C·B·H

a division of DBHIDS

CLINICAL PRACTICE GUIDELINES

Opioid Use Disorder (OUD)

Updated August 19, 2024

Community Behavioral Health

MAIN OFFICES 215.413.3100 | MEMBER SERVICES 888.545.2600 | PROVIDER RELATIONS 215.413.7660 | CBHPHILLY.ORG

TABLE OF CONTENTS

1. Background 3
2. Purpose 3
3. Practice Guidelines 4
    3.1. Screening and Referral 4
    3.2. Overdose Risk Assessment 5
    3.3. Assessment 5
    3.4. Cultural and Social Determinants of Health 6
    3.5. Diagnosis 7
    3.6. Laboratory Testing and Drug Screening 7
    3.7. Harm Reduction 8
    3.8. Treatment 9
    3.9. Monitoring of Treatment 11
    3.10. Coordination of Care/Linkages 12
    3.11. Aftercare Planning/Discharge 13
4. Monitoring 13
Appendix A: References 15
Appendix B: Provider Bulletins, Notices, and Other Addenda 17
Appendix C: Special Population – Co-Occurring Psychiatric Disorders 18
Appendix D: Special Population – Adolescents 19
Appendix E: Special Population – Pregnant Individuals 19
Appendix F: Special Population – Court-Involved 20
Appendix G: Resources for Members 21

1. BACKGROUND

The City of Philadelphia, like much of the United States, faces a crisis in opioid use disorder (OUD) and fatal opioid overdose deaths. Community Behavioral Health (CBH) is keenly aware of the unprecedented change and numerous challenges faced by our communities in Philadelphia in the last few years. This is particularly true in communities highly impacted by substance use disorders (SUDs). According to the Philadelphia Department of Public Health (PDPH), unintentional death by drug overdose increased 5% in 2021 from 2020, 11% from 2019, and 14% from 2018. In 2022, there were over 1,400 drug overdose deaths recorded in Philadelphia, another 11% increase from the prior year.[1]

In addition, contamination of the illicit drug supply continues to complicate the response to the high rate of unintentional overdoses in Philadelphia. Xylazine, also known as "tranq," is a non-opioid sedative or tranquilizer intended for use in animals. In 2021, 91% of purported heroin or fentanyl samples from Philadelphia also contained xylazine[2]. According to a Drug Enforcement Administration (DEA) **public safety alert**, xylazine, when mixed with fentanyl, places users at a higher risk of suffering a fatal drug overdose. PDPH indicates that of overdose deaths in 2022, fentanyl was present in 83% of cases, stimulants were detected in more than 70% of cases, and xylazine was present in 34% of cases[1]. Furthermore, Xylazine contributes to severe wounds in the opioid-dependent population.

In 2017, Mayor Jim Kenney's *Task Force to Combat the Opioid Epidemic in Philadelphia* released its **final report and recommendations,** which informed much of the work CBH and its provider network have done to improve access and quality of OUD treatment. A multimethod research project, **Mapping the Opioid Use Disorder Crisis in Philadelphia, PA**, can provide the status and capacity of the current treatment system to provide equitable access and insights into the factors that contribute to engagement, early exit, and retention.

2. PURPOSE

CBH has adopted clinical practice guidelines (CPGs) to outline best practices for treating specific disorders or particular populations. CBH uses these guidelines to assess the quality

---

[1] *PDPH CHART: Unintentional Drug Overdose Fatalities in Philadelphia, 2022*

[2] *PDPH Health Alert: Risks of Xylazine Use and Withdrawal in People Who Use Drugs in Philadelphia; March 16, 2022*

of care provided to CBH members. As such, providers are advised to review and, where appropriate, implement as many of these practices as possible in delivering care. These guidelines apply to all clinical settings where members are treated for these disorders. These guidelines should be used with any level-of-care-specific performance standards and all other required CBH, Network Improvement and Accountability Collaborative (NIAC), state, and federal regulations and standards. Recommendations from this CPG may be used in quality management, provider performance evaluations, and other incentive programs, such as value-based payment.

These guidelines draw from the **American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of OUD 2020 Focused Update** and describe expectations for quality of care. The aim is to articulate best practices and quality monitoring standards for SUD treatment providers and 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. In addition, all CBH providers offering OUD treatment should be familiar with the Substance Abuse and Mental Health Services Administration (SAMHSA) regulations under the Code of Federal Regulations **42 CFR Part 8** (Medications for the Treatment of Opioid Use Disorder), including regulations that guide opioid treatment programs. These regulations were revised, and the final rule was released in February 2024 by the U.S. Department of Health and Human Services through SAMHSA.

While designed for the CBH network, it is intended that 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. Information on special populations and a listing of resources and referenced materials can be found in the appendices. For assistance in accessing services, please contact CBH Member Services at 888-545-2600.

3. PRACTICE GUIDELINES

3.1. Screening and Referral

The first priority of screening is to assess safety and make appropriate referrals 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. Awareness and knowledge of slang terms and code words for drugs may be relevant in screening and assessment stages[3].

Validated, standardized, and structured screening should be used to assess the presence and severity of SUDs. CBH recommends incorporating screening instruments, such as those outlined by SAMHSA's ***Screening, Brief Intervention, and Referral to Treatment*** (SBIRT) or by the National Institute of Health's **Screening and Assessment Tools Chart**.

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 a minimum, a 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 recommends that providers sign up for the **Philadelphia Department of Public Health (PDPH) Opioid Overdose Notification Network**, a notification system establishing a coordinated rapid response to "outbreaks" or opioid overdose surges in Philadelphia. Providers are encouraged to stay informed of local news and follow **PDPH news** for identification of risk of overdose and new drugs of abuse. PDPH publishes annual reports on unintentional drug overdose fatalities in Philadelphia that include recommendations for health care providers[1]. These and other reports can be subscribed to via **PDPH CHART**. Further, providers can reference the **DEA's public safety alerts**.

3.3. Assessment

The **ASAM Multidimensional Assessment** should be completed and used to facilitate recommendations for a level of care (LOC). Assessors should be aware that members may not understand treatment terminology and may require education about the 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 assessing readiness for change, interest in medication-assisted treatment (MAT), and social and environmental factors to identify facilitators and barriers to treatment. A comprehensive assessment should include a physical exam in alignment with the LOC per ASAM Criteria when possible. At a minimum, the assessor

[3] ***DEA Intelligence Report: Slang Terms and Code Words: A Reference for Law Enforcement Personnel; July 2018***

should confirm the patient's access to physical health care or provide an appropriate referral. Collaboration with existing providers and/or supports is expected. The inability to immediately complete all aspects of the comprehensive assessment should not necessarily delay or preclude medically appropriate treatment.

After the treatment team has developed and implemented an initial treatment plan, the team should conduct periodic reassessments to monitor the patient's progress and inform clinical decision-making. Reassessments and treatment plan reviews should also be conducted in response to significant events or changes in the patient's condition or circumstances that may influence the treatment plan or recovery process. Assessment and treatment should align with ***The ASAM Criteria, 3rd Edition***.

3.4. Cultural and Social Determinants of Health

There is widespread evidence to support screening for various aspects of adverse social determinants of health within clinical care. Recent studies have demonstrated that reduced economic opportunity has been associated with heightened opioid overdose mortality[4]. PDPH finds there to be a disproportionate increase in the number of overdose deaths among Black, non-Hispanic individuals compared to other racial/ethnic groups in Philadelphia in recent years. Between 2018 and 2022, the number of overdose fatalities increased 87% and 43% among non-Hispanic Black and Hispanic individuals, respectively, and decreased 12% among non-Hispanic White individuals[1]. 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).

Modifiable factors should be noted, and attempts should be made to support or link members to resources to address those factors as part of a comprehensive treatment plan. When feasible, efforts should be made to reduce barriers to engagement (e.g., transportation difficulties). For more information, please refer to Section 4.2 of the **CBH Clinical Performance Standards: Opioid Centers of Excellence** and resources available through the **Department of Behavioral Health and Intellectual Disability Services (DBHIDS)**.

[4] ***Screening for Social Determinants of Health in Clinical Care: Moving from the Margins to the Mainstream***

3.5. Diagnosis

OUD diagnosis should be made in accordance with **DSM-5-TR** criteria. Before 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 and Drug Screening

Assessment of SUD should include obtaining or providing a referral for laboratory testing, regardless of a patient's self-report regarding use. This should consist of a urine/oral drug screen (UDS), instant or sent out at intake and retaken at random intervals. Members should be educated on the need for UDS as a public and patient safety measure, as there are widespread contaminations of multiple illicit deadly substances mixed with their substance of choice, often without their knowledge. The presence of xylazine may inform treatment decisions. Xylazine withdrawal syndrome and evidence-based treatment are still not well-defined and are distinct from MAT for OUD[2]. It is imperative for care, especially for the management of withdrawal symptoms, to obtain UDS results.

The education and process of obtaining UDS should be approached cautiously so as not to seem punitive and stigmatizing. The inability to rapidly obtain urine drug screening should not necessarily delay or preclude medically appropriate treatment, especially at higher acuity LOC.

Additional laboratory testing may also include pregnancy testing, CBC, LFTs, and appropriate screening for infectious diseases (e.g., hepatitis, HIV, TB, sexually transmitted infections) with patient-informed consent. The inability to rapidly obtain laboratory testing should not necessarily delay or preclude medically appropriate treatment.

If possible, monitoring progress in recovery with UDS should follow CBH LOC performance standards. See the **CBH Clinical Performance Standards: Opioid Centers of Excellence** where applicable. At a minimum, providers must have a protocol for collecting drug screens, determining the frequency of drug screening, and ensuring the review of results. Random unannounced testing is recommended over scheduled testing. The 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 LOC. Additional recommendations for all LOCs, including selecting an appropriate testing panel and collaborating with a national laboratory, can be found in the ***ASAM Consensus Statement on Appropriate Use of Drug***

Testing in Clinical Addiction Medicine (includes a pocket guide and app). ASAM also provides educational materials to educate patients.

3.7. Harm Reduction

Given the harmful sequelae of OUD, this disorder benefits from a variety of harm reduction practices. Members should be educated on interventions related to intravenous drug use (syringe exchange if available, etc.) and overdose. All individuals receiving SUD treatment, particularly those with OUD, should be provided with education about and access to naloxone[5]. The DEA has published a **public safety alert** detailing that while naloxone does not reverse the effects of xylazine, which is making fentanyl even deadliner, it is still recommended to administer naloxone if someone may be suffering from an opioid overdose.

In Philadelphia, naloxone can be accessed via the Pennsylvania Naloxone Standing Order, individualized prescriptions from providers, the 24/7 naloxone tower at Lucien E. Blackwell Library, mail-order through NEXT Distro, or directly dispensed by a provider agency or community-based organization[5]. 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 Bulletins** 16-04 (On-Site Maintenance, Administration, and Prescription of Naloxone) and 17-10 (Extended Deadlines and Associated Fines). PDPH maintains **resource hubs** that offer free naloxone. Additionally, these resource hubs offer free HIV test kits, fentanyl test strips, and xylazine test strips. Philadelphians are strongly encouraged to obtain and receive training on how to use naloxone to prevent opioid overdose deaths[5]. Above all, the wide availability of naloxone should become a universal tenet within our system, as its rapid use can save lives from overdose. Please refer to **Appendix G: Resources for Members**.

There should be a discussion of the risks of continued opioid use (e.g., serious health risks, legal risks, occupational risks, financial risks, relationship risks) and 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 SUDs, members should be asked about the use of other substances, as mentioned in **Section 3.3: Assessment**. Members should be

[5] ***Learn how to get and use naloxone (Narcan®), City of Philadelphia Mental & Physical Health Services***

offered available MAT for any comorbid conditions, particularly alcohol use disorder (AUD) or tobacco use disorder (TUD). For more information, please see **CBH CPGs** for these conditions. Providers should also educate members on the potential for contamination of the illicit drug supply. Specific to xylazine, providers should inform members of potential side effects, such as atypical wounds and increased risk for overdose, as well as harm reduction strategies[2]. In addition, PDPH recommends encouraging patients who use street drugs to test their drugs using fentanyl and xylazine test strips and providing sterile syringes to patients who inject drugs to reduce the spread of HIV and hepatitis[1].

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 Criteria LOC**, representing a continuum of services catered to an individual's needs. Pennsylvania maintains a **1115 Waiver** approved by the Centers for Medicare & Medicaid Services (CMS) that is valid through September 30, 2027. A key requirement of the waiver is that care must be consistent with ***The ASAM Criteria, 3rd Edition,*** at the residential and inpatient LOCs.

CBH recommends individualized, collaborative, evidence-based treatments. Providers should utilize non-stigmatizing language as much as possible when discussing substance use with patients[6].

3.8.1. Medication-Assisted Treatment (MAT)

MAT is recommended as a first-line treatment per the **ASAM National Practice Guidelines** and **SAMHSA TIP 63: Medications for OUD** and has been correlated with better long-term outcomes for individuals with OUD. The ASAM guidelines include extensive details regarding MAT, which 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, including a discussion of benefits, potential risks, and alternatives, and documented for each patient within the medical record. Given the risks associated, documentation for a medication-free treatment for OUD must include a discussion of the member's preferences despite appropriate education about available treatment options. For

[6] ***Division of Substance Use Prevention and Harm Reduction (SUPHR) Guidance: Language Matters***

individuals who elect 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 undergo 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 **CBH Provider Bulletins** 18-07 and 20-33.

For specific concerns related to prescription coverage, please see the **Statewide Preferred Drug List (PDL)**.

3.8.2. Psychosocial Treatments

Psychosocial treatments, including individual and/or group therapies, are recommended in conjunction with MAT. The ASAM guidelines provide information on evidence-based psychosocial treatments. Given the high incidence of trauma in this patient population, CBH encourages trauma screening as well as a trauma-informed approach. An individual's preference should be considered when 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."

3.8.3. Recovery Planning

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

Documentation of progress at each recovery plan update must include consideration of a higher LOC or other interventions to address any continued challenges. Alternatively, for members who are progressing in treatment and meeting treatment goals, a reduction in the intensity of services or LOC should be considered 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 multiple episodes following relapse. 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. Return to substance use reflects the natural history of OUD and should be considered an opportunity for heightened 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, considering possible triggers, the need to adequately treat cravings/withdrawal symptoms, inadequately treated behavioral health symptoms, etc. Examples of appropriate responses to continued substance use could include a change in the treatment plan, change in medication type/dose, change in LOC, and development of a behavioral plan. Monitoring progress with drug screening is discussed in **Section 3.6: Laboratory Testing and Drug Screening**.

MAT providers must regularly review the **PA Prescription Drug Monitoring Program (PDMP)** for each member as per state guidelines. If a PDMP query shows that a member is currently receiving controlled substances from an outside prescriber, the MAT provider should coordinate care with the other prescriber. Providers are encouraged to utilize the **PMP Interconnect Search** to search for their patients in bordering states.

Prescribers should be aware of the member's complete medication list. They should monitor for possible polypharmacy, drug-drug interactions, and any needed testing, including EKG, laboratory studies, or medication levels (see **Appendix A**). Some medications, particularly benzodiazepines, pose elevated safety risks 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 CPGs** on these topics.

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 **CBH Provider Bulletin 18-07**. Members should also receive appropriate referrals for underlying mental and physical health needs, such as comorbid Hepatitis C and HIV, major depressive disorder, case management, etc.

SUD 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 complex physical health or mental health needs.

Collaboration to coordinate care is expected between providers within an agency, as well as with external providers, methadone maintenance centers, and entities providing members' care. The purpose of this collaboration should be discussed with the member, including 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.

Specifically, staff working for care management agencies and outpatient care managers working with members with SUD issues should familiarize themselves with relevant **CBH CPGs.** Whether or not the case management agencies have clinical services, the staff at any LOC management services should help facilitate harm reduction practices, including helping members get access to naloxone and educating them on its use, collaborating on treatment planning, helping obtain UDS, and other relevant activities in the CPGs.

Collaboration should occur for ongoing care at a minimum frequency of every three months. CBH requires evidence of real-time collaboration efforts in high-risk circumstances, including, but not limited to, medical and psychiatric hospitalization,

relapse, referral to higher LOC, safety concerns, or any other significant events that could impact member's treatment and recovery process. For example, staff can host meetings with external psychiatric providers involved with a member's care to facilitate care coordination and revisions of a treatment plan during any point of a psychiatric or medical hospitalization. All staff should be aware that they can call CBH to ask about the services provided to members and help find members' real-time locations, such as when a member is hospitalized.

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 LOC. An appointment should be scheduled, and there should be a warm handoff whenever feasible. There should be a clearly stated plan regarding the provision of medications (including MAT) until the member can engage with the next provider. Discharge plans should always include a crisis and relapse prevention plan.

Unplanned discharges (including administrative, AMA, and AWOL discharge categories) 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 **CBH June 20, 2019, Provider Notice: Reminder – Administrative Discharges from Residential Substance Use Treatment**, **CBH Provider Bulletin 18-13**, and **DDAP Information Bulletin 19-01**.

4. MONITORING

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

CPG Component Assessed	Metric	Data Source
Treatment	MAT-OUD: Percentage of members with OUD who receive both MAT and counseling	CBH Data Informatics

CPG Component Assessed	Metric	Data Source
Coordination of Care/Linkages; Aftercare Planning/Discharge	HEDIS® FUI - Follow-up after high-intensity care for substance use disorder assessing inpatient, residential treatment and detoxification visits or discharges among patients 13+ that resulted in follow-up care within 7 and 30 days.	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 (DSM-5-TR)**
- 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.

APPENDIX B: PROVIDER BULLETINS, NOTICES, AND OTHER ADDENDA

- **Provider Bulletin 16-04 and 17-10: On-site Maintenance, Administration, and Prescription of Naloxone**
- **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**
- **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.**
- **CBH Clinical Guidelines for the Prescribing and Monitoring of Benzodiazepines and Related Medications**
- **CBH Clinical Guidelines for Tobacco Use Disorder**
- **CBH Clinical Guidelines for Alcohol Use Disorder**
- **Provider Bulletin 18-13: Significant Incident Reporting**
- **Provider Notice June 20, 2019: Administrative Discharges from Residential Drug and Alcohol Treatment Settings**
- **DDAP Bulletin 19-01: Reminder to Alert Emergency Contacts When Patients Leave Against Advice**
- **DBHIDS Practice Guidelines for Resiliency and Recovery-Oriented Treatment**
- 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-OCCURRING PSYCHIATRIC DISORDERS

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

If a member needs mental health services beyond what the SUD provider can offer, then the member should be assisted in being linked to a provider who can offer these additional services. Collaboration between the SUD 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 Guidelines** (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 Guidelines** (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. It is important to plan a pregnant patient's treatment in conjunction with their obstetrical care.

There are complex medical considerations in this population, including the need for appropriate obstetrical and prenatal care and awareness of how pregnancy can affect the 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 Guidelines** (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: A Research-based Guide**. Forensic goals should be assessed and included in recovery planning. All necessary patient consent for the release of information should be obtained promptly to allow providers to collaborate with any legal oversight (e.g., probation officers, defense attorneys, district attorneys). 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 ongoing treatment while another performs any court-stipulated assessment.

ASAM specifies that the "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 Guidelines** (Part 12) for additional details.

APPENDIX G: RESOURCES FOR MEMBERS

- **Naloxone accessibility for Philadelphians**
  - **Pennsylvania Naloxone Standing Order**
  - **Naloxone tower** at **Lucien E. Blackwell Library** (available 24/7)
  - **NEXT Distro** mail order
  - **Resource hubs** maintained by the Philadelphia Department of Public Health
  - Members may also obtain naloxone via individualized prescriptions from providers or via direct dispensation by a provider agency or community-based organization
- **Resource hubs** maintained by the Philadelphia Department of Public Health provide naloxone as well as free HIV test kits, fentanyl test strips, and xylazine test strips.
- **Training on overdose awareness and reversal** is offered through the Philadelphia Department of Public Health
- **Opioid Safety and Using Naloxone Brochure**
- **Naloxone Instructional Brochure (English)**
- **Naloxone Instructional Brochure (Spanish)**