
# Community Behavioral Health

# Clinical Guidelines for Opioid Use Disorder (OUD)

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# 1. BACKGROUND

The City of Philadelphia, like much of the US, faces a crisis in fatal opioid overdose deaths. From 2013 to 2018, the opioid overdose mortality rate rose from approximately 450 deaths to over 1000 deaths per year. In 2017, Mayor Jim Kenney's *Task Force to Combat the Opioid Epidemic in Philadelphia* released its final report and recommendations (see Appendix A) which have informed much of the work CBH and its provider network have done to improve access and quality of Opioid Use Disorder (OUD) treatment.

Community Behavioral Health (CBH) has adopted clinical practice guidelines to outline best practices for the treatment of specific disorders or certain populations. These guidelines will be used by CBH to assess the quality of care provided to CBH members. As such, providers are advised to review and, where appropriate, implement these practices in their care. These guidelines apply to all clinical settings where members are seen with these disorders. These guidelines should be used in conjunction with any level-of-care-specific performance standards, as well as all other required CBH, NIAC, state, and federal regulations and standards.

# 2. PURPOSE

These OUD clinical practice guidelines draw from the ASAM National Practice Guideline for the Treatment of OUD 2020 Focused Update (see Appendix A) and describe expectations for quality of care. The aim is to articulate best practices and quality monitoring standards for providers of substance use treatment and to help providers design and monitor their services. These shall be maintained and updated collaboratively with providers and system stakeholders to reflect evolving evidence-based practice or changes in the ASAM national guidelines. Information on special populations as well as a listing of resources and referenced materials can be found in the appendices.

While designed for the CBH network, it is intended that the CPGs can also be used/accessed by other Philadelphia Medicaid providers, including physical health providers, to facilitate high-quality evidence-based care for CBH members in all treatment settings. For assistance in accessing services, please contact CBH Member Services via phone at 888-545- 2600.

# 3. PRACTICE GUIDELINES

## 3.1. Screening and Referral

The first priority of screening is to assess safety and make appropriate referral(s) for any urgent or emergent medical or psychiatric problems. This includes assessment of imminent danger to self or others, substance intoxication, withdrawal, or overdose. In cases of emergency, assessors should directly facilitate and ensure transfer to appropriate emergency medical or psychiatric services.

Additional screening should be used to assess for the presence and severity of substance use disorder. CBH recommends incorporation of brief, validated, structured screening instruments such as those outlined by SAMHSA's SBIRT (see Appendix A).

## 3.2. Overdose Risk Assessment

Given the high risk of overdose death in individuals with OUD, priority should be given to assessing for overdose risk factors. Standardized instruments may be employed if available. At minimum, history of prior overdose, amount and type of opioid used (including fentanyl), concurrent substances used (particularly respiratory depressants), and high-risk medical conditions should be documented. CBH also recommends that providers sign up for the Philadelphia Department of Public Health (PDPH) Opioid Overdose Notification Network (see Appendix A).

## 3.3. Assessment

ASAM multidimensional assessment should be completed and used to facilitate recommendation for a level of care. Assessors should be aware that members may not understand treatment terminology and may require education related to treatment process and recommended interventions. Initial assessment should include presenting complaint, current symptoms, complete medical and psychiatric history, and detailed substance use history. This includes assessment of readiness for change, interest in Medication-Assisted Treatment (MAT), and social and environmental factors to identify facilitators and barriers to treatment. Comprehensive assessment should include a physical exam when possible. At minimum, the assessor should confirm the member's access to physical health care or provide appropriate referral. Collaboration with existing providers and/or supports is expected. Inability to immediately complete all aspects of the comprehensive assessment should not necessarily delay or preclude medically appropriate treatment.

## 3.4. Social Determinants of Health

There is widespread evidence to support screening for various aspects of social risk within clinical care. Recent studies have also demonstrated that reduced economic opportunity has been associated with opioid overdose mortality (see Appendix A). As part of assessment and recovery planning, providers should identify relevant social determinants of health including housing and food insecurity, transportation challenges, vocational and educational history and opportunities, cultural and linguistic needs for engagement, disability status, and experiences with crime and violence (including physical and sexual trauma).

## 3.5. Diagnosis

OUD diagnosis should be made in accordance with DSM-5 Criteria (see Appendix A). Prior to any MAT initiation, this diagnosis should be confirmed and documented by the MAT prescriber. Documentation of diagnosis should follow any other pertinent state and federal regulations.

## 3.6. Laboratory Testing

Assessment should include obtaining or providing referral for laboratory testing. This may include urine/oral drug screen (instant and/or send out), pregnancy testing, CBC, LFTs, and appropriate screening for infectious disease (hepatitis, HIV, TB, sexually transmitted infections). Inability to rapidly obtain laboratory testing should not necessarily delay or preclude medically appropriate treatment.

Monitoring of progress in recovery with urine/oral drug screen should follow CBH level of care performance standards, if available. At minimum, providers must have a protocol for collecting a drug screen, determining frequency for drug screening, and ensuring review of results. Random testing should be considered in lieu of routine testing. Results of drug screens must be incorporated into treatment planning. Repeated positive results should be accompanied by a documented discussion of how they will be addressed, including consideration of a higher level of care. Additional recommendations can be found in the ASAM Consensus Statement on Appropriate Use of Drug Testing in Clinical Addiction Medicine (see Appendix A).

## 3.7. Harm Reduction

Given the harmful sequalae of OUD, this disorder benefits from a variety of harm reduction practices. Members should be educated on interventions related to IVDU (syringe exchange, etc.) and overdose. All individuals receiving substance use treatment, but particularly those with OUD, should be provided with education about and access to naloxone. This can be accomplished through use of the PA standing order or through a prescriber providing written prescription and/or directly dispensing to the member. Members with OUD should be asked regularly about their access to naloxone, and support should be provided in obtaining naloxone when needed. For additional details see CBH Provider Bulletin 16-04 and 17-10, “On-site Maintenance, Administration, and Prescription of Naloxone” (see Appendix B).

When clinically appropriate, there should be discussion of risks of continued opioid use (health risks, legal risks, occupational risks, financial risks, relationship risks) as well as agreed-upon steps taken to reduce risk when possible. For individuals who may become pregnant, there should be discussions about the impact of OUD on pregnancy, neonatal opioid withdrawal syndrome, and available options for family planning.

Given the frequent co-occurrence of multiple substance use disorders, members should be asked about their use of other substances, as outlined above. Members should be offered available medication assisted treatment (MAT) for any comorbid conditions, particularly alcohol

use disorder or tobacco use disorder. For more information, please see clinical practice guidelines for these conditions (Appendix B).

## 3.8. Treatment

Providers should utilize the ASAM Multidimensional Assessment and initial evaluation to inform their recommendation for a specific LOC. CBH uses the ASAM LOC, which represent a continuum of services catered to an individual's needs. For more information see Appendix A. CBH recommends individualized, collaborative, evidence-based treatments.

### 3.8.1. Medication Assisted Treatment (MAT)

MAT is recommended per the ASAM National Practice Guidelines and SAMHSA TIP 63 and has been correlated with better long-term outcomes for individuals with OUD (See Appendix A). The ASAM National Practice Guideline includes extensive detail regarding use of MAT and should be used to help inform providers.

All individuals diagnosed with OUD must receive information regarding all FDA approved MAT options. The information should be provided in an "informed-consent" structured discussion which should include discussion of benefits, risks, and alternatives and be documented in the medical record. Given the risks associated, documentation for a "medication-free" treatment for OUD must include a discussion of member's preference despite appropriate education. For individuals that have elected to undergo withdrawal management (formerly referred to as detoxification), informed consent should be given about the medical, psychological, and social risks of medication-free treatment, and practitioners should continue to engage the person through the withdrawal management episode of care indicating that MAT remains an option.

Individuals who elect to have MAT must be provided with MAT services on-site or should be promptly linked with another provider who can offer the desired MAT services. In hospital-based settings where members cannot leave for connection to MAT through another provider, there should be the ability to provide MAT onsite, including both inductions and maintenance. For additional information, see Provider Bulletins 18-07 and 20-33 (Appendix B).

For specific concerns related to prescription coverage, please see PA Medical Assistance Preferred drug list (See Appendix A).

### 3.8.2. Psychosocial Treatments

Psychosocial treatments, including individual and/or group therapies, are recommended in conjunction with MAT. The ASAM Guideline provides information on evidence-based psychosocial treatments. Given the high incidence of trauma in this patient population, CBH encourages a trauma-informed approach. An individual's preference should be considered in selecting a psychosocial intervention. However, a person's decision to decline psychosocial treatment should not delay or preclude appropriate medication management. The National

Academies of Sciences, Engineering, and Medicine 2019 Consensus Study concluded that "withholding or failing to have available all classes of FDA-approved medication for the treatment of OUD in any care setting is denying appropriate medical treatment" (see Appendix A).

### 3.8.3. Recovery Planning

Treatment must be guided by a co-constructed recovery plan that adheres to DBHIDS NIC Standards for excellence (Domain 2, Standard C: Advancing Excellence in Resilience/Recovery Planning and Delivery of Services). Recovery plans must also adhere to the requirements detailed in DDAP licensing. A person's behavioral, physical, and substance use challenges should be considered in the development of the plan and all active issues should be addressed by a proposed intervention or referral to an appropriate service.

Documentation of progress at each recovery plan update must include consideration of a higher level of care or other intervention to address any continued challenges. Similarly, for members who are progressing in treatment and meeting treatment goals there should be consideration of reduction in intensity of services or discharge as clinically appropriate. All providers involved in the care should have a working knowledge of the recovery plan.

### 3.8.4. Duration

OUD is a chronic condition, and some members may require treatment for a long duration or for multiple episodes. There is no recommended time limit for the duration of MAT use. Research is limited but has suggested that longer treatment duration may be associated with better outcomes. Members who relapse following discontinuation of MAT should be encouraged to resume treatment with MAT. Additional details related to discontinuing MAT or transitioning from one form of MAT to another are available in the ASAM guidelines.

## 3.9. Monitoring of Treatment

Treatment should occur with an understanding that relapse/disengagement is a common occurrence. Relapse reflects the natural history of OUD and should be considered an opportunity for engagement between the member and the treatment team. Continued substance use by the member is not necessarily a reason to discontinue MAT. However, continued substance use must be addressed clinically by the treatment team in an individualized way, taking into account possible triggers, need to adequately treat cravings/withdrawal symptoms, untreated behavioral health symptoms, etc. Examples of appropriate response to continued substance use could include change in treatment plan, change in medication type/dose, change in level of care, and development of a behavioral plan.

Monitoring of progress with drug screening is discussed above in the laboratory section (3.7.).

MAT providers must review the PA Drug Monitoring Program (PDMP) as per state guidelines (see Appendix A). If a PDMP query shows that a member is receiving controlled substances from an outside prescriber, the MAT provider should coordinate care with the other prescriber.

Prescribers should have an ongoing awareness of the member's complete medication list. There should be monitoring for possible polypharmacy, drug-drug interactions, and any needed testing, including EKG, laboratory studies, or medication levels (see Appendix A). There are also some medications, particularly benzodiazepines, that pose significant risk when used in combination with some types of MAT. In most cases benzodiazepines should not be used in combination with MAT. For additional information related to benzodiazepine prescribing and tapering, see CBH Clinical Practice Guidelines on these topics (see Appendix B).

When members are absent from treatment, CBH requires that providers perform assertive outreach and document efforts to re-engage the member. Similarly, there should be efforts to reduce AWOL, AMA, and Administrative discharges for everyone receiving treatment.

## 3.10. Coordination of Care/Linkages

Providers must ensure members seeking services have access to and are quickly linked with evidence-based treatments, particularly MAT. For details please refer to Provider Bulletin 18-07 (see Appendix B). Members should also receive appropriate referrals for underlying mental health needs, physical health needs such as comorbid Hepatitis C and HIV, housing, case management, etc.

Substance use providers should have a structure in place that supports integrated care and collaboration with other treatment providers, including, but not limited to, physical health and mental health providers, case management services, housing services, justice system services, etc. Integrated care is particularly important for individuals with any complex physical health or mental health needs.

Collaboration to coordinate care is expected between providers within an agency, as well as with any external providers. The purpose of this collaboration should be discussed with the member, including discussion of the benefits—as well as risks and possible consequences—of declining coordination. The medical record should include documentation of this discussion and any attempts to coordinate care.

Collaboration should occur regularly for ongoing care. Additionally, CBH requires evidence of real-time collaboration efforts in high risk circumstances, including, but not limited to, relapse, abnormal UDS result, concerning finding in PDMP query, referral to higher LOC, or safety concerns.

## 3.11. Aftercare Planning/Discharge

The aftercare planning process should begin in the initial stages of treatment. Members should be involved in the aftercare planning, and the plan should reflect the individual's goals and preferences. Planning should include a clear and specific plan for follow up at the next recommended level of care. Whenever feasible, an appointment should be scheduled, and there should be a warm handoff. There should be a clearly stated plan regarding provision of medications (including MAT) until the member is able to engage with the next provider. Discharge plans should always include a crisis and relapse prevention plan.

Unplanned discharges (including categories of Administrative, AMA, and AWOL discharge) have been linked to poorer treatment outcomes (see Appendix A). CBH expects providers to adopt a therapeutic, clinically based approach. Attempts at outreach, engagement, and linkage should be documented in the medical record. For additional information please review the June 20, 2019 Provider Notice, CBH Provider Bulletin 18-13, and DDAP Bulletin 01-19 (Appendix B).

# 4. MONITORING

CBH providers are expected to follow the above guidelines for OUD. Adherence to the standards will be assessed through CBH monitoring and oversight, including Quality, Clinical, and Compliance Department protocols. Components may be reviewed as part of NIAC initial and recredentialling reviews. In addition, some standards will be assessed via quantifiable metrics, which are specified in the table below:

| CPG Component Assessed | Metric | Data Source |
|---|---|---|
| Overdose Prevention | Naloxone Prescription: Percentage of members with OUD who have at least one pharmacy claim for naloxone in the last year | CBH Data Informatics |
| Treatment | MAT-OUD: Percentage of members with OUD who receive both MAT and counseling | CBH Data Informatics |
| Coordination of Care/Linkages; Aftercare Planning/Discharge | HEDIS® Follow Up After High-Intensity Care for Substance Use Disorder (FUI) | TMG |

# APPENDIX A: REFERENCES


- The Mayor's Task Force to Combat the Opioid Epidemic in Philadelphia: Final Report and Recommendations. May 19, 2017. Mayor James F. Kenney.

- The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update.

- SBIRT Substance Abuse and Mental Health Services Administration. Systems-level Implementation of Screening, Brief Intervention, and Referral to Treatment. Technical Assistance Publication (TAP) Series 33. HHS Publication No. (SMA)13-4741. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Philadelphia Department of Public Health (PDPH) Opioid Overdose Notification Network.

- Andermann, A. Screening for social determinants of health in clinical care: moving from the margins to the mainstream. Public Health Rev 39, 19 (2018).

- Venkataramani AS, Bair EF, O'Brien RL, Tsai AC. Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality in the United States: A Difference-in-Differences Analysis. JAMA Intern Med. 2020;180(2):254–262. doi:10.1001/jamainternmed.2019.5686

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

- Jarvis, M. et al. Appropriate Use of Drug Testing in Clinical Addiction Medicine. ASAM Consensus Statement. J Addict Med. 2017 (11) 3: 163-173.

- Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder. January 2020.

- Williams et al. Am J Psychiatry. 2020 Feb 1;177(2):117-124. doi: 10.1176/appi.ajp.2019.19060612. Epub 2019 Dec 2.

- Krawczyk et al. Addiction. 2020 Feb 24. doi: 10.1111/add.14991. [Epub ahead of print]

- Pennsylvania Medical Assistance Preferred Drug List.

- "Medications for Opioid Use Disorder Save Lives." The National Academies of Sciences, Engineering, and Medicine Consensus Study Report. March 2019. See highlights here.

- McCance-Katz E et al. Drug Interactions of Clinical Importance among the Opioids, Methadone and Buprenorphine, and other Frequently Prescribed Medications: A Review. Am J Addict. 2010 ; 19(1): 4–16. doi:10.1111/j.1521-0391.2009.00005.x.

- PDMP Resources
  - Registration
  - PA PDMP FAQ
  - 2014 PA Act 191: Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Enactment

- Li X, Sun H, Marsh DC, et al. Factors Associated with seeking readmission among clients admitted to medical withdrawal management. Subst Abus. 2008; 29:65-72.

- Substance Abuse and Mental Health Services Administration (SAMHSA): Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide. HHS Publication No. SMA-19-5097. Rockville, MD: Office of Policy, Planning, and Innovation. Substance Abuse and Mental Health Services Administration, 2019.

# APPENIDX B: PROVIDER BULLETINS, NOTICES, AND OTHER ADDENDA

1. Provider Bulletin 16-04 and 17-10: On-site Maintenance, Administration, and Prescription of Naloxone

2. Provider Bulletin 18-07: Requirement for All Crisis Response Centers (CRCs) and Drug and Alcohol Licensed Providers to Establish Protocols to Assist Individuals in Accessing Evidence-Based Treatment, Including Medication-Assisted Treatment

3. Provider Bulletin 20-33: Requirement for all Hospital-Based Psychiatry Providers to Have Capability to Provide Medications for Opioid Use Disorder (MOUD) to Individuals with OUD Who Require Hospital-Based Care.

4. CBH Clinical Guidelines for the Prescribing and Monitoring of Benzodiazepines and Related Medications

5. CBH Clinical Guidelines for Tapering of Benzodiazepines

6. CBH Clinical Guidelines for Tobacco Use Disorder

7. CBH Clinical Guidelines for Alcohol Use Disorder

8. Provider Bulletin 18-13: Significant Incident Reporting

9. Provider Notice June 20, 2019: Administrative Discharges from Residential Drug and Alcohol Treatment Settings

10. DDAP Bulletin 01-19: Reminder to Alert Emergency Contacts When Patients Leave Against Advice

11. DBHIDS Practice Guidelines for Resiliency and Recovery-Oriented Treatment

12. Department of Behavioral Health and Intellectual Disability Services (DBHIDS), Network Inclusion Criteria (NIC) 3.0, 2019, (or most recent version)

# APPENDIX C: SPECIAL POPULATION: CO-OCCURING PSYCHIATRIC DISORDERS

All individuals with OUD should have an evaluation of their mental health status as a part of their comprehensive assessment. In cases of emergency or acute safety concern, assessors should directly facilitate and ensure transfer to appropriate crisis services.

If a member needs mental health services in excess of what the substance use treatment provider can offer, then the member should be assisted in being linked to a provider who can offer these additional services. Collaboration between the substance use provider and the mental health provider is expected.

Individuals with psychiatric disorders or suicide risk factors should be asked about suicidal ideation/behaviors and should have closer monitoring for adherence to prescribed medications.

Assertive Community Treatment (ACT) should be considered for patients with serious and persistent mental illness, repeated hospitalization, or homelessness.

Please refer to the ASAM National Practice Guideline (Part 11) for additional details.

# APPENDIX D: SPECIAL POPULATION: ADOLESCENTS

Special consideration should be given to treating adolescents with OUD. Clinicians should utilize ASAM criteria and consider all available treatment options, including pharmacotherapy for OUD and psychosocial interventions. This population may benefit from specialized multidimensional treatment programs to address the member's unique needs. Please refer to the ASAM National Practice Guideline (Part 10) for additional details.

# APPENDIX E: SPECIAL POPULATION: PREGNANT INDIVIDUALS

ASAM guidelines recommend that pregnant individuals who are "physically dependent on opioids should receive treatment with methadone or buprenorphine rather than withdrawal management or psychosocial interventions alone." Furthermore, guidelines highlight that methadone or buprenorphine should be started as early as possible during pregnancy.

There are complex medical considerations in this population, including need for appropriate obstetrical and prenatal care and awareness of how pregnancy can affect pharmacokinetics of particular medications. Treatment of pregnant individuals with OUD should be co-managed by a clinician experienced in obstetrical care and a provider experienced in treating OUD.

Please refer to the ASAM National Practice Guideline (Part 8) for additional details.

# APPENDIX F: SPECIAL POPULATION: COURT-INVOLVED

For members involved with the criminal justice system, providers should adhere to SAMHSA's Principles of Community-Based Behavioral Health Services for Justice Involved Individuals (see Appendix A). Forensic goals should be assessed and included in recovery planning. All necessary consents for release of information should be obtained promptly to allow for providers to collaborate with any legal oversight (e.g. probation officers, defense attorney, district attorney). Collaboration should occur as needed or when requested by the member. All collaboration efforts should be documented in the medical record.

Practitioners should avoid a dual role whenever possible to avoid conflict of interest. For example, one practitioner could provide on-going treatment while another performs any court-stipulated assessment.

ASAM specifies that "risk for relapse and overdose is particularly high in the weeks immediately following release from prisons and jails" and recommends continuation of OUD treatment, including pharmacotherapy for OUD.

Please refer to the ASAM National Practice Guideline (Part 12) for additional details.