Clinical Performance Standards:

Opioid Centers of Excellence

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1. PURPOSE

Philadelphia, Pennsylvania, has one of the highest opioid overdose rates of any metropolitan area in the U.S. Since 2007, the number of deaths in Philadelphia due to overdoses surpassed the number due to homicide and has been increasing since that year. In 2022, the Philadelphia Department of Public Health recorded 1,413 unintentional overdose deaths. This is an 11% increase from the previous high of 1,276 in 2021—more than 80% of the overdose deaths recorded in 2022 involved opioids, virtually always fentanyl. The historic opioid overdose deaths have not impacted Philadelphians equally, however. The Health Department also found that the number of Black and Hispanic individuals dying from drug overdose continues to increase. From 2018 to 2022, the number of overdose fatalities increased 87% and 43% among Black and Hispanic individuals, respectively, whereas the number of White individuals who died from a drug overdose decreased slightly (12%).

In addition, individuals with Opioid Use Disorder (OUD) suffer at high rates from comorbid mental health conditions, such as Post-Traumatic Stress Disorder, and other substance use disorders, such as Alcohol Use Disorder. They also frequently have higher rates of adverse Social Determinants of Health (SDOH) than the general public, such as unstable housing, unemployment, and neighborhoods with high levels of incarceration. They are frequently involved with multiple systems and experience barriers to accessing resources, services, and treatment that would address their complex needs. Therefore, effective interventions should provide rapid outreach to individuals with OUD who are frequently involved with multiple systems and connect these individuals to any resources and treatment for their complex needs.

The Opioid Centers of Excellence (COEs) were created as a response to the growing opioid public health crisis in the commonwealth. In 2016, Governor Tom Wolf introduced the COEs as one strategy for addressing the ever-increasing public health and public safety crisis related to opioid use. Additionally, the COEs were envisioned as a community resource that would be used to break down the barriers that have long impacted individuals' ability to receive the services and treatment that they need to adequately address their substance use disorders (SUD) and other health concerns.

The COEs were designed to reach local communities, identify individuals with OUD, and ensure they receive the treatment and non-treatment services to assist them in long-term recovery. Furthermore, the designated COEs were tasked with increasing access to Medication for Opioid Use Disorder (MOUD) and integrating physical and behavioral health services. Beginning in 2019, the HealthChoices Physical and Behavioral Health Managed Care Organizations (MCOs) paid COEs for the care management services provided to members. Finally, starting on January 1, 2023, the oversight of COEs transitioned from the Department of Human Services (DHS) to the MCOs.

Therefore, the purpose of the Community Behavioral Health (CBH) COE Performance Standards is to establish expectations for high-quality COE services for CBH members with an opioid use disorder (OUD) diagnosis so that they may achieve success and thrive in their lives and their communities. To achieve this goal, CBH expects the COEs to provide:

- Individualized and person-centered care management services for a population that has complicated needs and is more challenging to engage in treatment. This includes individuals who are at high risk for overdose, individuals who currently engage in intravenous drug use, individuals who use opioids in conjunction with multiple substances, individuals with a record of seeking emergency department treatment for opioid use, individuals who have experienced opioid overdose, and individuals who have undergone inpatient or residential treatment for substance use. Additionally, this includes individuals who are experiencing homelessness or housing insecurity and high-risk priority populations who use opioids, such as pregnant women, individuals who have recently been released from incarceration, and veterans.

- Assertive and community-based care management and coordination. These efforts aim to facilitate a transition from crisis to treatment, which includes promptly initiating medication for opioid use disorder

(MOUD) and ensuring access to an OUD treatment. Additionally, COEs function as a hub and spoke program for various treatment options, services, and community resources and strive to integrate interventions for mental health, substance use, physical health, and Social Determinants of Health. By doing so, COEs aim to address gaps in care and diminish the stigma associated with opioid use disorder.

The COE's provision of care management services should be implemented using a stepped-care approach that considers each individual's stability and specific needs. The services can be categorized into three phases spanning 12 months. The initial phase lasts approximately 30 days and involves engagement, initial treatment, and stabilization. Following this, the second phase, between months two and four, focuses on integrating global health and skills training. Lastly, the third phase, from month five onwards, involves the expansion of recovery capital, skills training, and the transition towards self-management. The phases are considered guidelines rather than mandatory timeframes. The specific services that should be provided in each phase of this stepped-care approach are detailed in these performance standards; a service timeline can be found in the **Appendix**.

These Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, increase the consistency of service delivery, and improve member outcomes. The Performance Standards reflect the core values of the City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Practice Guidelines. These Standards articulate requirements for COEs and provide a guide for providers to design and monitor their programs. This document does not supersede state or federal regulatory requirements or CBH Quality, Compliance, and Credentialing requirements. CBH expects providers to apply these Performance Standards when developing internal quality monitoring activities. CBH will use this document as a guide when conducting quality reviews. Providers entering the CBH Network following the publication of these Standards will be expected to meet the Standards before their program start date.

CBH providers will be expected to implement the Standards over time before their enforcement, as evidenced through CBH oversight and monitoring. The Standards emphasize alignment of services based on the need to promote accessibility, quality of care, and culturally and linguistically competent treatment while also addressing adverse social determinants of health, including trauma. Treatment should encompass the member's whole health with attention to their physical, educational, family, and social/recreational needs, in addition to addressing behavioral health challenges through effective identification and coordination of "whole person" care. This requires consistent and active family, school, and stakeholder engagement and inclusive treatment planning, progress monitoring, community support, and discharge planning.

Starting in 2024, all COE providers must submit a detailed service description of their COE services to their designated Provider Representative by March 31 and whenever there are any substantial changes to the program. The service descriptions must include eligibility criteria, screening tools, a description of the process to reduce disparities, and protocols for outreach, MOUD induction, referrals, and discharge.

Failure to adhere to COE Performance Standards—including consistent inability to connect members to needed care and services adequately—may require remediation through technical assistance, a corrective action plan, or termination of COE from a provider's contracted services. A provider must notify CBH immediately of their inability to comply with these standards and implement an interim plan to ensure continuity of care for members.

2. PROGRAM REQUIREMENTS

2.1. Medication for Opioid Use Disorders (MOUD)

COEs must provide at least one form of medication approved by the Food and Drug Administration for use in Medication for Opioid Use Disorder (MOUD) at the enrolled service location in which COE services are offered and schedule

individuals eligible to receive COE services (COE Members) for MOUD induction within 48 hours of their initial encounter with the COE Provider.

MOUD utilizes prescribed medications to address the physiological responses to opioids, including cravings and withdrawal symptoms. There are three FDA-approved medications used to treat OUD: methadone, buprenorphine, and naltrexone. MOUD is recommended with concurrent behavioral health/psychosocial treatment and support to improve treatment attendance, retention, completion, and outcomes.

Medication for Opioid Use Disorder (MOUD)	*Brief Description*
Methadone	Methadone may be appropriate for individuals who need high levels of monitoring or may have polysubstance dependence. A methadone recipient must meet criteria for admission to an opioid treatment program (OTP). The goal is to enable individuals to function in daily activities without physical or psychological impairment due to medication or withdrawal symptoms. Prescriber must be working within an OTP.
Buprenorphine	Buprenorphine may be appropriate for individuals who are currently physically dependent on opioids, have a history of overdose, limited social supports, experience chronic pain, and require chronic opioid treatment. There are three phases of buprenorphine treatment: induction, stabilization, and maintenance. Formulations that include naloxone are commonly known as SuboxoneTM and are administered orally. Buprenorphine can also be prescribed as an extended-release injection, commonly known as Sublocade TM. Prescriber must obtain X-Waiver.
Naltrexone	Naltrexone may be appropriate for those with less severe OUD, have been abstinent for at least one week, are not able to take other forms of opioid agonists (e.g., Methadone), or have a co-occurring alcohol use disorder. Laboratory testing is utilized to monitor compliance. The oral formulation is commonly known as Revia TM, and the extended-release injection is community known as Vivitrol TM. These medications have been shown to have no euphoric or analgesic effects. Prescriber must have an active DEA license.

2.2. Warm Hand-Offs

A warm hand-off is a transfer of care between two healthcare providers in front of the prospective COE member or the member already enrolled in COE. Warm hand-offs are a mandate of COEs that involves making and receiving hand-offs from the time the prospective member is identified and enrolled in COE services through discharge. COEs facilitate warm hand-offs between a member referral source to treatment services, from treatment services to non-treatment recovery support services, or between levels of care for treatment services.

To rapidly identify and engage potential members within the community requires that COEs establish practical and formal warm hand-off agreements with agencies in the community that may interact with individuals with OUD, such as hospital emergency departments, hospital inpatient units, county jails, local police departments, emergency medical service (EMS) providers, and community service agencies. The formal warm hand-off agreements should specify the process for conducting the warm hand-off and providing information between the two entities.

COEs must be able to accept referrals 24 hours per day, seven days per week, through mobile engagement teams that facilitate warm hand-offs by traveling to the location where an individual needing COE services presents or partnering with another program that can accept referrals after business hours. The warm hand-off process includes a plan for the COE to take new enrollees within 24 hours of the interception. COEs will ensure that the referral sources for enrollment are documented in the individual’s chart.

2.3. Community-Based Care Management (CBCM) Teams

COEs must have the capacity and capability to employ a CBCM team to conduct mobile outreach, rapid identification and engagement of prospective members, and care management services to the existing COE members in the community.

CBCM teams are composed of licensed and unlicensed professionals (e.g., nurses, peer navigators, social workers, care managers, etc.) and are required to include at least one certified recovery specialist (CRS). CRSs are individuals with lived experience as a person in recovery warm hand-off completed a qualifying training course and received a credential from the Pennsylvania Certification Board. Licensed professionals must provide services within the scope of their license as defined by the Pennsylvania Department of State. Unlicensed professionals may not provide services that must be provided by licensed provider types and must receive regular and adequate supervision.

Members of the COE team should be treated as equals in the treatment decision-making process. It is very important to specify the roles of CBCM team members concerning what services they will be providing to each member, how they will be providing these services, how they will document the services provided, and how they will interface with other COE healthcare team members. It is also important to note that not every position will be part of the CBCM for every COE. COE evaluation outcomes have found that clear role specification within the CBCM team is associated with improved staff retention, which is associated with improved member care outcomes. The CBCM team should be adaptive, inclusive, culturally competent, and pragmatically member focused.

2.4. Outreach

Outreach is a specific requirement for COEs, which includes dedicated efforts to identify and engage members with OUD who are not participating in treatment yet and would benefit from the comprehensive coordination of supports offered by COEs. CBCM team members involved in outreach efforts should have documentation to demonstrate training in the application of the processes and workflows outlined by the COE, as well as therapeutic engagement strategies (i.e., use of Motivational Interviewing techniques).

For prospective and new members, the CBCM team must develop a protocol for outreach, rapid identification, and engagement by "meeting them where they are" in the community rather than just recruiting members from the COE's internal referral process. An outreach protocol should have a defined written strategy addressing an inclusive approach for outreach to marginalized individuals who tend to experience greater disparities in accessing care (e.g., LGBTQ+, Black, Indigenous, and People of Color communities). Notably, active use of opioids should not exclude someone from COE participation; a harm reduction approach should instead be taken with prospective members who are actively using opioids. The protocol should also outline the specific validated screening tools used to determine eligibility criteria and current risk determination (see the **Assessment section** for more information).

The COE's focus on providing care management services should allow for the expansion of mobile response services to include the ability to meet with members where they are located. Furthermore, a care management visit is not required to take place on location at the COE, which allows for the CBCM team to meet members where they are in the community to coordinate their care needs and ensure that their treatment and non-treatment needs are met.

2.5. Naloxone

COEs must provide access to naloxone to COE members for overdose prevention purposes. In the event of a warm hand-off from an overdose event, the OUD-COE must provide education related to overdose risk and naloxone.

2.6. Monitoring of Standards

- Provider has developed policies, protocols, and procedures to operationalize the following:

- » Provision of at least one form of MOUD for at the enrolled service location
- » Warm hand-off / referral agreements with referral sources
- » Description of CBCM team and its processes, protocols and functions, including mobile capability, team members' professional credentials and specific roles
- » Outreach protocol that includes a process for reducing disparities among member population
- » Access to naloxone

- Members receive induction to MOUD within 48 hours of initial encounter with the COE provider.
- Members are identified and recruited through an outreach process that includes active warm hand-off.
- COE staff have clearly defined roles and have been trained in the processes and workflows defined by COE and evidence-based member engagement strategies.

3. ENROLLMENT

The enrollment process first requires identification of potential COE participants through a documented outreach and warm hand-off process that includes a referral network, as described above. In addition, each COE should have a written strategy for identifying as well as reducing disparities (e.g., racial, ethnic, cultural, language, gender) in the identification or enrollment processes.

Individuals should not be automatically enrolled in COE when they enter MOUD, outpatient, or inpatient services. Instead, COE's outreach and enrollment efforts should focus on individuals with OUD who require coordinated care and management to rapidly access OUD treatment, non-OUD treatment (i.e., mental health services, physical health services, hepatitis B and C testing, HIV testing), and services that address the social determinants of health (SDOH), including but not limited to housing, employment, and transportation. Lastly, the team should strive to align their efforts with the recovery-oriented goals of each individual they serve.

The ideal individual to enroll in the COE should:

- Be 18 years of age or older
- Currently be enrolled in or eligible for Medicaid coverage
- Meet the criteria for an opioid use disorder (OUD) and not in sustained remission based on DSM-V criteria
- Not be currently enrolled, or enrolled for less than 30 days, in a substance use treatment program, including but not limited to:
  - » MOUD treatment
  - » Office-Based Opioid Treatment (OBOT)
  - » Opioid Treatment Program (OTP)

- Other outpatient treatment

Exceptions:

- The individual has been enrolled in a MOUD program beyond 30 days but shows reasonable harm, including a recent increase in substance use, recent overdose or other opioid related medical event, or a treatment episode in an inpatient or residential level of care in the past 30 days (psychiatric or SUD treatment);
- The individual has experienced a change in their SDOH which could impact recovery;
- The individual is a transfer from another COE and is still eligible for COE services.

Pennsylvania Department of Drug and Alcohol Programs (DDAP) has also identified five special populations who are to be given preference for treatment admission and, in this case, COE enrollment. It is important to be aware of these priority populations when coordinating care for members, as they may have different options than those who are not in a priority population. The special populations include:

- Pregnant individuals who inject drugs
- Pregnant individuals who use substances
- Individuals who inject drugs
- Overdose survivors
- Veterans

Eligibility criteria should be outlined in the COE's annual service description.

The following activities are required to be completed on the day of enrollment:

- COE confirms individual's eligibility for COE services.
  - Determine that the person resides in or is going to reside in the service catchment area and can receive care management services.
- All individuals who are eligible for the COE must be provided with a brief description of the program (verbal or in writing) and sign a formal consent to receive COE services at the time of their enrollment in COE.
  - Enrollment may be delayed until the person understands the purpose of COE program and provides consent for COE services.
  - Individuals who decline enrollment in COE services should be provided with the CBCM team's contact information. With the individual's consent, a CBCM team member should follow up with a phone call/contact within a week of the initial encounter to reassess their readiness for OUD treatment and COE services.
  - It is recommended that COE programs provide rapid access to MOUD either prior to or during the enrollment process. It is essential not to delay access to MOUD in order to complete the COE enrollment. If the individual consents, MOUD should be initiated without delay, even if they decline enrollment in COE services.

- COE completes COE-specific enrollment documentation and enrollment screening/assessment (i.e. risk assessment). Initial intake assessment may be brief to cover the essentials; more thorough data can be gathered over the course of a few days or a week. COE staff and the individual develop an Initial Care Management Plan to decrease the risk of overdose and substance use behaviors during the first month. The plan may also include addressing other risks identified during the initial assessment (i.e., medical, mental health, safety) as well as engagement in COE services.

- The individual is introduced to their care manager (preferably face-to-face physically or virtually and not merely telephonically or via a referral).

Enrollment date is the date of completion of all of the above activities during one session on one calendar day.

Individuals with immediate and high-risk needs (i.e., suicide risk, overdose risk), as determined by risk assessment, require rapid access to care and quick appropriate referral.

4. ASSESSMENT

Measurement-based care (MBC) is defined as the “practice of basing clinical care on client data collected throughout treatment” and is “considered a core component of evidence-based practice”. MBC involves the use of validated assessment measures for baseline conditions and to determine the impact of a treatment, service, or intervention. All COEs integrate an MBC approach to treatment through the required administration of overdose and suicide risk assessments, the Brief Assessment of Recovery Capital (BARC-10), an SDOH assessment, and the American Society of Addiction Medication (ASAM) Criteria Assessment.

4.1. Rapid Assessment/Risk Determination Screening

The COE should immediately assess the risk of overdose and suicide using validated assessment tools such as Columbia Suicide Severity Rating Scale (CSSS-RS) or other validated assessment tools, which they will submit to CBH with their service description. An initial (“care management plan, developed on the day of enrollment, should address all identified risks.

Since individuals who are not connected to MOUD have a higher risk of overdosing, the COE medical team should begin the process of induction to MOUD for every individual who is not yet connected. This means that on the first day of COE enrollment, the medical team of COE must be available to review the MOUD options and the individual’s preference for MOUD. This review includes the client’s concerns around stigma and MOUD.

Individuals are assessed using the Risk Assessment and SDOH Assessment at least monthly for the first two months and every two months thereafter while they are enrolled in the program.

4.2. Social Determinants of Health (SDOH)

SDOH are defined as the “conditions in the environments where people are born, live, learn, work, play, worship, and age that affects a wide range of health, functioning, and quality-of-life outcomes and risks.” Historically, the role of SDOH and the societal context in which drugs are consumed have been overlooked in research and healthcare delivery for minority and marginalized groups.

To address healthcare disparities, all COEs are required to assess SDOH using a validated assessment tool. COEs are permitted to select a measure of their choosing but are strongly encouraged to consider The Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) **Screening Tool**, which is a brief ten-item screener developed

by the **Centers for Medicare and Medicaid Services** (CMS). The HRSN screening tool includes items across five SDOH domains: housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety.

At a minimum, the SDOH assessment should be:

- Ideally administered during the initial visit, especially for SDOH that may increase risk for overdose, such as homelessness. These SDOH should be addressed in the initial care management plan.
- Administered within 30 days of initial contact
- Readministered at least monthly for the first two months and every two months thereafter while they are enrolled in the program
- Administered in home and community-based settings whenever practicable.

Results must be integrated into COE initial and ongoing care management plan plans in order to identify client needs and determine appropriate referrals for services and resources. To assist in this process, COEs should maintain an accurate, and up-to-date, resource referral list to connect clients to services in the community that address the needs identified through the SDOH assessment.

4.3. Level of Care Assessment

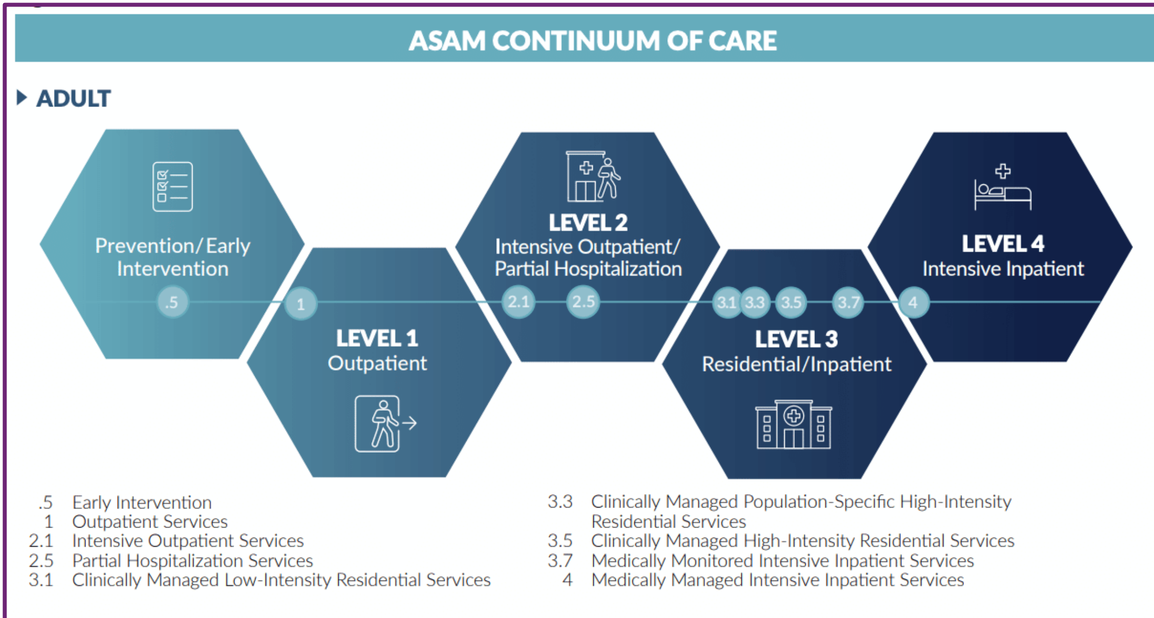
The **American Society of Addiction Medication** (ASAM; 2023) Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.

The standardized tool uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for care management planning and treatment across all services and levels of care. The ASAM dimensions are:

- Dimension 1 (Acute Intoxication and/or Withdrawal Potential)
- Dimension 2 (Biomedical Conditions and Complications)
- Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)
- Dimension 4 (Readiness to Change)
- Dimension 5 (Relapse, Continued Use or Continued Problem Potential)
- Dimension 6 (Recovering/Living Environment).

The ASAM Level of Care Assessment (LOCA) must be administered by a trained individual to each client within 72 hours of their enrollment, which can be completed either by the OUD-COE or through a referral, and every 6 months thereafter. The assessment must be completed by an individual who meets the qualifications and minimum experience and training requirements identified in Part 5.08 of DDAP's Case Management and Clinical Services Manual or who is a licensed individual trained in administering LOCAs. Results from the LOCA provide information to determine the appropriate level of care across continuums (see image below for visual depiction). If a level of care assessment results

in a recommendation of MOUD, the OUD-COE must provide education related to MOUD. All COE staff are expected to be **trained** and familiar with the ASAM Criteria.



4.4. Brief Assessment of Recovery Capital (BARC-10)

Recovery capital (RC) is a conceptual framework for identifying and understanding the facilitators and barriers to the recovery process. Defined as “the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery,” RC is essentially the total available resources a person has during their recovery process.

While comprehensive assessments are permitted and encouraged, the BARC-10 is a 10-item self-report measure to assess the level of personal, social, physical, and professional recovery resources. The BARC-10 is a required assessment for all COEs and the scores must be maintained within the client’s treatment record.

“Assessment of RC highlights a client’s recovery strengths” and the BARC-10 serves as a valuable care management and treatment planning tool for measurement-based care with administration at onset and routinely throughout care. At a minimum, the BARC-10 must be:

- Administered within 30 days of initial contact but encouraged during the initial visit with the client
- Readministered every six months during a client’s engagement with the COE

4.5. Co-Occurring Disorders

Beyond the required BARC-10, ASAM Criteria, and SDOH assessments, COEs may opt to utilize a more robust or comprehensive MBC approach. Research has demonstrated that co-occurring disorders contribute to a range of adverse treatment impacts including poor compliance, poor prognosis, and higher utilization of acute services; therefore, the use of validated and empirically supported assessments could be considered for the following commonly co-occurring disorders: nicotine use disorder, trauma and anxiety-related disorders, depressive disorders, bipolar and mood disorders, psychotic disorders, as well as physical health conditions. All assessments should be reviewed to ensure acceptable

psychometric properties with applicable reference norms standardized for the specific individual receiving the assessment.

SAMSHA recommends an integrated treatment approach that addresses co-occurring disorders simultaneously; rather than previous stepwise models of care (e.g., requiring abstinence prior to address mental health conditions).

4.6. Monitoring of Standard

- Individuals are assessed using the risk assessment at least monthly for the first two months and every two months thereafter while they are enrolled in the program.
- BARC-10 is administered within 30 days of initial contact but encouraged during the initial visit with the client and readministered every six months during a client's engagement with the COE.
- SDOH assessment is administered at least monthly for the first two months and every two months thereafter while they are enrolled in the program.
- ASAM criteria assessment is administered within the first 72 hours of initial contact and readministered every six months.
- COE demonstrates administration of assessment tools that identify co-occurring physical and mental health conditions.

4.7. Laboratory Testing

Urine Drug Screening (UDS) should be conducted monthly if UDS information is not available from the member's treatment provider, to determine whether someone is using opioids and, if so, whether the ongoing care management plan (as described below) needs to be updated accordingly.

5. RECOVERY-ORIENTED CARE PLANNING

Initial and ongoing care management plans are created through collaboration between the COE team member and COE member, using an individualized and strength-based approaches. Care management plans should include information on members' progress in accessing treatment and services and reaching their recovery goals. They should also take into account information gathered through member engagement and assessment tools.

An initial care management plan is developed at the time of enrollment. The initial plan does not have to be elaborate, but it should prioritize opioid treatment, risks identified with the risk assessment, and urgent SDOH needs, as well as the member's engagement with COE. By the second month of enrollment (first 30 days), an ongoing care management plan should be developed and incorporate information the member has provided through engagement activities as well as information obtained from SDOH, LOC, BARC-10 assessments, all completed within the first 30 days of enrollment. If there is a lack of decrease in substance use behaviors, the recommended approach should prioritize harm reduction and lowering substance use, with an emphasis on addressing social determinants of health requirements.

An ongoing care management plan that includes addressing SDOH gaps should be developed by the second month. The ongoing care management plan should consider and reflect the individual's clinical status and needs, which is the foundation of the stepped-care approach. They should be reviewed with the individual monthly and updated every six months or sooner if there are significant changes to an individual's circumstances. If substance use behaviors appear to be constant with no reduction, maintain focus on harm reduction (if appropriate to programming with which the individual

is involved) and reducing substance use, with a focus on pressing SDOH needs, until substance use behaviors decrease. The following describes the three phases of COE recovery-oriented care planning:

5.1. Phase 1: Engagement and Stabilization

In the first month, the primary focus is retaining the individual in treatment and connecting to services and providers to assist in SDOH barriers. Encourage individuals to integrate family members in the program during the engagement phase and provide family members with education on the client's service options and needs (e.g., benefits of MOUD, need for long-term care). Any emergent medical or mental health needs can also be addressed in this phase, such as pregnancy or need for psychiatric consultations (e.g., hospitalization for suicidal behaviors). Focusing on active substance use behaviors is critical, however, as disengagement from COE within the first 30 days is common and is mostly due to substance using behaviors. All newly enrolled individuals should receive the Brief Assessment of Recovery Capital (BARC-10) in the first 30 days.

5.2. Phase 2: Integration of Global Health and Skills Training

In the second phase, assuming clients can be engaged or reengaged in COE services (e.g., does not need to be transferred to another COE or an inpatient or residential program), begin to focus screening, assessments, and care management activities on more global healthcare and co-occurring needs as well as social support systems that can help individuals stay actively involved in any behavioral health treatment. Care managers can focus on gaps in SDOH during this phase, mental health and primary care needs/services (can also include dental, pre-/post-natal care, HCV/HIV screening and treatment). During the second phase, focus consistently on individual's substance use patterns, as most disengage because of ongoing substance use (even if they want COE services). Substance use patterns should be monitored weekly, if not more frequently for those who are known to disengage and reengage. Substance use can be assessed through biometrics, weekly check in for risk of substance using patterns, and monitoring of emotional states known to trigger substance use (e.g., weekly screening or check ins using the PHQ-9, GAD-7, or other validated psychiatric scales with psychometric properties). Integrate family members in the individuals care management plans, as family members can help re-engage individuals during this phase. Help family members see the value of MOUD as well as how to provide support.

5.3. Phase 3: Expansion of Recovery Capital, Skills Training, and Transition to Self-Management

During the third phase, focus on expanding social supports for individuals, through educating family members on helping them to manage urges, family therapy to reduce stigma, and/or coaching on how to support recovery (e.g., Community Reinforcement Approach). Focus also on addressing critical healthcare needs, such as screening and treatment for HCV/HIV (if not already done in phase 2), sexually transmitted diseases, smoking cessation and medications for those who smoke cigarettes, and unmet SDOH/recovery capital needs (e.g., education, employment, expanding social networks). The third phase is also used to identify a PCP/FQHC or OTP where individuals can receive MOUD and healthcare services beyond the COE. The BARC-10 should be assessed at six-month intervals to demonstrate recovery capital. Successful discharge includes enrolling individuals in a PCP/FQHC/OTP where they can receive ongoing MOUD and health care services.

5.4. Monitoring of Standard

- The initial care management plan is completed within 24 hours of enrollment in COE services.
- The ongoing care management plan is completed within 30 days of enrollment.

- The ongoing care management plan is updated at least every six months.
- The plan is strength-based, individualized, and reflects member's involvement in plan development.

6. REFERRALS, CARE MANAGEMENT, AND COORDINATION

Referral represents a two-way connection of the CBCM team to providers for treatment of OUD and co-occurring conditions (mental and physical health) and non-treatment services for the COE-engaged members. To be a referral, there must be a notification back to the CBCM team that information was received, and the member accessed services. COEs, therefore, are responsible for facilitating referrals from COE to treatment services, from treatment services to non-treatment services, or between levels of care for treatment services.

Facilitating referrals to necessary and appropriate clinical and non-clinical services according to the member's care management plan, include:

- Primary care, including screening for and treatment of positive screens for: HIV, hepatitis A (screening only); hepatitis B; hepatitis C; and tuberculosis
- Perinatal care and family planning services
- Mental health services
- Forms of medication approved for use in MOUD not provided at the COE provider's enrolled service location(s)
- MOUD for pregnant members, if the COE provider does not provide MOUD to pregnant individuals
- Drug and alcohol outpatient services
- Pain management
- Facilitating referrals to any ASAM LOC that is clinically appropriate according to an LOC assessment
- Facilitating referrals to necessary and appropriate non-clinical services according to the results of the individual's needs identified through a SDOH screening including but not limited to transportation, housing, nutrition/food, education, employment, training, legal services, and childcare

6.1. Referral Network

Each COE is required to demonstrate a referral network as part of its COE designation application. An individual's needs must never be left unaddressed because of a lack of specific services offered within the COE. When treatment needs are identified, COEs should provide those services when able; otherwise, referrals to other providers or entities must occur if or when COEs cannot provide the service directly. It is expected that the CBCM team will exhaust all options to successfully refer the individual to the needed services. Partnerships with external entities should take the form of formal written referral agreements that include how referrals will be made (warm hand-off will receive the referral, contact information, when referrals can be made, etc.), how referrals will be acknowledged, and what information will be shared

(with appropriately applied informed consent). COEs should regularly check in with referral entities to review referral information (i.e., numbers, access data, etc.) and document plans for improving referral access for individuals.

6.2. Evidence-Based Practices

Evidence-based practices (EBP) incorporate the best available research, along with clinical expertise and patient treatment preference, into treatment planning and clinical practice. For COE team members to effectively coordinate care to EBP, familiarity with behavioral health treatments for substance use disorders (SUD) is essential. Staff involved in the identification process must receive appropriate documented training in evidence-based client engagement strategies, such as the use of motivational interviewing principles. COE staff have up to one year from the implementation of these performance standards or the start date of their hire (if that date is later) to complete the required training. The following review is not adequate, nor does it qualify as training for EBP.

The **Evidence-Based Practice and Innovation Center** (EPIC) was established in 2013 to advance system-wide strategies that support the implementation, sustainability, and accessibility of behavioral health evidence-based therapy practices in Philadelphia. Within the Philadelphia CBH Network, providers and independent practitioners can achieve an EPIC EBP program designation. COE team members can review the EPIC website for more information and resources related to training opportunities, EBP program designation, and initiatives geared towards a recovery-oriented behavioral health system.

EBP for SUD	*Overview of Key Principles*
Motivational Interviewing (MI)	A person-centered, collaborative approach to assist individuals as they identify areas for change and pursue their goals. MI utilizes communication techniques (e.g., OARS; open-ended questions, affirmations, reflective listening, summaries) to reinforce change talk and strengthen a person's motivation for change.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Based upon MI principles, SBIRT incorporates the utilization of standardized screening tools to motivate treatment access and engagement. During review of positive symptom screeners, positive behavior change is encouraged through POLAR*S (permission, open-ended questions, listen reflectively, affirmation, roll with ambivalence, summarize).
Assertive Community Treatment (ACT)	ACT is focused on providing the various services needed by an individual to facilitate recovery through community treatment and habilitation (in the community, places, and situations where the problems arise). While not a case management program, the service delivery model often utilizes case management techniques to address the individual's needs.
Contingency Management (CM)	With the view that substance use is a positive experience, CM targets the behaviors that maintain engagement in substance use. The approach provides rewards and incentives for desirable behaviors, and in some CM programs, also includes withholding of privileges or disciplinary measures for engagement in undesirable behaviors.
Cognitive Behavioral Therapy (CBT)	CBT is based on the interconnectedness of thoughts, feelings, and behaviors. The approach aims to disrupt and modify maladaptive thoughts and behaviors through various interventions (e.g., cognitive reframing, relaxation techniques, behavioral activation, Socratic questioning).
Dialectical Behavior Therapy (DBT)	Originally designed for individuals with significant emotion dysregulation or a diagnosis of borderline personality disorder, DBT has been found effective in changing thoughts, behaviors, emotions, and social responses through skill building (i.e., distress tolerance, emotion regulation, interpersonal effectiveness, mindfulness).
Functional Family Therapy (FFT)	A strength-based approach that addresses the needs of an adolescent on an individual and family-system level. FFT is offered in a variety of settings (school, home, clinic) with

EBP for SUD	*Overview of Key Principles*
	principles that prioritize acceptance, respect, engagement, behavior change, and generalization of skills.

6.3. Monitoring of Standard

- COE has developed a formal referral agreement with its referral network.
- The number of documented referrals COE made for a member
- The number of documented appointments the member completed as a result of the referrals
- COE staff have up to one year (either from date of implementation of performance standards or hire start date) to complete required EBP training.

7. ENGAGEMENT

7.1. Member Engagement

Member engagement is essential for obtaining maximum COE program benefits and supporting progress toward individual care plan goals. Engagement can be evaluated with two primary metrics – participation in program activities through attendance tracking and participant satisfaction through surveys or other feedback mechanisms. Members should be included in all components of the COE program (e.g., care coordination meetings, care management plan creation, review, and updates).

Providers must use data to "understand the common characteristics of clients who terminate services prematurely and develop an individualized approach to maintain treatment engagement. Lower education level, younger age, being in an ethno-cultural minority group, injection substance use, and being female are all associated with premature termination of services."

The purpose of member engagement is to provide therapeutic engagement, assess current treatment and non-treatment needs and risk, improve care coordination (with warm handoffs), integrate physical and behavioral health care needs with an individualized care plan, and increase access to clinical services such as MOUD and Evidence-Based Practices (EBP).

Approaches to increasing member engagement in COE services include:

7.1.1. Therapeutic Engagement

While coordination to care are the primary functions of COE services, the team does provide therapeutic engagement until connection to behavioral health clinical services (e.g., EBPs, medication management) can occur. Therapeutic engagement is defined as the active process of developing rapport for the purposeful gathering of information to determine current treatment needs and risk in order to engage an individual in shared decision making and promote recovery with an individualized care management plan. Motivational Interviewing (MI) is an EBP designed to assist with therapeutic engagement efforts by reinforcing change talk and strengthening a person's motivation for change. All COE team members are encouraged to be trained and familiar with MI techniques to optimize their effectiveness with engaging individuals throughout the care coordination and recovery process.

7.1.2. Trauma Informed Care (TIC) Approach

With recognition that there is a bidirectional relationship between trauma and substance use, COEs utilize a TIC approach through all service provisions. The potential for re-traumatization occurs in every aspect of service delivery (e.g., paperwork verbiage and forms, assessments, clinical interventions, treatment practices, organizational policies, and procedures). While re-traumatization is rarely intentional, COEs are responsible for minimizing the potential for re-traumatization through recognition of trauma responses, utilizing person-first and culturally inclusive, non-stigmatizing language, establishing, and maintaining healthy professional boundaries, integrating peer support services, and recognizing when referrals for trauma-specific treatment are clinically necessary.

7.1.3. Family and Social Support

Family and social support are key factors for program engagement. COEs utilize shared decision-making (SDM), foster cultural humility, and ensure diversity and inclusion for all individuals identified by the program participant as part of their care team (i.e., family of choice). The intersectionality of stigma around behavioral health conditions and cultural identity needs to be recognized and SDM interventions need to be flexible and adaptable to meet the needs of individuals in real-world practice. “Healthcare practices can adopt a variety of strategies to improve person and family engagement. Changes can range from improving office workflow, to improving how care team members interface with the patient and family, to developing shared decision-making strategies that ensure treatment is understood by and meaningful to the individual patient. When patients and families are partners in planning and making decisions about their care, health outcomes are better, patient experience and satisfaction improves, and often, costs are lower.” Families-of-choice can also support re-engagement when a rupture in treatment continuity occurs and provide valuable context to an individual’s response to interventions.

7.1.4. Harm Reduction Approaches

Harm reduction is a public health approach focused on decreasing the negative effects associated with substance use through education and addressing individual/community needs. Rather than prohibiting substance use altogether, harm reduction focuses on acknowledging the dignity and humanity of people warm hand-off use substances, as well as minimizing negative consequences of substance use and promoting health and inclusion. There are a range of harm reduction approaches, and no one prevention or treatment approach works reliably for everyone. To mitigate harm and preserve safety, the following harm reduction strategies may be considered: overdose prevention (e.g., Naloxone, education about overdose potential), safe use strategies (e.g., knowing source of substance, carrying Naloxone, seeking medical treatment, rotating injection site), overdose reversal (e.g., carrying Naloxone, identifying signs of overdose), syringe exchange/access (e.g., identifying organizations that provide syringe access), and safe consumption sites (e.g., overdose prevention centers).

Practical harm reduction approaches also involve advocacy on behalf of the individual to reduce stigma and eliminate barriers to care, as well as addressing the medical needs associated with substance use (e.g., abscesses, wound care, transmittable diseases).

7.1.5. Peer and Community Recovery Services

Recovery from an SUD involves several interrelated intrapersonal, interpersonal, environmental, and biobehavioral health-related factors. In the development of a care management plan, consideration of the peer and community environment is essential for holistic care. Peer support and community services (e.g., 12-step programs, SMART recovery) are associated with improved program retention when added to COE care management.

7.1.6. Monitored Engagement

Monitored engagement refers to the COE's documented contact with the member as well as with the agency that is providing treatment and services for the member. Member's treatment and non-treatment needs ultimately drive the frequency of contacts COE has both with members and providers members are referred to.

7.1.7. Monitored Engagement with Members

From the time of member enrollment, the COE will provide at least one individualized contact per month to help members engage and stay engaged in treatment. Care management sessions with members should last for a minimum of 15 continuous minutes in alignment with CMS requirements for both certified recovery specialist services and case management services. The care management sessions should include one or more of the following: a discussion of members' progress toward their care management goals, an update on the status of both clinical and non-clinical referrals, and the addition of new referrals as needed. Examples of engagement activities include helping a member find community resources such as individual and group therapy, social services, and recovery supports; referring a member for housing, job transportation services, food assistance, and self-help meetings; monitoring a member's health status and achievement of goals within the member's care management plan; motivating and encouraging members with OUD to stay engaged in both physical health and behavioral health treatments.

7.1.8. Monitored Engagement with Providers

Monitored engagement with providers include documented contacts with mental health services, healthcare services (e.g., PCP/hepatitis B/hepatitis C/HIV testing, pain management, pregnancy testing/prenatal care), health insurance benefits coordination, SUD treatment, peer support, housing, transportation, identification/birth certificate/other identification, self-help meetings, food assistance, advocacy (e.g., adult probation, criminal justice, police), job training/vocational services, and educational services.

7.2. Monitoring of Standard

- Each COE member receives at least one individual care management contact per month.
- COE team members make and document contact with treatment and service providers to follow up on member's progress and appointments.

8. TREATMENT REQUIREMENT

During the first month the member is engaged with the COE, the COE must provide at least one individual care management encounter service and one treatment service ("treatment requirement"). The treatment must be related to the member's care and treatment of the diagnosis code and may be provided on-site or referred to and followed up with an external provider. It includes but is not limited to: behavioral health assessment and treatment, mental health assessment and treatment, physical health assessment and treatment, OB-GYN health assessment and treatment, drug testing, and HIV/hepatitis C testing. The COE site does not have to provide the treatment service but must coordinate and document the service provision.

In subsequent months of member engagement with the COE, the COE must demonstrate the provision of at least one individual care management service encounter per month to bill the COE case rate. A member is considered disengaged from COE services if, despite CBCM's outreach efforts, no contact has been made for two or more consecutive months.

Members disengaged from the COE service for two or more consecutive months should be provided with a rapid reengagement in COE services if requested. Within the first month of reengagement, the member must receive a care management service and a treatment service.

8.1. Monitoring of Standard

- The COE has developed and documented eligibility criteria.
- Members enrolled in COE meet eligibility criteria.
- Percent of new COE participants
- Percent of re-engaged COE participants
- High-risk members, including those in one or more special populations, are identified during enrollment and provided rapid access to treatment.
- The COE has documented attempts to obtain information about members receiving potentially duplicative services from members, referral sources, and CBH Member Services.
- A care management service and a treatment service are provided within the first month of engagement or re-engagement with COE.

9. DUPLICATION OF SERVICES

The CBCM team's activities must not overlap or be redundant with already existing care management services. These include:

- Services provided to the same member by another COE
- Drug and alcohol intensive case management
- Drug and alcohol resource coordination
- Drug and alcohol LOC assessment
- Drug and alcohol service, other/not specified (drug and alcohol other requires service description approved by OMHSAS)
- Certified recovery specialist services

CBCM teams should make every effort to obtain information about existing care management services prior to and during the member enrollment and engagement in COE services by directly soliciting this information from the individual, the referral sources, or CBH Member Services. While the information may not always be readily available at the time of enrollment, the efforts should continue and be documented in the member's chart.

Continuing to provide COE services to a member enrolled in more than one COE beyond two months may result in the recoupment of payments CBH made to the COE. Similarly, recoupment of COE case rate payments may also result after

CBH establishes that the client was concurrently receiving other drug and alcohol services duplicative of services provided by COE.

COE providers should also be aware of the overlapping services provided by other levels of care. For example, inpatient treatment already includes coordination of care, and COE involvement will be most effective in working collaboratively with the inpatient discharge team to ensure the post-discharge continuation and coordination of care.

10. AFTERCARE PLANNING/DISCHARGE

10.1. Discharge Criteria

Discharge should occur if one or more of the following criteria are met:

1. Individual had no contact with the program for over 60 days, and there is a record of three or more attempts to contact by the COE that includes friends or family members as well as other providers warm hand-off have worked with the individual in the past (e.g., residential treatment providers, CMHCs, or PCPs). The date of this discharge ascertainment is as close to the 61-day window with contact attempts as possible. COE indicates the discharge date and a qualifier that this is a discharge without contact (DWC).

2. Individual is incarcerated and cannot be contacted for at least two months, in which case the estimated release date from jail or prison is provided or estimated, based on the sentence. COE indicates the discharge date and a qualifier that this is a "client incarcerated." COE will indicate in the discharge plan in the EHR the name and location where the individual is incarcerated, if available. If the individual can be reached, even if Medicaid cannot be billed, and will likely be released within the next two to three months, COEs should keep the individual as active and indicate incarcerated status.

3. Individual has completed planned COE care management services and has been successfully transitioned to self-management, as described above; the COE indicates the "transition" date and that is a successful "transition from COE services" and codes it as "client completed planned COE services."

4. Individual requires more intensive care coordination or alternative medication such a methadone; the COE indicates the discharge date and codes it as "client transferred to other COE." If the individual transfers to a provider that is not a COE, care management can be provided by their current COE.

5. Individual has died. The COE indicates the discharge date (which is the date the death is known) and code the discharge reason as "deceased."

6. Individual has contact with the COE but declines to continue receiving COE services, code the discharge reason "voluntary discharge: AMA."

COE will list in the discharge plan in the individual's chart the names and locations of primary care physician, MOUD provider, peer services/recovery support and/or other treatment provider(s) warm hand-off will provide ongoing care and medication after discharge from the COE. If the information is unknown, the fields are to be coded as "9." In addition to the providers noted above, the discharge plan should also include but is not limited to:

- Last available BARC-10 score
- Current recommendations for continued care

- Referrals placed
- Documentation that individual received information on how to return to the COE if needed

Individuals who no longer meet eligibility criteria for MA can sometimes receive funding for continued care via the relevant Single County Authority (SCA). Thus, the COEs are strongly encouraged to understand how to access the SCAs sources of funding for those who are not eligible for MA or other third-party payment.

Individuals who continue to submit positive drug screens for any substance should not be discharged from the COE.

10.2. Monitoring of Standard

- Number of re-engaged COE participants
- Admission to higher level of care within 90 days after COE completion

11. DOCUMENTATION

Documentation should be made in the member's medical record, whether electronic or not. However, it is strongly recommended that all COE services are placed into the EHR and be documented in a designated section of a member's chart and separate from other services. In addition, the COE must continue to follow all guidelines of the Medicaid Program and should consult the provider handbook as necessary.

A complete member COE records should include, at minimum, documentation of:

- Referral source and outreach process
- Enrollment documentation (see **Section 3**)
- Assessment information including but not limited to ASAM LOC assessments, completed either by the OUD-COE or through a referral, SDOH, and BARC-10
- Concurrent drug and alcohol services member is receiving, including COE's attempts to obtain that information (see **Section 9**)
- MOUD induction information
- Treatment service ("treatment requirement") provided during the first month of member engagement or reengagement in COE services (see **Section 8**)
- Care planning, including initial care management plan developed within 24 hours of enrollment
- Ongoing care management plan developed within 30 days of enrollment and updated every six months; referrals, follow-up, and outcomes of referrals
    - The COE provider must adhere to all internal policies required by CBH surrounding creation and maintenance of evidence-based treatment linkage policy.

- Documented referrals for treatment (behavioral, mental, physical health) and non-treatment services
- Documented follow-up with treatment and service providers regarding the status of referral/appointment

- All care management service encounters should include at a minimum the following information:
  - Date and times (with a.m./p.m. designation) of encounter
  - Location of encounter
  - Type of encounter (scheduled appointment; unscheduled/walk-in; outreach call, text, email)
  - Identity of the individual employed by the COE providing the service during the encounter
  - Description of care management services provided during the encounter
  - Next planned activities that the OUD-COE and the member will undertake

A care management contact billed under the G9012 code must document any activity that involves reduction in substance use, helping individuals access or re-engage with services, enhancing recovery capital (e.g., social support), eliminating deficits in SDOH, working with family members to support the individual, or assessing their needs for the aforementioned treatment and services (e.g., a ASAM LOCA).

Billable care management services must include a minimum of 15 minutes of face-to-face or telehealth encounter with the individual. Please refer to the most recent OMHSAS requirements for telehealth and audio-only encounters, including the use of correct modifiers and encounter verification requirements. Texting, emailing, and other text-based communication methods can only be used to confirm interactions with the individual, but cannot be used to bill the G9012 code.

12. SUMMARY OF KEY PERFORMANCE INDICATORS (KPI)

- Provider has developed policies, protocols, and procedures to operationalize the following:
  - Provision of at least one form of MOUD for at the enrolled service location
  - Warm hand-off/referral agreements with referral sources
  - Description of CBCM team and its processes, protocols, and functions, including mobile capability, team members' professional credentials and specific roles
  - Outreach protocol that includes a process for reducing disparities among member population
  - Access to naloxone
- Members receive induction to MOUD within 48 hours of initial encounter with the COE provider

- Members are identified and recruited through an outreach process that includes active warm hand-off
- COE staff have clearly defined roles and have been trained on the processes and workflows defined by COE and evidence-based member engagement strategies.
- The COE has developed and documented eligibility criteria.
- Members enrolled in COE meet eligibility criteria.
- Percent of new COE participants
- Percent of re-engaged COE participants
- High-risk members, including those in one or more special populations, are
  - identified during enrollment
  - provided rapid access to treatment
- The COE has documented attempts to obtain information about members receiving potentially duplicative services from members, referral sources, and CBH Member Services.
- A care management service and a treatment service are provided within the first month of engagement or re-engagement with COE
- Individuals are assessed using the risk assessment and SDOH assessment at least monthly for the first two months and every two months thereafter while they are enrolled in the program BARC-10 is administered within 30 days of initial contact but encouraged during the initial visit with the individual and readministered every six months during an individual's engagement with the COE.
- ASAM LOCA is administered within first 72 hours of initial contact and readministered every six months.
- COE demonstrates administration of assessment tools that identify co-occurring physical and mental health conditions.
- COE has developed a formal referral agreement with its referral network.
- The number of documented referrals COE made for a member
- The number of documented appointments the member completed as a result of the referrals
- COE staff have up to one year (either from date of implementation of performance standards or hire start date) to complete required EBP training.
- COE members receive at least one individual care management contact per month.
- COE team members make and document contact with treatment and service providers to follow up on members' progress and appointments.
- Average length of COE episode

- Percent of COE participants receiving medication for opioid use disorder
- Duration of MOUD
- Percent of COE participants using the emergency department during COE episode
- Percent utilizing higher LOCs during COE episode
- Number of re-engaged COE participants
- Admission to higher LOC within 90 days after COE completion

13. REFERENCES

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14. APPENDIX: COE TIMELINE

COE Activities	*Timeframe*
Outreach (Section 2.4) Referral (Section 6.1) Warm Hand-off (Section 2.2)	➡ Starts prior to enrollment; ongoing
Enrollment (Section 3) ➡ Confirmation of eligibility ➡ Program description ➡ Informed consent ➡ Enrollment screening/assessment including: » Rapid assessment/risk determination screening (Section 4.1) » Recommended: SDOH assessment (Section 4.2) or portion of SDOH that identifies contributing factors to immediate needs/risks (e.g., homelessness as a risk factor for overdose). ➡ Initial care management plan (Section 5) ➡ Introduction to care manager	➡ Within 24 hours
Engagement (Section 7) ➡ Engagement with members (Sections 7.1, 7.2) ➡ Engagement with providers (Section 7.2)	➡ Starts at enrollment; ongoing: » Engagement with members: at least once a month » Engagement with treatment and service providers: ongoing
Risk Assessment (Section 4.1)	➡ Within 24 hours ➡ Readministered at least monthly for the first two months and every two months thereafter
MOUD Induction (Section 2.1)	Within 48 hours of enrollment or sooner
ASAM Level of Care Assessment (Section 4.3)	➡ Within 72 hours of enrollment, unless completed within 6 months prior to enrollment ➡ Readministered every six months
Social Determinants of Health (Section 4.2)	➡ Within 30 days of enrollment ➡ Readministered at least monthly for the first two months and every two months thereafter
BARC-10 (Section 4.4)	➡ Within 30 days of enrollment ➡ Readministered every six months

COE Activities	*Timeframe*
Ongoing Care Management Plan (Section 5)	➡ Within 30 days of enrollment ➡ Updated every six months
Treatment Requirement (Section 9)	➡ Within 30 days
UDS Testing (Section 4.7)	➡ Monthly by COE if UDS information is not available from the treatment provider