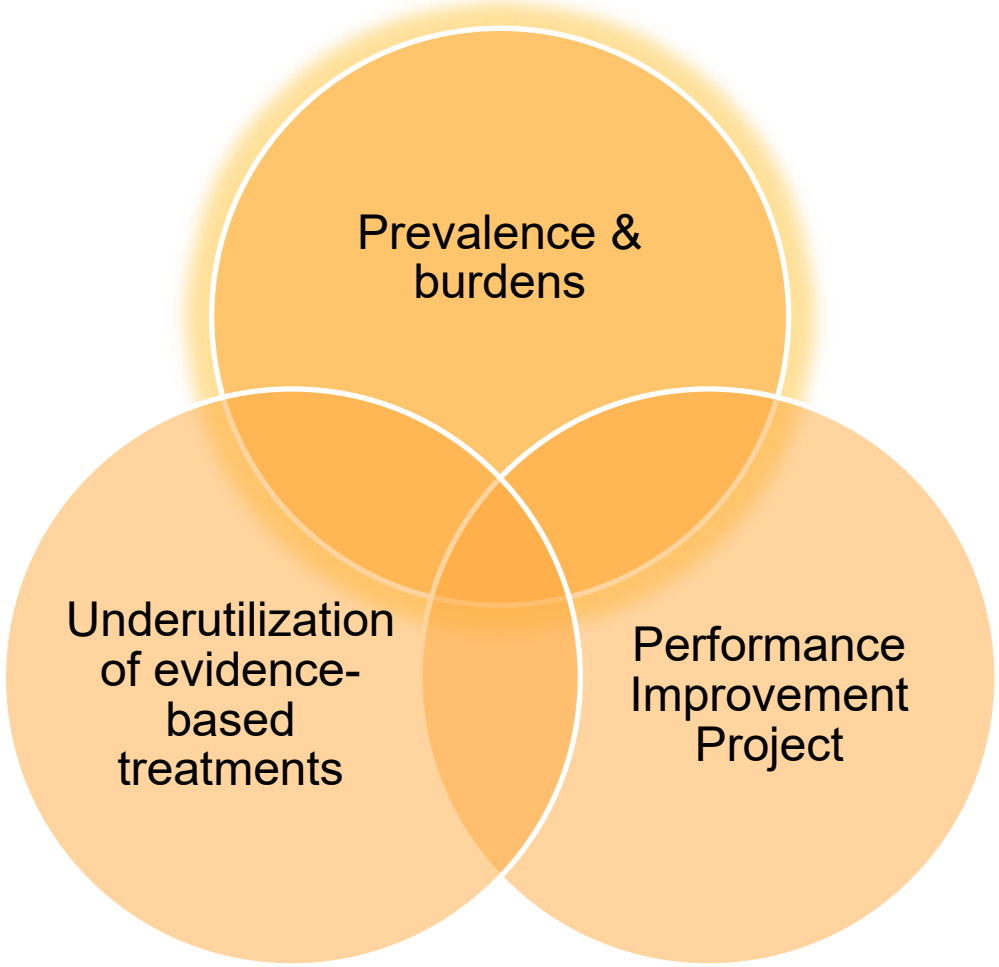
December 1, 2020

Alcohol Use Disorder Clinical Practice Guidelines

Background

Why are we here today?

Alcohol Use Disorder (AUD)



Background

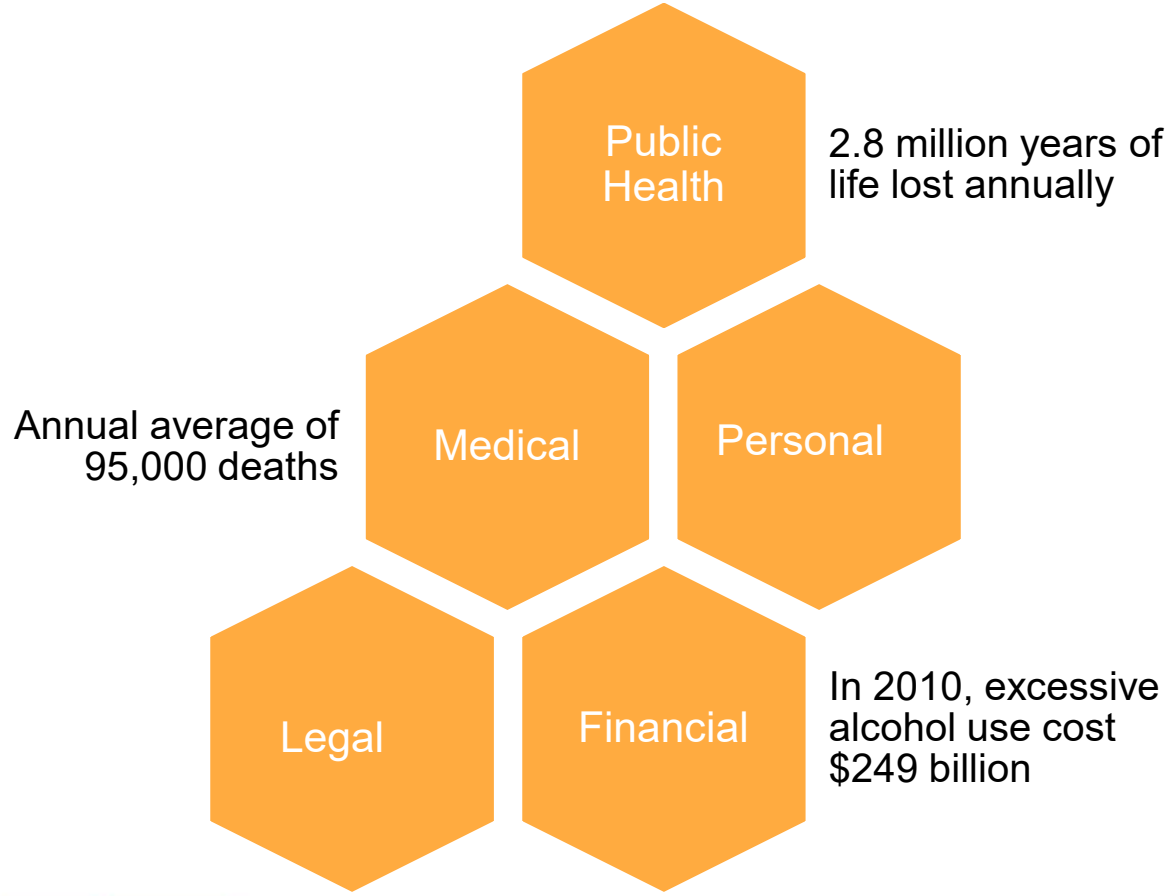
Prevalence & Burdens of Alcohol Use Disorders

Lifetime prevalence **30%**

Grant et al 2015, Mark et al 2009, Hasin et al 2007, Kendler et al 2016, Bouchery et al 2006

Background

Prevalence & Burdens of Alcohol Use Disorders



Grant et al 2015, Mark et al 2009, Hasin et al 2007, Kendler et al 2016, Bouchery et al 2006, CDC Website: https://www.cdc.gov/alcohol/data-stats.htm

Background

Alcohol Use and COVID-19

Increasing rates of drinks per day, exceeding recommended ETOH use, and binge drinking. More pronounced in women and Black, non-Hispanic individuals. (Barbosa et al 2020, J Addict Med)

Increase in frequency (14%; 17% for women) and increase of 41% in days of heavy drinking, as well as 39% increase in alcohol related problems. (Pollard et al 2020, JAMA Network Open).

Kaiser Health News: Hospital admissions for alcoholic liver disease were up 30-50% , felt to be due to isolation, unemployment and hopelessness associated with Covid-19 are driving the explosion in cases

Nielsen IQ Polls: "Rebalancing the COVID-19 effect on alcohol sales"

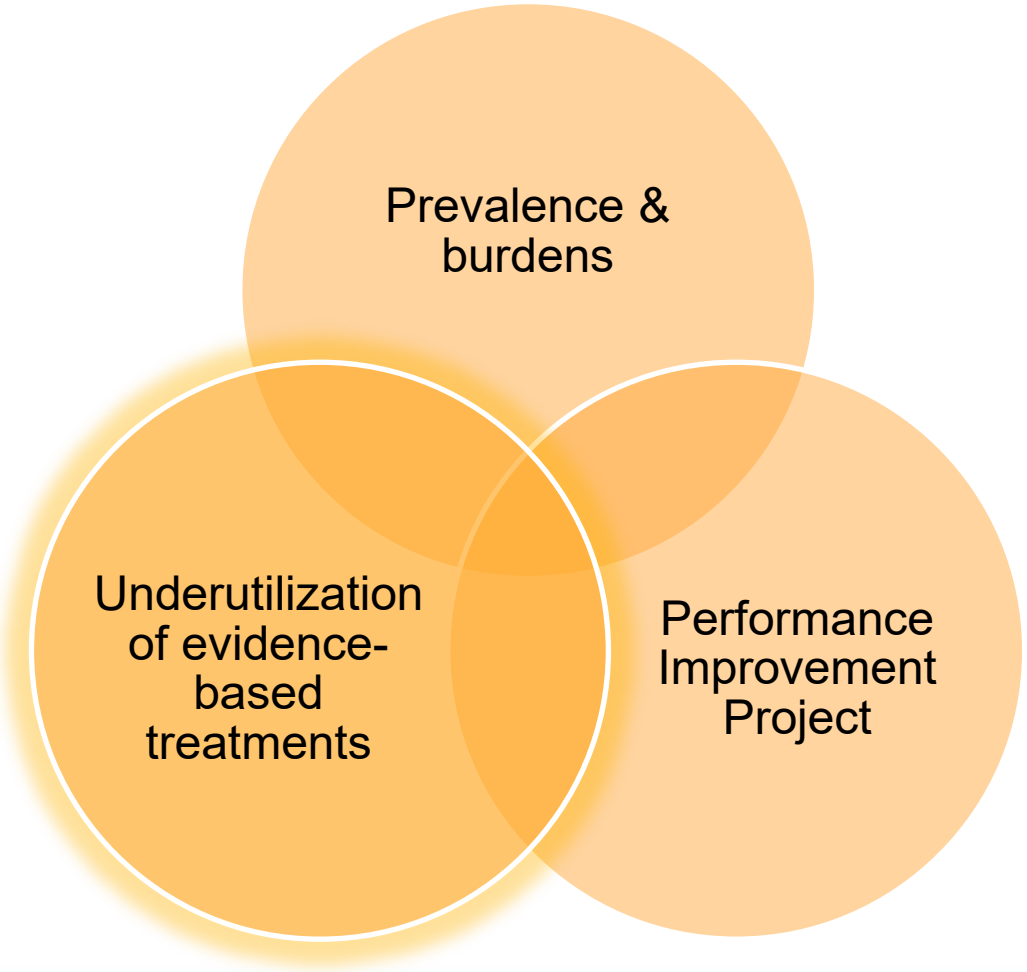
Sales rise in brick and mortal shops (up 21%), and online (up 234%)

Noted trending towards larger pack size (boxed wine up 10X, 1.75 Liter spirits up 23X, 30-packs of beer up 21%, 24-packs up 20%)

Background

Why are we here today?

Alcohol Use Disorder (AUD)



Background

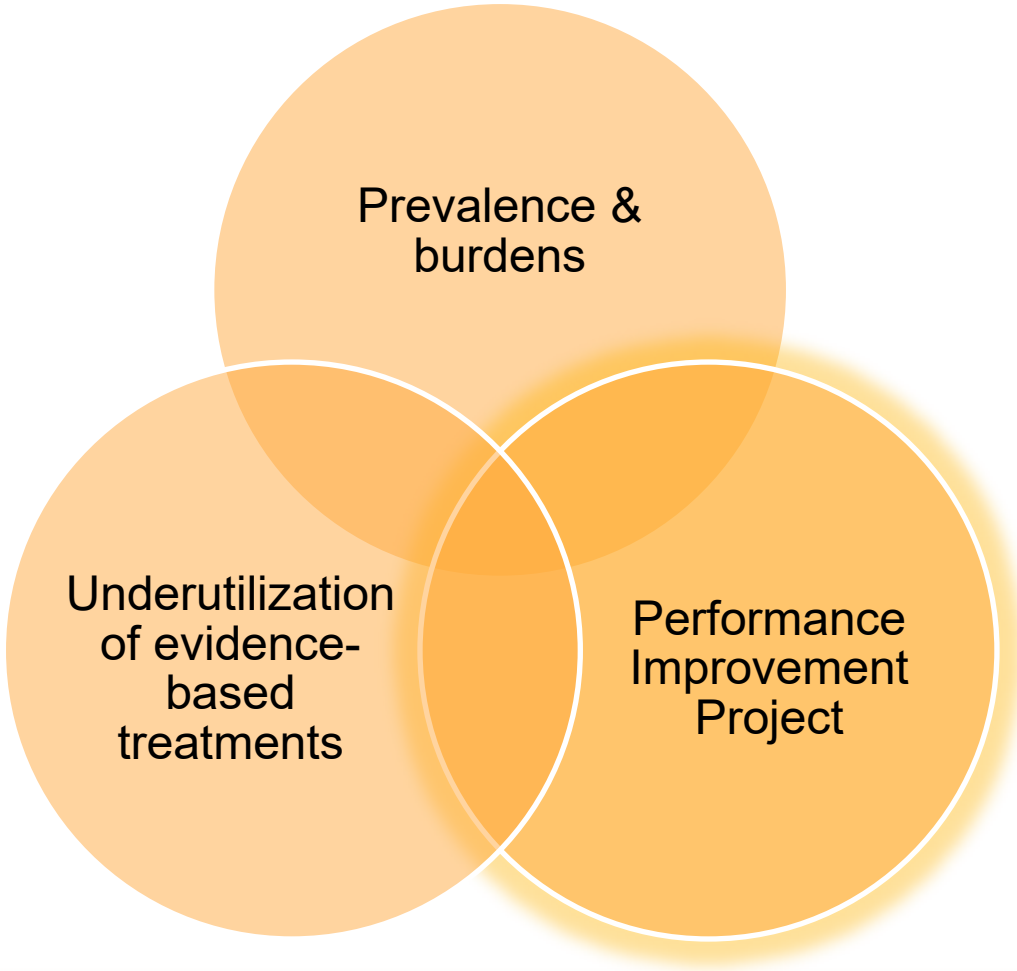
Research estimates only 8 – 20% of patients receive any treatment for AUD and far fewer get evidence-based treatment.

Grant et al 2015, Mark et al 2009, Hasin et al 2007, Kendler et al 2016, Bouchery et al 2006

Background

Why are we here today?

Alcohol Use Disorder (AUD)



Background

CBH PIP Development Process

Review of data and literature

Development of aims/objectives/goals

Identify barriers

Develop interventions

Implement interventions

Ongoing assessment of data and progress

Background

IET (HEDIS) for Alcohol Use Disorder

Metrics

Initiation and engagement of alcohol and other drug abuse or dependence treatment

Component		CBH Network
Denominator	Individuals >13 years of age with a new episode of alcohol or other drug (AOD) dependence	1875
Numerator (Initiation)	**# initiated treatment** through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) **within 14 days** of diagnosis.	Rate: 54.83%
Numerator (Engagement)	# initiated treatment **and** had **two or more additional AOD services or MAT within 34 days** of the initiation visit.	Rate: 23.52%

https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/

Background

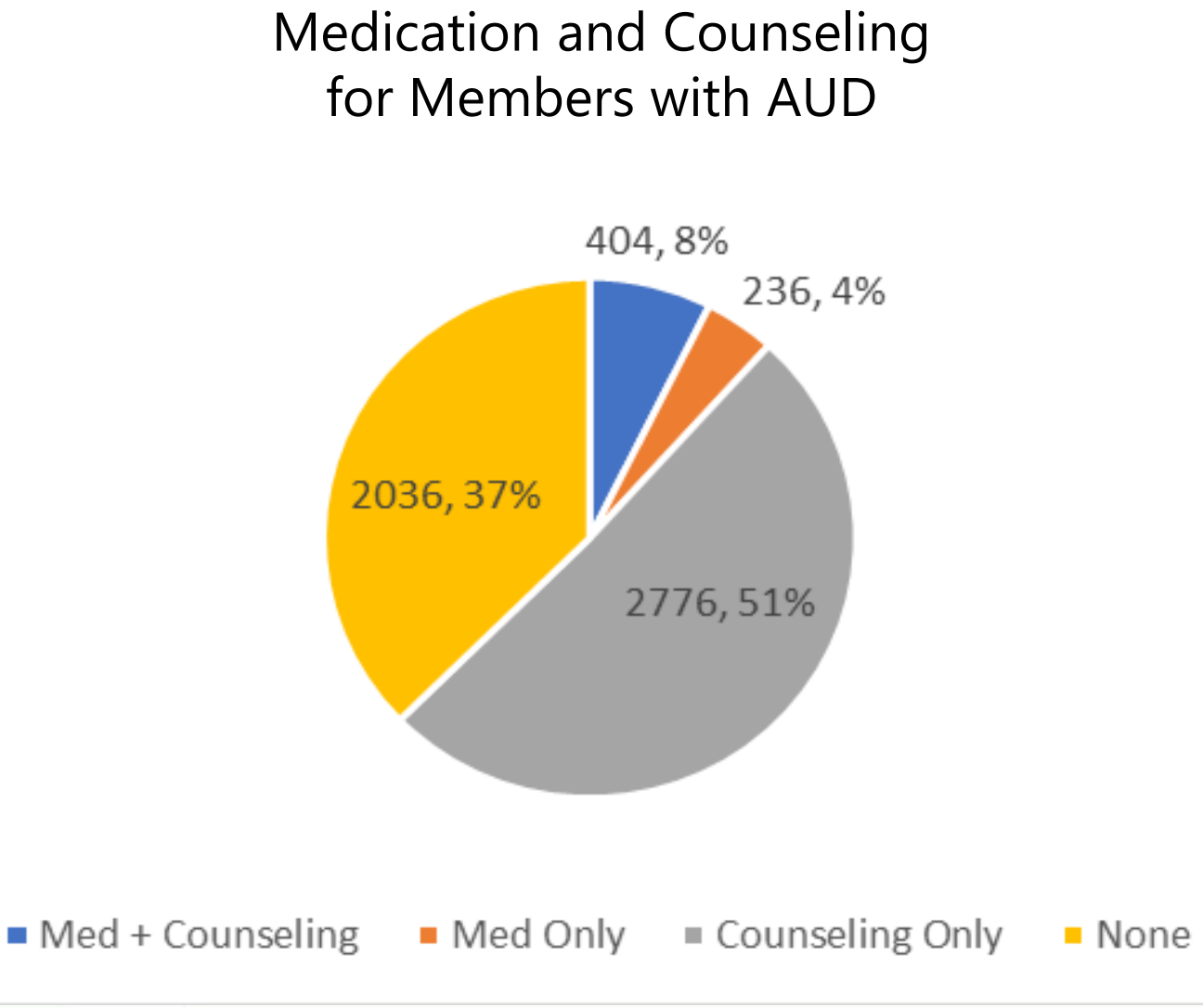
Metrics

MAT-AUD

OMHSAS PIP Metric

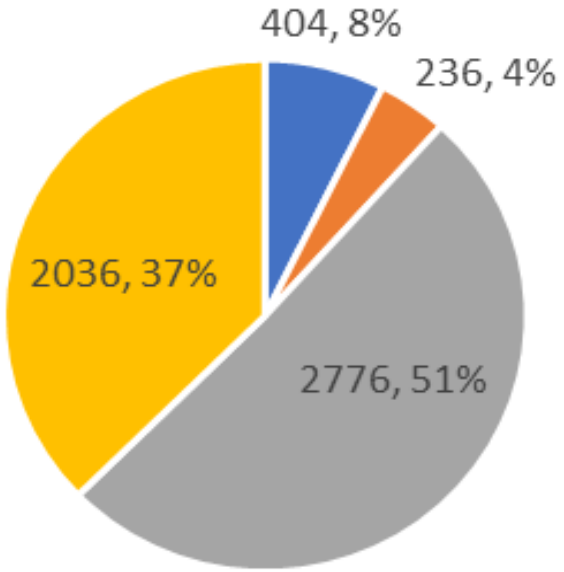
Component		CBH Score
Denominator	Individuals >13 years with a diagnosis of Alcohol Use Disorder	5452
Numerator	# receiving concurrent medication and counseling	404 Rate: 7.41%

AUD


Medication and Counseling for Members with AUD
404, 8%
236, 4%
2036, 37%
2776, 51%
Med + Counseling
Med Only
Counseling Only
None

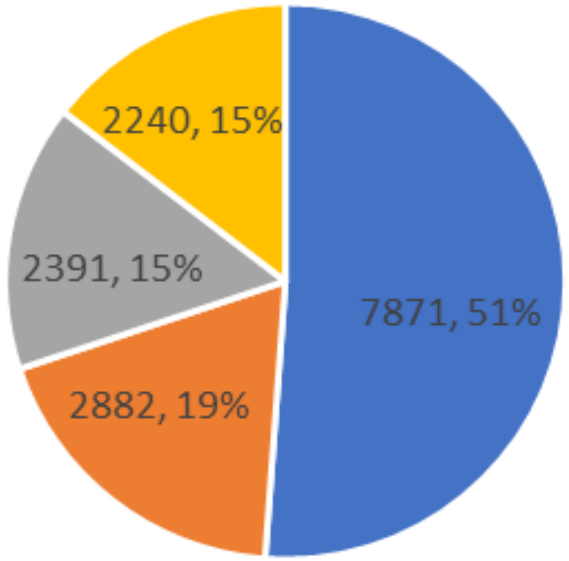
AUD

Medication and Counseling for Members with AUD



OUD

Medication and Counseling for Members with OUD



Background

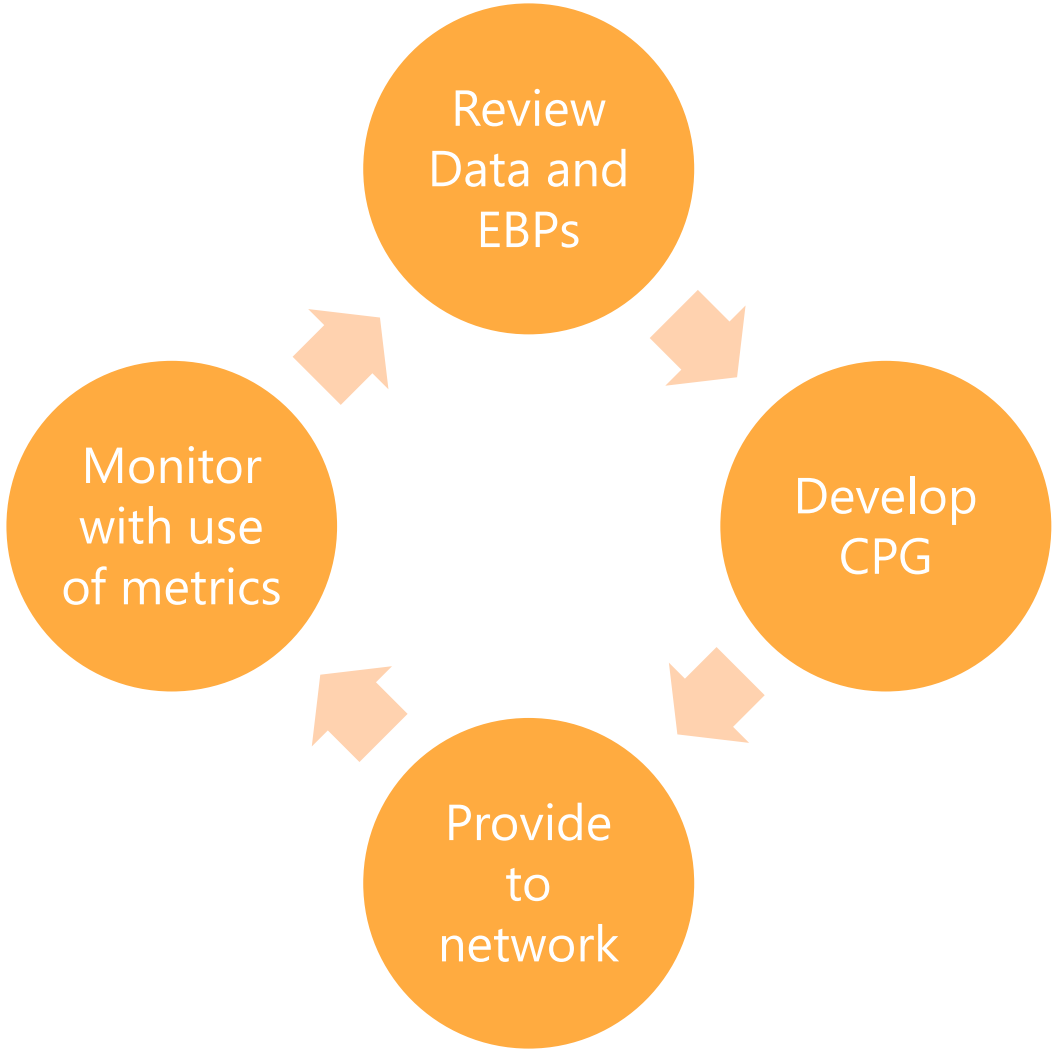
Summary

1. Alcohol use disorders are very common
2. Medical sequalae are both common and debilitating
3. Most people do not get treatment
4. Those that do often receive substandard care

Background

Lessons learned:

Streamline a standardized approach.



Example:
Opioid Use Disorder
Tobacco Use Disorder
Alcohol Use Disorder

Background

CBH Clinical Practice Guidelines

Specific to a diagnosis or population

Ex: AUD, OUD, Depression Clinical Practice Guideline

CBH Performance Standards

Specific to a level of care

Ex: ASAM Out-Patient Performance Standards

Thank You!

Subject Matter Experts:

Dr. Maryem Hussein, University of Pennsylvania Addictions Fellow

Dr. John Northrop, General and Forensic Psychiatrist at University of Pennsylvania and Philadelphia VA Medical Center, Consulting Physician at CBH

CBH:

Dr. Casey Walker & Dr. Oluwatoyin Fadeyibi, Pharmacy Initiatives Department

Lisa Thaler, CPHQ, Manager of Quality Improvement

Erin Maloney, LMFT, Quality Improvement Specialist

Dr. Chris Tjoa, Acting Chief Medical Officer

Dr. Don Tavakoli, Acting Deputy Chief Medical Officer

Dr. Violet Henighan, Physician Advisor

Carol Larach, DrPH, Director CBH Integrated Care Services

CBH AUD CPG Draws From:

2018 American Psychiatric Association (APA) Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder

2015 Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute on Alcohol Abuse and Alcoholism, Medication for the Treatment of Alcohol Use Disorder

2020 American Society of Addiction Medicine (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management

AUD CPG: Content

Community Behavioral Health

Clinical Guidelines for Alcohol Use Disorder (AUD)

December 1, 2020

References

*Full list of refences from the AUD CPG is found in Appendix A and B of the guideline

Grant BF, Goldstein RB, Saha TD, et al : Epidemiology of DSM-5 alcohol use disorder: results from the National Epidemiologic Survey on alcohol and related conditions III. 2015. JAMA Psychiatry 72 (8):757-766. doi: 10.1001/jamapsychiatry.2015.0584

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Hasin DS, Stinson FS, Ogburn E, Grant BF. Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States. Arch Gen Psychiatry. 2007;64(7):830–42

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CDC Website. 2020. "Excessive drinking is draining the US Economy" Last Reviewed 12,30,2019. Accessed Feb 18 2021 at : <https://www.cdc.gov/alcohol/features/excessive-drinking.html

NCQA Website. Accessed 18 Feb 2021. Initiation and Engagement in Treatment. https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/

Cahan, Eli. Kaiser Health News. "Pandemic-Fueled Alcohol Abuse Creates Wave of Hospitalizations for Liver Disease." February 10, 2021. Accessed at https://khn.org/news/article/pandemic-fueled-alcohol-abuse-creates-wave-of-hospitalizations-for-liver-disease/

Drinking Alone: COVID-19, lockdown, and alcohol related harm. Editorial. 2020. 5 (7) 625. DOI: https://doi.org/10.1016/S2468-1253(20)30159-X

Barbosa C, Cowell A, Dowd W. Alcohol Consumption in Response to the COVID-19 pandemic in the United States. J Addict Med. 2020 Oct 23. Doi 10.1097/ADM.0000000000000767

Pollard M, Tucker J, and Green H. Changes in Adult Alcohol Use and Consequences During the COVID-19 Pandemic in the US. 2020. JAMA Network Open. 2020;3(9):e2022942. doi:10.1001/jamanetworkopen.2020.22942

Nielsen IQ. "Rebalancing the 'COVID-19 effect' on alcohol sales." 07 May 2020. accessed at : https://nielseniq.com/global/en/insights/2020/rebalancing-the-covid-19-effect-on-alcohol-sales/

Medications for the Treatment of Alcohol Use Disorder

Why Do We Need Medications for Alcohol Dependence?

Although psychosocial treatments are effective in reducing alcohol consumption and in maintaining abstinence in many patients, 40 to 70 percent of patients resume drinking within a year after treatment.

New England Journal of Medicine 340, 1482–1490.

What is the Goal of Pharmacological Treatment?

Help patients REDUCE drinking, avoid RELAPSE to HEAVY drinking (harm reduction), ACHIEVE/MAINTAIN abstinence

The Ideal Medication:

- Stops withdrawal
- Reduces craving
- Blocks the high from abused drugs

How Do These Medications Work?

Medications alter the reinforcing effects of alcohol by affecting neurotransmitters that interact with the reward pathway in the brain (endogenous opioids, gamma-aminobutyric acid (GABA), glutamate)

Endogenous opioids: rewarding effects

GABA/Glutamate: withdrawal effects

Beyond Detox: Medications for Alcohol Use Disorder

Disulfiram (*Antabuse*)

Naltrexone (*Vivitrol, ReVia, Depade*) - oral and injectable

Acamprosate (*Campral*)

Topiramate (*Topamax, Trokendi XR, Qudexy XR*) – not FDA approved for AUD

Gabapentin (*Neurontin*) – not FDA approved for AUD

Choosing a Medication: Considerations

Comorbid medical

Comorbid psychiatric/other substance use

Detoxed or actively using

What does the patient want: abstinence vs. reduction

Family History of AUD

Cravings

How reliable is the patient - Addressing adherence will maximize effectiveness

Medical Considerations:

Liver function

Renal function

Pregnancy – medications only indicated for acute withdrawal in this case

Considerations: Patient Goals

REDUCTION of heavy drinking vs ABSTINENCE

Most clinical trials (except topiramate) were conducted on recently abstinent individuals

BETTER outcomes when patients have a goal of abstinence or can abstain for a few days prior to starting the medications

Disulfiram (*Antabuse*) for AUD

First medication approved for alcohol

Does not decrease cravings or ameliorate withdrawal symptoms – creates an aversive reaction to alcohol to discourage drinking

MUST be committed to abstinence

Works best if dose observed

Disulfiram (*Antabuse*) Mechanism of Action

Blocks enzyme called acetaldehyde dehydrogenase and prevents breakdown of acetaldehyde (an intermediate metabolite of alcohol)

When a patient drinks alcohol, acetaldehyde builds up

Accumulation of acetaldehyde results in numerous unpleasant symptoms, including tachycardia, headache, nausea, vomiting, flushing, sweating, and hypotension

Aversive disulfiram-ethanol reaction is typically self limited (30 minutes to several hours)

Disulfiram (*Antabuse*)

Disulfiram CONTRAINDICATED in patients who wish to continue to drink

Contraindicated: severe myocardial disease or CAD, psychosis, pregnancy, suicidality, high impulsivity, alcohol containing preparation of medications (e.g., liquid sertraline) and products/foods (mouthwash), metronidazole

Caution: cirrhosis, cerebrovascular disease, diabetes mellitus, epilepsy, hypothyroidism, and renal impairment , age over 60

Bottom line: Medically stable patients only

Disulfiram (*Antabuse*)

Dose 250 mg daily

Side effects: dizziness, metallic taste, urticaria, acneiform eruptions, and headaches.

Rarely: optic neuritis, peripheral neuropathy, and hepatotoxicity (severe and sometimes fatal hepatitis associated with disulfiram may develop after many months of therapy)

Check LFTs baseline, at two weeks, three months and six months

No alcohol for 12 hours before, and up to two weeks after

Not a first line medication

First Line: Acamprosate and Naltrexone

Naltrexone (*Vivitrol, ReVia, Depade*) is an opioid receptor antagonist that reduces the reward or excitement associated with drinking alcohol and/or coming in contact with alcohol-related cues in the environment (anticipatory excitement)

Acamprosate (*Campral*) is thought to be a brain glutamate receptor stabilizer that promotes abstinence by alleviating the physical and psychological discomfort (sweating, anxiety, and sleep disturbances) experienced by many alcohol-dependent individuals once they stop drinking (protracted withdrawal)

Naltrexone (*Vivitrol, ReVia, Depade*)

Blocks opiate receptors- Reduces positively reinforcing effects of alcohol

Enhances sedative effects

Decreases cravings

Appears most effective in endorphin sensitive patients (FH and Cravings)

Detoxed patients do better

Good for both abstinence and reduction

Good for comorbid OUD (if detoxified)

Neuropsychopharmacology 43, 891–899 (2018).

Naltrexone (*Vivitrol, ReVia, Depade*)

Contraindications:

Prescribed opiates (or not detoxed from opiates)- will precipitate withdrawal

Severe liver disease/acute hepatitis

Side effects are relatively benign, and common side effects are nausea, sedation, headaches, fatigue, and anxiety

Naltrexone: Oral (*ReVia, Depade*)

Oral 50 mg daily most common dose – can start with 25 mg at bedtime for seven days, then increase to 50 mg

Check LFTs before starting, at six months, and then annually

Do not use if LFTs >4.5x upper limit of normal

Naltrexone: Depot (*Vivitrol)*

Naltrexone embedded in biodegradable polymer microspheres

One dose only, 380 mg every four weeks

Eliminates adherence problems/improves compliance

For some patients, effects wear off between 21 – 24 days,

Can either supplement with oral naltrexone until next injection, or, if possible, administer q3 weeks

Hepatically safer– bypasses first pass metabolism

Acamprosate (*Campral*)

Glutamate antagonist “artificial alcohol”

Reduces protracted withdrawal (can last months-years)

Reduces craving

Best if detoxified (abstinence promoting/preventing relapses) - still drinking? Don’t use acamprosate

If they slip and relapse, move on to another medicine

Other than detox no predictors of efficacy

Non-endorphin sensitive alcoholics likely target group

Addiction 108, 275–293 (2013).

Acamprosate (*Campral*)

Contraindicated: severe renal impairment

Caution: moderate renal impairment (adjust dose)

Mild side effects: diarrhea, somnolence, anxiety

Acamprosate (*Campral*)

666 mg TID

Renally excreted, no hepatic metabolism

Check renal function before starting

Reduce to 333 mg TID in moderate renal disease (CrCl 30-50 mL/min, CKD 3)

Don’t use in severe renal disease

Acamprosate and Naltrexone Compared

Acamprosate larger effect size for abstinence

Naltrexone larger effect size for reducing heavy drinking

Detoxification prior to starting medications improved outcomes for both medications

Addiction 108, 275–293 (2013).

Topiramate (*Topamax)*

GABA potentiation

Glutamate antagonism

Don’t need to be detoxed

Reduces heavy drinking days and promotes abstinence

Curr. Drug Abuse Rev. 2, 135–142 (2009)

Topiramate (*Topamax)*

FDA Approved for: migraines, seizures, obesity

Side effects include word finding deficits and general mental slowing, paresthesias, taste perversion, anorexia, and decreased cognition

More serious side effects: Metabolic acidosis, secondary angle closure glaucoma

Caution in patients with kidney stones or glaucoma, renal impairment, anorexia, elderly

Taper if discontinuing

No hepatic metabolism, excreted in urine

Topiramate (*Topamax)*

Titrate slowly to 200 mg daily, divided BID dosing

Dose reduction in renal impairment

Stop where they stop drinking

Can go higher but tend to have side effects

Week 1: 25 mg qhs
Week 2: 50 mg qhs
Week 3: 25mg am/ 50 mg qhs
Week 4: 50 mg am/ 50 mg qhs
Week 5: 50 mg am/100 mg qhs
Week 6: 100 mg am/100 mg qhs

Gabapentin (*Neurontin*)

Effects on both GABA and glutamate

Reduces alcohol withdrawal

Prevents relapse

Three or more days of abstinence at start predicts better outcome

Beware: abuse potential

JAMA Intern Med. 2014;174(1):70–7.

Gabapentin (*Neurontin*)

FDA approved for: seizure, neuropathic pain

Target dose 1800 mg daily in divided doses with rapid titration

Start at 300 mg qhs, increase by 300 mg daily, give as TID dosing

Dose reduction in renal disease, caution in elderly

Few side effects, variable sedation and dizziness

Taper to discontinue

Some evidence for additive effects of combination of naltrexone +gabapentin

Am J Psychiatry. 2011;168(7):709–17.

Summary - Medications for Alcohol Dependence

There are now four approved medications:

- Disulfiram
- Acamprosate
- Naltrexone oral
- Naltrexone injectable

Topiramate not approved but may be useful – Topiramate seems better at reducing drinking than Naltrexone in non-detoxed patient

Gabapentin not approved but may be useful

Summary

First line: Naltrexone or Acamprosate

Second line: Disulfiram, Topiramate, and Gabapentin

No Acamprosate in severe renal impairment

No Naltrexone in severe hepatic impairment or concomitant opioid use

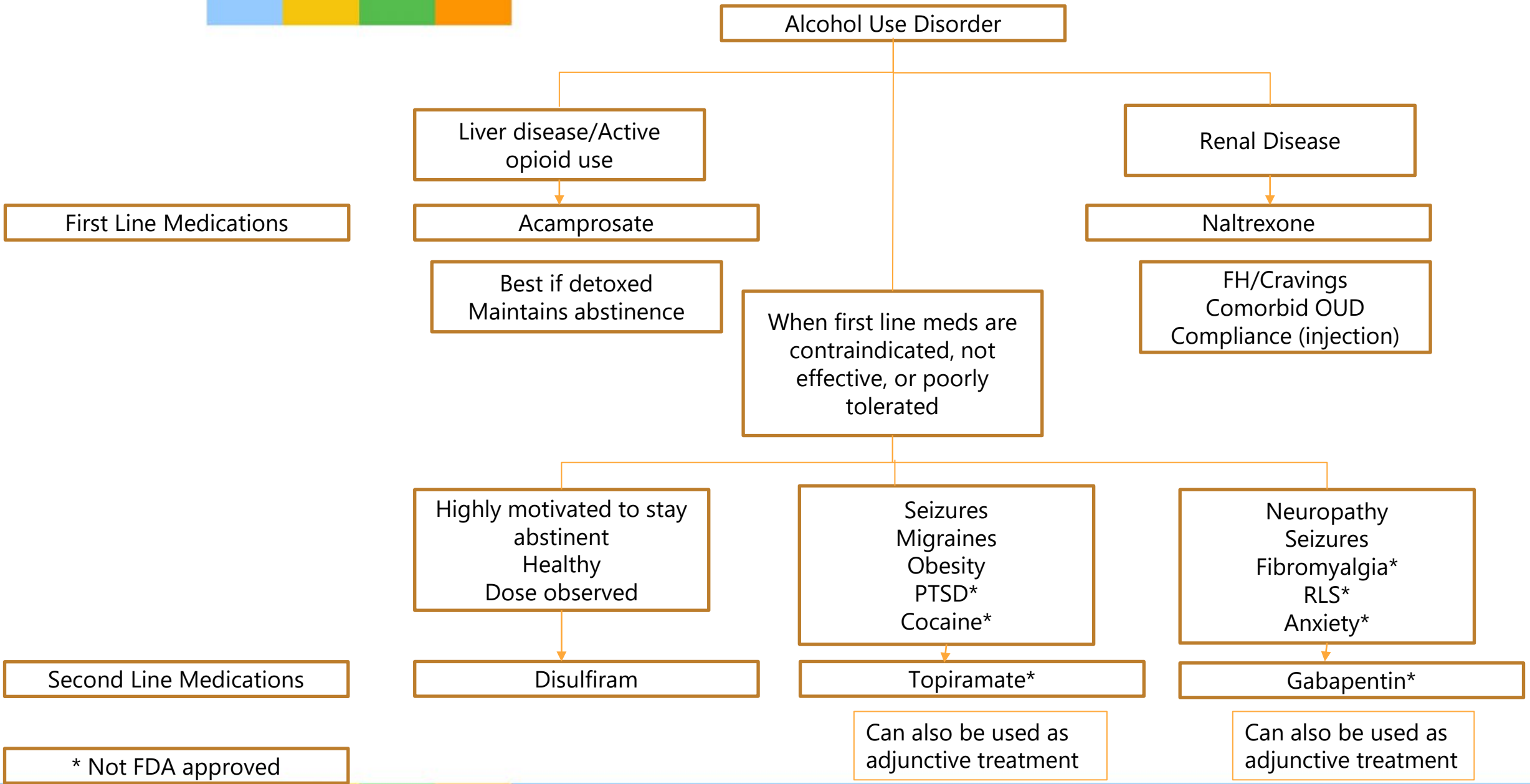
No concrete evidence that combining medications helps (could consider adding Topiramate or Gabapentin to a first line medication)

Assessment of Efficacy

Abstinence

Elimination of heavy drinking days (more than four drinks a day for men, more than three drinks a day for women)

Breathalyzer at appointment, urine ethanol (approx. 18 h)


Alcohol Use Disorder
Liver disease/Active opioid use
Renal Disease
First Line Medications
Acamprosate
Naltrexone
Best if detoxed
Maintains abstinence
FH/Cravings
Comorbid OUD
Compliance (injection)
When first line meds are contraindicated, not effective, or poorly tolerated
Highly motivated to stay abstinent
Healthy
Dose observed
Seizures
Migraines
Obesity
PTSD*
Cocaine*
Neuropathy
Seizures
Fibromyalgia*
RLS*
Anxiety*
Second Line Medications
Disulfiram
Topiramate*
Gabapentin*
Can also be used as adjunctive treatment
Can also be used as adjunctive treatment
* Not FDA approved

Vitamin Supplementation

Inadequate dietary intake/impaired absorption

Folate deficiency: Macrocytic anemia

Folic acid 1 mg daily

B1 (thiamine) deficiency puts patients at risk for Wernicke-Korsakoff Syndrome, cerebellar degeneration, and cardiovascular dysfunction

Thiamine 100 mg daily

Psychiatric Co-Morbidities

Higher frequency of substance abuse among psychiatric patients

Bidirectional negative impact

Failure to address comorbid psychiatric diagnosis leads to higher rates of adverse clinical outcome

Sequential, parallel, integrated treatment models

Weaker evidence-base for pharmacotherapy (historically excluded population)

Current Evidence-Based Treatments: Psychosocial Approaches

Medication is an ADJUNCT. Combination of psychosocial treatments and medications is ideal

Motivational Enhancement therapy (ambivalence)

Contingency management (incentivizes abstinence)

CBT (prevent relapse)

Mutual help groups (AA)

CBH Member Services

Who is Member Services?

Mission Statement:

Member Services is a team of dedicated employees who value the lives of others. Member Service Representatives are dedicated to respecting the faith, values, and integrity of every individual and family in need of mental health and substance use disorder treatment. We are committed to the treatment, recovery, and improving the behavioral health for all our members.

- 51 diverse individuals
- Combinations of behavioral health career experience and personal experience with the behavioral health and substance abuse systems in Philadelphia
- Philadelphia residents

CBH Member Services Department

We are available 24 hours, 7 days a week. If you or someone you know has questions about behavioral health or drug and alcohol services, please contact Member Services at: **1-888-545-2600**

Toll Free Hotline

Member support regarding treatment needs

Serve as a connection between members & providers

Provide assistance with understanding the behavioral health system

Complaints & Grievances

Schedule appointments during calls

Care Coordination

Aftercare outreach

Appointment reminders

Behavioral Health screenings

Clinical outreach

Treatment availability

On-site scheduling

DPW coordination

Transfer of services

Warm Line

The Warmline is operated by trained Certified Peer Specialists for Philadelphia Residents who are experiencing anxiety, depression, loss, stress, loneliness, relationship difficulties, and other life challenges.

Call **1(855) 507-WARM (9276)** for help. Hours M-F 8am-7pm

Language Access

Coordinate non-language & non-English speaking appointment requests

Coordinate interpretation services for Behavioral Health Treatment

Education & Development

Community Events sponsored by DBHIDS

Provide presentations to the community & internal stakeholders to enhance awareness of CBH services

Language Access for Non CBH Members

For non-CBH members (uninsured and underinsured) language access services, please contact:

1. Contact GLOBO (for telephonic, in-person, or video remote interpretation) by calling 267-318-4423 and provide the assigned access code # as follows:

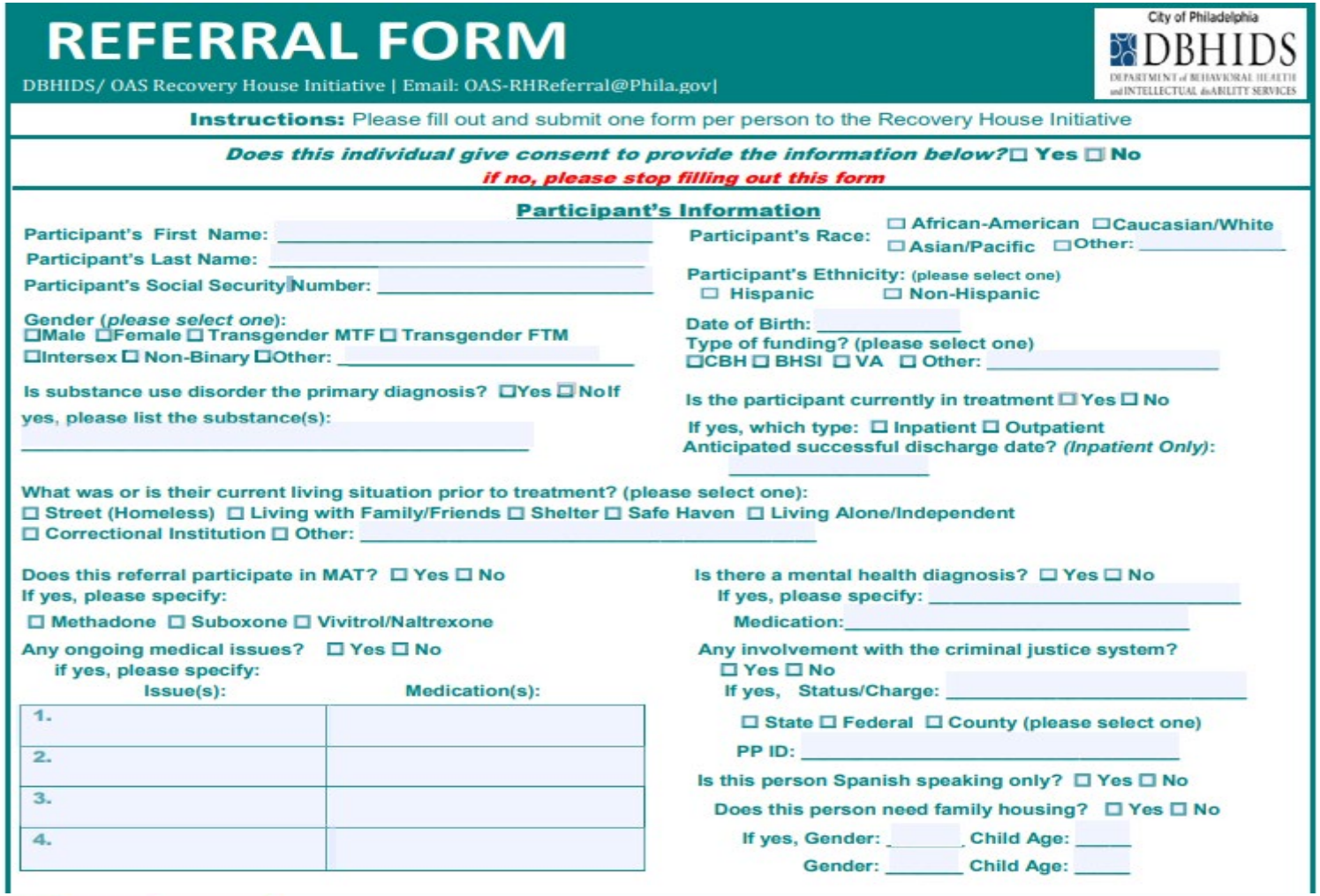
· Intellectual Disability Services: 1001 · Behavioral Health Services – Office of Addiction Services and Office of Mental Health: 1002 · Planning Innovation: 1003 · BHSI: 1004

2. Or call Language Line Services Inc. (for telephonic and video remote interpretation) at 866-874-3972 and provide access code #585089. For in-person interpretation, please complete this online form: NSCPhila.org/language-access-services/request-services

For American Sign Language, please complete this online form: https://dhcc.org/request-interpreter/ at least hours in advance. Please choose Existing DHCC Customer.

For document translation or questions about DBHIDS language access services, please email Sarorng Sorn, Director of Immigrant Affairs and Language Access Services, at Sarorng.Sorn@phila.gov and copy the DEI Team at DBHIDS.Diversity-Inclusion@Phila.gov. For questions or concerns not related to DBHIDS, please email Orlando Almonte, Philadelphia's Office of Immigrant Affairs, at Orlando.Almonte@phila.gov

DBHIDS/OAS Recovery Housing Referral Form



REFERRAL FORM

DBHIDS/ OAS Recovery House Initiative | Email: OAS-RHReferral@Phila.gov|

City of Philadelphia DBHIDS Department of Behavioral Health and Intellectual disAbility Services

Instructions: Please fill out and submit one form per person to the Recovery House Initiative

Does this individual give consent to provide the information below? ☐ **Yes** ☐ **No**

if no, please stop filling out this form

Participant's Information

Participant's First Name: _____

Participant's Last Name: _____

Participant's Social Security Number: _____

Participant's Race: ☐ African-American ☐ Caucasian/White ☐ Asian/Pacific ☐ Other: _____

Participant's Ethnicity: (please select one) ☐ Hispanic ☐ Non-Hispanic

Gender (*please select one*): ☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM ☐ Intersex ☐ Non-Binary ☐ Other: _____

Date of Birth: _____

Type of funding? (please select one) ☐ CBH ☐ BHSI ☐ VA ☐ Other: _____

Is substance use disorder the primary diagnosis? ☐ Yes ☐ No If yes, please list the substance(s): _____

Is the participant currently in treatment ☐ Yes ☐ No

If yes, which type: ☐ Inpatient ☐ Outpatient

Anticipated successful discharge date? (*Inpatient Only*): _____

What was or is their current living situation prior to treatment? (please select one):

☐ Street (Homeless) ☐ Living with Family/Friends ☐ Shelter ☐ Safe Haven ☐ Living Alone/Independent ☐ Correctional Institution ☐ Other: _____

Does this referral participate in MAT? ☐ Yes ☐ No

If yes, please specify:

☐ Methadone ☐ Suboxone ☐ Vivitrol/Naltrexone

Any ongoing medical issues? ☐ Yes ☐ No

if yes, please specify:

	Issue(s):	Medication(s):
1.		
2.		
3.		
4.		

Is there a mental health diagnosis? ☐ Yes ☐ No

If yes, please specify: _____

Medication: _____

Any involvement with the criminal justice system? ☐ Yes ☐ No

If yes, Status/Charge: _____

☐ State ☐ Federal ☐ County (please select one)

PP ID: _____

Is this person Spanish speaking only? ☐ Yes ☐ No

Does this person need family housing? ☐ Yes ☐ No

If yes, Gender: _____ Child Age: _____

Gender: _____ Child Age: _____

For Individuals Without Insurance…

Base Service Units throughout the city receive funding from the state to provide mental health services to individuals without insurance. For more information, please contact CBH Member Services at 1-888-545-2600.

Behavioral Health Specialist Initiatives (BHSI) provides funding for individuals who need substance abuse treatment and are uninsured or underinsured. BHSI can be reached at 215-546-1200 M-F 8am-5pm.

CBH Clinical conducts authorizations for BHSI after hours and on weekends.

Service Access

City of Philadelphia

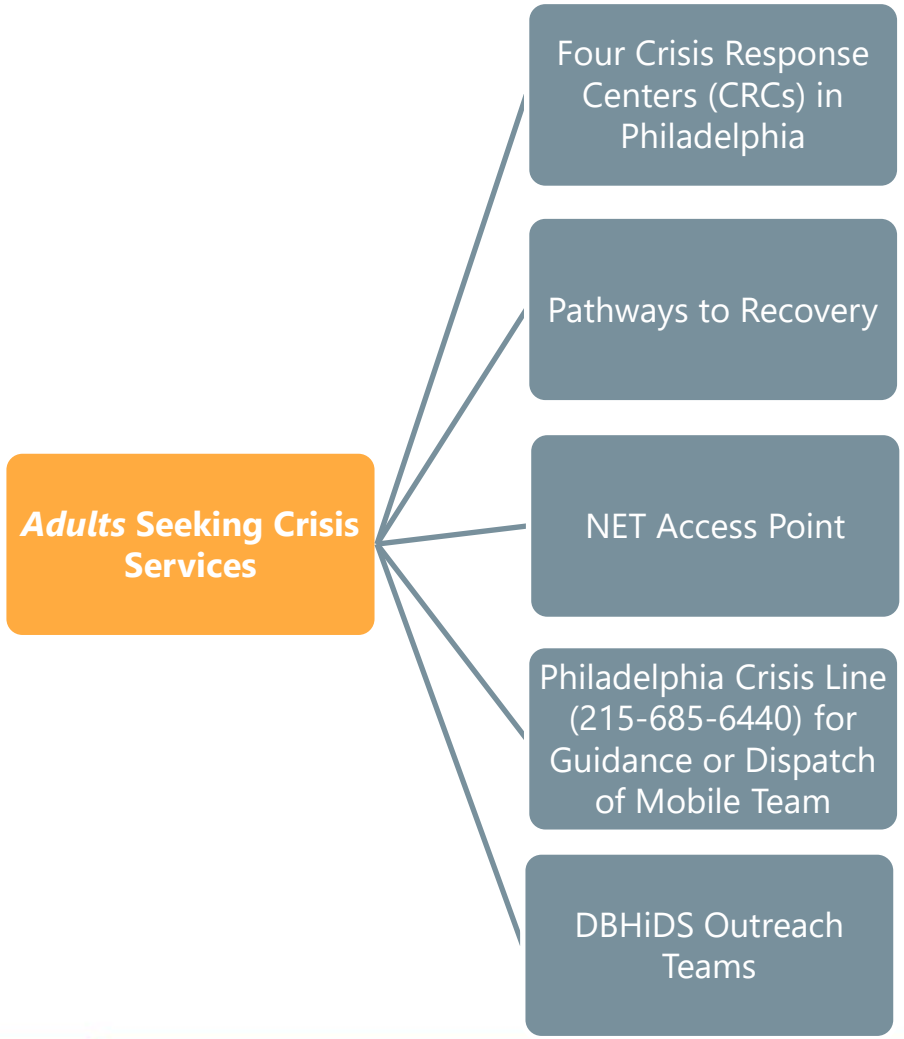
Types of Services

Emergency or emergent: Treatment is needed immediately (crisis response team, hospital, or CRC)

Urgent: Treatment is needed within 24 hours (substance abuse assessments, partial hospitalization)

Routine: Treatment is needed within seven days (outpatient services)

Entry Points for Emergency and Urgent Services



*Providers can also refer to other levels of care.

Crisis Response Centers for Adults

Friends Hospital 4641 Roosevelt Blvd, 215-831-2600

Einstein Medical Center 5501 Old York Road, 215-951-8300

Pennsylvania Hospital (Hall Mercer) 800 Spruce Street, 215-829-5433

Temple/Episcopal Hospital 100 East Lehigh Avenue, 215-707-2577

Crisis Response Center for Children Only (ages 17 or below)

Philadelphia Children's Crisis Response Center 3300 Henry Ave. Falls Two Building, 3rd Floor 215-878-2600

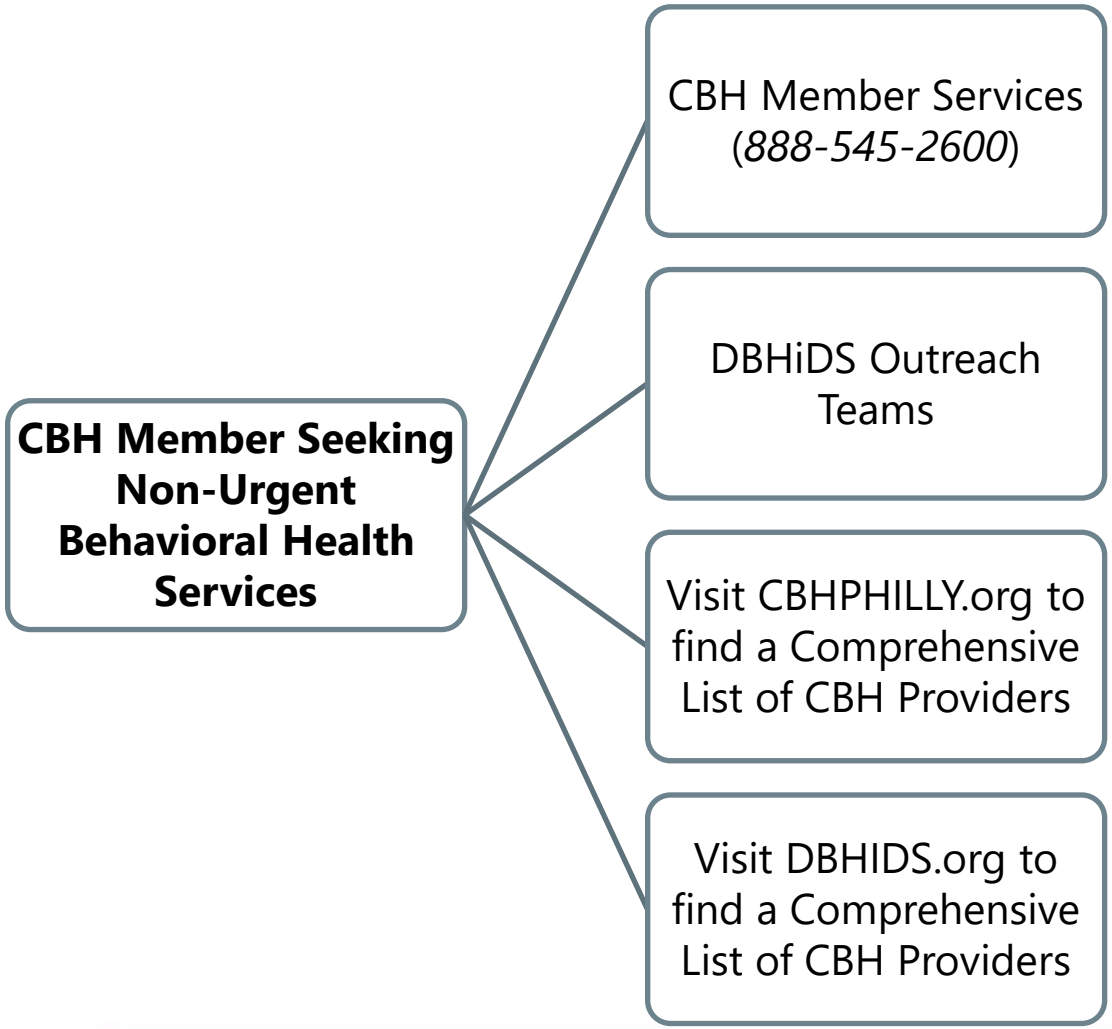
Substance Abuse Assessment Centers

NET Access Point 499 N. 5th Street, Suite B, 19123, 844-533-8200 or 215-408-4987

Pathways to Recovery Partial Hospitalization, 2301 East Allegheny Avenue, 19134, 215-731-2404

Gaudenzia 1306 Spring Garden Street, 19123, 215-238-2150

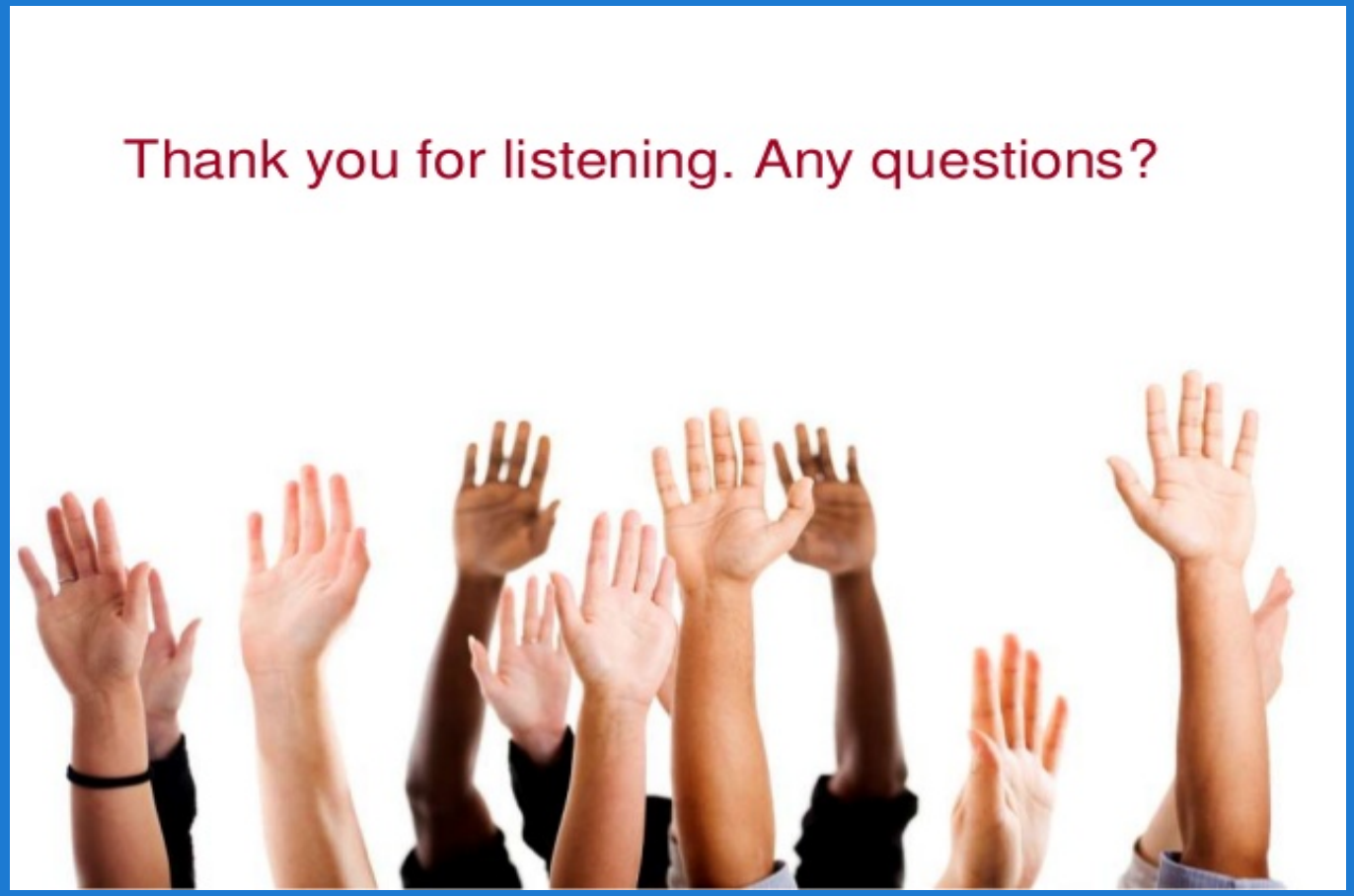
Entry Points for Routine Services



Who Can Refer to Treatment?

Referrals can come through a variety of channels:
Primary Care Physicians,
Emergency Departments,
School District,
Juvenile Justice System,
Philadelphia Department of Human Services,
Walk-in appointments to a behavioral health provider,
Via behavioral health screenings at a community event,
Self-referral,
Homeless outreach & Prevention Point outreach,
Family, friend, co-worker, neighbor

Note: CBH Member Services may be contacted 24/7 for any type of referral.



Please complete our post-event survey: https://www.surveymonkey.com/r/DKK8SX2

City of Philadelphia

DBHIDS

DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

C·B·H

Community Behavioral Health

Community Behavioral Health
801 Market Street 7th Floor Philadelphia, PA 19107
www.cbhphilly.org ● 215-413-3100
Member Services 1-888-545-2600