CENTERS OF EXCELLENCE

RESOURCE GUIDE

April 2021

pennsylvania
DEPARTMENT OF HUMAN SERVICES

University of **Pittsburgh** | School of Pharmacy

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A. ACRONYM DEFINITIONS

ACNP	acute nurse practitioners
AHRQ	Agency for Health Research and Quality
APNP	advance practice nurse practitioners
ASAM	American Society of Addiction Medicine
BARC-10	Brief Assessment and Recovery Capital
CAAC	Certified Associate Addiction Counselor
CAADC	Certified Advanced Alcohol and Drug Counselor
CADC	certified alcohol and drug counselor
CCDP	Certified Co-Occurring Disorders Professional
CCDPD	Certified Co-occurring Disorders Professional Diplomate
CCJP	Certified Criminal Justice Addictions Professional
CBCM	care-based care management
CCS	certified clinical supervisor
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
COE	center of excellence
CRS	Certified Recovery Specialist
DDAP	Pennsylvania Department of Drug and Alcohol Programs
DEA	Drug Enforcement Administration

DHS	Pennsylvania Department of Human Services
EMS	emergency medical services
FQHC	Federally Qualified Health Centers
IOP	intensive outpatient program
LCSW	Licensed Clinical Social Worker
LOC/LOCA	Level of Care/Level of Care Assessment
MAT	medication-assisted treatment
MH	mental health
MI	motivational interviewing
MOUD	medication for opioid use disorder
NATP	narcotic treatment program
OTP	opioid treatment program
OUD	opioid use disorder
PCPC	Pennsylvania Client Placement Criteria
PERU	Program Evaluation and Research Unit
PHP	partial hospitalization
PMPM	per member per month
QI	quality improvement
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	screening, brief intervention, referral to treatment
SCA	single county authority
SDOH	social determinants of health
STI	sexually transmitted infection
SUD	substance use disorder

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B. INTRODUCTION TO THE RESOURCE GUIDE

The purpose of this guide is to provide a comprehensive resource for existing and newly designated Pennsylvania Opioid Use Disorder (OUD) Centers of Excellence (COE) sites across the Commonwealth of Pennsylvania.

B.1 How to Use the Resource Guide

Since 2016, Pennsylvania OUD COE sites have utilized Community-Based Care Management Teams (CBCM) to break down barriers historically associated with attaining recovery for individuals with an Opioid Use Disorder (OUD). This comprehensive guide meets the needs of two staff groupings: COE leadership and staff. The guide includes a history of the Pennsylvania COEs, expectations of a COE, and the qualifications for a COE-designated organization within a larger system.

The staff section provides relevant information from the Pennsylvania Department of Human Services (DHS) and the Pennsylvania Department of Drug and Alcohol Programs (DDAP). The staff section provides information associated with meeting the needs of clients on a day-to-day basis, including documentation requirements and instruments (e.g., American Society of Addiction Medicine (ASAM) and Brief Assessment of Recovery Capital (BARC-10)) and guidance on how to tailor care for special client populations.

The leadership section provides guidance on how to manage a COE to support optimal clinical outcomes using quality improvement (QI) best practices, and how organizational health can be assessed and used to improve staff morale and retention as well as client care quality.

B.2 Organization Policy/Procedure

It is critical for all members of an organization to be highly informed about and skilled in the application of organizational policies and procedures so that clients receive high-quality, standardized care.[1,2] Standardized practices including how staff are on-boarded and receive training, how their roles are specified, and how patient care workflows are defined and followed, create a predictable clinical environment in which clients feel safe to disclose health status and barriers to care they may be experiencing, and staff feel confident about to how they can successfully provide care and address barriers clients reveal. This resource guide presents recommended organizational policy and procedures based on scientific and peer-reviewed the literature and DHS for COEs to guide their staff towards achieving optimal care quality.

Note
This guide does not supersede individual COEs' or their parent organization's policies.

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C. CENTERS OF EXCELLENCE MISSION: PURPOSE OF CENTERS OF EXCELLENCE

C.1 Opioid Public Health Crisis

C.1.1.1 Opioid Overdose Crisis across the United States

Between 1999 and 2011, hydrocodone usage increased by 100 percent, and oxycodone usage increased by 500 percent.[3] Overdose deaths involving opioid substances increased by 300 percent during that same period.[4] Given these numbers, the United States Centers for Disease Control and Prevention (CDC) declared the opioid overdose death crisis one of its top five public health threats in 2014.[5]

The following year, in 2015, the Drug Enforcement Administration (DEA) issued an alert that fentanyl, an opioid that is 50-100 times more potent than morphine, was becoming a rising trend, threatening public health and safety.[6,7] Because fentanyl is so potent, it takes very little of the substance to experience a potentially fatal overdose. Some people who use substances are not aware that the substances they consume have been laced with fentanyl because it is a fine white powder that is easy to disguise in mixtures containing other less potent opioids. Fentanyl is a synthetic opioid that is relatively easy and inexpensive to manufacture, which makes it easy to distribute, and thus a greater threat to public health and safety.

By 2017, opioids were involved in approximately 68 percent of the 70,237 drug overdose deaths in the United States. The next year, 2018, the United States saw a drug overdose death rate of 21.7 deaths per 100,000 people.[8] In 2018, The United States reported an overall decrease in the number of overdose deaths; however, there was an increase in the number of overdose deaths involving opioids from 68 percent to 70 percent, representing a total of 46,802 deaths.[9]

C.1.1.2 Opioid Overdose Crisis across Pennsylvania

In 2018, Pennsylvania coroners and medical examiners reported 4,491 substance-related overdose deaths (ruled as either accidental or undetermined).[10] This number represents a rate of 35 deaths per 100,000 people, which was higher than the national average listed above. Between 2015 and 2018, there was a 36 percent increase in the number of substance-related overdose deaths in Pennsylvania.[11] According to the 2018 DEA Drug-Related Overdose Deaths in Pennsylvania Report, fentanyl was the most frequently identified substance in substance-related overdose deaths (70 percent of deaths), which was the same frequency as in the previous year. In 2018, coroners and medical examiners found opioid substances (opioids in addition to fentanyl, whether illicit or prescription) in 82 percent of substance-related overdose deaths in Pennsylvania.[10]

Young people in Pennsylvania between the ages of 15-34 were the most likely to have fentanyl-related overdose deaths compared with toxicology results from overdose deaths in older age groups. Fentanyl was found in 75 percent of overdose-related deaths in the 15-24 and 25-34 age groups in 2018. People in the 25-34 age group represented the greatest proportion of overdose deaths in Pennsylvania that year, with 29 percent of substance-related overdose deaths.[10]

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C.1.2 Pennsylvania's Centers of Excellence History

The COEs were created as a response to the growing opioid public health crisis, which continues to impact counties across the commonwealth. In 2016, Governor Tom Wolf introduced the COEs as one strategy for addressing the growing 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.

DHS oversaw the distribution of a grant funding application that invited physical and behavioral health providers across the commonwealth to apply to become a designated COE for OUD, which provided them with funding to establish CBCM teams that were designed to outreach into local communities, identify individuals with OUD, and ensure that they receive the treatment and non-treatment services that will assist them into 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. Funding was awarded to 45 providers across the commonwealth, representing a unique blend of providers including health systems, Federally Qualified Health Centers (FQHCs), SUD treatment providers, and Single County Authorities (SCAs) serving clients in counties across the commonwealth.

As the COEs continued to mature and engage thousands of individuals with OUD, there was a need to implement a sustainable funding stream that would ensure that these providers could continue to remain as part of an integrated care system for individuals in the commonwealth with OUD. Beginning in 2019, the HealthChoices Physical and Behavioral Health Managed Care Organizations (MCOs) paid COEs for the care management services that were provided to members. Under a directed per-member-per-month (PMPM) payment structure, the COEs were provided with the opportunity to improve their sustainability prospects and work to expand their services in their communities. In 2020, DHS announced that it would enroll providers in the Medical Assistance Program as using Specialty Designation 232 – Opioid Centers of Excellence, which allowed additional physical and behavioral health providers to enroll in the Medical Assistance Program as COEs and receive payment for care management services provided to individuals with OUD. The application became available in July 2020, with new providers being able to bill HealthChoices MCOs beginning in January 2021.

C.1.3 Expectations of a Center of Excellence

As discussed, COEs were established to provide care management services to individuals across the Commonwealth of Pennsylvania with OUD. These care management services are intended to be provided by a diverse group of providers, including social workers, physicians, and Certified Recovery Specialists (CRS), and tailored to the unique needs of the community in which they are provided. Although the design of the CBCM team at each COE will look different, each COE is charged with achieving the same goals—to increase access to MOUD, improve care coordination, and integrate physical and behavioral healthcare for individuals with OUD. DHS has issued more specific guidance for the COEs, and this guidance is described in more detail in the July 2020 Medical Assistance Bulletin.

The role of the CBCM team is to ensure that all clients are connected to identified treatment and non-treatment services, as well as provided the essential follow-up care that is often required as individuals move into recovery. Although the roles of each member of the CBCM team may differ, it is the overarching expectation that the members of the COE care management teams will provide the following:

- **Rapid Identification and Engagement** – members of the COE CBCM team must be prepared to rapidly identify and engage potential clients within the community. The rapid engagement strategy requires that the COE establish effective warm hand-off agreements with agencies in the community which 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. According to the Agency for Healthcare Research and Quality (AHRQ), a warm hand-off is a transfer of care between two healthcare providers that takes place in front of the patient.[1, 12] It is generally considered best practice for there to be formal warm hand-off agreements that specify the process for conducting the warm hand-off and providing information between the two entities.[13]

- **Mobile Response Capability** – to support rapid identification and engagement of clients within the community, the COEs must have the capacity and capability to conduct mobile outreach within communities. The COEs have the unique responsibility of being able to focus on providing care management services, which should allow for the expansion of these mobile response services to include the ability to meet with clients where they present. Furthermore, a care management visit is not required to take place on location at the COE, which allows for the CBCM team to meet clients where they are in the community to provide services and enhance engagement.

- **Timely Assessments** – members of the COE CBCM team must have the capability of providing timely assessments, as defined by DDAP and DHS, to identify a client's treatment and non-treatment needs. This will help to ensure that clients are provided with the services they need, right when they need them.

- **Timely and Coordinated Referrals** – members of the CBCM team must ensure that clients are receiving the care they need when they need it. We know that members of the CBCM team understand the importance of connecting individuals to services, especially SUD treatment, the moment the client indicates willingness to access this service. The ability to conduct timely and coordinated referrals helps to build rapport with clients and increases the likelihood that they will remain engaged with the services to which they have been referred. A list of common referral partners is included in the Referrals section of this guide.

C.2 Organization

An organization's vision is the overarching purpose of the organization; the vision is the ideal the organization strives to be through its work and services. In a way, the vision represents the developing future of the organization. It's important to know an organization's vision so that it is always present in staff decision-making and approach with clients. In times of confusion, an organization's vision can help guide staff and leadership toward action that is consistent with the organization's purpose.

D. HARM REDUCTION

Harm reduction is a public health approach focused on decreasing the negative effects associated with substance use by educating individuals and meeting them "where they are".[14] There is no standard "definition" for harm reduction. Though all harm reduction approaches involve interventions/policies that are designed to reduce risk for people who use substances, they reflect specific individual/community needs. Thus, harm reduction is a mindset and a set of practical strategies and ideas aimed at reducing negative consequences associated with substance use.[14] Simply put, harm reduction is a way of thinking, acting, and supporting persons at-risk for poor health and psychosocial outcomes as a result of their SUD. These principles can be summarized as the following:

- Reducing negative effects of substance use and unhealthy behaviors.

- Accepting that some will continue to use and aren't ready for abstinence.

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[1] It should be noted that in the era of telehealth, there are evolving definitions of "warm hand-off" processes that may occur virtually.

- Preventing health complications and fatal/non-fatal overdose.

- Respecting the person's autonomy and choice, being nonjudgmental.

- Adapting to meet the person where they are.

- Providing resources and support.[14]

The principles of harm reduction are in contrast to a punitive approach to substance use.[15] Rather than condoning substance use altogether, harm reduction focuses on acknowledging the dignity and humanity of people who use substances, as well as minimizing negative consequences of substance use and promoting health and inclusion.[16]

We use harm reduction strategies daily. Some examples include buckling a seatbelt, abiding by speed limit signs, having a fire extinguisher, wearing a helmet when riding a bike, locking the front door, brushing one's teeth, and wearing a life jacket.[17] Let's look at the seatbelt example in more detail. Of course, we want to avoid an accident altogether, but we wear the seatbelt just in case. We know that, if an accident does happen, the injuries are significantly less severe than if we didn't have the seatbelt on. Another example of a harm reduction strategy is avoiding driving under the influence.[17] The social norm is when someone plans on drinking and may not be able to keep within the legal driving limit to designate a sober driver or to use a ride-share service. The same basic thought processes used for using seat belts and designated drivers is applicable when discussing harm reduction for SUD.

D.1 Harm Reduction for Substance Use

Figure 1. Harm Reduction Continuum

Consider harm reduction as a continuum, spanning from complete abstinence to maximum use (see Figure 1).[18] The provider meets the client where they are along the harm reduction continuum to mitigate risks. In this case, the primary goal of harm reduction is to keep individuals alive, mitigate the physical and social issues, and provide the individual with the ability to make changes in the future if they so choose.[18] Wherever the person is on the continuum, harm reduction accepts and supports the person.

Harm reduction recognizes that people who use substances benefit from a variety of different approaches.[19] There is no one prevention or treatment approach that works reliably for everyone. Providing options and prompt access to a broad range of interventions is what helps keep people alive and safe. Someone who is using substances may not be willing to quit "cold turkey," but they may consider using some of the following approaches to mitigate harm and preserve their safety even if they decide to continue to use substances. Harm reduction strategies span safe use strategies, overdose prevention efforts, overdose reversals, syringe exchange/access, safe consumption sites, substance test strips, peer support, and advocacy.[20]

D.2 Overdose Prevention

Overdose prevention and reversal are also key attributes of harm reduction principles.[16] Clients with OUD should be provided continuous education regarding a variety of strategies that can reduce their risk of overdose.

First, clients should be taught the importance of using with others around to reduce the risk of an overdose (especially fatal overdoses). If no one is with the client when they overdose, there is no one around to call 911 or revive them with naloxone. Statutes like 42 PA CSA § 8331-8338 (also called the Good Samaritan Act) have been enacted to reduce the risk of persons who call emergency services for someone who has overdosed. Naloxone is a lifesaving medication and is another element of overdose prevention. If an individual is using in a group, it is best if they stagger who uses and when. If everyone consumes at the same time, then no one is available to revive others if the substance used is an extremely potent batch that causes an overdose in all users. Individuals can "start low and go slow" to control their use and prevent an overdose.

Second, it is important for clients to recognize if they fall within a high-risk group, such as previous overdose survivors, those who were recently released from incarceration, and those recently discharged from an inpatient facility.[19] Third, clients who choose to use can use fentanyl test strips to understand the contents of their sample and adjust use accordingly. If fentanyl test strips are not available at the COE, they can check with the local SCA as many SCAs now carry fentanyl test strips for their clients. These are easy to use and require dipping the test strip into a sample of the substance mixed with water. Finally, those who use should carry naloxone and understand how to administer it in the case of an overdose[16] (see more information below about naloxone use). All these suggestions can help prevent an overdose and save lives.

D.3 **Safe Use Strategies**

A major component of harm reduction is encouraging safe substance use strategies. In this case, the provider is not encouraging or enabling use; they are not saying to forget recovery and use as much as possible. Rather, safe use strategies respect the individual's choice to use and asks, "How can the client reduce the risk of a severe repercussion?"[21] Safe use strategies include knowing the source of the substance, using clean water and supplies, carrying naloxone, using fentanyl test strips, seeking medical care for health issues (i.e., wounds, damaged veins, infections, etc.), accepting tests/screens for transmittable diseases (i.e., HIV, sexually transmitted infections (STIs), and hepatitis C), and rotating veins if injecting.[17] Other tips regarding safe substance use include knowing the source of the substance, chopping pills finely, using clean devices for nasal consumption (such as a rolled post-it note as opposed to a dollar bill), and avoiding sharing straws or other equipment.[22] Safe use strategies do not encourage mixing substances, sharing supplies, driving while under the influence, using alone, or using where others can't get to the client in case of an emergency, such as an overdose.[17]

D.4 **Overdose Reversal**

Carrying and using naloxone is an effective way to reverse an overdose and save a life.[20,23,24] All COEs must provide access to naloxone for clients.[25] If a client needs naloxone training and the COE staff cannot provide it, the SCA can often assist. It is also important to know the signs of an overdose: small, constricted pinpoint pupils; falling asleep or loss of consciousness; slow, shallow breathing; choking or gurgling sounds; pale, blue, or cold skin; and blue nails or lips. Anyone who sees any of these overdose signs should call 911 immediately.[24]

The COE must ensure that it trains clients on how to recognize an overdose and strategies that clients can use to reduce their risk. Additionally, each COE staff member must be trained on how to respond to an overdose and how to administer naloxone.[25]

D.5 **Syringe Exchange/Access**

Research indicates that syringe access is effective in preventing the transmission of infectious disease and skin and soft tissue infections. Syringes can be provided by organizations that also indicate their support for an individual's overall health and well-being as well as linkages to SUD treatment, medical care, and social services.[20]

D.6 **Safe Consumption Sites**

Safe consumption sites are also commonly referred to as overdose prevention centers or safe/supervised injection facilities. This service allows individuals to consume pre-obtained drugs under the supervision of clinical staff members and is designed to reduce health issues associated with consumption. Here, faculty are present and able to provide sterile injection supplies and answer questions on safe use strategies. Staff members can administer first aid and monitor individuals for an overdose, and can refer clients to SUD treatment, medical treatment, and other social services. A safe consumption site is intended to complement existing prevention, harm reduction, and treatment interventions.[26]

D.7 **Advocacy**

Another crucial component of harm reduction is advocacy.[27] Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use substances, and can also take the form of advocacy.[16] This aspect of harm reduction includes the notion that people who use substances should have a voice in the creation of policies and programs, as it directly relates to them. Harm reduction advocacy efforts fight discrimination based on an individual's substance use, race, gender, gender identity, sexual orientation, choice of work, or economic status. These advocacy efforts also focus on eliminating barriers to services, ending stigma toward those who use substances, and adjusting substance policies and laws to do so.[16]

D.8 **Medical Needs**

Harm reduction also includes caring for medical needs associated with substance use, including abscesses, damaged veins, and general wounds. Additionally, these services include providing education, testing, and treatment for hepatitis B and C and HIV. COE staff members should discuss transmittable diseases with clients who have previously injected substances and screen for hepatitis B and C as well as HIV as clinically appropriate. If the COE does not have medical staff available to treat the medical needs of their COE-engaged clients, then staff members must refer clients to these services.

Utilizing harm reduction principles and policies has numerous evidence-based benefits.[21] The distribution of naloxone is associated with a decrease in fatal overdose deaths.[16] Discussing harm reduction services leads to positive service connections, increased treatment retention, and increased treatment satisfaction.[21] Additionally, a decrease in criminal justice involvement, reduced recurrence of use rates, and reduced substance use in general are associated with the implementation of harm reduction initiatives. Finally, harm reduction activities reduce overdose deaths, reduce stigma toward substance use, reduce hepatitis and HIV transmissions, increase knowledge about safer substance use, and increase knowledge about safe sex practices. In sum, harm reduction contributes to saved lives, increased education, and decreased overall harm.[21]

D.9 **Conversation Examples**

- "Adam, I respect your choice to continue using, and I want to help you take care of yourself. Are you open to discussing overdose prevention tactics?"

- "You're being released from treatment tomorrow, have you considered getting naloxone and carrying it with you?"

- "Let's talk about keeping you safe—have you ever used the needle exchange program? That can help reduce the risk of Hep C transmission. They also have fentanyl testing strips, so that you can decide how much to use based on whether there's fentanyl in it."

- "I'd like to review what we talked about with overdose prevention. If you decide to use, that's ok, just start low because your tolerance is different. Be sure to use when others are around. Let them know you have naloxone and that they should use it on you if you aren't responding."

For additional resources regarding harm reduction, please see Harm Reduction.

E. ASAM LEVELS OF CARE

In 2017, Pennsylvania's DDAP announced that it would be transitioning to use the ASAM Criteria, Third Edition, for level of care designation and determination. Previously, adults in Pennsylvania were assessed for level of care (LOC) eligibility using the Pennsylvania Client Placement Criteria (PCPC), and adolescents were assessed using the ASAM. With the transition to the ASAM (effective July 2018) for all clients, the adolescent and adult world of SUD treatment came together to work from the same model, with special considerations for the adolescent population.

E.1 The ASAM Explained

The ASAM Criteria is an assessment tool, utilized through a face-to-face interview, to determine which level of substance use treatment is most appropriate for a client—referred to as the LOC.

E.2 Levels of Care

Levels of care are placed along a continuum, from lowest (on the left) to highest (on the right) intensity of services and intervention (Figure 2). Each level represents an increase in the intensity of services from its predecessor. Levels of care are described in detail in Table 1.

Figure 2. Reflecting a Continuum of Care
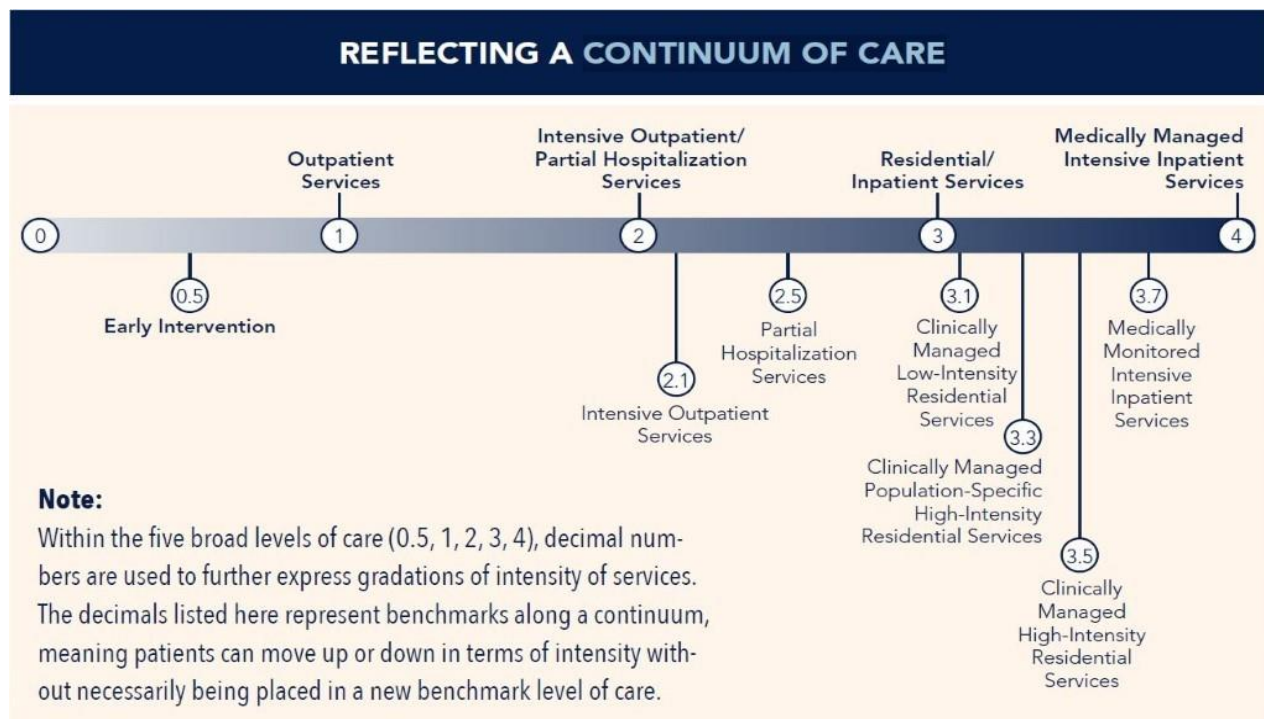
www.asam.org

Table 1. Levels of Care

Level	Description	Setting	Features	Focus
0.5 Early Intervention	"Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and addictive behavior, and to help the individual recognize the harmful consequences of high-risk substance use and/or addictive behavior."[28]	Clinical offices, schools, work settings, community centers, emergency departments, primary care settings, or an individual's home	Screening Brief Intervention Referral to Treatment tool 1:1 counseling with at-risk individuals Educational programs	Psychoeducation on risks of substance use and how to avoid substance use engagement
1 Outpatient Services	"In Level 1 services, SUD, mental health treatment, or general health care personnel, including SUD-credentialed physicians, provide professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services."[28]	Clinical offices, health clinics, school-based programs, primary care facilities, SUD treatment programs, mental health clinics, child/adolescent behavioral health clinics	Ongoing services, typically less than nine contact hours per week for adults and less than six contact hours per week for adolescents May be the initial LOC or the "step down" from a higher LOC Length of service dependent on the severity of individual's substance use and response to treatment—can be ongoing to maintain recovery Individuals may enter treatment while actively using substances or while in recovery and requesting support to maintain their recovery	Enact change in substance use and related behavioral issues
1 Opioid Treatment Program (OTP)	Same as Level 1 – Outpatient Services with the addition of medication	Methadone – clinical offices Buprenorphine – primary care, behavioral health, and SUD treatment settings Naltrexone – primary care, behavioral health, and SUD treatment settings	Methadone – can only be prescribed through a licensed Narcotic Treatment Program (NATP); Buprenorphine – medical provider must have X-Waiver for DEA license; Naltrexone – any medical provider with a DEA license can prescribe	Enact change in substance use and related behavioral issues

Level	Description	Setting	Features	Focus
2.1 Intensive Outpatient Services	"Intensive outpatient programs (IOPs) generally provide 9-19 hours of structured programming per week for adults and 6-19 hours for adolescents, consisting primarily of counseling and education. about SUD-related and mental health problems."[28]	Any appropriate setting that meets state licensure or certification criteria	Majority of structured programming is group counseling Can occur during the day, evening, or weekend (goal is least disruption to the client's school/work schedule) Once someone completes IOP, they typically "step down" to outpatient services Someone can participate in OTP and IOP concurrently	Structured support to assist in gaining insight and motivation to enact change
2.5 Partial Hospitalization (PHP) Services	"Partial hospitalization programs (PHP), known in some areas as 'day treatment,' generally feature 20 or more hours of clinically intensive programming per week."[28]	Any appropriate setting that meets state licensure or certification criteria	Typically have in-house services for one or all the following: psychiatry, medical, laboratory Adolescents: educational needs must be addressed by the treatment provider Treatment services: counseling (group, individual, family), psychoeducation, occupational/recreational therapy	More intense provision of services at lower LOC with increased multi-disciplinary treatment

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Level	Description	Setting	Features	Focus
3.1 Clinically Managed Low-Intensity Residential Services	"Level 3.1 programs offer at least 5 hours per week of low-intensity treatment of substance-related disorders … When the clinical services and recovery residence components are provided together, Level 3.1 programs often are considered appropriate for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment."[28]	Usually, a freestanding facility that meets state licensing criteria Example: halfway house, group homes with treatment component, supportive living environment (SLE)	Clients live and receive clinical services on-site Treatment services: counseling (individual, group, family), medication management, psychoeducation, mental health treatment, vocation rehabilitation, job placement, life skills Additional peer/self-help groups to supplement professional services Residential services of this level can be combined with IOP under certain circumstances, Residential component: 24-hour staffing, opportunity to work on interpersonal skills NOT: sober/recovery houses, group homes without treatment, boarding houses	Establishing and strengthen healthy living and coping skills with discharge to an independent setting

Level	Description	Setting	Features	Focus
3.3 Clinically Managed Population-Specific High-Intensity Residential Services (Adult, no adolescent equivalent) *Currently, there are not any Level 3.3 facilities in Pennsylvania	"Level 3.3 programs provide a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of clients to support recovery from substance-related disorders. For the typical client in a Level 3.3 program, the effects of the substance use or other addictive disorder or a co-occurring disorder resulting in cognitive impairment on the individual's life are so significant, and the resulting level of impairment so great, that outpatient motivational and/or relapse prevention strategies are not feasible or effective."[28]	Usually, a freestanding facility that meets state licensing criteria Examples: therapeutic rehabilitation facility, traumatic brain injury program	Clients live and receive clinical services on-site Alternative residential levels of care likely ineffective due to client's cognitive limitations Cognitive limitations contribute to problems with interpersonal relationships, emotional coping skills, or comprehension Cognitive limitations may be temporary (compromised cognitive abilities due to substance use) or long-term (chronic brain syndrome, traumatic brain injury, older adult, etc.) Treatment services: counseling (individual, group, family), psychoeducation, occupation and recreational therapy, medication management, mental health, medical, physical therapy	Highly structured program – daily activities Transition out of Level 3.3 includes ancillary services for housing, vocation services, transportation assistance, etc.

Level	Description	Setting	Features	Focus
3.5 Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent)	"Level 3.5 programs are designed to serve individuals who, because of specific functional limitations, need safe and stable living environments to develop and/or demonstrate sufficient recovery skills so that they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care."[28]	Freestanding residential and clinical facility that meets state licensing criteria	Clients live and receive clinical services on-site Common stepdown from inpatient treatment Clients at this level need 24-hour support due to a lack of progress with previous recovery attempts Emphasis on treatment community as the therapeutic agent (connecting with those around what is effective) Clients typically lack stable, supportive and healthy relationships/supports; clients commonly involved criminal justice system and have extensive history of previous treatment Effective treatment is often habilitative rather than rehabilitative—one can't rehabilitate things someone never learned in the first place Clients commonly have experienced significant mental health issues and trauma—more complex histories among clients Treatment services: activities to bolster interpersonal skills, counseling (group, individual), medication management, skill-building groups, occupational and recreational supports, health education	Assists client in building a support system and addressing basic needs (housing, employment, etc.) while facilitating recovery

Level	Description	Setting	Features	Focus
3.7 Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High-Intensity Inpatient Services (Adolescent)	"Level 3.7 programs provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and SUD treatment in an inpatient setting."[28]	Freestanding residential and clinical facility that meets state licensing criteria	What someone typically thinks of when they hear "inpatient detox" Appropriate for those who need inpatient care due to biomedical, emotional, behavioral or cognitive problems, but not acute medical need Examples: medically monitored withdrawal without any complications Treatment services: physician monitoring, nursing care, psychiatric services, counseling (individual, group, family), recreational activities, medication management, withdrawal symptom management Daily treatment decisions are not made by a physician, rather by an interdisciplinary team	Stabilization of physical and emotional health for transition to a lower LOC This LOC isn't going to be the place where intensive counseling leads to long-term recovery; this LOC is about stabilizing the person's overall health to enable their pursuit of recovery
4 Medically Managed Intensive Inpatient Services	"Level 4 Medically Managed Intensive Inpatient Services is an organized service delivered in an acute care inpatient setting. It is appropriate for clients whose acute biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care."[28]	Held within an acute care general hospital, an acute psychiatric hospital or psychiatric unit within an acute care general hospital, or a licensed SUD treatment specialty hospital with acute care medical and nursing staff	Physical health (including potentially severe withdrawal symptoms) and mental health take precedence over enacting change toward recovery Treatment services: daily physician monitoring, 24-hour nursing care/monitoring, psychiatric services, counseling (individual, group, family), recreational activities, medication management, withdrawal symptom management Physician makes daily decisions regarding treatment	Stabilize acute signs and symptoms with emphasis on case management and coordination of care for transition to a lower LOC

E.3 Know the Options

Clients may need to be referred to alternative LOCs at any time. A best practice is to identify options for each LOC in case a referral is warranted. See Appendix 3: Level of Care Options Form for an easy-to-use form to identify various LOC providers to which staff can refer clients.

For additional resources regarding ASAM, please see ASAM.

F. STAGES OF CHANGE

The stages of change, introduced as part of the Transtheoretical Model of Health Behavior,[29] were originally applied to treatment programs for smoking cessation.[30] The stages of change have since been utilized when assessing a SUD treatment client's willingness and readiness to enact change (ASAM Dimension 4, see Safe Use Strategies). The stages of change model describes a client's progress through six stages of enacting behavior change. Although the stages are progressive, the client can enter the cycle of stages at any point (Figure 3).

Figure 3. Six Stages of Change
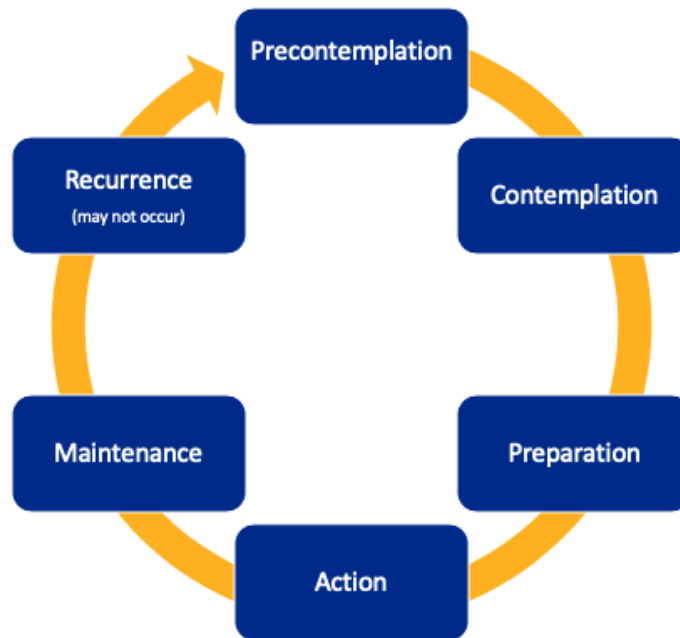
The person can enter, exit, and re-enter at any stage

The six stages of change are not boxes to be checked, but rather a conceptualization of someone's readiness to enact change, acceptance of their SUD, and potential mindset. By understanding the stages of change, appropriate interventions and treatments can be utilized to assist the client in moving to the next stage of change, to eventually reach and sustain the maintenance stage. Please note that clients with a SUD may move rapidly between stages as they move through withdrawal and adverse consequences of their SUD.[31]

F.1 Pre-Contemplation

This stage is often the "beginning" and where someone is when they are actively using. Someone at this stage does not acknowledge any issues with their substance use and doesn't have any intention of enacting change. The primary task of this stage is to increase awareness of their SUD and the resulting challenges associated with their use. Consider using Motivational Interviewing (MI) techniques to elicit change talk.

F.2 Contemplation

In this contemplation stage, the client has acknowledged that there is a problem with their substance use and recognizes the impact of substance use on various aspects of their life. At this stage, the client is ambivalent about making changes. The primary task of this stage is the resolution of ambivalence and acceptance of making change.

F.3 Preparation

When in the preparation stage, the client has not only acknowledged that a problem exists but is also committed to making change. During this stage, the person is still using while determining how to proceed; the client may be looking at intervention/treatment options and making arrangements to start treatment or reduce use, such as contacting a local treatment provider to ask about the admission process. The primary task of this stage is to identify the next steps to enact change.

F.4 Action

The client in the action stage of change is taking steps toward making necessary changes. This could be starting treatment, attending meetings, or reducing use. During this stage, the client is learning coping skills as they stabilize in their recovery. The primary task of this stage is to implement change strategies and eliminate the potential for recurrence of use.

F.5 Maintenance

A client who is stabilized in their recovery is considered to be in the maintenance stage of change. During this stage, the client has been successful in their recovery and focuses on maintaining their recovery and enacted change. The primary task of this stage is to continue building skills to maintain recovery.

F.6 Recurrence of Use

The Recurrence of Use stage, also known as the relapse stage, is not experienced by everyone. However, it is possible that, at any stage, someone may experience a recurrence of use. During this stage, the person can reflect on their previous experiences of what worked for their recovery and what treatment approaches were not as effective and use those reflections to inform their next steps. The primary task of this stage is to process the recurrence of use with the client and decide how they want to proceed.

G. NON-STIGMATIZING LANGUAGE

G.1 Overview and Definition

All staff at COE facilities are expected to actively utilize non-stigmatizing language. Awareness of language usage is critical in creating and maintaining a space where all individuals, regardless of health status, feel safe in seeking care.

Stigma is defined as a "set of negative beliefs that a group or society holds about a topic or group of people" that can manifest in different ways, including prejudice and discrimination.[32,33] Social stigma may manifest publicly or internally, and/ is perceived or exists in many areas (e.g., substance use, the LGBTQIA+ community, and physical or mental/behavioral health disability). Further, when categorization is perceived as a controllable choice, these groups are significantly more likely to face stigma in the form of prejudice or discrimination.

Self-stigma is directly associated with poor self-image and self-esteem and is reinforced by public or perceived stigma. When stigma among healthcare professionals is perceived by clients, this creates a significant barrier to seeking treatment services, i.e., "They just think I'm a junkie, so why bother going there if they're just going to make me feel bad?" Barriers to care manifest as delayed treatment, decreased health status, increased complexity of health needs, and increased costs of care. Examples of stigmatized beliefs about an individual that uses substance may include lack of responsibility ("they just don't care"), dangerousness ("they are all criminals who will hurt you"), and that SUD or use is a choice or moral failing ("she's a bad person"). Studies have demonstrated that when an individual is referred to as a "substance abuser" vs. "having a substance use disorder," healthcare providers judged the former as less deserving of treatment and in more control of their substance use.[32]

G.2 Recommendations for Non-Stigmatizing Language

G.2.1 Substance Use Disorder

Effective ways for individuals to help reduce stigma include:[34]

- Offering compassionate support.

- Displaying kindness to people in vulnerable situations.

- Listening while withholding judgment.

- Seeing a person for who they are, not what substances they use.

- Doing the research; learning about SUD and how it works.

- Treating people with SUD with dignity and respect.

- Avoiding hurtful labels (see Table 2).

- Replacing negative attitudes with evidence-based facts.

- Speaking up when someone is mistreated because of their substance use.

- Sharing one's own stories of stigma.

Table 2. Language Recommendations for Substance Use Disorder

Don't say ...	Instead, say ...	Reason
Addict, Druggie, Junkie	Person with SUD	Puts the person first and removes stigmatizing language
Substance abuse	Substance use	Removes negative implications associated with the word "abuse"
Drug of abuse	Substance of use	Removes negative implications associated with the words, "drug" and "abuse"
"Clean" or "Dirty" (when discussing urine screen results)	Positive or Negative screen for [substance]	Removes negative implications associated with the word "dirty"
Denial	Ambivalence	Removes negative language
Clean/Sober	Substance Free	Removes stigmatizing language and promotes recovery
Relapse Prevention	Recovery Management	Promotes recovery
Manipulative	Has unmet needs	Removes negative language
Resistant to Treatment	Choosing not to	Removes negative language

G.2.2 Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual Plus (LGBTQIA+) Clients

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2015 National Survey on Drug Use and Health, 4.3 percent of adults aged 18 or older identified as a sexual minority, including 1.8 percent who identified as being lesbian or gay and 2.5 percent who identified as being bisexual.[35,36] Sexual minority individuals are more likely to use illicit substances and/or have a SUD.[35] As a result of stigma, historical oppression, and discrimination, this population is historically underserved and few social programs are targeted to and/or appropriate for them. SUD treatment providers, counselors, therapists, administrators, and facility directors can be more effective in treating LGBTQIA+ clients when they have a better understanding of the issues LGBTQIA+ clients face.[36]

G.2.3 LGBTQIA+ Recommendations

- **Ask all clients** which pronouns they use, document this preference as part of their health record, and use the pronouns they indicate in all interactions. By asking all clients, and not just clients who self-identify as transgender, clinicians, and staff avoid differential treatment based on gender identity. This will also provide the client the opportunity to express their gender identity without having to find a time on their own, which can be uncomfortable for clients. "Hi, my name is Joe. I am a nurse. My pronouns are he/him."

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- **Avoid making any assumptions** about a person based on their gender identity, gender expression, or sexual orientation. The LGBTQIA+ community is highly stereotyped—clinical settings should be free of any stereotypes to provide clients with a safe and supportive environment to be themselves. Basic examples of heterosexism include assuming a married woman has a husband or that a man only has female sexual partners. Solutions, in these instances, include asking about a non-gendered spouse or partner and opened ended questions like "Are you married?", "Do you have sex with men, women, or both?" Or "What genders do you have sex with?"

- **Provide specialized groups** based on gender identity, gender expression, and sexual orientation—such specialized groups have been shown to lead to better outcomes for clients.

- **Recognize and incorporate** into treatment the individual's experience with discrimination, family problems, violence, social isolation, and homophobia/transphobia.

- **Pursue continuing education** focused on working with the LGBTQIA+ community. It is the clinician's responsibility to pursue education to appropriately provide services to clients. It is no longer considered appropriate to ask clients to educate professionals on gender identity, gender expression, or sexual orientation.

- **Conduct ongoing screenings** for suicidality due to the population's increased risk.

- **Utilize a trauma-informed care approach**, taking into consideration the likelihood the client experienced minority stress, discrimination, separation from family, and potentially violence due to their gender identity, gender expression, and/or sexual orientation.

- **Include LGBTQIA+-friendly photographs/posters** in the facility; avoid only displaying heterosexual and cisgender individuals in promotional materials and decorations.

G.2.4 LGBTQIA+ Key Terms

- **Asexual:** An individual who does not experience sexual attraction.

- **Bisexual**: An individual who is attracted to others of the same and different gender.

- **Gay**: An individual who is attracted to others of the same gender. Often used to reference a man who is attracted to men.

- **Gender Affirmation Surgery**: Elective medical procedures an individual can pursue to change their physical appearance to more closely resemble their gender identity.

- **Gender Expression**: The external presentation of gender (names, pronouns, clothing, behavior, hairstyle, voice, body characteristics, etc.).

- **Gender Identity**: An individual's internal sense of gender, regardless of which gender the person was assigned at birth. Gender identity is not visible to others. There are more gender identities than male and female.

- **Gender Nonconforming**: An individual whose gender identity and/or expression does not conform to cultural or social expectations of gender.

- **Heteronormativity/Heterosexism** – The belief that heterosexuality is the norm or default sexual orientation. It assumes that sexual and marital relations are most fitting between people of the opposite sex.

- **Intersex**: An individual who has reproductive organs/sexual anatomy that does not fit the typical definitions of the female or male sex.

- **Lesbian**: A woman who is attracted to other women. Some women may choose to identify as a gay woman.

- **LGBTQIA+**: Acronym for lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual. The + sign represents the additional identities, such as queer, and questioning.

- **Pride**: Celebration of LGBTQIA+ communities, with a focus on reducing discrimination and violence against LGBTQIA+ individuals. Pride is held in June each year to commemorate the Stonewall Riots that took place in New York City in June 1969.

- **Queer:** An individual who does not identify as heterosexual or **cisgender** (a person whose gender identity matches the gender they were assigned at birth).

- **Questioning**: An individual who is questioning or experimenting with their gender expression, gender identity and/or sexual orientation.

- **Sex**: Assigned at birth to an individual based on the appearance of external anatomy and bodily characteristics such as chromosomes, hormones, and external reproductive organs. There are more sexes than just male and female.

- **Sexual Orientation**: The desire an individual has for emotional, romantic, or sexual relationships with others based on gender expression, gender identity, and/or sex.

- **Transgender**: An individual whose gender identity is different from what they were assigned at birth. Note: transsexual is outdated and not appropriate.

- **Transition**: The process in which an individual who identifies as transgender changes their gender expression to align more closely with their gender identity. This can consist of personal, medical, and legal steps, such as changing one's name and sex on legal documents.[37]

G.2.5 Physical and Mental Disability

Stigma associated with disability is lowest toward individuals with physical disabilities (i.e., missing limbs) and highest among those with intellectual or psychiatric disabilities.[38] Disabilities that are not visible are physical and mental impairments that, in general, do not require assistive devices such as wheelchairs or hearing aids. Examples of invisible disabilities include SUD, renal failure, Crohn's Disease/IBD, mental illness (autism, PTSD, depression, etc.), and fibromyalgia.

A general rule is that if a phrase has a clinical connotation or is a possible diagnosis, using it for other purposes is inappropriate and perpetuates stigmatizing language. Table 3 includes substitution for stigmatizing language.

Please see Co-Occurring Disorders for detailed clinical information about mental health conditions.

Table 3. Language Recommendations for Mental Illnesses

Don't say …	Instead, say …	Reason
Psycho or schizo	A person who has experienced psychosis or a person who has schizophrenia	Puts the person first and removes stigmatizing language Someone who is angry is not psychotic
The mentally ill, a person suffering from, a sufferer, a victim, or the afflicted	Someone who "has a diagnosis of" is "currently experiencing" or "is being treated for …"	Puts the person first and removes stigmatizing language
Released (from a hospital)	Discharged	Released implies lack of choice
Happy pills	Antidepressants, medication, or prescription drugs	Medications provide numerous effects for an individual
I'm so/that's so OCD	I am very organized or meticulous	Dismissive of individuals with an OCD diagnosis Obsessive-Compulsive Disorder is a serious illness associated with recurrent, intrusive thoughts that lead to irrational and excessive behaviors that are unwanted and often emotionally and sometimes physically painful
That work report gave me PTSD or That presentation was so traumatic	That work report was very stressful	Dismissive of individuals with a PTSD diagnosis Individuals diagnosed with PTSD often experience depression, self-harm, SUD, eating disorders, hypervigilance, sleep disturbances, flashbacks, somatic memories, and a higher likelihood of chronic pain and disease[39]

H. STAFF ROLES

The CBCM teams within the COEs are comprised of peer support staff, case/care managers, counselors, and other healthcare providers. Members of this team should be treated as equals in the treatment decision-making process. It is very important to specify the roles of those providing CBCM concerning what services they will be providing to each client, how they will be providing these services, how they will document the services provided, and how they will interface with other COE health care 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 of the CBCM team is associated with improved staff retention, and staff retention is associated with improved client care outcomes.[40] The CBCM team should be adaptive, inclusive, culturally competent, and pragmatically client-focused. The information below provides an overview of each CBCM position in relation to its purpose within the COE as well as position descriptions and qualifications.

COE Expectations by Position

Role	Responsibilities	Other
Care/Case Manager	• Create an individualized care plan with client involvement • Facilitate referrals to appropriate services • Conduct ASAM level of care assessments, if appropriately qualified and trained • Collaborate with COE team, including CRS/CFRS, to address client needs • Maintain clear and consistent boundaries with clients • Conduct the BARC-10 assessment per DHS-identified frequency • Monitor the client's progress and evolving needs • Advocate for the best interest of the client	• NOT based on shared lived experience. • See DDAP's Case Management and Clinical Services Manual for additional information on the role of the Care/Case manager and position qualification requirements.
Certified Recovery Specialist/ Certified Family Recovery Specialist	• Act as a role model, mentor, advocate, and motivator • Connect with the client through shared lived experience • Support recovery planning – encouraging goal identification, problem-solving, and dreaming of possibilities • Accompany clients to community activities and appointments • Share information about skills related to health, wellness, and recovery • Serve as part of the client's support system • Collaborate with COE team to address client needs • Respects the client's personal choices and method of recovery (does not promote their personal recovery model)	• Required position within all COEs • Have more fluid boundaries with clients than the rest of COE staff. • NOT a sponsor, case manager, or therapist. • Engagement with CRS/CFRS tends to improve client engagement and retention over the first six months of treatment.[1] • COEs may opt to include the creation of a recovery plan (previously a relapse prevention plan) as part of the services offered by a CRS/CFRS.
Counselor/Therapist	• Provide evidence-based treatments • Complete and regularly update treatment plans in collaboration with the client • Maintain clear and consistent boundaries with clients • Collaborate with COE team, including CRS/CFRS, to address client needs	• NOT based on a shared lived experience. • As outlined in DDAP's Case Management and Clinical Services Manual, "An individual who meets the qualifications of a counselor or counselor assistant but is providing case management services, must deliver the services separately from treatment or therapy services."

References: [1]Sells D, Davidson L, Jewell C, Falzer P, Rowe M. The treatment relationship in peer-based and regular case management for clients with severe mental illness. Psychiatry Serv. 2006;57(8):1179-1184.

H.1 Peer Support

In Pennsylvania, the CRS is a "credential for individuals with personal, lived experience in their own recovery." All COEs are required to have at least one CRS, which can be a Certified Family Recovery Specialist (CFRS), as a member of the CBCM team. Recovery services are an important component in recovery-oriented systems of care.[41] In sharing personal, lived experiences of recovery, CRSs expertly demonstrate to the client that recovery is possible. The CRS is not a sponsor, case manager, or therapist but rather a role model, mentor, advocate, and motivator.[41] The peer support/CRS supports engagement with the case/care manager. Peer support services, when added to case management, are associated with improved client retention over the first six months of treatment.[42] To be successful in his role, the CRS must embrace the individual journey or pathway of those in recovery and understand that this may be very different from their personal experience. Unlike clinical personnel, such as counselors, the CRS has more fluid boundaries with clients due to the nature of the role being founded on shared experiences.

The CRS is expected to demonstrate the following core competencies as defined by SAMHSA[43]:

> **CRS Core Competencies**
> 1. Exhibits recovery-oriented, person-centered, voluntary, relationship-focused, trauma-informed values and experience.
> 2. Engages peers in collaborative and caring relationships.
> 3. Provides support to treatment providers to assist with client retention and client education.
> 4. Shares (appropriately) lived experiences of recovery.
> 5. Personalizes peer support.
> 6. Supports recovery planning (including setting goals and encouraging dreaming of possibilities).
> 7. Links clients to resources, services, and supports (including accompanying peers to community activities and appointments).
> 8. Provides information about skills related to health, wellness, and recovery.
> 9. Helps peers to manage crises.
> 10. Values communication.
> 11. Supports collaboration and teamwork.
> 12. Promotes leadership and advocacy.
> 13. Promotes growth and development.

In addition to the SAMHSA core competencies, CRSs need to respect a client's autonomy and right to choose the recovery path that they feel is best for them, which may differ from the CRS's chosen recovery path.

H.2 Case/Care Manager

Case/care managers advocate for the client as a response to the fractured and inadequate nature of services required for an individual's optimal health and well-being inside and outside the typical healthcare and social service systems.[44] Each client should have an assigned and dedicated care manager. The case/care manager position generally requires a minimum of an RN diploma or bachelor's degree in

a related field (i.e., nursing, psychology, etc.). The case/care manager "oversees the processes of care delivered to clients, works collaboratively and provides leadership to the health care team, and is committed to the organization's goals for professional case management services."[45] Retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery. Second, treatment may be more likely to succeed when a client's other problems are addressed concurrently with substance use.[44]

The functions that comprise case/care management are:[44]

1. Screening and assessment;

2. Care planning;

3. Referrals;

4. Monitoring; and

5. Advocacy.

H.3 **Clinical Supervisor**

The role of the clinical supervisor is to provide tools and resources for supervisees to provide the right care to every client when it is needed. Tools and resources can be physical, such as computers and handbooks, but often are more abstract. The clinical supervisor must be easily and explicitly accessible to those they supervise via email and scheduled weekly check-ins. At these check-ins, the supervisee must feel safe to discuss the challenges their clients face, shared trauma, burnout, countertransference, and as applicable, the staff person's own recovery. Further, the supervisor-supervisee relationship must be a constantly evolving conversation to ensure success. Clinical supervision is required for those that are DDAP licensees.

While not required by DHS to be enrolled as a COE, to qualify for the Pennsylvania Certified Clinical Supervisor (CCS) credential must have:[46]

- **Credential**: CAAC, CADC, CAADC, CCDP, CCDPD or CCJP; or

- **Degree**: Master's degree in a relevant field.

- **Experience**: five (5) years of full-time employment or 10,000 hours of part-time employment providing primary, direct, clinical, SUD or co-occurring counseling to persons whose primary diagnosis is that of SUD or providing supervision of said counseling;

- **Experience**: two (2) years of full-time employment or 4,000 hours of part-time employment providing clinical supervision to SUD or co-occurring counselors. This experience may be included in the five-year counseling requirement; and

- **Supervision**: 200 hours with a minimum of 10 hours in each domain.

Guidance on clinical supervision best practices is discussed in detail in the section on Clinical Supervision.

H.4 **Counselor**

Within the COE treatment setting, the counselor may have a variety of titles such as Licensed Clinical Social Worker (LCSW) or Certified Alcohol and Drug Counselor (CADC). Each of these credentials requires at least a master's degree.

Counselors provide evidence-based treatments including cognitive behavioral therapy (CBT) and motivational interviewing (MI), clinical monitoring (i.e., oversight and verification of adherence to the treatment plan or prescribed medications), evaluations, and develop treatment plans with clients. Counselors may provide individual or group therapy to clients. SAMHSA utilizes a transdisciplinary foundation hub-and-spoke model to illustrate the requirements of a counselor. This approach was developed to be utilized by a variety of counselor-types beyond the SUD counselor. Figure 4 illustrates the key competencies for counselors as defined by SAMHSA. Definitions of each component are provided; however, additional detail may be found in its respective section as indicated (i.e., Ethics).

Figure 4: Components in the Competencies Model[47]
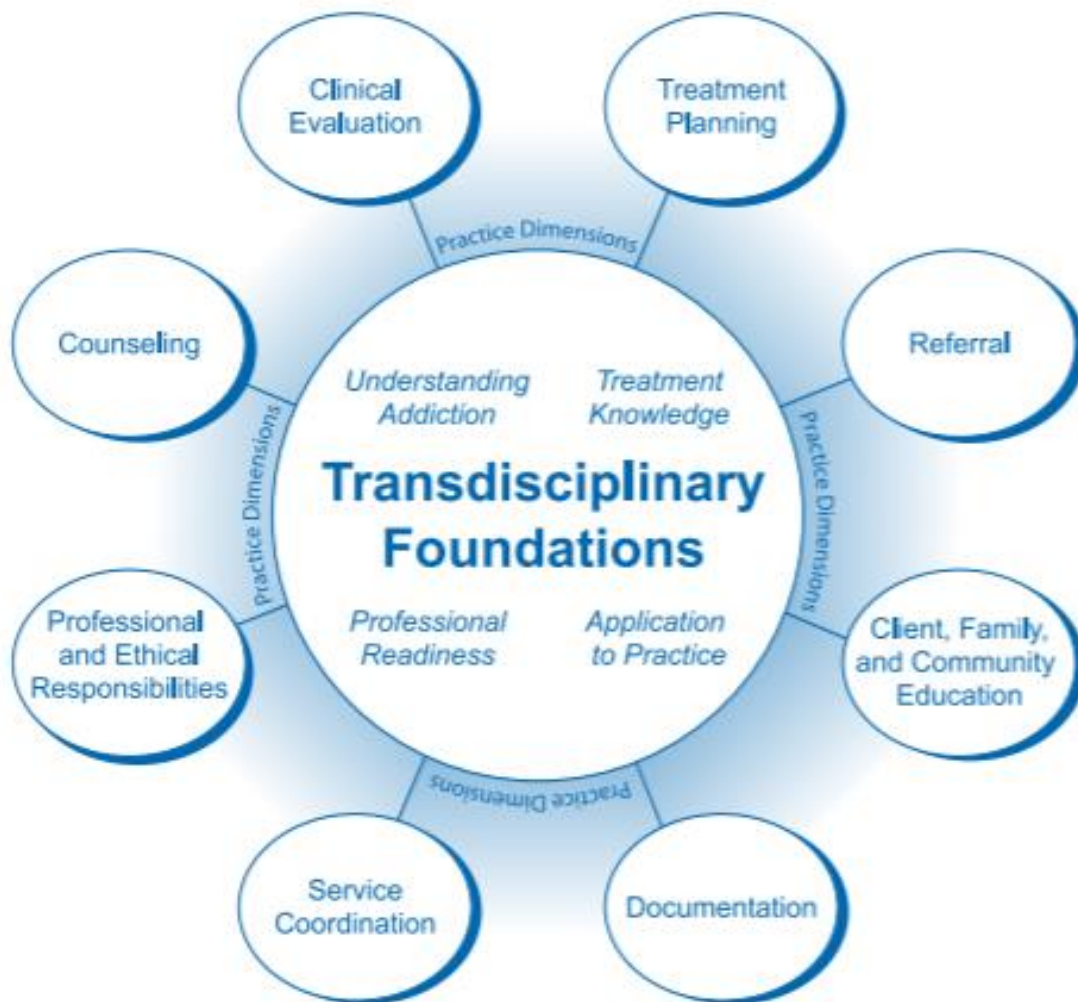
- Clinical Evaluation – "The systematic approach to screening and assessment of individuals thought to have a SUD, being considered for admission to SUD-related services or presenting in a crisis situation." Screening and assessment allow providers to determine the most appropriate course of action.

- Treatment Planning – "A collaborative process in which professionals and the client develop a written document that identifies important treatment goals; describes measurable, time-sensitive action steps toward achieving those goals with expected outcomes; and reflects a verbal agreement between a counselor and client."

- Referral – "The process of facilitating the client's use of available support systems and community resources to meet needs identified in clinical evaluation or treatment planning."

- Client, Family, and Community Education – "The process of providing clients, families, significant others, and community groups with information on risks related to psychoactive substance use, as well as available prevention, treatment, and recovery resources." Clients are significantly more likely to succeed in reaching their treatment goals when individuals in their immediate social circle provide support and understand the process or disease course. Further, education must be culturally relevant and appropriate to health literacy levels.

- Documentation – Refer to the Documentation section.

- Service Coordination – "The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan."

- Professional and Ethical Responsibilities – Refer to the section on Organizational Health.

- Counseling – "A collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives."

H.5 Provider

The SUD treatment provider provides SUD treatment services, including, but not limited to, MOUD such as buprenorphine. Providers at the COE may include primary care physicians and SUD specialists that support the full-body wellness of an individual. SUD specialists are those providers that have received special training and certification from the American Board of Addiction Medicine to screen and treat individuals that use substances. SUD specialists may include physicians, Advance Practice Nurse Practitioners (APNP), Acute Care Nurse Practitioners (ACNP), psychologists, and psychiatrists. It is the role of the care coordinator to facilitate and ensure the completion of referrals between providers involved in a client's care.

I. CONFIDENTIALITY

Disclaimer: This document is intended to be used for general guidance/reference and should not be viewed as legal advice or counsel. It is the responsibility of each individual professional and organization to educate themselves on relevant laws regarding confidentiality in SUD treatment. Individuals are also encouraged to familiarize themselves with their organization's policies and procedures related to confidentiality.

Information concerning SUD treatment is subject to specific confidentiality requirements under state and federal law, including 42 C.F.R. § 2.64 and 4 Pa. Code §255. The contents of this section are not legal advice and should not be understood as such. Providers should consult their legal counsel regarding any confidentiality issues or questions.

It is imperative that individuals working in a SUD treatment organization, from administrative staff to licensed clinicians, understand the rules and regulations governing SUD treatment engagement and patient records (Table 4).

Table 4. Applicable Regulations*

Federal	State
Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2)*	• Pennsylvania Drug and Alcohol Abuse Control Act • 4 Pa. Code §255 • 28 Pa Code §709.28
*This document will be referred to as 42 CFR Part 2 throughout this document.	

I.1 Consent to Release Information

I.1.1 Informed Consent to Release Information

Informed consent to release information must be compliant with the following § 2.31 Consent requirements:

 (a) *Required elements for written consent.* A written consent to a disclosure under the regulations in this part may be paper or electronic and must include:

(1) The name of the patient.

(2) The specific name(s) or general designation(s) of the part 2 program(s), entity(ies), or individual(s) permitted to make the disclosure.

(3) How much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed.

(4)

(i) *General requirement for designating recipients.* The name(s) of the individual(s) or the name(s) of the entity(-ies) to which a disclosure is to be made.

(ii) *Special instructions for entities that facilitate the exchange of health information and research institutions.* Notwithstanding paragraph (a)(4)(i) of this section, if the recipient entity facilitates the exchange of health information or is a research institution, a written consent must include the name(s) of the entity(-ies) and

(A) The name(s) of individual or entity participant(s); or

(B) A general designation of an individual or entity participant(s) or class of participants that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed. When using a general designation, a statement must be included on the consent form that the patient (or other individual authorized to sign in lieu of the patient), confirms their understanding that, upon their request and consistent with this part, they must be provided a list of entities to which their information has been disclosed pursuant to the general designation (see § 2.13(d)).

(5) The purpose of the disclosure. In accordance with § 2.13(a), the disclosure must be limited to that information which is necessary to carry out the stated purpose.

(6) A statement that the consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. Acting in reliance

includes the provision of [treatment](#) services in reliance on a valid consent to [disclose](#) information to a third-party payer.

(7) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is provided.

(8) The signature of the [patient](#) and, when required for a [patient](#) who is a minor, the signature of an individual authorized to give consent under [§ 2.14](#); or, when required for a [patient](#) who is incompetent or deceased, the signature of an individual authorized to sign under [§ 2.15](#). Electronic signatures are permitted to the extent that they are not prohibited by any applicable law.

(9) The date on which the consent is signed.

(b) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in [paragraph (a)](#) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through reasonable diligence could be known, by the individual or entity holding the [records](#) to be materially false.

For more information about informed consent, please refer to the [American Medical Association](#) and the [Office for Victims of Crime](#).

I.1.2 Limited Disclosures with Consent

4 Pa. Code §255 (b) restricts which information can be released to judges, probation or parole officers, insurance companies, health or hospital plan, or governmental officials.

The information that can be provided is often referred to as a "Five-point" consent (Table 5).

Table 5. Five-Point Consent

Information Permitted	Description of Content/Example
Whether the patient is or is not in treatment	Simple confirmation that they are or are not in treatment.
The prognosis of the patient	What is the likely outcome for the patient? "Mr. Smith will likely be able to maintain recovery if he has consistent housing." "Ms. Adams does not seem to be at a place to sustain lasting recovery."
The nature of the project	Describe the services offered: letter of consent, frequency of services, types of services, etc.
A brief description of the progress of the patient	Without getting into specifics, provide a brief overview of the patient's progress in treatment, or lack thereof. "Mr. Smith has demonstrated a commitment to his recovery and consistently makes strides toward his goals. He is making good progress in treatment. "Ms. Adams hasn't demonstrated much progress during treatment."
A short statement as to whether the patient has relapsed into substance, or alcohol use, and the frequency of such relapse	"Mr. Smith has been free of illicit use for the past three months." "Ms. Adams experienced a recurrence of use, which lasted for approximately three weeks."

I.1.3 Disclosures to Legal Entities with Consent

When disclosing information to a legal entity, such as a parole/probation officer, CFR § 2.35 provides the following guidance:

> (a) A part 2 program may disclose information about a patient to those individuals within the criminal justice system who have made participation in the part 2 program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:
>
> > (1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (*e.g.,* a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or post-trial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent meeting the requirements of § 2.31 (except paragraph (a)(6) of this section which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment;

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and

(3) Such other factors as the part 2 program, the patient, and the individual(s) within the criminal justice system who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on re-disclosure and use.* An individual within the criminal justice system who receives patient information under this section may re-disclose and use it only to carry out that individual's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

I.2 **Disclosures without Patient Consent**

There are specific situations in which disclosure of patient information is permitted without the signed consent of the patient. Patients should be informed during the intake process, and throughout their engagement in services, of the limitations on confidentiality and situations in which staff are required to report and share their information. The following are situations (not an inclusive list) that qualify for permitted disclosure without patient consent.

I.2.1 Medical Emergencies

If a patient is experiencing a medical emergency, patient-identifying information can be provided to medical personnel in accordance with 42 CFR § 2.51(c):

(a) *Procedures*. Immediately following disclosure, the part 2 program shall document, in writing, the disclosure in the patient's records, including:

(1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(2) The name of the individual making the disclosure;

(3) The date and time of the disclosure; and

(4) The nature of the emergency (or error, if the report was to FDA).

I.2.2 Audit, Evaluation, and Research

Audits conducted on behalf of a federal, state, or local government agency, an entity that provides financial assistance to the organization or other entities determined qualified to conduct an audit or evaluation can

review patient identifying information, as defined under 42 CFR § 2.11. For audit or evaluation purposes, copying, removing, downloading or forwarding of patient identifying information is permitted under 42 CFR § 2.53 (b):

(a) *Copying, removing, downloading, or forwarding patient records.* Records containing patient identifying information, as defined in § 2.11, may be copied or removed from the premises of a part 2 program or other lawful holder or downloaded or forwarded to another electronic system or device from the part 2 program's or other lawful holder's electronic records by any individual or entity who:

(1) Agrees in writing to:

(i) Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under § 2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (f) of this section; and

(2) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to the part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder; or

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a QIO review, or the contractors, subcontractors, or legal representatives of such individual, entity, or quality improvement organization.

(iii) An entity with direct administrative control over the part 2 program or lawful holder.

Regarding re-disclosure, 42 CFR § 2.53 states:

(a) *Limitations on disclosure and use*. Except as provided in paragraph (e) of this section, patient identifying information disclosed under this section may be disclosed only back to the part 2 program or other lawful holder from which it was obtained and may be used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under § 2.66.

Disclosure of patient identifying information for research purposes must comply with CFR § 2.52:

(a) Notwithstanding other provisions of this part, including paragraph (b)(2) of this section, patient identifying information may be disclosed for the purposes of the recipient conducting scientific research if:

(1) The individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer or their designee, of a part 2 program or other lawful holder of part 2 data, makes a determination that the recipient of the patient identifying information is:

(i) A HIPAA-covered entity or business associate that has obtained and documented authorization from the patient, or a waiver or alteration of authorization, consistent with the HIPAA Privacy Rule at 45 CFR 164.508 or 164.512(i), as applicable;

(ii) Subject to the HHS regulations regarding the protection of human subjects (45 CFR part 46), and provides documentation either that the researcher is in compliance with the requirements of 45 CFR part 46, including the requirements related to informed consent or a waiver of consent (45 CFR 46.111 and 46.116) or that the research qualifies for exemption under the HHS regulations (45 CFR 46.104) or any successor regulations;

(iii) Subject to the FDA regulations regarding the protection of human subjects (21 CFR parts 50 and 56) and provides documentation that the research is in compliance with the requirements of the FDA regulations, including the requirements related to informed consent or an exception to, or waiver of, consent (21 CFR part 50) and any successor regulations; or

(iv) Any combination of a HIPAA covered entity or business associate, and/or subject to the HHS regulations regarding the protection of human subjects, and/or subject to the FDA regulations regarding the protection of human subjects; and has met the requirements of paragraph (a)(1)(i), (ii) (iii), and/or (iv) of this section, as applicable.

(2) The part 2 program or other lawful holder of part 2 data is a HIPAA covered entity or business associate, and the disclosure is made in accordance with the HIPAA Privacy Rule requirements at 45 CFR 164.512(i).

(3) If neither paragraph (a)(1) or (2) of this section apply to the receiving or disclosing party, this section does not apply.

I.2.3 Mandated Reporting

COE staff play an important role in identifying children who may be victims of abuse or neglect. As such, COE staff are obligated to comply with mandated reporter requirements as described in this section.

I.2.3.1 Child Abuse

Mandated reporters are required to immediately file a report with ChildLine (1-800-932-0313) when they have reasonable cause to suspect a child is experiencing physical, emotional, mental, or sexual abuse or neglect. Reasonable cause to suspect child abuse or neglect can be in the form of observations of the child or comments made to the mandated reporter by the child of concern directly or a sibling, other child, or any adult interacting with the child of concern. Mandated reporters are required to follow-up within 48 hours with a written notice to the department or county Children and Youth Services (CYS).

Specifically, Subchapter B, Provisions and Responsibilities for Reporting Suspected Child Abuse § 6311 (c) states:

> Whenever a person is required to report under subsection (b) in the capacity as a member of the staff of a medical or other public or private institution, school, facility or agency, that person shall report immediately in accordance with section 6313 and shall immediately thereafter notify the person in charge of the institution, school, facility or agency or the designated agent of the person in charge. Upon notification, the person in charge or the designated agent, if any, shall facilitate the cooperation of the institution, school, facility or agency with the investigation of the report. Any intimidation, retaliation or obstruction in the investigation of the report is subject to the provisions of 18 Pa. C.S. § 4958 (relating to intimidation, retaliation or obstruction in child abuse cases). This chapter does not require more than one report from any such institution, school, facility or agency.

Roles and occupations in Pennsylvania that may be mandated reporters:

- Individuals licensed or certified to practice in any health-related field under the jurisdiction of the Department of State;

- Medical examiner, coroner, or funeral director;

- Employees of a health care facility or providers licensed by the Department of Health who are engaged in the admission, examination, care, or treatment of individuals;

- School employees;

- Employees of childcare services who have direct contact with children in the course of employment;

- Clergymen, priests, rabbis, ministers, Christian Science practitioners, religious healers, or spiritual leaders of any regularly established church or other religious organization;

- Individuals—paid or unpaid—who, based on the individuals' role as an integral part of a regularly scheduled program, activity, or service, are responsible for the child's welfare or has direct contact with children;

- Employees of a social services agency who has direct contact with children in the course of employment;

- Peace officers or law enforcement officials;

- Emergency medical services providers certified by the Department of Health;

- Employees of a public library who have direct contact with children in the course of employment;

- Individuals supervised or managed by a person listed above or an independent contractor noted below, who have direct contact with children in the course of employment;

- Independent contractors who have direct contact with children;

- Attorneys affiliated with an agency, institution, organization or other entity, including a school or regularly established religious organization that are responsible for the care, supervision, guidance, or control of children;

- Foster parents; and

- Adult family members who are responsible for the child's welfare and provide services to a child in a family living home, community home for individuals with an intellectual disability, or host home for children who are subject to supervision or licensure by the department under Articles IX and X of the Human Services Code.

Mandated reporters have a right to remain anonymous, as described in § 6340 - Release of information in confidential reports:

- *Release of information to subject of report*. At any time and upon written request, a subject of a report may receive a copy of all information, except that prohibited from being disclosed by subsection (c), contained in the Statewide central register or in any report filed pursuant to section 6313 (relating to reporting procedure). supervised or managed by a person listed above, who have direct contact with children in the course of employment;

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- *Protecting identity of person making report*. Except for reports pursuant to subsection (a)(9) and (10) and in response to a law enforcement official investigating allegations of false reports under 18 Pa.C.S. § 4906.1, the release of data that would identify the person who made a report of suspected child abuse or the person who cooperated in a subsequent investigation is prohibited unless the secretary finds that the release will not be detrimental to the safety of that person. Law enforcement officials shall treat all reporting sources as confidential informants.

For more information on mandated reporting, visit www.keepkidssafe.pa.gov. Additional information is available from the Pennsylvania Department of Human Services at www.dhs.pa.gov/contact/Pages/Report-Abuse.aspx.

I.2.3.2 Imminent Intent to Harm Self and Civil Commitment

There may be situations in which a patient is an imminent risk of harming oneself or others. In such cases, the provider has a responsibility to act to ensure the patient's safety. Action may include contacting family, contacting law enforcement for assistance, and civil commitment. Civil commitment is a legal action that requires involuntary admission of the patient to an inpatient or outpatient psychiatric program to ensure safety of the patient or others. When it is determined that a patient poses a risk to self or others, disclosure of patient information is permitted to obtain treatment and protect others.

I.2.4 Licensed and Certified Professionals

For staff who hold professional licenses with the Pennsylvania State Board or professional certifications with the Pennsylvania Certification Board, 49 Pa. Code § 49.79 (a) states:

> Licensees, supervisors and trainees have a responsibility to report alleged violations of the act or this chapter to the Board. If a licensee has knowledge or reason to suspect that a colleague or other licensee is incompetent, impaired or unethical, the licensee shall report that practitioner to the Board. Licensees shall make these reports in a manner that does not violate a client's/patient's right to confidentiality.

If there are questions or concerns about confidentiality or COE staff roles in complying with the legal requirements for confidentiality, please consult with COE administration or legal counsel.

J. ASSESSMENTS

J.1 BARC-10

When it comes to successfully battling a SUD and achieving recovery, both physical and behavioral health providers have observed an increased level of biobehavioral stress exhibited by clients who are on the pathway toward successful recovery.[48] Providers must be able to assess this biobehavioral stress within each client and assess the ability of their clients to engage in, sustain, and increase their chances of recovery. This probability of a successful recovery is referred to as "recovery capital." Substantial literature exists to document the significant association between the client's ability to actively increase their recovery resources and their ability to sustain and evolve their recovery.[49] The domains associated with increasing the breadth and quality of a client's recovery resources (capital) also dovetail well with how SUD treatment assesses and addresses a client's biopsychosocial needs.

Recovery capital is an identified concept to measure the grouping of internal and external resources each client can use to support the initiation and maintenance of recovery from a SUD.[50] Assessment of recovery capital highlights a client's recovery strengths by assessing the psychological, physical, social, and environmental resources that are either externally or inherently available to them. There are more in-depth assessments that are currently available to assess recovery capital. However, in many instances,

providers and clients may appreciate a more brief and concise assessment of their recovery capital. The BARC-10 is an effective tool to implement to assess each client's recovery capital status.

Similar to more in-depth assessments of recovery capital, the BARC-10 broadly but accurately measures the personal, social, physical, and professional resources in an individual's environment that initiate and sustain recovery and demonstrates a high correlation with longer assessment versions.[48] Although brief, the BARC-10 possesses excellent psychometric properties[51] and, more importantly, effectively accounts for client changes in recovery capital status over time. Also, the scoring can be used by COE staff to determine the specific salient resources and approaches attributed to increases (and decreases) in scores.

As such, the BARC-10 assessment offers an alternative measure of recovery capital in settings where brevity is valued. The BARC-10 is a concise questionnaire that determines a client's recovery capital and can serve as a valuable treatment tool for COE clinicians and recovery support staff to ensure a successful and sustainable recovery for the clients they serve.

COEs are **required** to administer the BARC-10 to every COE client within 30 days of initial contact at the COE (can be administered during the initial visit with the client) and every six months during a client's engagement with the COE. Further, the BARC-10 scores are part of the outcome survey that the COE initiative uses to assess client progress across its entire portfolio.

J.2 **Social Determinants of Health**

COEs are required to assess each COE client's social determinants of health (SDOH), using an assessment tool of their choosing.

Social determinants of health are the social constructs that impact a person's life and health that are not directly related to their physiology. These include (but are not limited to): a person's socioeconomic status (income, job status, etc.); where they are born; where they go to school; where they play; where they work; the communities and cultural/racial entities to which they belong; their communities' relationships with the police and other community support entities; and the social and physical supports available to them based on all these factors. A person's socioeconomic status can determine what kind of food, healthcare, and recreational activities they have access to. If an individual has little to no income, they cannot afford to buy things like fresh produce, which tends to be more expensive and spoils quickly. They also may or may not have good health insurance, which determines which doctors they can see and what procedures they can afford to have done. Clients of certain racial groups may have had negative experiences with healthcare access and may not seek or access care to the same degree as other racial groups.[52] Taking these factors into account when treating a client for OUD is extremely important so that the COE can effectively wrap services around the individual according to their individual needs in all areas of their lives.

COE staff must familiarize themselves with the COE's chosen SDOH assessment tool. The SDOH assessment results should be incorporated into creating service plans, identifying client needs, and facilitating appropriate referrals for services. Additionally, COE staff should be prepared to provide resources or complete referrals to appropriate services in the client's community to address the needs identified through the SDOH assessment.

K. **REFERRALS**

As part of COE care management, the CBCM team members facilitate referrals for both treatment and non-treatment services for each client, based on their individual needs. As defined by PA DHS, a referral is a two-way connection of the CBCM team to a recipient agency that provides services for the COE-engaged subscriber. Table 6 lists CBCM direct services and referrals, and Table 7 lists CBCM referrals to ASAM levels of care. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services.

To aid in this process, the CBCM team needs to know local community resources, such as primary care, HIV/hepatitis screenings, perinatal care, and family planning services, mental health care, and pain management. There may be a resource guide describing the availability of these services already created by the county's human services department, and the facility may already have this directory. If not, it is recommended that COEs research available resources and develop partnerships with facilities before client appointments.

Each COE was required to demonstrate a referral network as part of its COE designation application. Staff can request guidance from their supervisor as to which organizations are within the COE's referral network. A client's need must never be left unaddressed because of a lack of that service within the COE. Although COEs can provide SUD treatment and other treatment or social services in-house as they are able, they must refer to other entities if the COE cannot perform the service directly. It is the expectation that the CBCM team will exhaust all options to successfully refer the client to needed services. Partnerships with external entities should take the form of formal written referral agreements that include how referrals will be made (who 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 discuss ways of improving referral access for clients. When referral improvement processes are discussed, they should be reflected the written formal referral agreements, so they are always accurate and up to date.

COEs must provide at least one form of MOUD at the enrolled service location and CBCM teams must schedule COE clients for MOUD induction within 24 hours of their initial encounter with the COE provider. Additionally, the CBCM team must utilize an assessment tool to identify a COE-engaged client's treatment (i.e., SUD, mental healthcare (MH), and primary care) and non-treatment needs and must refer clients to resources to meet those needs such as transportation, housing, nutrition/food, education, employment, training, legal services, and childcare. Each COE client with an OUD diagnosis should also be referred to naloxone access and should be trained on its use for overdose prevention purposes.

Table 6. CBCM Direct Services and Referrals

The CBCM team will provide each of the following services directly or by referral:
Primary care (including screening for and treatment of positive screens for HIV, hepatitis A, hepatitis B, hepatitis C, and tuberculosis)
Perinatal Care and Family Planning Services
Mental Health
Drug and Alcohol Treatment (including forms of MOUD not provided at the COE Provider's enrolled service location/s)
MAT for pregnant women (if the COE Provider does not provide MOUD to pregnant women)
Drug and Alcohol Outpatient Services
Pain Management

Table 7. CBCM Referrals to ASAM Levels of Care

The CBCM staff will also refer and connect COE-engaged clients as clinically appropriate to all ASAM LOC:
Early Intervention
Outpatient
Intensive Outpatient
Partial Hospitalization
Clinically Managed Low-Intensity Residential
Clinically Managed Population-Specific High-Intensity Residential
Clinically Managed High-Intensity Residential
Medically Monitored Intensive Inpatient
Medically Managed Intensive Inpatient

The CBCM team will utilize an electronic health record system to document all care management activities including treatment and non-treatment referrals. A COE data staff member will report these services monthly using REDCap. The COE staff member conducting data entry should utilize the "Referral" codes for the treatment and non-treatment referrals. After the referral is made, the COE care coordinator should continue to monitor the client's treatment and non-treatment needs. At this point, the data staff member should use the "Monitored Engagement" distinction for treatment and non-treatment services. During each care coordination appointment, the care coordinator should ask the client about the status of their treatment and non-treatment referrals and assess if further referrals are needed. For additional resources regarding data, please see Using Data to Support Quality.

L. DOCUMENTATION

Documentation is an essential aspect of high-quality treatment as it provides accountability for the collaboration of care, progress assessment, standards compliance, and organizational fidelity. Each COE must outline its own unique documentation templates and expectations, however, there are some overarching aspects of documentation that are applicable across organizations noted below.

L.1 General Tips

- Utilize appropriate terminology; avoid stigmatizing language, such as "baby daddy" and slang words, such as "dope."

- The length of documentation does not indicate quality; strong documentation is succinct and supportive of the clinical process.

- On documents shared with clients, such as treatment plans, use client-friendly language and avoid technical terminology.

- When documentation is completed with a client, such as an assessment, explain to the client why the information is being requested, how the information will be used, and who will have access to the information in their record.

- Use person-first language: "Client reports a past diagnosis with Bipolar Disorder," not, "Client says he's Bipolar."

- All documentation should be completed as close to the time the service was provided as possible. Most regulations dictate documentation to be completed within 24 hours of the service being provided.

- Documentation within a client's record should be interconnected; assessments should indicate treatment, recovery, and case management goals while such goals direct the content of sessions.

L.2 Service Initiation Assessment

- Explain to the client why the assessment is important and occurring at the beginning of services.

- Acknowledge that it may be difficult for the client to discuss such things so early in services.

- Review confidentiality regulations with the client to reinforce the privacy of their personal information and education on mandated reporting laws for child abuse, duty to warn, and suicidal intent.

- Be mindful of potentially triggering questions (trauma, family, use history, etc.).

- Be thorough when documenting the assessment; this will provide the foundation for treatment planning and justifies the need for services.

- Utilize direct quotes when necessary to appropriately capture a client's experience.

- Never use one's own words to describe what a client has shared.

L.3 Treatment Plan

Treatment plans are created through collaboration between the professional and client, using an individualized and strength-based approach.

L.3.1 Individualized

- Each plan should be unique to the individual, their needs, sources of support, and interests.

- Ensure that each plan is tailored to the unique needs and strengths of each client. Several clients may have the same issue to address, but treatment plans should not be "cookie-cutter."

- Avoid the use of generic goals and objectives because they can negatively impact client progress.

- Remember that what worked for one client is not guaranteed to work for another.

- Plans should be reflective of what the client wants to achieve and should not be influenced by staff opinions, beliefs, or direction.

- Ideally, a treatment, service or recovery plan should be individualized so that staff can identify the client based on the content of the plan without any client-identifying information.

L.3.2 Client Involvement

- Clients should lead the identification of "problems" to be addressed.

- Staff should assist clients with exploring areas for improvement and developing strategies to accomplish goals.

L.3.3 Strength-Based

- Plans should identify goals and objectives that are connected to the client's strengths. This is best practice to increase engagement and build a sense of accomplishment within the client.

- Plans should avoid goals that are unachievable due to client limitations (such as illiteracy, health issues, etc.) as this will deter the client from engaging in treatment and result in loss of hope for improvement.

L.3.4 Components

Treatment plans typically consist of goals, objectives, and interventions.

L.3.4.1 Goals

Goal: An identified intended outcome that is determined through clinical assessment and discussion with the client.

- A goal answers the question, "What do we want the outcome of our work together to be, as we address this identified need?"[53]

- Goals are the "long-term" targets of treatment.

- Although goals can be global and long-term, they should not be vague.

- It is important to make all goals SMART goals (Table 8).

Table 8. SMART Goals[54]

	Attribute	Content
S	Specific	What exactly is to be accomplished? Answer: Who, What, When, Where, and Why.
M	Measurable	How can the extent to which the goal has been met be known? How will it be demonstrated and clear to anyone who would review the goal of how it would be determined if the goal was met?
A	Attainable	It's realistic for the client to achieve the goal. It's reasonable to expect them to achieve the goal in the amount of time determined.
R	Relevant	Related to the purpose of services and the client's needs/interests.
T	Timely (or Timeframe)	Identify the timeline for the goal to be accomplished. A specific date should be used, not vague references to time, such as "soon" or "in the future."

L.3.4.2 Objectives

Objective: An identified step to be achieved in progress toward an identified goal or goals.

- Objectives answer the question, "To achieve the goal by the date identified, what smaller steps have to be accomplished and by when?"[55]

- Objectives should be:

    o Meaningful to the client;

    o Achievable;

    o Stated in behaviorally measurable terms; and

    o Subject to objective assessment of progress.

- Objectives are "short-term" targets toward the identified goal.

- Typically, there are at least two objectives for every goal.

L.3.4.3 Interventions

Intervention: The strategy/action items that will be taken by staff to assist the client in achieving objectives toward overall goal completion.

- Interventions are identified in relation to the objectives they will achieve.

- If an intervention is unsuccessful with assisting the client to achieve an objective, new interventions should be used.

- Plans should only include interventions that the staff member is capable of providing (i.e., they have the appropriate training/education).[56]

- Typically, there is at least one intervention for each objective.

Interventions (and the corresponding objectives) should take into consideration the ways targeted behaviors typically change. The interventions should be provided with enough frequency, intensity, and duration so the targeted behavior can be achieved and sustained. Some interventions are provided with an intentional delay before they address the targeted behavior.

L.4 **Progress and Case Notes**

- When completing a progress or case note, be mindful of treatment goals and objectives. Progress and case notes should reflect what action was taken toward each specific goal and/or objective.

- Progress and case notes should be written so that any authorized reviewer understands what staff are working on with the client, which goals and objectives are related to the content of the interaction, and which services to which the client is referred or provided are relevant to which goals/objectives.

- There may be situations in which the session is not related to the treatment due to acute stressors the client is experiencing, such as the death of a loved one and the need to process their grief. In

such situations, it is essential that the reason the session was not reflective of the treatment plan should be documented. If the situation is going to be an ongoing area addressed in the treatment, an updated treatment plan should be completed.

L.4.1 What to Include

- New and relevant information shared by the client.

- Observed changes in mental status or presentation.

- Which goals and objectives were addressed.

- Intervention(s) provided by staff and how that is connected to the identified treatment plan goals.

- How the client responded to the intervention(s).

- The client's progress, or lack thereof, toward the goals and objectives identified in the treatment, service, or recovery plan.

- A plan to address the lack of progress toward goals should be included if applicable.

- A plan for ongoing work toward the goals and objectives.

- If unsure of whether a piece of information should be included, review the following questions. If the answer is "yes" to any of them, then include the information:

    o "Does this information impact any aspect of treatment?"

    o "Will I need to know this later to continue treatment?"

    o "Will this information be needed for any audits or clinical reviews?"

    o "Does this information help explain why I made a certain clinical decision?"

L.4.2 What Not to Include

- Gossip, hearsay, discussions about others not connected to treatment progress.

- Statements that would be insulting, embarrassing, overly critical, or judgmental to the client.

- Informal diagnoses and terminology, such as addict, drinker, criminal, wife beater, etc.

    o Do not include: "My wife always says I'm bipolar."

    o Do include: "I saw a psychiatrist about five years ago, and he diagnosed me with Major Depressive Disorder, but I don't remember his name." In the note, document "Client reports receiving a diagnosis of Major Depressive Disorder approximately five years ago from a psychiatrist; client does not recall the name of the psychiatrist."

    o Information about criminal activity that has occurred, is ongoing, or planned to occur in the future outside of illicit substance use and its associated activities. NOTE: This does not apply to situations that require mandated reporting. Should a situation occur that requires mandated reporting, thorough documentation of the client's statements should be completed.

- Specific details about a client's sexual practices unless the information is essential to treatment.

- Abbreviations and acronyms that are not universally known.

- Staff's personal shorthand for documentation.[55]

L.4.3 Note Formats

COEs must provide staff with direction on the format to use for progress and case notes. Staff can find examples of common formats used within the behavioral health field in Appendix 8: Note Formats.

L.5 Electronic Health Records (EHR)

- One of the greatest benefits of an EHR is the ability for multiple service providers in one organization to have up-to-date information about all services being provided to a mutual client.

- COE staff should become familiar with the organization's policies for EHR confidentiality and record access.

- EHRs typically cannot be altered, and if amendments can occur, they are typically limited to within 24 hours of the documentation being submitted.

- In general, when working with an EHR, staff should:

  o Only access client records for which they have a business need.

  o Never access a record based on personal interest or media attention to a client.

  o Always use a timed screen lock to avoid accidental disclosure.

  o Ensure their screen is not visible to passers-by.

  o Utilize the information from in-organization services to provide comprehensive care to the client.

L.6 Using Data to Support Quality

In the COEs' ongoing efforts to provide high-quality care to clients in SUD services, it is important for each site to routinely identify aspects of care that need to be improved. To identify these aspects of client care, it is essential to collect and analyze performance measurement data. Specifically, these data points allow the COEs to track the quality of care they are providing in terms of client engagement and retention. Research has shown that performance measurement data is an integral component of an organization's overall quality strategy for improvement.[57,58]

Performance measures can certainly drive high-quality care and are generally developed to establish clear standards of accountability to improve quality of care. The continuous process of collecting and analyzing client care data spearheads the COEs' efforts of accountability and helps to quickly identify gaps in care quality, allowing the organization to focus resources on meaningful change. In turn, the COEs can gauge their performance regarding client care against DHS standards in the monthly COE Checklist. It is this process of ongoing analysis and appraisal that is critical to client-centric organizations like the COEs.

L.6.1 Data Collection and Submission

All COEs should submit their collected data to REDCap®, a secure web application for electronic data capture hosted by the University of Pittsburgh. The COEs should designate two to three individuals within their organization who will be responsible for filling out REDCap® forms and submitting this information on an ongoing basis. Once these staff persons are identified, they will need to be set up with a *REDCap®* account, which can be coordinated through the University of Pittsburgh School of Pharmacy, Program Evaluation and Research Unit (PERU).

Data collection is required for all COE clients that are engaged monthly. The REDCap® data collections are described in more detail in section L.6.2 below.

PERU is responsible for reviewing the data that is collected and producing data reports that are shared back with the COE. The data reports are an important part of the QI efforts that are undertaken by the COE. Additionally, PERU maintains a historical record of the data submitted by the COEs. All questions concerning submitted data can be directed to PERU.

L.6.2 REDCap® Data Collection Forms

REDCap® data collection forms are required to be filled out for all clients that are engaged in the COE.[25] The COE should ensure that the necessary information is updated and reflective of the current information available for each engaged client. The REDCap® forms consist of the following:

- **Client Profile** – documenting a client's date of initial contact and other demographic information.

- **Client Interaction** – documenting details of treatments, assessments, and other activities that happen between a client and a COE.

- **BARC-10** – a survey administered to clients within thirty days of initial contact and every six months thereafter in follow up.

- **Client Discharge** – documenting a client's date and reason for discharge.

- **Client Profile Update** – documenting changes to values within the initial Client Profile, such as changes in overdose history, military status, and gender identity.

More details about the fields in these forms can be found in the REDCap® Data Appendix.

L.7 Documenting Incidents and Ethical Matters

L.7.1 Incidents

- Staff should become familiar with the documentation expectations of the COE for unusual incidents and emergencies. The local SCA will likely have requirements for the reporting of critical incidents, for which a supervisor can provide direction.

- In general, at a minimum, the following incidents should be documented in the client's record:

  o Release of client information with or without the client's consent. This should include whom the information was provided to, for what reason, and what information was disclosed.

  o Client disclosures regarding self-harm or suicidal ideation with the steps taken by the staff member to ensure the client's safety.

  o Disclosures that qualify for mandated reporting (see I.2.3).

- o Emergencies that impact the client's treatment, such as interruptions to services due to COVID-19.

- o Any unusual occurrences that are related to client care or professional boundaries, such as atypical behavior that is perceived as harassment or drug seeking (i.e., texting CRS to obtain information about where to obtain substances).

L.7.2 Ethical Matters

- Record all ethical and clinical decision-making—this may be essential for future treatment decisions, treatment justification, or even self-defense if the staff member's approach is questioned.

- Include any consultations with supervisors in documentation to demonstrate the decision-making process.

- If a staff member addresses a client's inappropriate behavior toward staff or other organization clients, be sure to document this discussion for later reference and to demonstrate the issue was addressed.

- Reference use of any professional decision-making processes that may have been used. American Counseling Association's Ethical Decision-Making Process: https://www.counseling.org/docs/default-source/ethics/ethical-dilemma-poster_fa.pdf?sfvrsn=2

> **Example**
> A client, Mr. Smith, arrives for the scheduled appointment and hands you a wrapped gift, explaining they overheard other staff discussing your birthday. Your organization's policy and your professional license's ethical code state that you cannot accept gifts from clients.

Documentation:

10/1/2020 3:00 pm – Mr. Smith arrived for his scheduled appointment with this writer. Upon entering this writer's office, Mr. Smith handed this writer a wrapped gift and stated that he overheard COE staff discussing this writer's approaching birthday. This writer thanked Mr. Smith and explained that, in accordance with COE policies and the ethical guidelines of this writer's professional license, the gift could not be accepted. This writer explained to Mr. Smith that his thoughtfulness was appreciated and that the policies and regulations are in place to ensure appropriate relationships between clients and professionals. Mr. Smith expressed his understanding and took the gift with him at the conclusion of his appointment.

After Mr. Smith's appointment, this writer spoke with COE Director Mrs. John and informed Mrs. John of the interaction with Mr. Smith.

Signature
Printed name
Date and time

M. EVIDENCE-BASED PRACTICES FOR SUBSTANCE USE DISORDER

Please note that the information provided below does not qualify as adequate training for the evidence-based practices (EBPs).

M.1 Assertive Community Treatment (ACT)

Originally developed and used in the treatment of severe mental illness, ACT has been adapted and found effective for the treatment of SUD. At its core, ACT is focused on providing the various services needed by an individual *in vivo*—in the community, places, and situations where the problems arise—to facilitate recovery through community treatment and habilitation (Table 9). ACT is *not* a case management program; it is a service delivery model. Although case management may occur through ACT, the difference from traditional case management is that clients are not referred out to external providers but rather provided the services as part of the ACT program.[59]

Table 9. Key Principles of Assertive Community Treatment (ACT)

ACT Basic Characteristics	
• Team approach	• *In Vivo* services
• Small caseloads	• Unlimited length of services
• Shared caseloads	• Flexible service delivery
• Identified and fixed point of responsibility	• 24/7 crisis response

M.2 Motivational Interviewing (MI)

As described by its creator, William R. Miller,[60] MI is "a style of communication designed to bring out the other person's motivations to change." MI utilizes a person-centered, collaborative approach to assist individuals as they identify areas for change and pursue their goals. Extensive research has found MI to be effective in treating all SUDs, with an observed effect on increased client engagement and decreased risky behaviors.[61] The principles of MI, known as the Spirit of MI, is the overarching vision of the approach and is present in all interactions and interventions (Figure 5). Table 10 outlines the key communication skills that are practices in MI, known as OARS.

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Figure 5. Spirit of Motivational Interviewing (MI)

The OARS acronym, listed in Table 10, has been used in teaching MI skills to guide client communications.

Table 10. Key Communication Skills

Key Communication Skills
Open-ended questions
Affirmation
Reflective listening
Summarizing

M.3 Cognitive Behavioral Therapy (CBT)

CBT has been found effective for a plethora of mental health and SUDs. Based on the interconnectedness of an individual's thoughts, feelings, and behaviors, CBT focuses on disrupting maladaptive thoughts and their connected emotional and physical responses. The cognitive model, depicted in Figure 6, asserts that

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the way an individual perceives a situation is influenced more by their response than the situation itself. [62,63]

Figure 6. Cognitive Behavioral Therapy Model[63]
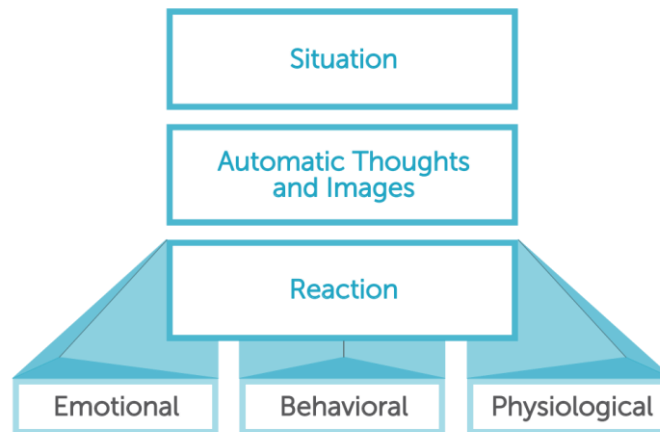
Through a CBT approach, clients learn skills to change their thinking, responses, and behavior to enact lasting improvement in their life. Table 11 describes the common CBT interventions.

Table 11. Common CBT Interventions

Common CBT Interventions	
Cognitive restructuring/reframing	Guided discovery
Exposure therapy	Journaling and thought tracking
Behavioral experiments	Relaxation techniques
Role-playing	Success approximation
Playing the script	Challenging cognitive distortions

M.4 Dialectical Behavior Therapy (DBT)

DBT is a broad-based cognitive behavioral treatment, was initially found to be effective in the treatment of individuals diagnosed with borderline personality disorder. Since its creation, however, it has been researched and found effective in SUD treatment. The overarching goal of DBT is for the client to build skills to change behavioral, emotional, thinking, and social skills that are connected to their problems in life (Table 12). DBT is rooted in the view that our emotions are unconscious, involuntary, acute, and all-encompassing patterns of responses to internal and external stimuli. That is, a person has developed a consistent, learned response to stimuli to the extent that it occurs without their awareness. This learned response was likely effective at some point in the individual's past, like when they processed traumatic events they experienced. [64]

Table 12. DBT Skills Modules

DBT Skills Modules	
ACCEPTANCE SKILLS	**CHANGE SKILLS**
Mindfulness	Emotion Regulation
Distress Tolerance	Interpersonal Effectiveness

M.5 Contingency Management (CM)

CM is focused on providing rewards for positive, desired behaviors, and the lack of engagement in unwanted behaviors (Table 13). Depending on the program, CM can also include disciplinary measures or the withholding of privileges when the client engages in unwanted behaviors. When used for SUDs, CM posits that substance use is a positive experience, thus using positive reinforcements for desirable behaviors will eliminate the desire for substance use.[65] Table 13 describes CM's guiding principles.

Table 13. Guiding Principles of CM

Guiding Principles of CM	
Target the behaviors: Either a negative behavior to be reduced/eliminated or a positive behavior to be increased.	Choice of eligible clients: Best used with clients who lack intrinsic motivation.
Proportionate incentive: Rewards should be balanced between what's feasible and what's rewarding.	Incentive Distribution: How frequently will the reward will be provided? Will it be a specified or variable rate?
Immediacy: Rewards, or the withholding thereof, should be provided immediately after the desired behavior.	Duration of CM: Determined on a case-by-case basis to reach sustained desirable behaviors in the absence of the rewards.

M.6 Functional Family Therapy (FFT)

FFT is an evidence-based practice specifically for adolescents with a variety of diagnoses, including SUD. FFT is offered in a variety of settings (school, home, clinic, etc.), pending the availability and need of the client. Founded on the principles of acceptance and respect, FFT uses a strengths-based approach to address the needs of the client on an individual and family-systems level (Table 14).[66]

Table 14. FFT Major Components

FFT Major Components	
Engagement	Motivation
Relational Assessment	Behavior Change
Generalization	

M.7 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

COE staff members may find themselves in situations where they are asked to help primary care practices/emergency department sites screen clients for SUD/OUD risk. SBIRT is the appropriate EBP to accomplish this. SBIRT applies standardized screening tools, and for clients screened as positive, a brief communication method to motivate the clients to access subsequent assessment and treatment. This brief communication method is called a brief intervention and uses MI principles. This can be learned using a training process called POLAR*S.[67]

POLAR*S is a client-centered communication process that can help elicit a client's motivation to change and guide them toward positive behavior change. POLAR*S is comprised of asking **P**ermission, using **O**pen-ended questions, reflective **L**istening, providing **A**ffirmation, **R**olling with ambivalence, and **S**ummarizing the conversation. COE staff can use POLAR*S, as outlined in Table 15, to navigate a brief intervention using the Spirit of MI (see Motivational Interviewing).

Table 15. POLAR*S Steps

Step	Goal	Example
Permission	Asking permission to discuss a health behavior respects the client's autonomy, keeps the focus on them, and minimizes conflict.	"Is it okay if we talk about your use of drugs/alcohol?"
Open-Ended Questions	Open-ended questions elicit important information from the client about their goals, concerns, feelings, and preferences regarding a health behavior.	"What do you like about using drugs/alcohol? What do you dislike?"
Listen Reflectively	Listening reflectively demonstrates engagement and can confirm that the client's perspective was both heard and understood. Reflective listening can help to highlight ambivalence and explore the client's confidence to make a behavior change.	"On the one hand, there are things you enjoy about drugs/alcohol. On the other hand, there are some negatives."
Affirmation	Affirmation helps to support self-efficacy and build confidence by drawing attention to things under the client's control and highlighting strengths, successes, and abilities.	"Your health is important to you. You started exercising more last year and have seen some real improvements in your well-being."
Roll with Ambivalence	Rolling with the client's ambivalence enables the provider to minimize conflict and maximize collaboration. Rolling with ambivalence may involve exploring other options or smaller steps the client can take toward behavior change.	"It's okay if you don't want to talk about this today. Do you mind if I follow up with you about this at your next appointment?"

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Step	Goal	Example
Summarize	Summarization confirms mutual understanding and helps to transition the conversation from exploring options to identifying a plan of action. The client should be confident that they can move forward with the selected plan.	"Today, we agreed that you would like for me to refer you for further evaluation. You will call me if you have any concerns about attending your first appointment. I will call you to check in after your first visit."

POLAR*S can also be used to guide brief client discussions that encourage access to COE services. COE staff who have already been trained in MI counseling may find POLAR*S helpful in cementing their skills. Further, staff who have received little to no MI training can be easily trained in POLAR*S.

N. TRAUMA-INFORMED CARE (TIC)

On May 7, 2020, Pennsylvania Governor Tom Wolf announced a plan to build a trauma-informed state, highlighting the importance of recognizing the diverse, potentially traumatic experiences of all individuals.[68] The significance of understanding traumatic experiences is not new for organizations that serve individuals with SUDs; the necessity for TIC is well-established and now highlighted as the expectation, not the exception.

N.1 Trauma

N.1.1 Definition

SAMHSA provides the following definition of trauma:

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being."[69]

Experienced by an individual: Trauma is not the event or events in and of themselves, trauma is the personal experience of the event by the individual. That experience can vary between two people who encounter the same event or series of events.

Lasting adverse effects on the individual's functioning: When an event(s) is/are experienced as traumatic, it can impact every aspect of the person and their world.

Table 16 describes the potential impacts on a client after they have experienced trauma.

Table 16. Potential Impacts of Trauma

Area	Example
Functioning	An individual may be unable to tend to usual responsibilities, maintain focus for extended periods, or have difficulty recalling information.
Mental Health and Brain Development	Can impact brain development (particularly when trauma is experienced in childhood) and circuitry. Often, executive functions are "on hold" due to being in a state of hypervigilance and overwhelming stress. Trauma increases the likelihood of developing a mental health disorder and experiencing cognitive distortions.

Area	Example
Physical	Somatic symptoms can occur, such as headaches, sleep disturbances, and gastrointestinal issues.
Social	The individual may be fearful of interactions with others and may engage in unhealthy relationships as a result of the trauma. Shame is a common experience following trauma, which can impact an individual's self-esteem and willingness to socialize.
Emotional	Emotional dysregulation is common. The individual may pursue ways to "numb" their feelings and memories associated with the trauma through risky behaviors and/or substance use. The individual may present with a blunted effect.
Spiritual	The individual may question their belief system, purpose in life, and self-worth. They may also disconnect from faith-based associations.

Another way of understanding trauma is with the following explanation provided by Claudia Black,[70] "Trauma is not a disease or a condition. It is the body's and the brain's response to a severe, painful experience that overwhelms one's ability to cope with the resulting rush of feelings and thoughts."

Table 17 describes potential events that can precede a client's traumatic experience.

Table 17. Examples of Potential Events Preceding a Traumatic Experience

Examples of Potential Events Preceding a Traumatic Experience		
Physical Abuse	Emotional Abuse	Sexual Harassment, Abuse, or Assault
Kidnapping	Death of a Loved One	Witnessing Violence
Loss of Home	Racism	Sexism
Health Diagnoses	Ageism	Injuries
Natural Disasters	Incarceration	Pandemic
Infidelity	Bullying	Failure
Generational Trauma	Poverty	Neglect
Sexual Orientation	English as a Second Language	Witnessing or Experiencing Domestic Violence
Persistent Manipulation	Discrimination	

N.1.2 Prevalence of Trauma

- 70.4 percent of respondents in a World Health Organization survey on Mental Health across 24 countries with varying socioeconomic status, reported at least one traumatic experience in their lifetime.[71]

- 61 percent of men and 51 percent of women in the United States report at least one traumatic experience in their lifetime.[71]

- Over 90 percent of individuals involved in behavioral health services in the United States report at least one traumatic experience in their lifetime.[71]

N.1.3 Big T and little t Trauma

The terms "Big T" and "little t" trauma do not imply the severity, impact, or importance of the trauma experience. The terms instead are a conceptualization of different types of experiences that can be traumatic; some traumatic experiences are obvious to others (Big T traumas), whereas other traumatic experiences, with just as significant of an impact, are not as recognizable (little t traumas) (Figure 7).

The terms Big T and little t trauma should never be used when speaking with a client about their trauma experience. Referring to a client's trauma as a "little t trauma" could minimize their experience, diminish rapport, and halt progress in services.

Figure 7. Big T and Little t Trauma Examples
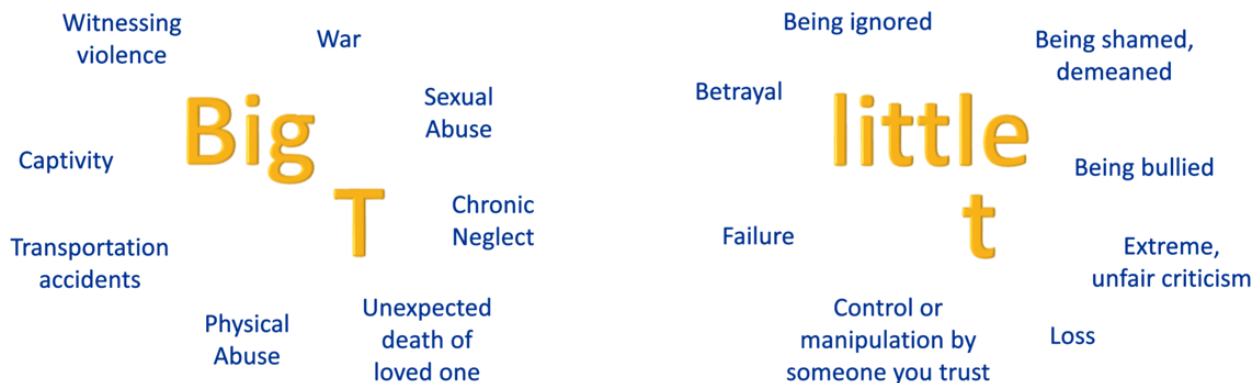
N.1.3.1 Big T Trauma

Big T traumas are the events most associated with Post-Traumatic Stress Disorder (PTSD)—the events that most people think of when they hear the words "trauma" or "PTSD." These events tend to be more obvious and acute. Typically, Big T traumas result from a single, identifiable event that almost everyone would find disturbing if they were to experience it, such as witnessing a loved one be murdered. Some Big T traumas can result from a series of repeated and ongoing events, such as war.[70]

N.1.3.2 Little t Trauma

Little t traumas are more subtle, chronic, and much more common than Big T traumas. In fact, little t traumas are so common that they are often overlooked, dismissed, and undervalued in their potential impact. It is not uncommon for a survivor of little t trauma to question why they are having a traumatic response to something that isn't as clearly traumatic.[70]

N.1.4 Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are events that occur between the ages of 0 and 17 that are potentially traumatic, including aspects of the child's environment that negatively impacts their sense of safety, stability, and bonding to caregivers (Figure 8). It is quite common for children to experience an event that would qualify as an ACE; 61 percent of adults surveyed across 25 different states reported experiencing at least one adverse childhood experience growing up, and nearly one in six reported four or more ACEs.[72]

Figure 8. Adverse Childhood Experiences

https://www.preventchildabuseillinois.org/childhood-trauma

ACEs have a long-lasting and far-reaching impact with the ability to interfere with every aspect of a person's life. In general, ACEs are linked to risky behaviors, chronic health conditions, low life potential, and early death. Specifically, individuals who report any number of ACEs are more likely to experience traumatic brain injuries, fractures, burns, depression, anxiety, suicide, PTSD, chronic diseases such as cancer and diabetes. In fact, it's believed that up to 1.9 million cases of heart disease and 21 million cases of depression could have been potentially avoided had ACEs been prevented. ACEs are also linked to less education, limited occupation opportunities, lower-income, increased risk of alcohol and substance use, greater likelihood of unsafe sex, and exposure to infectious diseases. Women who endured ACEs are more likely to have an unintended pregnancy, complications during their pregnancy, and are at greater risk for fetal death.[72]

N.1.5 Trauma Responses

Humans have an innate focus on survival that is rooted deep within the oldest part of our brain. When our brain perceives a threat, our body responds at an unconscious level to act to ensure our survival. These same unconscious processes occur as a result of trauma. There are four common trauma responses, which can occur during the exposure to the traumatic event, in the immediate aftermath of the event, and when the traumatic experience is recalled in the future.

1. **Fight:** Fight is a hyperarousal state, meaning that the body is in a constant state of GO, functioning at an "all systems go" level. At the core of the fight response is the attempt to regain a sense of safety through control. Attempts to obtain this control can manifest through aggressive behavior, criticism, and confrontation. For some, the fight response can manifest through self-harming behaviors, suicidal ideation, and homicidal ideation.

   a. *Personal Life Example:* During her childhood, a woman witnessed her father physically abuse her mother whenever he was angry. In adulthood, this same

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woman becomes physically aggressive toward her partner whenever she senses her partner becoming angry.

b. *Clinical Setting Example:* A client is informed that she tested positive for illicit substances on her urine drug screen. The woman immediately becomes confrontational, raising her voice and claiming that someone made a mistake.

2. **Flight:** Flight is also a hyperarousal state that results in the individual desperately trying to escape the event, reminder, emotion, or thought. The most well-known flight response is for the individual to physically depart the environment in which the traumatic or stressful experience is occurring. Flight can also occur through substance use, unhealthy eating, and other avoidance tactics that distract the individual, temporarily, from the traumatic experience.

a. *Personal Life Example:* An individual enters a local store and sees the person who has caused them pain in the past. The individual experiences a state of distress and quickly leaves the store and is unable to calm down until a significant reduction in the stressor.

b. *Clinical Setting Example:* A staff member is meeting with a client and references the latest news story of a child dying after being physically abused by a caregiver. The client, having experienced similar abuse, suddenly stands up and claims they forgot they had somewhere else they were supposed to be.

3. **Freeze:** Freeze is considered a hypoarousal state in that all processes slow down, if not stop completely. In this trauma response, the individual is disconnecting from the world around them, essentially "shutting down" to focus on the minimal needed to survive. This disconnection is an attempt to experience a sense of safety. Examples of freeze reactions include dissociation, a sense of numbness/a mental fog, and an inability to make or act on decisions.

a. *Personal Example:* An individual is walking down the street when someone approaches them, holding a gun. When directed to hand over their phone and money, the person is unable to move or speak.

b. *Clinical Setting Example:* You are completing an assessment with a new client, and, when asked if they have experienced any type of abuse, the client appears to have "zoned out."

4. **Fawn**: The fawn reaction has only recently been identified and, like freeze, is considered a hypoarousal state. The purpose of the fawn response is to avoid further distress. This desire for peace leads the individual to conform to others to avoid losing the relationship, experiencing conflict with the person, or enduring a physically aggressive response from the individual.

a. *Personal Example:* A young girl's mother unexpectedly left her life without any explanation. Despite her father treating her poorly, the young girl never challenges him and complies with his every demand for fear of losing her remaining parent.

b. *Clinical Setting Example:* When prompted to identify goals, a client is passive and states they will work on whatever the clinician thinks they should work on. A second example is a client participating in an intervention, such as exposure therapy, that they are not fully comfortable with but unwilling to share that discomfort with the staff member for fear of upsetting staff.[69]

N.1.6 Potential Losses Due to Trauma

Experiencing trauma often results in a number of significant losses, often losses that are not obvious or immediately known. Often, these losses are subtle, subsurface losses that can, at times, have a greater impact on the trauma experience of the individual than the initial event. Below are potential losses that can result from traumatic experiences:[70]

- Trust (in self, others, the world).

- Connection.

- Innocence.

- Understanding of what is real.

- Safety.

- Sense of self.

- Boundaries with others.

- Orientation to time and space.

- Control.

- Faith.

N.2 Trauma and Substance Use Disorders

Trauma and SUDs have a symbiotic relationship—an experience of one increases the risk of the other occurring (Figure 9).

Figure 9. Trauma and Substance Use Relationship
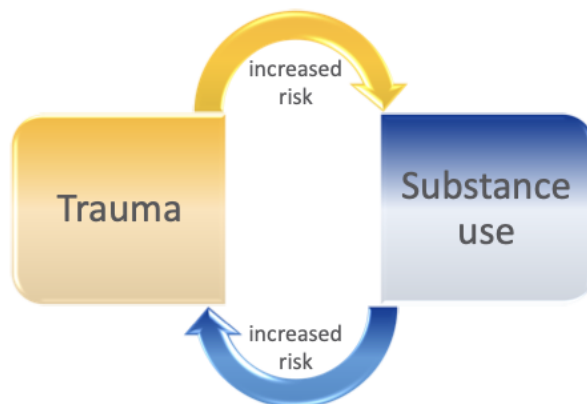
N.2.1 Trauma Preceding Substance Use Initiation

Experiencing trauma increases the likelihood of developing a SUD, regardless of whether the individual consumed any substances before the trauma experience. Survivors of trauma may use substances in attempts to cope with the emotions, memories, and somatic symptoms that resulted from a traumatic

experience. Substances may be used to numb (flight response) oneself to trauma reminders and symptoms.

When a survivor of trauma begins using substances, they are at a significantly higher risk of re-traumatization. Additionally, the substance, which initially was effective in reducing trauma symptoms, stops being effective and results in poorer long-term trauma recovery outcomes. Some individuals struggle to cope with trauma experiences during childhood and pursue substances to "fit in" socially or because they have lost their sense of self-worth.

N.2.2 Trauma Following Substance Use Initiation

Engaging in substance use increases the risk of enduring a traumatic experience. Substance use, and its affiliated behaviors, is itself traumatizing regarding actions taken to obtain a substance, the methods of using a substance—such as injection, the potential for death, and so on. Additionally, if someone endures a traumatic experience after they have been using substances, the trauma itself can propel the substance use to numb (freeze response) the trauma-related feelings and memories.

N.3 Trauma-Informed Care

Understanding the symbiotic relationship between substance use and trauma is the basis for utilizing a trauma-informed care (TIC) approach when treating SUDs. Trauma integration in treatment settings can be conceptualized as a continuum, with one end being the complete lack of trauma recognition and the other being solely focused on trauma, TIC falls in a place of recognizing trauma without treating trauma (Figure 10).

Figure 10. Continuum of Trauma-Informed Care – Trauma-Informed

TIC acknowledges and respects the relationship between trauma and substance use. While treating the SUD, the provider assists the client in building healthy coping skills, creating a sense of safety, and eliminating or reducing activities that can increase the risk of re-traumatization.[69] TIC programs refer out for trauma treatment. Organizations that utilize a TIC approach are vigilant in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals, such as assessments that elicit a trauma response or protocols such as a monitored urine drug screen, that can be retraumatizing to a survivor of sexual abuse.[69] Finally, organizations that utilize a TIC approach uphold the importance of consumer participation in the development, delivery, and evaluation of services. Feedback is requested from clients to identify areas that need improvement to be consistent with TIC.[69]

TIC is not a checklist or step-by-step guide; TIC is a mindset of a comprehensive approach that impacts every aspect of an organization and each client it serves. TIC follows four core principles[69]:

N.3.1.1 Safety

Trauma is a response to a threat to one's safety. Thus, it is essential to establish the client's sense of safety. Attention is paid to the client's nonverbal communication during interactions to monitor for potential distress. Consent for interventions should be obtained to reduce the potential for anxiety or feelings of helplessness. Staff can also practice this principle by only offering services in which they have been adequately trained and qualified to provide.

N.3.1.2 Trust and Transparency

Rapport is essential in any substance use service. Trust and transparency extend beyond strong rapport to reflect openness, authenticity, respect, and clear boundaries. Survivors of trauma have often had their boundaries disrespected or have been treated inappropriately by authority figures. It is the responsibility of the staff member to ensure there are healthy, clear, and consistent boundaries with clients. Something as "small" as being late to a scheduled meeting can do significant damage to a client's sense of trust in the working relationship.

N.3.1.3 Collaboration

Clients should always be involved in, if not leading, decision-making for their services and future. Staff are there to assist the client in pursuing the life they want to live, not to direct the client on how to live their life.

N.3.2 Choice and Empowerment

Choice and empowerment often go together. Remember that a common loss of trauma experiences is the loss of a sense of control. The client should have control of their life and options, even in situations in which options appear pre-determined by an outside entity (such as a judge). The client should be provided every opportunity for autonomy. Staff can create a wide array of opportunities for clients to practice these skills by setting attainable goals to facilitate personal wins or using person-first and gender-affirming language.

N.4 Trauma-Informed Substance Use Disorder Treatment

N.4.1 Avoiding Re-traumatization

There is a potential for re-traumatization in every aspect of service delivery including paperwork verbiage and forms, assessments, clinical interventions, treatment practices, and organizational policies and procedures. With each aspect of service delivery, COE staff should ask themselves, "Could this be retraumatizing to a client with a trauma history? If I were a survivor of trauma, would this document/protocol/intervention be difficult for me?" Rarely is re-traumatization intentional, which highlights the need for intentionality and mindfulness when interacting with clients. It is the responsibility of staff to minimize the potential for re-traumatization.

N.4.2 Recognizing Trauma Responses

Become familiar with situations that the client has identified as particularly distressful as these may be eliciting a trauma response within the client. As previously mentioned, be attentive to clients' nonverbal communication; inability to sit still, rapid speech, inability to maintain eye contact, and sweating can be a sign that a client is experiencing a trauma response. When a client is observed having a trauma response, do not continue the discussion that elicited the trauma response. Instead, check in with the client, provide them with space and time to calm down, and offer to walk them through healthy coping skills, such as deep breathing.

N.4.3 Language

Staff should always utilize appropriate terminology to avoid stigmatizing or retraumatizing clients. Always utilize person-first language— refer to a client as a survivor of trauma, not a "victim." Appropriate terminology, or the use of inappropriate terminology, directly impacts the trust and transparency principle of TIC. Research demonstrating the significant impact of language on treatment engagement and outcomes continues to grow.

N.4.4 Boundaries

As previously mentioned, it is the responsibility of staff to maintain clear, healthy, and consistent boundaries with clients. The specifics for boundaries will vary between positions, with peer supports having the most flexible boundaries with clients. Clinical staff should maintain a clear "line in the sand" of what is and is not appropriate in sessions. Maintaining such boundaries will eliminate the possibility of a client acting a certain way to appease a staff member or misunderstanding the purpose of the working relationship. Additionally, healthy boundaries also require staff to maintain appropriate behaviors and interactions; if COE staff say they are going to do something, they need to make sure that they do it—they cannot dismiss it thinking that the client "will understand." COE staff are the professionals. They are expected to be consistent, appropriate, fair, and equal in their interactions with clients.

N.4.5 Peer Support

Experiencing trauma can lead an individual to feel as though they are alone in the world, undeserving of love, and unworthy of connections with others. Peer supports can play a pivotal role in demonstrating what healthy connections can entail. Additionally, peer supports can serve as role models for how to build healthy relationships, coping skills, and support systems. Peer supports normalize the trauma and SUD recovery process. This function of peer support cannot be overstated.

N.4.6 Referrals to Trauma-Specific Treatment

Trauma-specific treatment providers are specialized programs that utilize EBPs to facilitate recovery from trauma. Staff in such organizations have received extensive education, experience, training, and supervision in trauma treatment (Figure 11). It is inappropriate for someone without the appropriate background to state they are providing trauma treatment. Some organizations can appropriately treat trauma and substance use concurrently; however, space in such organizations can be difficult to come by as demand for specialized care is high.

Figure 11. Trauma-Informed Care Continuum – Trauma-Specific

For a TIC approach, organizations will have a screening tool that staff should use for assessing trauma history. When a client screens positive, meaning they would benefit from trauma-specific treatment, a referral should be made to an appropriate program if the organization does not offer the service on-site. Having a trauma history does not always equate to a need for trauma-specific treatment. People often recover from trauma events on their own without a need for specialized treatment. This assesses trauma symptoms essential in determining if individuals are at risk of developing trauma-related disorders and need specialized services.

For a TIC approach, organizations will have a screening tool that COE staff should use for assessing trauma history. When a client screens positive, meaning they would benefit from trauma-specific treatment, a referral should be made to an appropriate program if the organization does not offer the service on-site. Having a trauma history does not always equate to a need for trauma-specific treatment. People often recover from trauma events on their own without a need for specialized treatment. This assesses trauma symptoms essential in determining if individuals are at risk of developing trauma-related disorders and require specialized services.

Considerations for a referral should include: the severity of trauma-related symptoms as determined through the assessment process; cognitions the patient experiences resulting from the trauma, also known as the cognitive triad; continued trauma; and physical health consequences such as chronic pain or disfigurement. If symptoms, thoughts, and physical health are functionally impaired due to past trauma experiences, it is important to address these issues as soon as they are identified. With these factors in mind, and consulting with professionals familiar with specialized trauma treatments, COE staff can refer the patient to trauma-specific services while also continuing with SUD treatment.

For additional resources regarding TIC, please see ASAM.

O. CO-OCCURRING DISORDERS

O.1 Co-Occurring Disorders

A co-occurring disorder is a term used to describe a condition where an individual is diagnosed with two disorders at the same time. This term is most often used to refer to the combination of SUDs and mental health disorders, as well as other combinations of disorders, such as a mental health disorder and an intellectual disability.[73] Within the United States, co-occurring disorders are prevalent. According to the 2018 National Survey on Drug Use and Health (NSDUH), approximately 9.2 million American adults (3.7 percent) had any mental illness (AMI) as well as a SUD within the past year. It also found a co-occurrence of serious mental illness (SMI) and a SUD within 3.2 million (1.3 percent) of American adults.[74] Treating a client with a co-occurring diagnosis can present challenges for the provider in understanding which diagnosis should be addressed first and is one disorder a symptom (secondary to) of another. Another aspect of co-occurring disorders is the risk of suicidal ideation/behaviors. In 2018, approximately 10.7 million adults 18 years and older, expressed serious suicidal ideation; this study found that about 1 in 3 adults who had serious suicidal ideation (made suicide plans), and about 1 in 8 adults who had serious suicidal ideation made a suicide attempt.[74]

O.2 Common Co-Occurring Mental Health Disorders

O.2.1 Depression

Depression is a common and serious mental health disorder that affects a person's mood. Those who suffer from depression experience ongoing feelings of sadness, hopelessness, and loss of interest in activities they once enjoyed. A critical part of being diagnosed with depression requires the person to experience significant impairment in either social, occupational, or other areas of their life.[75] According to the Diagnostic and Statistical Handbook of Mental Disorders, Fifth Edition (DSM-V), one of the primary symptoms is either a depressed mood or anhedonia (loss of interest or pleasure). Secondary symptoms include loss of appetite, sleep disturbances, psychomotor agitation or retardation, fatigue or loss of energy, decreased ability to concentrate, excessive feelings of worthlessness or guilt, and suicidal thoughts.[76]

O.2.2 Bipolar Disorder (I and II)

Bipolar I and II disorders are disorders that cause fluctuations in a client's mood, functioning ability, and energy. These changes have been described as switching between periods of increased energy (mania or hypomania) and periods of depression. During manic states, a client may feel energetic, abnormally happy, and make dangerous or impulsive decisions. During a hypomanic state, the client may feel pretty good—with a better sense of well-being and productivity.[77] According to the DSM-V, a manic episode is characterized by a distinct and abnormal state of elevated, expansive, or irritable mood occurring for at least one week. The manic episode is tirelessly driven by goal-directed behavior or energy.[77] During depressive states, they may feel the overwhelming feeling of sadness, hopelessness, and helplessness.

O.2.2.1 Bipolar I Disorder

Someone diagnosed with Bipolar I Disorder experiences at least one manic episode that lasts at least seven days. These symptoms can occur simultaneously with depressive episodes that last at least two weeks.[78]

O.2.2.2 Bipolar II Disorder

Someone diagnosed with Bipolar II Disorder experiences a milder form of mania called hypomania, along with depressive episodes. These depressive episodes occur many times more than the number of hypomanic episodes.[78]

O.2.3 Generalized Anxiety Disorder (GAD)

Generalized Anxiety Disorder is a disorder where a person is constantly worried about anything and everything in their life. This overwhelming sense of worry not only impacts a client's mental well-being, but also attributes to physical symptoms including tense body, aches, increased heart rate, shakes or trembles, cold chills or hot flashes, numbness, digestive issues, and/or fatigue. A diagnosis of GAD requires a client to have an ongoing feeling of worry which is experienced for at least six months.[79]

Co-occurring disorders also include PTSD, schizophrenia, borderline personality disorder, obsessive personality disorder, and others (Table 18). Many times, a client suffering from a mental health disorder will begin or continue to use substances to diminish their severe and ongoing mental health symptoms.

Table 18. Definitions of Common Co-Occurring Mental Health Disorders

Other Common Co-Occurring Mental Health Disorders	Definition
Post-Traumatic Stress Disorder (PTSD)	A mental health disorder developed after an individual experiences/witnesses extremely terrifying event(s). Some symptoms include flashbacks, nightmares, anxiety, and reliving the event(s).[80]
Schizophrenia	A severe mental health disorder where an individual has an abnormal perception of reality. Some symptoms include hallucinations, delusions, disorganized thinking, reduced emotional expression, and/or poor personal hygiene.[81]
Borderline Personality Disorder	A mental health disorder that affects an individual's relationship with themselves and others. Some symptoms include fear of abandonment, unstable relationships with others, inconsistent expression of one's self-image, risky and impulsive behavior (drug use, promiscuity, spending sprees, quitting a job, etc.), suicidal thoughts or injurious behavior, and more.[82]
Obsessive Compulsive Disorder	A mental health disorder that includes patterns of obsessions (fears) and compulsions (repetitive behaviors) that require an individual's attention and time. Some obsessions include fear of contamination, increased feeling of stress when objects are not orderly, doubt a task was completed, and more. Some compulsions include constant washing and cleaning, counting, checking, rearranging, and more.[83]

O.3 **Substance Use Disorder**

O.3.1 New Criteria in DSM-V compared to DSM-IV

The DSM-V now categorizes substance abuse and substance dependence into a single disorder ranging from mild-to-severe. These disorders are classified as an SUD (e.g., alcohol use disorder, stimulant use disorder, etc.), and now requires two to three symptoms to be present instead of only one.[84] Changes from the DSM-IV to the DSM-V related to SUD are summarized in Table 19.

Table 19. Changes from the DSM-IV to the DSM-V

DSM-IV	⟶ DSM-V
Criteria Changes REMOVED: Legal Problems ADDED: Craving	**Research Applications** DSM-V OUD (moderate or severe) most closely correlates to DSM-IV opioid dependence—treatment findings relevant for moderate or severe OUD

O.3.2 Opioid Use Disorder – DSM-V

The DSM-V defines OUD as a mental health disorder where an individual has ongoing opioid use leading to significant impairment or distress in social, occupational, or other important areas of functioning. This diagnosis requires an individual to have at least two of the following symptoms within one year: using larger amounts or taking a substance longer than intended; ongoing desire or inability to control opioid use; an excessive amount of time is used to obtain, use, or recover from opioid use; uncontrollable cravings; inability to maintain responsibilities with work, school, or home; ongoing opioid use regardless of recurring social or interpersonal issues; surrender or isolative behaviors due to opioid use; risking one's life to use; ongoing use despite experiencing physical or psychological problems caused or worsened by opioids; tolerance and/or withdrawal. Some symptoms of withdrawal include pain, chills, cramps, diarrhea, nausea, vomiting, insomnia, and intense cravings. A client may continue using opioids to prevent them from experiencing any of these symptoms, causing a potentially deadly cycle of use.[85]

O.4 **Treatment**

O.4.1 Integrated Treatment Approach

SAMHSA recommends an integrated treatment approach to address co-occurring disorders. Facilities that offer integrated treatment address both mental health and SUDs by implementing behavioral treatments, such as CBT or DBT, which are known to help to develop and build coping skills while decreasing problematic behaviors. These treatments are implemented along with medications while providing psychoeducation and relapse prevention strategies to improve awareness of triggers and building different responses to those triggers.[86] SAMHSA has a toolkit available that provides substantive information for implementing an integrated treatment approach for mental health and SUDs.[87]

P. PREGNANT CLIENTS

P.1 Prenatal

Women who have OUD face many health challenges, especially if they are pregnant. Pregnant women who have OUD are less likely to receive prenatal care, more likely to receive delayed rather than timely prenatal care, and are more likely to be hospitalized or visit the emergency department (ED) compared to women who have other SUDs or no SUD diagnosis.[88] Infants born to mothers with OUD have a 70-95 percent incidence rate of neonatal abstinence syndrome (NAS).[89]

Children born to mothers with OUD have higher rates of being admitted to the neonatal intensive care unit (NICU) and longer birth hospitalizations than children of mothers with other (non-OUD) SUD diagnoses. If mothers with OUD were treated with methadone before to giving birth, those infants could have double the rate of NAS than those infants of mothers with OUD who received no treatment before giving birth.[88]

Findings like these tell us that pregnant women can benefit greatly from care management services to ensure that they receive the best treatment for them and receive it consistently. Care managers and other COE staff can have a great impact on the lives of the women and their children by connecting them to proper prenatal care and OUD treatment.

P.2 Barriers to Treatment for Pregnant Clients

Pregnant clients with OUD face a myriad of barriers to treatment, including mental health comorbidities,[90] stigma, shame, guilt, childcare, and fear of having their children taken away from them by the Office of Children, Youth, and Families.[91] MOUD providers may be reluctant to accept new patients with OUD who are pregnant, especially in rural areas of the country where rates of opioid overdose deaths are disproportionately high.[92] Pregnant clients who have other children may not be able to obtain reliable or affordable childcare while they attend treatment appointments, and many hesitate to bring their children with them to these appointments because they want to shield their children from the stigma. Some pregnant clients feel intense guilt and shame when they know they will have to see their infant experience withdrawal symptoms, and those intense emotions can prevent them from seeking or remaining engaged in treatment. Improved psychosocial education can be the first step in helping these clients overcome the emotional or cognitive barriers that prevent them from seeking or adhering to MOUD treatment. Interacting with care managers and treatment providers who do not shame or punish them for where they are or the fact that they need help will greatly improve both their treatment experiences and their children's outcomes.[91,93]

Although each pregnant client's experience will be unique, below are some potential approaches to address common barriers:

- Facilitate referrals to any needed services (physical health, mental health, transportation, housing, etc.).

- When possible, minimize the number of locations/separate providers for necessary services. For example, utilize an organization that offers housing, transportation, and childcare assistance in one location rather than connecting the pregnant client to three separate organizations for each need.

- Be mindful of language to reduce the potential of reinforcing stigma, shame, and guilt.

- Provide thorough explanations, multiple times if needed, on confidentiality laws and mandated reporting laws. Ensure the client is aware of her rights and what can/cannot be disclosed and in what circumstances.

- Connect the pregnant client to peers to enhance the client's sources of support.

P.3 Postnatal

NAS occurs in 55-94 percent of infants who were exposed to opioids or other substances for an extended length of time *in utero*.[7,94] Infants with NAS experience withdrawal when they are born, as they are no longer receiving the drugs they did in the womb. While all substance use can cause NAS (including alcohol and nicotine), it is most commonly caused by opioid use, and opioid use can cause the most severe symptoms. States that have the highest rates of prescription opioid use also have the highest rates of NAS.[95]

Research suggests that neonates exposed to opioids *in utero* remain at the hospital for observation for five days,[96] but infants born with NAS require up to 17 days of hospitalization, or up to 23 days if they require treatment.[95]

Symptoms can differ from child to child, as does the severity of symptoms. They can range from irritability and mild trembling to excessive weight loss, fever, and seizures.[7] Clients can manage NAS in their children several ways, with rooming-in and breastfeeding being some of the most effective non-pharmacological methods.[97]

Like most problems, the best solution for clients whose babies are susceptible to NAS is prevention. COEs can help pregnant women prevent NAS in their babies by ensuring these clients have access to consistent and appropriate MOUD treatment as well as care management that facilitates their access to high quality, consistent prenatal healthcare.[98]

P.4 MOUD Options

Best practices currently dictate that the safest medical treatment for pregnant women with OUD is methadone.[94] However, research on buprenorphine (without naloxone) indicates buprenorphine may be just as effective as methadone and may lead to more positive postnatal outcomes, including reducing the chance of the infant developing NAS.[99-101]

For infants with NAS, the most common pharmacological treatment is either an oral morphine solution or methadone.[102]

Q. CRIMINAL JUSTICE-INVOLVED CLIENTS

Q.1 Communicating with Probation/Parole Officers

As care managers for people with OUD, it is likely that COE staff will come into contact with the criminal justice system at some point, typically to coordinate or confirm services with a parole/probation officer. Therefore, care managers should be prepared to communicate with clients' parole or probation officers to advocate for them. Parole/probation officers may not be familiar with or supportive of MOUD treatment,[103] so it may be necessary to educate them about the client's treatment options and EBPs. For information about the limitations on what can be disclosed to legal entities, see Limited Disclosures with Consent.

Parole is defined by the Pennsylvania Department of Corrections (DOC) as, "the conditional release from imprisonment of an inmate from a correctional facility to serve the remainder of his/her unexpired sentence in the community under supervision as long as (s)he satisfactorily complies with all terms and conditions provided in the parole order." DOC defines probation as "A sentence whereby an individual serves the period of time mandated by the sentencing court in the community under the supervision of either county or state authorities rather than being imprisoned; subject to the terms and conditions imposed by the sentencing court."[104]

Individuals with OUD who experience incarceration are at increased risk of post-release overdose death and are in special need of OUD treatment services.[105] While clients are on parole or probation, it is imperative to help them find the resources they need for treatment and to avoid violating the terms of their release. Interdepartmental cooperation and collaboration between the COE and the parole or probation officer can provide a great benefit to the client by ensuring that their treatment does not conflict with the terms of their parole or probation (or vice versa). DOC provides this flyer specifically for staff working with people involved with the criminal justice system that promotes MOUD (referred to as Medication-Assisted Treatment, or MAT) as an effective and evidence-based treatment for people with OUD. If clients recently released from incarceration have parole or probation officers who are unhelpful or obstructive to their recovery, it may be helpful to share resources like this with those officers to advocate for the client.

Q.2 County Jail-Involved Clients

Although there is a dearth of research in city and county jail settings compared to research in state prison settings, some research suggests that those in management roles in county jails have an interest in how to better address OUD. Pennsylvania expanded access to MOUD to jails in early 2020. Using a model that originated in the California correctional system, they are using technical assistance developed by Health Management Associates in Armstrong, Bucks, Cambria, Franklin, Lawrence, Lehigh, and Montgomery counties.[106]

People recently released from incarceration tend to have many needs in addition to OUD treatment, including employment opportunities, housing, and food. Individuals with OUD who experience incarceration are at increased risk of post-release overdose death and are in special need of OUD treatment services.[105] Individuals who reenter the same communities and environments where they were using substances before incarceration are especially at risk of dying from an opioid overdose. Their physiological substance tolerance goes down while they are incarcerated and not using any substances, but when they return to the last places where they used before their incarceration, they use the same dosages they used when they had a higher tolerance. This puts them at greater risk for lethal overdose. Returning to substance-using peers is also a large barrier to treatment for individuals recently released from incarceration.[103,107] It is imperative for care managers to wrap services around recently released individuals as soon as possible after their release to get them the support and resources they need to avoid high-risk situations.

Q.3 Building Rapport with Criminal Justice-Involved Clients

Clients who have been involved with the criminal justice system may initially be distrustful of COE staff and treatment providers. Because of their experiences with law enforcement, they may view SUD treatment as a way to entrap them in a parole or probation violation. Because of this, it is important for care managers to dedicate special time and effort to establishing rapport with these clients.

COE staff can build trust with clients involved with the criminal justice system by assuring them that their recovery and well-being is the COE's top priority, and COE staff gain nothing from losing clients to incarceration. These clients may not have experienced a patient-centered approach anywhere else. Take time to understand all their needs using active listening techniques. Active listening is achieved when the listener fully concentrates on the speaker, understands the information, responds to it, and retains it.[108]

Q.4 Treatment Interruptions – Incarceration

Some clients face a greater risk of treatment discharge due to incarceration than others do, so it is important to be aware of risk factors that clients in treatment might face in their recoveries. Clients who are Black, Latinx, and Native American generally face a greater risk of treatment interruption due to incarceration than clients who are white. Additionally, clients whose treatment referrals came from criminal justice institutions also face a greater risk of incarceration.[105,109]

Many people in correctional settings are in recovery, and many report very negative opinions about MOUD.[110] These people are generally mistrustful of MOUD and do not advocate for MOUD program expansions within the criminal justice system because the issue is so politically fraught. Twelve-Step communities inside as well as outside prisons generally do not support the use of MOUD, so even if an inmate with OUD is interested in pursuing MOUD treatment that their facility provides, they face many challenges.

The PA DOC instituted some changes in state correctional institutions' (SCI) therapeutic communities (TC) to provide evidence-based treatment for inmates with SUDs. The following SCIs provide opioid-specific TCs:

- Camp Hill.

- Laurel Highlands.

- Chester.

- Albion.

- Quehanna Boot Camp (State Intermediate Punishment).

- Cambridge Springs (State Intermediate Punishment and Female).

Each of these institutions provides oral naltrexone maintenance. Additionally, as of 2018, Vivitrol™ is available at all SCIs.[111] Check [this website](#) for the most up-to-date information about MOUD available to clients involved with DOC.

DOC provides methadone maintenance to pregnant inmates. It recently began a Vivitrol™ program for inmates nearing their release dates and oral naltrexone for "select new intakes with short minimums who will be admitted to one of our Opioid Use Disorder Therapeutic Communities (OUDTC)."[111]

R. OPIOIDS

R.1 Opioids vs. Opiates

Opioids are a class of drugs comprising synthetic substances that bind to the brain's opioid receptors, which are the parts of the brain that control pain, reward, and addictive behaviors.[112] Opioids are typically prescription medications, which can be obtained illicitly and licitly. Examples of opioids include hydrocodone, hydromorphone, oxycodone, oxymorphone, tramadol, fentanyl, and methadone.[112] More information about specific opioids is available in the below sections.

Opiates are naturally derived substances that originate from the opium poppy plant.[112] Examples of opiates include heroin, codeine, and morphine. Morphine is a non-synthetic opiate derived from the opium poppy, used as a severe pain reliever.[113] Morphine is a Schedule II drug. Heroin is processed from morphine and produced as either a white powder or a "black tar" brown powder. Heroin is a Schedule I drug. Codeine is a derivative of morphine, which is also used to treat mild-to-moderate pain, and it is commonly used as a treatment for coughing. Codeine is a Schedule II drug. Opium poppies are grown in Mexico, South America, and Asia.[113]

Both opioids and opiates have generally similar psychological and physical effects.[112] Physiological effects include pain relief, respiratory depression, pupillary constriction, itching, constipation, and dependence.[112] Psychological effects include mental confusion, loss of memory, lethargy/apathy, euphoria/tranquility, mood swings, depression, and withdrawal.[112]

R.1.1 Prescription Opioids

R.1.1.1 Oxycodone & Oxymorphone

Oxycodone is a semi-synthetic, prescription opioid analgesic used to treat pain through the introduction of euphoria, relaxation, and sedation when consumed.[114] Oxycodone is about 1.5 times stronger than morphine. Oxycodone is currently a Schedule II drug. It is commonly known by OxyContin™, Percocet™, Percodan™, and Tylox™.

Oxymorphone is a prescription opioid used to treat pain, designed to manage moderate-to-severe pain on a continuous basis.[115] Oxymorphone is commonly known as Opana™.

R.1.1.2 Hydrocodone & Hydromorphone

Hydrocodone is a semi-synthetic opioid synthesized from codeine, one of the opioid alkaloids found in the opium poppy.[114] Hydrocodone is used orally to treat mild-to-moderate pain, and it is also administered in liquid form as an antitussive/cough suppressant. Hydrocodone is commonly known as the brand name Vicodin™. Hydrocodone is comparable in strength to morphine. Hydrocodone metabolizes into hydromorphone.

Hydromorphone is commonly known as Dilaudid™, and much like hydrocodone, it is also used to treat pain.[116] It is two to eight times more powerful than morphine. Hydromorphone is commonly administered in the ED as well as other acute care settings.[116]

R.1.1.3 Tramadol

Tramadol is an opioid analgesic that acts on the central nervous system to relieve pain. It is used to treat moderate-to-severe pain, such as pain after surgery.[117] It is commonly administered in extended-release capsules or tablets for ongoing chronic pain. Tramadol is commonly known as the brand names ConZip™, Rybix ODT™, Ryzolt™, and Ultram™.[117]

R.1.2 Fentanyl and Fentanyl-Related Substances

R.1.2.1 Fentanyl

Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent.[113] It is a Schedule II prescription drug and is used to treat clients with severe and/or chronic pain. As fentanyl has extremely strong opioid properties, it is often used for both heroin and prescription opioid users. Pharmaceutical fentanyl is abused and diverted because of its high potency, though this occurs on a smaller scale than use of clandestinely produced fentanyl. Clandestinely produced fentanyl emerged in the illicit drug market in 2013, and the manufacture of fentanyl-related substances (FRSs) followed shortly after.[113]

Illicit fentanyl and other synthetic opioids are the most lethal types of opioids in the U.S.[113] These substances are primarily sourced from China and Mexico. Fentanyl, FRSs, and Non-Prescription Synthetic Opioids (NPSOs) are wittingly or unwittingly mixed in other controlled substances, including heroin, cocaine, etc., and they are also sold as counterfeit prescription pills.[113] For more information on these substances, see Appendix 10: Fentanyl-Related Substances and Non-Prescription Synthetic Opioids.

R.1.2.2 Fentanyl-Related Substances

FRSs are a group of chemically manufactured drugs that are modeled after fentanyl but contain different chemical structures.[113] FRSs and fentanyl have similar pharmacological effects. Most of

the FRS drugs are not approved by the FDA, and the lethal dosages are frequently varied and unknown.[113]

R.1.2.3 Non-Prescription Synthetic Opioids

NPSOs are synthetic drugs that have similar chemical structures to other opioids but are not approved for human consumption.[113] NPSOs are similar to fentanyl and FRSs, though they can resemble the chemical structure of other opioids rather than fentanyl. NPSOs are also clandestinely produced and distributed, much like FRSs. It is also important to note that novel FRSs and NPSOs are clandestinely developed often, so new substances are frequently added to the list.

R.2 **How an Opioid Use Disorder Develops**

The reward pathway, or the Mesolimbic pathway, is a neural pathway connecting dopamine-releasing neurons.[118] The brain's pleasure centers respond to rewards, such as petting a cute dog or eating an ice cream cone. The release of dopamine regulates the response to a rewarding stimulus—in this case, an opioid.[118] This response facilitates reinforcement and motivation to engage in more rewarding behaviors (Figure 12). Opioids activate the opioid receptors when acting upon the brain reward pathway, and this releases a surplus of dopamine.[112] In turn, opioids overstimulate the receptors and create a feeling of intense euphoria. Over time, this change in dopamine levels leads to the inability to feel pleasure from naturally rewarding activities, and the brain desires more opioids to feel pleasure. Thus, opioid use changes the chemistry of the brain.[119]

Figure 12. Natural Rewards vs. Drug-Induced Rewards
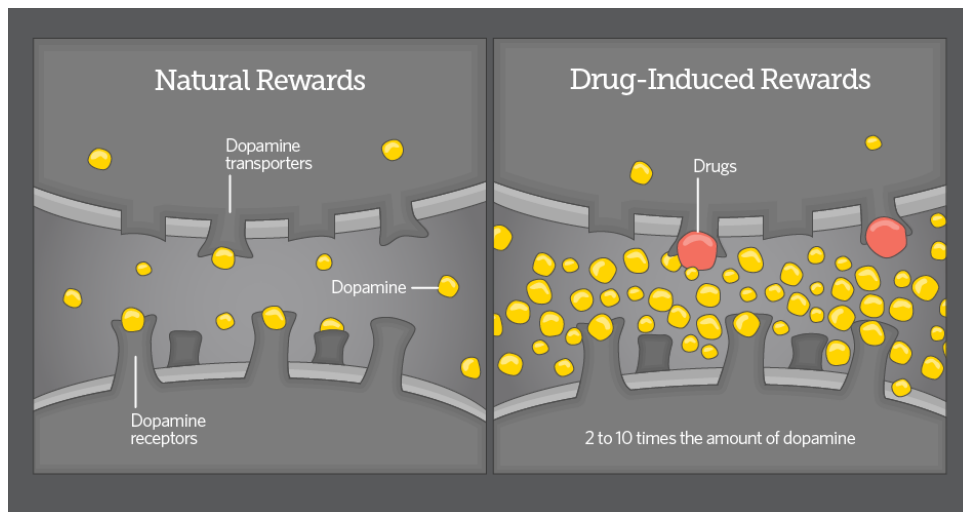
northcarolinahealthnews.org

R.3 **Short-Term Health Effects**

Using both opioids and opiates results in short-term and long-term health effects. In the short-term, these substances cause sedation, abscesses, slowed breathing, constipation, sexual dysfunction for men, and irregular menstrual cycles for women.[120,121]

R.4 **Long-Term Health Effects**

Long-term effects of using these substances include damage to the lining of the heart, liver disease, kidney disease, sexual dysfunction for men, and irregular menstrual cycles for women. Additionally,

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injecting substances can cause veins to collapse, and sharing needles can lead to disease transmission, particularly hepatitis C. Finally, using opioids/opiates damages the nervous system, which can cause a heightened sensitivity to pain.[120,121]

R.5 Tolerance and Withdrawal

Tolerance to opioids/opiates develops when the individual's body adapts to the presence of the substance within its system.[121,122] People who regularly use prescription opioids and heroin build up a chronic tolerance to the substance's euphoric effects. This leads to an increase in dosage taken or a switch to a more potent way of taking substances (such as snorting or injecting) to strive for similar euphoric effects.[121,122]

Individuals with a SUD mention that there is nothing like that "first high" and that each time they use they are chasing that initial feeling of euphoria.[121,122] Whether the initial use was to experience euphoria or pain, the motivation for use follows the same pathway to avoiding feeling bad (and withdrawal symptoms) (Figure 13). Instead of achieving a greater and greater high, the individual builds a tolerance where the substance becomes less effective, and they require more to maintain a baseline and avoid going into withdrawal.[121,122]

Figure 13. Evolution of Motivation to Use Substances
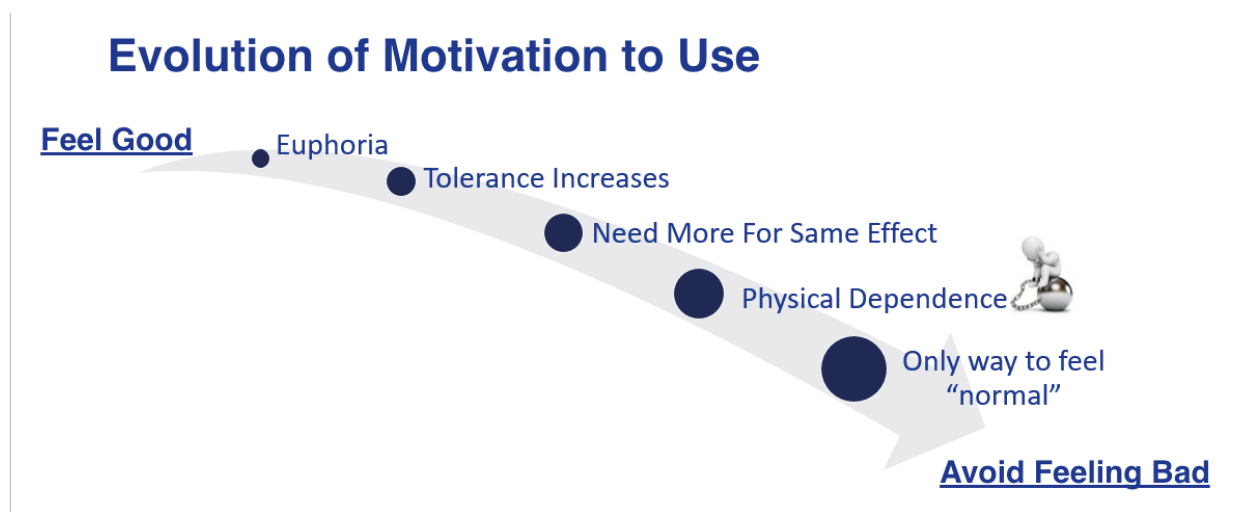
For more information on tolerance and withdrawal from opioids, you may find a series of online training modules available at www.overdosefreepa.pitt.edu/make-an-impact/online-training-modules.

R.6 Common Substance Combinations

COE staff members must understand the risks of polysubstance use, which is when an individual uses multiple substances simultaneously. Individuals may take multiple substances to experience greater effects of each substance. While this may result, polysubstance use also enhances the potential negative effects of each substance, depending on the combination of substances. Negative side effects of the substances are increased exponentially, including nausea, vomiting, body pain, changes to heart rate, and changes in blood pressure. The risk of overdose is also heightened when combining substances.[123,124]

R.6.1 Benzodiazepines

It is common for those who use opioids to take them alongside benzodiazepines to increase relaxation and sedative effects. Both substances suppress the central nervous system, which slows down breathing and can cause an overdose. Common benzodiazepine medications include alprazolam

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(Xanax™), clonazepam (Klonopin™), and diazepam (Valium™).[123] Additionally, the withdrawal from benzodiazepines can be extremely dangerous. Typical withdrawal symptoms include sleep disturbance, irritability, panic, increased tension and anxiety, nausea, headache, muscle pain, and stiffness. In some cases, seizures and psychotic reactions can occur. Furthermore, clients that use benzodiazepines should be monitored carefully for withdrawal symptoms, as well as the return of anxiety and insomnia symptoms.[125]

Due to the potentially fatal effects of benzodiazepine use and withdrawal, it is essential that MOUD prescribers query the Prescription Drug Monitoring Program (PDMP) to ensure appropriate concurrent prescribing. It should be noted that not all benzodiazepine use will be evident through a PDMP query as the benzodiazepines may have been obtained illicitly, thus requiring the completion of a urinalysis drug screen in addition to the PDMP query.

R.6.2 Alcohol

Both alcohol and opioids also suppress the central nervous system, which is also a deadly combination. Short-term effects of this combination include a rush of emotions, euphoria, drowsiness, apathy, slow-moving, and slow rate of breathing. Long-term effects include constipation, irritability, mood swings, and brain damage. As this combination is common, an individual may need treatment for both opioid and alcohol use.[126] Similar to benzodiazepine withdrawal, alcohol withdrawal can be extremely dangerous. Common symptoms include trembling, insomnia, and anxiety. Some individuals may experience more severe withdrawal symptoms that postdate years of heavy drinking, including delirium tremens, which causes dangerous shifts in breathing, circulation, and temperature control, which can increase the risk of a heart attack or stroke. This condition needs to be treated immediately by a medical professional.[127]

R.6.3 Cocaine

The combination of opioids and cocaine is referred to as a "speedball." Both cocaine and heroin are injected together, though the drugs can also be snorted together or separately. Combining these substances results in a longer-lasting, intense high compared to taking the substances alone. Individuals may use this combination to bring someone "out" of an opioid-induced state of intoxication and individuals may use opioids to come down from a cocaine high. Combining cocaine and opioids is particularly dangerous because opioids slow down breathing and can lead to respiratory failure, while cocaine is a stimulant and increases the heart and breathing rate. A common misconception is that these drugs balance out the other's effects. However, these drugs, in combination, put a greater strain on the body as breathing rates are inconsistent. Common side effects of speed-balling include drowsiness, paranoia, incoherence, confusion, and mental impairment.[128]

R.6.4 Marijuana

Marijuana and opioids are both commonly used to treat chronic pain. Both substances also have slow reaction times and have depressant effects. When used together, they can suppress the central nervous system, which may result in decreased brain function, low blood pressure, extreme sedation, and potential overdose. Combined opioid and marijuana use may show greater symptoms of anxiety and depression.[129]

R.6.5 Methamphetamine

There is an increase in the use of methamphetamine as individuals are fearful of overdosing from fentanyl contaminated in the opioid supply. This combination is similar to the speedball details covered in the above cocaine section, where methamphetamine and opioids are commonly used together to establish an equilibrium between the effects of both substances. Both substances provide two different pleasurable effects; however, methamphetamine is the hardest substance to recover from, largely due

to the effects on the dopamine receptors. Using methamphetamine releases high levels of dopamine in the brain, and repetitive stress of the dopamine levels can negatively affect the nerve terminals in the brain. Methamphetamine may cause cardiovascular issues, such as rapid heart rate, irregular heartbeat, and increased blood pressure. As such, in combination with opioids, this can be deadly.[124,130]

S. MEDICATION FOR OPIOID USE DISORDERS

MOUD, also known as MAT, is one path to recovery that a client may choose to pursue. By utilizing medications, the physiological response to opioids, including cravings and withdrawal symptoms, can be addressed. Treatment retention and outcomes improve when MOUD is utilized in treatment.[131] Additionally, MOUD use reduces illicit opioid use and the risk of opioid overdose death.[131]

Currently, there are three FDA-approved medications used to treat OUD: methadone, buprenorphine, and naltrexone (Table 20). As with all matters related to OUD, there is not a "one size fits all" approach to MOUD; The duration of MOUD treatment can be short- or long-term (including lifelong treatment), depending on the client's preference and continued appropriateness for the medication.[131] Unnecessary termination of MOUD increases the risk of recurrence of use and a fatal opioid overdose.[131] COE staff play a pivotal role in eliminating the stigma associated with MOUD. For that reason, COE staff should use caution when talking about MOUD options with their clients and should ensure that these conversations respect the autonomy of clients and should not attempt to persuade or dissuade a client from engaging in, or terminating, MOUD.

S.1 Methadone

Methadone was approved by the FDA in 1947, and it was used to treat opioid withdrawal by 1950, making it one of the most commonly associated MOUD types.[131] Methadone is an opioid receptor full agonist medication (See Figure 14). It has a high receptor binding affinity and has no ceiling effect. Methadone helps to reduce cravings and eases the symptoms associated with opioid withdrawal.[132] Methadone is appropriate for clients with moderate-to-severe OUD.[131]

Figure 14. Agonists and Antagonists

Agonists and Antagonists

Agonists — Drugs that occupy receptors and activate them.

Antagonists — Drugs that occupy receptors but do not activate them. Antagonists block receptor activation by agonists.

Agonist alone — Full activation

Agonist + antagonist — Less activation

Antagonist alone — No activation
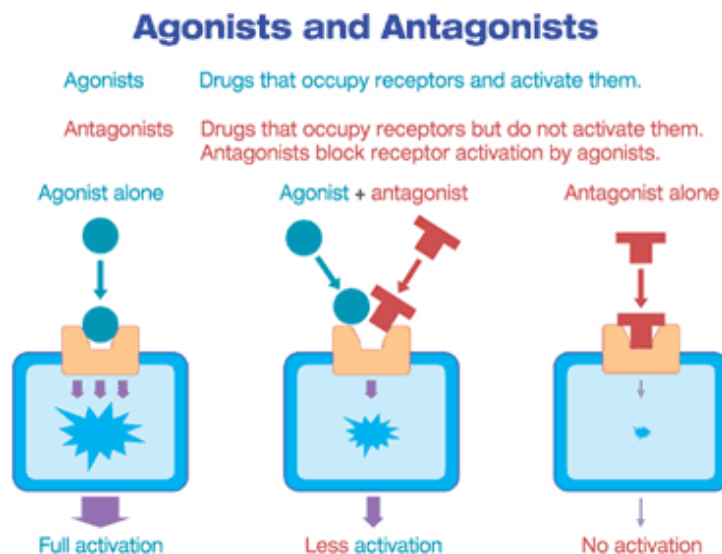
www.membrancereceptors.com

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Methadone may be appropriate for clients who need high levels of monitoring or may be dependent on several substances. Methadone is also an option for clients who have a history of medication diversion. A methadone client must meet the criteria for opioid treatment program (OTP) admission.[131]

Individuals who have at least one year of moderate-to-severe OUD can be admitted to OTPs.[131] If clinically appropriate, a physician may waive this requirement for pregnant women, those previously treated with methadone (up to two years post-discharge), or those released from a correctional facility within the past six months. For individuals under 18 years old, providers may waive the requirement if the client has had two prior unsuccessful attempts at a substance-free psychosocial treatment within 12 months, if the client has written parental consent, or if the client is pregnant.[131]

Methadone dosing is specifically tailored to the client, based on how the individual feels at the "peak period," which is the point of maximum concentration of medication in the blood.[131] Some clients experience a "trough period," which is the low point of medication in the blood just before the next dose. Generally, the induction phase takes place during the first two weeks of treatment. Day one dosing is between 10 and 30 mg, and the client should be monitored for two to four hours after administration. After week two, the client enters the maintenance phase, where dosing is typically between 80 and 120 mg. The goal of the maintenance phase is to enable the client to function in day-to-day life without physical or psychological impairment due to medication.[131]

Clients should be cautioned that it is dangerous to try to relieve withdrawal symptoms with benzodiazepines, other opioid medications, or with illicitly obtained methadone, other substances, or alcohol.[131]

S.2 **Buprenorphine**

Buprenorphine is a partial mu-opioid agonist medication that is used to treat OUD.[131] Buprenorphine has a high receptor binding affinity and has a ceiling effect as it is a partial agonist. Buprenorphine will displace full opioids agonists from the receptors in the brain to quiet the effects of withdrawal (also known as a competitive antagonist).[131]

Formulations are available for transmucosal (buccal or sublingual) administration contain both buprenorphine and naloxone medications.[131] This is commonly known as Suboxone™. Suboxone™ is effective when taken as directed due to poor bioavailability of naloxone when administered orally. The addition of naloxone decreases the risk of use by injection. If the individual chooses to inject the Suboxone™, the individual will immediately experience withdrawal symptoms.[131] Buprenorphine is also offered as an extended-release injection, commonly known as Sublocade™. In this form, buprenorphine is delivered in a monthly injection that is appropriate for treating moderate-to-severe OUD. Sublocade™ treatment, as is true of all medications for opioid use disorder, should also include psychosocial support.[133]

Physicians must have a DATA-2000 waiver to prescribe buprenorphine to clients.[134] The physician must be licensed under state law, registered with DEA to prescribe controlled substances, complete the 8-hour buprenorphine training, and have the ability to refer clients to counseling and other services.[135] Physician assistants and nurse practitioners can prescribe buprenorphine if they are registered with DEA to prescribe controlled substances; attend 24 hours of required buprenorphine training, work in collaboration with a qualified physician that has a DATA-2000 waiver to prescribe medication to treat OUD if the state requires physician oversight; and have the ability to refer clients to counseling and other services.[134,135] Buprenorphine treatment, in conjunction with therapy, can lead to higher rates of treatment retention, completion, and attendance, reductions in opioid use, and improved medication/treatment compliance. Concurrent behavioral/psychosocial treatment can further improve these outcomes.[136]

Buprenorphine may be appropriate for clients who are currently physically dependent on opioids, have a history of overdose, have limited social supports, experience chronic pain, and require chronic opioid treatment.[131]

There are three phases of buprenorphine treatment: induction, stabilization, and maintenance.[131,132] The induction phase marks the start of treatment once the client has abstained from using opioids for 12 hours. Buprenorphine induction can occur in an office-based setting or at the client's home. Office-based induction allows the provider to ensure the client knows how to take the medication, assess withdrawal and verify the absence of precipitated withdrawal, and enhance the therapeutic relationship. With home-based buprenorphine induction, the clinician must ensure that the client can describe, understand, and assess withdrawal, understand and follow dosing instructions, and contact their provider about problems.[131,132]

The stabilization phase is where the clinician determines the appropriate dosing where the client no longer exhibits cravings or withdrawal.[131,132] A client is in the stabilization phase once they have significantly reduced or eliminated illicit opioid use, blunted or blocked euphoria during illicit opioid use, reduced cravings for opioids, suppressed opioid withdrawal, and are experiencing no or minimal side effects.[131,132]

The maintenance phase is where the steady-state dosing is achieved, and routine adjustments are no longer needed.[131,132] The client responds optimally to treatment and has stopped misusing opioids and other substances. In the maintenance phase, the goal is to prescribe the lowest dose that can eliminate withdrawal, reduce or eliminate opioid cravings, reduce or eliminate euphoric effects of opioid use, and be well-tolerated. A typical maintenance dose is between 4 and 24 mg daily.[131,132]

S.3 **Naltrexone**

Naltrexone is another MOUD option that comes in either an oral formula commonly known as Revia™, which is a daily 50 mg tablet or in a monthly, extended-release, intramuscular 380 mg injection commonly known as Vivitrol™.[131,137,138] Naltrexone is an opioid receptor antagonist, and there is no euphoria or analgesia with this medication. Naltrexone has a very high receptor binding affinity, and naltrexone will displace partial and full opioid agonists from the receptors and blocks the effects.[131,137,138]

Naltrexone is an appropriate MOUD option for clients who have less severe OUD, have been abstinent for at least one week, do not want to take opioid agonists or are not able to receive them (e.g., parolees), have been unsuccessful with agonist treatment (or want to transition to antagonist treatment), and/or have a co-occurring alcohol use disorder. Clients who receive naltrexone also receive periodic laboratory testing to ensure they are complying with their dosing schedule as part of their medication maintenance.[137,138]

Prior to naltrexone induction, clients must be opioid-free for seven to 10 days (short-acting opioids), or 10 to 14 days (long-acting opioids). This is due to the risk of precipitated withdrawal if naltrexone is administered when there are opioids present in a person's system.[131,138]

Concurrent behavioral/psychosocial treatment alongside naltrexone use can enhance treatment outcomes. Naltrexone and therapy can lead to clients having fewer cravings, decreased opioid use, and improved treatment retention.[139]

Table 20. MOUD at a Glance

	Methadone	Buprenorphine	Naltrexone
Route of Administration	Oral – liquid	Oral – sublingual film or pill Injection	Oral – pill Injection
Frequency of Medication	Once daily (some pregnant women may be provided morning and evening)	Oral – twice daily Injection – once monthly, at least 26 days between injections	Oral – once daily. Injection – once monthly
Treatment Expectations	Daily attendance at a program until "take-home" privileges are earned; must participate in counseling	Dependent on the provider; no standard of care for frequency or counseling requirement	Dependent on the provider; no standard of care for frequency or counseling requirement
Prescribing Requirements	Prescriber must be working within an OTP	Prescriber must obtain X-Waiver	Any prescriber with an active DEA license

T. RESOURCES

To ensure the COE has the information it needs to excel, we have collected a variety of helpful resources, organized below by subject. In addition to the resources provided in this guide, a growing library of resources is also available at https://www.overdosefreepa.pitt.edu.

T.1 Adolescents

National Institute on Drug Abuse – Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide

https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podata_1_17_14.pdf

T.2 ASAM

Level of Care Designation Chart (Pennsylvania)

https://www.ddap.pa.gov/Documents/ASAM/LOC%20Designation%20Chart%208-2019.pdf

Pennsylvania Department of Drug and Alcohol Programs ASAM Transition

https://www.ddap.pa.gov/Professionals/Pages/ASAM-Transition.aspx

Pennsylvania Department of Drug and Alcohol Programs Treatment Manual

https://www.ddap.pa.gov/Documents/Agency%20Manuals/Treatment%20Manual.pdf

Pennsylvania Guidance for Applying *The ASAM Criteria, 2013*

https://www.ddap.pa.gov/Documents/ASAM/ASAM%20Application%20Guidance%20Final.pdf

T.3 **Buprenorphine**

Substance Abuse and Mental Health Services Administration – The Facts about Buprenorphine for Treatment of Opioid Addiction

https://store.samhsa.gov/product/The-Facts-about-Buprenorphine-for-Treatment-of-Opioid-Addiction/SMA15-4442

T.4 **Client Engagement and Retention**

Clinical Technical Assistance: Client Engagement and Retention

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2020/06/COE_ClientEngagement_20200429.pdf

TCU Client Evaluation of Self and Treatment (CEST)

http://ibr.tcu.edu/wp-content/uploads/2013/09/UsingCESTGuideAug08.pdf

Washington State Retention Toolkit

https://adai.uw.edu/retentiontoolkit/barriers.htm

T.5 **Clinical Supervision**

Center for Substance Abuse Treatment. Clinical Supervision and Professional Development of the Substance Abuse Counselor. Treatment Improvement Protocol (TIP) Series 52. HHS Publication No. (SMA) 14443.

Durham TG. *Clinical Supervision: An Overview of Functions, Processes, and Methodology.* Alexandria, VA: NAADAC, the Association for Addiction Professionals; 2019.

Clinical Technical Assistance: Improving Clinical Supervision

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2020/06/COE_ClinicalSupervision_20200428.1.pdf

Powell DJ. *Clinical Supervision in Alcohol and Drug Abuse Counseling.* Revised ed. San Francisco, CA: Jossey-Bass; 2004.

For online clinical supervision training (additional trainings are available through other organizations):

NAADAC, The Association for Addiction Professionals

https://www.naadac.org/webinars

https://www.naadac.org/supervision-peer-recovery-webinar

https://www.naadac.org/clinical-supervision-online-training-series

https://www.naadac.org/increasing-effective-clinical-supervision-webinar

Pennsylvania Department of Drug and Alcohol Programs (DDAP)

https://apps.ddap.pa.gov/tms/

Serve, Inc.

https://www.serveincstore.org/products/approved-clinical-supervisor-online-training-45-hour-program

Zur Institute

https://www.zurinstitute.com/course/clinical-supervision/

T.6 Confidentiality

4 Pa. Code § 255.5

https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/004/chapter255/s255.5.html&d=reduce

28 Pa Code § 709.28

https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter709/s709.28.html&d=reduce

55 Pa. Code § 5100.37

https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter5100/s5100.37.html&d=reduce

DDAP Federal and State Confidentiality Regulations Overview

ddap.pa.gov/Documents/Agency%20Publications/Confidentiality_Federal_State_Regulations_Guide.pdf.

Disclosure of Substance Use Records with Patient Consent: 50 State Comparison

http://www.healthinfolaw.org/comparative-analysis/disclosure-substance-use-records-patient-consent-50-state-comparison-0

Pennsylvania Law and Policy Governing the Confidentiality of Substance Use Treatment Information: Challenges and Opportunities

http://www.healthinfolaw.org/PA_substance_use_information_confidentiality

The Pennsylvania Drug and Alcohol Abuse and Control Act, also known as Act 1972-63

https://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=1972&sessInd=0&smthLwInd=0&act=0063

T.7 Co-Occurring Disorders

Clinical Technical Assistance: Mental Health Month

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2020/06/COE_MentalHealth_20200512.pdf.

Substance Abuse and Mental Health Services Administration – Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit (Updated 10/2019)

https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366

T.8 Counseling/Therapy

Substance Abuse and Mental Health Services Administration – TIP41: Substance Abuse Treatment: Group Therapy.

https://store.samhsa.gov/product/TIP-41-Substance-Abuse-Treatment-Group-Therapy/SMA15-3991

T.9 Drug Testing

American Society of Addiction Medicine – Appropriate Use of Drug Testing in Clinical Addiction Medicine

https://www.asam.org/docs/default-source/quality-science/the-asam-appropriate-use-of-drug-testing-in-clinical-addiction-medicine-full-document.pdf?Status=Temp&sfvrsn=700a7bc2_2

T.10 Enhancing Motivation

Substance Abuse and Mental Health Services Administration – TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment (Updated 10/2019)

https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003

T.11 Ethics

American Counseling Association – Code of Ethics

https://www.counseling.org/docs/default-source/ethics/2014-code-of-ethics.pdf?sfvrsn=2d58522c_4

NAADAC: The Association for Addiction Professionals – Code of Ethics

https://www.naadac.org/assets/2416/naadac-nccap-code-of-ethics11-04-16.pdf

National Association of Social Workers – Code of Ethics

https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Pennsylvania Certification Board – Certified Peer Specialist Code of Ethical Conduct

https://www.pacertboard.org/sites/default/files/peer%20code.pdf

T.12 Goals

Substance Abuse and Mental Health Services Administration – Setting Goals and Developing Specific, Measurable, Achievable, Relevant, and Time-bound Objectives

https://www.samhsa.gov/sites/default/files/nc-smart-goals-fact-sheet.pdf

T.13 Harm Reduction

Harm Reduction Coalition

https://harmreduction.org/about-us/principles-of-harm-reduction/

Harm Reduction International

https://www.hri.global/what-is-harm-reduction

Pennsylvania Harm Reduction Coalition

https://www.paharmreduction.org/

Prevention Point Philadelphia

https://ppponline.org/step-plate

Prevention Point Pittsburgh

https://www.pppgh.org/

T.14 **Hiring Process**

FBI Fingerprint Criminal Background Check

https://uenroll.identogo.com/

PA Access to Criminal History

https://epatch.state.pa.us/Home.jsp

PA Child Welfare Portal

https://www.compass.state.pa.us/cwis/public/home

PA License Verification

https://www.pals.pa.gov/#/page/logsinstructions

T.15 **Levels of Care**

ASAM Training In-Person – Train for Change

https://www.trainforchange.net/events

ASAM Training Online – The Change Companies, eTraining

https://www.changecompanies.net/etraining/#theTrainings

Pennsylvania Department of Drug and Alcohol Programs ASAM Transition

https://www.ddap.pa.gov/Professionals/Pages/ASAM-Transition.aspx

Pennsylvania Guidance for Applying *The ASAM Criteria, 2013*

https://www.ddap.pa.gov/Documents/ASAM/ASAM%20Application%20Guidance%20Final.pdf

Pennsylvania Level of Care Designation Chart

https://www.ddap.pa.gov/Documents/ASAM/LOC%20Designation%20Chart%208-2019.pdf

T.16 **LGBTQIA+**

American Psychological Association – Lesbian, Gay, Bisexual, and Transgender Health

https://www.apa.org/pi/lgbt/resources/lgbt-health

National Alliance on Mental Illness – LGBTQ

https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/LGBTIQ

National Institute on Drug Abuse (NIH) – Substance Use and SUDs in LGBTQ Populations

https://www.drugabuse.gov/related-topics/substance-use-suds-in-lgbtq-populations

National LGBT Health Education Center – Learning Resources

https://www.lgbthealtheducation.org/resources/

LGBT+ Pride Month – June 2020

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2020/06/CHI_LGBT_20200601.1-1.pdf

Substance Abuse and Mental Health Services Administration – A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

https://store.samhsa.gov/product/A-Provider-s-Introduction-to-Substance-Abuse-Treatment-for-Lesbian-Gay-Bisexual-and-Transgender-Individuals/SMA12-4104

T.17 **Mandated Reporting**

Pennsylvania ChildLine

http://www.keepkidssafe.pa.gov/

Pennsylvania Department of Human Services – Mandated Reporter Frequently Asked Questions

http://keepkidssafe.pa.gov/cs/groups/webcontent/documents/document/c_137646.pdf

T.18 **Men**

American Psychological Association – APA Guidelines for Psychological Practice with Boys and Men

https://www.apa.org/about/policy/boys-men-practice-guidelines.pdf

T.19 **Motivational Interviewing**

Motivational Interviewing

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2020/06/Motivational-Interviewing-One-Pager.pdf

T.20 **Online Support Groups**

PA Department of Drug and Alcohol Programs – List of Online Recovery Meetings

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2020/04/DDAP-Recovery-Resources.pdf

PRO-A Pennsylvania Recovery Organizations Alliance – Online and Virtual Recovery Support Resource List

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2020/04/DDAP-Recovery-Resources.pdf

WEconnect and Unity Recovery

https://unityrecovery.org/digital-recovery-meetings

T.21 Peer Supports

City of Philadelphia, Department of Behavioral Health and Intellectual disability Services – Peer Support Toolkit

https://dbhids.org/wp-content/uploads/1970/01/PCCI_Peer-Support-Toolkit.pdf

Motivational Interviewing Ideas for Peer Mentors

https://chess.wisc.edu/niatx//toolkits/system/IA_MIforPeerMentors.pdf

Substance Abuse and Mental Health Services Administration – Core Competencies for Peer Workers in Behavioral Health Services

https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

T.22 Pennsylvania Department of Drug and Alcohol Programs (DDAP)

DDAP Treatment Manual (Revised December 2019)

https://www.ddap.pa.gov/Documents/Agency%20Manuals/Treatment%20Manual.pdf

SCA Operations Manual (Effective 7/1/20)

https://www.ddap.pa.gov/Professionals/Documents/SCA%20Manuals%20and%20incorporated%20documents/2020-2025%20Operations%20Manual%20-%20FINAL%20.pdf

Training Management System

https://apps.ddap.pa.gov/TMS/

T.23 Pregnant and Parenting Women

Substance Abuse and Mental Health Services Administration – Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants

https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054

Substance Abuse and Mental Health Services Administration – Opioid Use Disorder and Pregnancy

https://store.samhsa.gov/product/Opioid-Use-Disorder-and-Pregnancy/SMA18-5071FS1

T.24 Quality Improvement

Plan, Do, Study, Act

https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf

T.25 **Suicide Concerns**

Substance Abuse and Mental Health Services Administration – TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381

Substance Abuse and Mental Health Services Administration – Treating opioid Use Disorder During Pregnancy

https://store.samhsa.gov/product/Treating-Opioid-Use-Disorder-During-Pregnancy/sma18-5071fs2

T.26 **Trauma-Informed Care**

ACEs Aware

https://www.acesaware.org/heal/covid19/

International Society for Traumatic Stress Studies

https://istss.org/public-resources/covid-19-resources

The National Child Traumatic Stress Network

https://www.nctsn.org/trauma-informed-care

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

SAMHSA-HRSA Center for Integrated Health Solutions, Trauma

https://www.integration.samhsa.gov/clinical-practice/trauma-informed

SAMHSA TIP 57: Trauma-Informed Care in Behavioral Health Services

https://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf

University of South Florida Trauma Informed Care Organizational Self-Assessment

http://traumatransformed.org/wp-content/uploads/tia_usf.pdf

T.27 **Twelve Step Programs**

Narcotics Anonymous

https://www.na.org/

Narcotics Anonymous Meeting Search

https://www.na.org/meetingsearch/

Generic Twelve Step Information

https://www.12step.org/the-12-steps/

Twelve Step Glossary

https://www.12step.com/glossary-of-terms.

Medication-Assisted Recovery Anonymous (MARA)

https://www.mara-international.org.

T.28 **Women**

Substance Abuse and Mental Health Services Administration's Concept of Trauma and Guidance for a Trauma-Informed Approach

https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Substance Abuse and Mental Health Services Administration-HRSA Center for Integrated Health Solutions, Trauma

https://www.integration.samhsa.gov/clinical-practice/trauma-informed

Substance Abuse and Mental Health Services Administration TIP 57: Trauma-Informed Care in Behavioral Health Services

https://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf

University of South Florida Trauma Informed Care Organizational Self-Assessment

http://traumatransformed.org/wp-content/uploads/tia_usf.pdf

National Institute on Drug Abuse – Substance Use in Women

https://www.drugabuse.gov/node/pdf/18910/substance-use-in-women

Clinical Technical Assistance: Women

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2020/06/Women-Awareness-Info-Sheet.pdf

Substance Abuse and Mental Health Services Administration – TIP 51 Substance Abuse Treatment: Addressing the Specific Needs of Women

https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4426.pdf

Substance Abuse and Mental Health Services Administration – TAP 21: Addiction Counseling Competencies

https://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171

U. COE LEADERSHIP: PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

U.1 Requirements for Centers of Excellence

To work toward the goals of the COE program, each COE is expected to utilize the following requirements developed by DHS:

1. Provision of at least one form of FDA-approved MOUD (e.g., naltrexone, buprenorphine, methadone) on-site AND the ability to schedule a client's induction or initiation onto MOUD within 24 hours of initial contact with the COE.

2. Ability to accept referrals 24 hours per day, seven days per week, through a mobile engagement team that will be able to be deployed within the community to meet individuals where they are located. These mobile engagement teams will have the ability to facilitate warm hand-offs to the COE. Warm hand-offs can occur from an emergency department to treatment services, from treatment services to non-treatment recovery services, or between levels of care within treatment services. [A warm hand-off is a transfer of care between two healthcare providers that takes place in front of the patient[2]].

3. Utilization of an assessment tool (typically a semi-structured interview or client self-report questionnaire) whereby the COE can identify a client's treatment and non-treatment needs. The COE must have the capacity to make referrals to the appropriate services based on the results of the assessment tool. At a minimum, the COE should be able to make referrals to the following non-treatment services based upon documented need within an appropriate standardized assessment tool: transportation, housing, nutrition/food, education, childcare, employment, and legal services.

4. Development and utilization of a CBCM that must include a CRS credentialed by the Pennsylvania Certification Board, which can be a CFRS, and may include additional providers including, but not limited to, peer navigators, nurses, social workers, physicians, case managers, and other provider types that can address the needs of the community.

5. Ability to ensure that each COE client receives an American Society of Addiction Medicine (ASAM) Level of Care Assessment, conducted either on-site by a qualified provider or through a referral to a qualified provider.

6. Ability to provide each of the following services *directly on-site at the COE* or *through a referral* to the COE client's choice of provider enrolled in the Pennsylvania Medicaid program:

   1. Primary Care, including screening for and treatment of positive screens for HIV, hepatitis A (screening only), hepatitis B, hepatitis C, and tuberculosis.
   2. Perinatal Care and Family Planning Services.
   3. Mental Health Services.
   4. Forms of MOUD that are not provided on-site at the COE.
   5. MOUD for pregnant women, if the COE is not providing MOUD to pregnant women.
   6. Drug and Alcohol Outpatient Services.
   7. Pain Management.

7. Ability to refer and connect all clients, as clinically appropriate, to all ASAM LOC, adhering to the standards and timelines set forth in the HealthChoices Program's Service Access Standards for **emergency, urgent, and routine** situations. The COE must also have the

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[2] It should be noted that in the era of telehealth, there are evolving definitions of "warm hand off" processes that may occur virtually.

ability to conduct ASAM Level of Care Assessments on-site or through a referral to an appropriate community partner. The ASAM LOC is described in more detail in ASAM Levels of Care

8. Utilization of an electronic health record to document care management activities (i.e., what was provided, when it was provided, why it was provided, who provided the services, and what the next step will be in the provision of care management).

9. Assurance that the COE complies with relevant federal and state client confidentiality regulations when obtaining the client's consent to share protected information. Confidentiality is described in more detail in the Confidentiality section.

10. Ability to provide access to naloxone to all enrolled clients for overdose prevention measures.

11. Administration of the *Brief Assessment of Recovery Capital-10 (BARC-10)* to each COE client within 30 days of initial contact at the COE; and re-administering the BARC-10 at six-month intervals during the clients' engagement at the COE. The data gathered through these surveys will be reported to DHS.

12. Identification of quantitative outcomes for clients, such as the target number of clients to receive COE care management services per month, target average duration of COE care management service receipt, target rate of referrals, or target average rates of improved scores on the BARC-10 (information on the BARC-10 can be found in Appendix 1.

13. Utilization and documentation of quality improvement strategies.

14. Compliance with the requirements of 62 P.S. § 1406(a) and the Medical Assistance regulations cited in 55 Pa. Code § 1101.63(a) by agreeing not to charge any COE Member enrolled in Pennsylvania's Medicaid program for services beyond the level of Medicaid payment.

U.2 Partnering with Pennsylvania Managed Care Organizations

COE and organizational leadership must establish working relationships with the relevant managed care organizations (MCOs) that will be reimbursing for the care management services provided by the CBCM team. It is COE leadership's responsibility to ensure that care management services provided by the CBCM team are reimbursed on time, which may require proactive follow-up with the relevant MCO(s) to ensure that requirements are being met for timely reimbursement. Additionally, the MCO is a partner for coordinating and providing care to clients. Often, MCOs can assist with the identification of treatment and non-treatment resources that may need to be accessed by COE clients. MCOs can also be partners in QI initiatives. Through audits and chart reviews, the MCOs may identify areas in which COEs can improve documentation, retention, and the overall quality of client care.

U.3 Contacts

The COEs will have access to DHS staff who may be able to help answer questions. For general questions about the COE program, please reach out to the Office of Medical Assistance Program, Pennsylvania Department of Human Services at RA-PWSUDCOE@pa.gov.

The COEs should also contact their respective Physical or Behavioral Health MCOs for questions related to billing and payment. Additionally, the MCOs can provide supportive services to providers and COE clients, including access to Special Needs Units that can help connect clients to services and improve care coordination. Please see Appendix 2 for contact information that COEs might find useful.

V. PENNSYLVANIA DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS (DDAP)

V.1 Priority Populations

DDAP has identified five (5) special populations who are to be given preference for treatment admission and, in this case, COE enrollment by SCA and providers who serve an injection drug use population. Essentially, if an individual is within one of the priority populations, they are to be enrolled with the COE and admitted to SUD treatment immediately. It is important to be aware of these priority populations when coordinating care for clients, as they may have different options than those who are not in a priority population.

- Pregnant women who inject drugs

- Pregnant women who use substances

- Persons who inject drugs

- Overdose survivors

- Veterans

V.2 Single County Authorities

Service providers will likely have ongoing contact with the local SCA. Each county has an SCA, which is responsible for program planning and administration of state and federally funded grants. SCAs frequently hold trainings required by the DDAP and offer connections within the service provider community. Information about the role, expectations, and services of SCAs, as well as additional resources, can be found in the [SCA Operations Manual](#) (see [Pennsylvania Department of Drug and Alcohol Programs](#) (DDAP)).

W. ONBOARDING STAFF

Orientation and onboarding are the experiences that welcome new employees into the organization and ensure they have the tools and resources necessary to succeed.

W.1 Orientation

By law and necessity, orientation tends to be well established in most organizations and is typically conducted in eight hours or less. The following checklist can be used to identify missing elements and opportunities to improve orientation.

W.2 Preparation

- To become accurately prepared, orientation team members must be aware of their roles and responsibilities at a high level of detail during orientation to ensure a smooth presentation.

- Schedule incoming staff for orientation with plenty of time to ensure 100 percent attendance.

- Prepare a specific orientation agenda, so incoming staff know what to expect of orientation.

- Provide new staff with a guide with protocols (clinical and administrative), a general history of the organization, the organization's vision statement, an organizational chart, and relevant trainings or certifications that the staff are expected to complete with deadlines.

W.3 Presentation

- Begin with a heartfelt welcome and review of the organization's history and **vision**. This is most

effective when it is delivered by the organization's **leader**, even if by video message. Emphasis should be placed on the organization's values and how they define the organization's **culture** and **behavioral expectations**. It has been shown that new employees will build personal connections with organizations whose servant leaders,[140] those leaders who combine their motivation to lead with a need to serve, can give a sincere description of their commitment to ensuring employees have the tools and resources necessary to succeed. Servant leaders are also committed to developing and empowering those they lead and expressing humility and authenticity.[140] Furthermore, they are committed to providing direction to ensure that all those who work with them are empowered to work toward the vision.

- Each new employee should be introduced to the others and invited to share a bit of their career history, as well as what they hope to accomplish in their new role. The organizational chart should be explained to help the employee understand how their role fits in the **organizational structure**.

- It is not premature for orientation to introduce the methodology the organization uses to pursue its vision. This should include a review of the **performance measures** that are used to chart progress, the **internal learning** or continuous QI process that is in place, and how **external learning or continuous staff development** ensures that improvement efforts incorporate scientific evidence, best practices, and benchmarks.

W.4 **Processing**

When processing new staff, it is important to provide and obtain the following information:

- Contact information;

- Clearances – Pennsylvania Acts 33 (Child Abuse History),[141] 34 (Criminal Record Check),[142] & 114 (FBI Fingerprint Criminal Background Check)[143] Clearances;

- Payroll;

- Benefits (medical, dental, vision, paid time off, education, other perks);

- Legal and regulatory notices; and

- An overview of key policies and procedures that will be reviewed in greater detail during onboarding.

W.5 **Post-Orientation**

Orientation should conclude with an evaluation designed to understand the extent to which the new employees feel welcomed, inspired, and clear about their roles and expectations. This feedback should be compiled, reviewed, and used to continually improve the orientation program.

New employees should be given clear instructions on any actions that need to be taken after orientation. A Post-Orientation Checklist will serve them well. The checklist should include contact information for an individual who is designated, available, and qualified to answer questions and provide support as the Post-Orientation Checklist is being completed. This is often, but not always, the person who will conduct their onboarding.

W.6 **Using the Resource Guide**

Leadership/supervisors are encouraged to have a copy of this Resource Guide for reference and assistance in onboarding and the ongoing supervision of staff.

There are opportunities within the guide to personalize the information for the organization. Leadership is encouraged to integrate their organization into the sections identified in Table 21, with recommendations on that integration provided.

Table 21. Organization Integration

Resource Guide Section	Organization Integration Opportunity
C. – Centers of Excellence Mission: Purpose of Centers of Excellence	1. Prior to providing the guide to staff, leadership can add the organization's vision. 2. Staff, upon receiving the guide, can add the organization's vision.
D. – Overdose Prevention	Outline steps for clients to receive naloxone from staff.
E.3 – Know the Options	1. Have staff complete Appendix 3: Level of Care Options Form for quick reference for treatment providers in each LOC for client referrals. 2. Leadership can provide a list of referral options for each LOC when the guide is distributed to staff.
I. – Confidentiality	1. Provide a copy of your organization's confidentiality policy to staff. 2. Inform staff of expectations for situations in which mandated reporting is required.
K – Referrals	1. Inform staff of documentation expectations and formats. 2. Provide an example of a progress note, treatment/service/recovery plan, and assessment consistent with organizational expectations.

W.7 **Staff Retention**

Finding qualified personnel to fill a vacancy can be quite a challenge between scheduling interviews, the disruption to services, and the additional work taken on by team members. The following are examples of ways to avoid specific issues that negatively affect staff retention. Please note, many of these experiences that can negatively affect staff retention have been noted within COEs. COE leadership can utilize the Resource Guide to improve staff retention and avoid the scenarios that contribute to staff turnover identified in Table 22.

Table 22. Negative Staff Experiences

Negative Experience to Avoid	Resource Guide
Feeling alone without direction	"Sense of isolation is amplified for new hires—who often feel like a stranger in a foreign land."[144] The guide provides an overview of what makes the COEs unique, the expectations of COEs, and a resource for reference when needed (Expectations of a Center of Excellence). COEs can ask existing employees to be available to new employees to help them with the transition. Also, managers should check in often with new staff to ensure that they have the resources and tools necessary to do their work and a development plan that guides their familiarity with the organization as well as the acquisition of skills necessary for them to succeed at their positions.
Lack of assimilation into the organization	"Organizations must be intentional about helping new hires adapt to organizational values and norms ..."[144] The SME outlines overall COE and organizational values and norms. Be sure to provide new hires with your organization's vision and mission statement to personalize their SME. (Organizational Health). It is also important that managers check in frequently with new staff to see how they are feeling about their new role, and whether they have the resources and tools to succeed. A development plan should be provided to each employee that covers in a step by step process how they can gain the knowledge and skills to succeed in the organization.
Confusion of role/position	Lack of role clarity has been identified as a predictor of staff turnover.[145] Understanding one's role and the responsibilities of colleagues can eliminate duplication of efforts and confusion of expectations (Organizational Structure). Lack of role specification is the single most frequent cause of workplace conflict and eventual turnover.[47]

X. CLINICAL SUPERVISION

X.1 Keys to Successful Supervision

"The mediocre supervisor tells people what to do, the superior supervisor demonstrates what to do, and the great supervisor inspires people to do what they know should be done."[146] There is significant evidence linking excellence in supervisory skills with improved work performance.[147] Perhaps there is no better indication of this linkage than in healthcare. The following are some tips that COE supervisors can use to improve their supervisory skills.

X.2 Balancing Clinical and Administrative Responsibilities

Supervisors are rarely without managerial or administrative responsibilities. One common challenge is being present in the supervision session when administrative tasks are piling up. Try practicing mindfulness to focus on being present in the moment with supervisees. If scheduling allows, separate clinical and administrative tasks to separate days or times of day to create mental separation. Supervisees should be told whether their supervisors are communicating with them in a clinical or administrative capacity.[148]

X.3 Being Available with Boundaries

As with clients, boundaries must be established with supervisees to facilitate their autonomy. Saying "now isn't a good time" doesn't make one a bad supervisor, but it is important to be present for supervisees during their identified time for supervision. Provide a list of questions for a supervisee to process before they reach out for guidance— "Is this an emergency? Can this wait until my next scheduled supervision?" Remember, healthy boundaries are beneficial for both the supervisor and supervisee.[149]

Dedicate time and attention to supervisees when conducting supervision. Be consistent with a supervision schedule and avoid interrupting the scheduled time. This will demonstrate respect for supervisees and commitment to the importance of supervision.[149]

X.4 Cultural Competence

Cultural humility, which has been defined as "both an openness toward self-reflection about our personal existence as a culturally embedded being and a willingness to hear and strive to understand aspects of the cultural backgrounds and identities of others,"[150] can be gained by acknowledging one's own cultural identity and biases while also being open to learning about supervisees' cultural identity. Integrate cultural knowledge into supervision as appropriate based on the supervisee's cultural identity and preference. Demonstrate how leadership and the organization value cultural diversity and history among clients and staff with specific processes that permit the organization to consistently improve its ability to become culturally competent and demonstrate cultural humility.[147]

X.5 Working Alliance

The supervisor-supervisee relationship should be built on trust and the ability of the supervisee to speak openly about their experiences, countertransference, challenges, and successes. Mutually agreed-upon goals and expectations must be identified and clarified using an individualized development plan (IDP). As part of the IDP, supervisors should explain how the supervisee will be evaluated/assessed.[147,148]

X.6 Dual Relationships

When possible, avoid dual relationships with supervisees (friendships, romantic relationships, etc.). The presence of a dual relationship will not only impact the working alliance (the collaborative relationship between supervisor and supervisee towards the goals of quality client care and supervisee professional growth) with that supervisee but also working alliances with other supervisees. However, it is not always possible to avoid dual relationships, particularly when a peer is promoted to supervisor. When a dual relationship occurs, ask, "Does this dual relationship impair my judgment and open the supervisee to risk of exploitation?" If the response is yes, then the dual relationship is unethical and should be changed.[147]

X.7 Effective Communication

Be clear in expectations, goals, strategies to achieve those goals and feedback on performance. Treat all members of the organization with dignity and respect.[147,148]

X.8 "Four A's of Supervision"

Although each supervisor brings to supervision their personality and professional experience, some commonalities have been identified among successful supervisors. The traits of an effective supervisor are best reflected in Powell's "four A's of supervision":[146]

- Available: open, receptive, trusting, nonthreatening.

- Accessible: easy to approach and speak freely with.

- Able: having real knowledge and skills to transmit (qualified).

- Affable: pleasant, friendly, reassuring.[146]

X.9 Motivational Interviewing

As with clients, MI is effective in supervision to elicit internal motivation and growth.[147,148] Here are some examples of how MI can be applied in a supervisory role:

- A staff member is frustrated with a client for their lack of action. Reflective listening will validate their staff member's frustration and provide them with the opportunity to identify what is contributing to their frustration, perhaps the amount of time they have exerted arranging services for the client.

- The COE has just implemented a new policy that a staff member dislikes. Although they maintain their disapproval, they are making comments indicative of change talk, such as "I guess the old way really wasn't working." The supervisor can meet the staff member where they are and foster additional change talk.

X.10 Organizational Support

Leadership (at all levels) should support the same principles of leadership and visibly demonstrate that support to its supervisory staff. When all levels of leadership embrace the same positive values and organizational vision, the organization is better able to achieve an improved quality of care and staff wellbeing.[146]

X.11 Supervisory Triad

Supervisors need to recognize the "presence" of the client in the supervisory relationship. Although not physically present during supervision, the supervisee may unconsciously present in a manner that is similar to how the client presents, which is known as the parallel process. For example, a supervisee is working with a client who has difficulty ordering their thoughts, and when meeting with the supervisor, the supervisee, who is normally very clear and organized, demonstrates some traits similar to the disorganized client.[148] To effectively address the parallel process, a strong supervisory working alliance (see below) is essential as addressing parallel processes without such an alliance can result in the supervisee becoming defensive. Strategies to address the parallel process include using Motivational Interviewing, having the supervisee role-play the client, or the supervisor modeling in interactions with supervisee how the supervisee can respond to the client's issue.[147]

X.12 Clinical Supervision

"Clinical supervision is a mutual endeavor by a trusting bi-directional relationship that leads to professional development and enhanced client care through mentoring, guidance, and clinical oversight."[148]

X.13 Best Practices

X.13.1 Supervisee-to-Supervisor Ratio

Too many supervisees for one supervisor can compromise the quality of supervision. Remember, DDAP (28 Pa. Code § 704.6) staffing requirements dictate no more than a combined eight counselors or counselor assistants per supervisor in an SUD treatment facility.[148]

X.13.2 Observation/Evaluation

Clinical supervision is a key factor in the professional growth of the clinician; avoid only providing feedback during administrative personnel evaluations. Supervisee anxiety has been found to be significantly reduced when regular discussion of the mutually identified goals occurs naturally during supervision.[146-148]

X.13.3 Training and Education

Pursue training specifically for clinical supervisors. Often, the "best clinician" is promoted to the role of clinical supervisor. This may seem logical but can be detrimental to the supervisor and supervisees if the proper training has not been completed before or proximal to the promotion.[149]

X.13.4 Direct Observation

Although sometimes uncomfortable (especially at first), direct/live observation has been described as the "backbone of a solid clinical supervision model." Sitting in on group or individual sessions, co-facilitating a service, or observing through a one-way mirror provides the supervisor with specifics to process and discuss with the supervisee.[148]

X.13.5 Clinical Supervision Stages

Be aware of which stage of supervision the supervisee is in (Entry-level, Mid-Stage, Advanced) and adjust the supervision approach to their supervision stage/need (see Appendix 4).

X.14 Common Challenges

X.14.1 From Peer to Supervisor

Transitioning from a peer to a supervisor is a delicate dance of adjustment for all involved. It can be helpful to have an open discussion with supervisees about the change in the nature of the relationship. This allows the supervisor to address what will be different (if anything) and what supervisees can expect from their new supervisor. If it seems to continue to affect a supervisee, bring it into the supervision session just as one would with a client: "I get the sense that you are still adjusting to me as your new supervisor and maybe are having some difficulties with the transition?"[149]

X.14.2 Live Observation

Research has found that live observation, such as direct observation and co-facilitation, has improved the supervisory alliance and reduced the anxiety of the supervisee. To help them feel comfortable with live observation, particularly if it's the first time they'll have a supervisor sit in on a group or individual session, one can consider the following: give them advance notice of when they will be observed, emphasize that observation is a tool for professional growth and not a personnel evaluation, observe them doing something they've done before, explain what they can expect from the observer in the session and what notes, if any, the observer will be taking.[148]

X.14.3   Resistant Supervisees

Supervisee resistance can stem from a variety of factors such as age (compared to the supervisor), education level, number of years in the field, personality differences, etc. Utilizing a MI approach can be effective in connecting with a resistant supervisee: "You don't seem to be finding our supervision sessions beneficial. What do you think could make these sessions more helpful for you?" With resistant supervisees, be sure to take their supervision stage into consideration. For example, a supervisee in the entry-level stage may be resistant because the reason they pursued their career isn't lining up with what's in the best interest of the client, such as supporting a client's preference for MOUD over a supervisee's preference for Twelve Step/abstinence.[147,148]

X.14.4   Peer Support Supervision

"Supervision is a professional and collaborative activity between a supervisor and a worker in which the supervisor provides guidance and support to the worker to promote competent and ethical delivery of services and supports through the continuing development of the worker's application of accepted professional peer work knowledge, skills, and values."[151]

X.14.5   Facilitating Organization Integration

The acceptance and integration of peer support into the organization and clinical setting overall is dependent on the actions of the supervisor and organization leadership. Supervisors should model the inclusion of peer support in interdisciplinary treatment/service planning. Additionally, the supervisor is responsible for highlighting the importance of peer support and the integral role they play in a client's care. In other words, the supervisor is the advocate for the role of peer support within the organization.

X.14.6   Non-Peers Supervising Peer Workers

Supervising individuals in different roles than a supervisor has personally held can be challenging. Some common challenges for non-peer supervisors of peer workers include:[151]

1. Lack of experience and/or knowledge of peer support worker practices.

2. Difficulty removing the "clinical hat."

3. Switching between clinical and peer supervision.

4. Maintaining recovery-oriented values in an organization that hasn't integrated such values in its culture.

It is the responsibility of the supervisor to educate themselves on the role and practices of peer support/CRS workers.

X.14.7   Recovery-Oriented Values in Supervision

Recovery-oriented values include:[151]

- Values that are individualized and strength-based.

- Personal accountability for commitments and responsibilities.

- Education and opportunities for personal and professional growth.

- An appropriate balance of autonomy, teamwork, and mutual support.

- Recognition of past experiences and potential traumas on the work of the peer support worker.

Supervisors using recovery-oriented values:[152]

- Believe in the ability of the peer support worker to grow and develop professionally.

- Utilize challenges encountered through peer support work as learning opportunities for the peer's growth and development.

- Assist the peer support worker in developing and accomplishing individualized professional goals.

- Facilitate the integration of peer workers and recovery values.

X.14.8 Supporting the Peer's Recovery

Unlike with most clinical staff, the peer supports' personal recovery is an integral part of their employment. It may be daunting to discuss such a personal matter with an employee; however, the supervisor must be mindful of the peer's ongoing recovery journey. This may consist of familiarizing oneself with the peer's personal recovery plan and checking in to support their ongoing self-care when experiencing stress at work or with clients. Peer supports are at increased risk of experiencing shared trauma and vicarious trauma. Additionally, organization celebrations and gatherings should be respectful of staff recovery by ensuring all staff can attend an event without concern for difficult situations, such as exposure to alcohol.

For additional resources regarding clinical supervision, see the Resources section.

Y. ORGANIZATIONAL HEALTH

For COEs to be effective and formidable agents of change, leadership needs to ensure that the organizational health of their COE is vigorous and high functioning. To ensure that the organizational health of the COE is strong, it is helpful to have a thorough understanding of the Systems Transformation Framework (STF). It is similar to other models that characterize complex and adaptive systems such as exists with COEs. The framework is intended to provide a guide to system transformation around one domain: the vision or greater purpose of the organization.

STF domains regarding the function of the organization are divided into four levels: (1) culture, or employee values, beliefs, and assumptions about their work; (2) behavior, or how employees handle relationships, power, decision-making, conflict, and learning; (3) structure, or how the organization is designed so lines of communication in the organization can facilitate decisions and innovations; and (4) the use of performance measurements for system improvement (Appendix 5). Ultimately, these domains are continually managed by the facility/organization's leadership and are influenced by external learning (methods to provide learning and skills development to the workforce) and internal learning (systematic processes used to improve organizational functioning) which can transform the culture, behavior, use of performance measurements, and structure of the organization so that the organization can continuously transform toward its intended vision.

Y.1 Vision

The vision is the greater ideal or purpose an organization strives toward through its daily work practices and functions. A united vision is a powerful and essential tool for system transformation and innovation. A strong vision has three characteristics: (1) it is clear, succinct, and highlights the key goal of the organization; (2) every member of the organization knows this vision, can recite this vision, and firmly supports this vision as the key goal of the organization (the members adhere to the vision); and (3) this vision is explicitly used to guide all work in the organization by all employees when making important decisions and implementing innovations or system changes.

Vision Statement Example

The Centers of Excellence for Opioid Use Disorder (COE) are one solution to the growing overdose crisis within the state, as well as a solution to the barrier of engaging and retaining clients with OUD in treatment.

Y.2 Leadership

Leadership is the second most important lever to induce system change. Effective leaders must assume the role of "agents of change" and must selflessly motivate the organization by striving for the common vision (described above); otherwise, system transformation is not possible. It is important that all levels of leadership have the same vision in mind, empower the members (and leaders) below them through delegation, setting high expectations but providing the resources and tools to achieve these expectations, providing consistent and fair accountability, and effectively communicating the needs of their organizational unit to the leadership above them (among other principles).

Y.3 Organizational Behavior

Organizational Behavior is how the organization behaves across five sub-domains: Relationships, Decision-making, Power, Conflict, and Learning. Relationships involve how members of an organization or unit work together. Strong relationships are seen when members have mutual and professional respect and appreciation for everyone's role, expertise, and contributions to the unit. Organizations and units with strong relationships are more effective at working collaboratively toward achieving the organization's intended vision.

Decision-making often is a difficult process within an organization. Decisions, especially those made by leaders that will affect the members of the units they supervise, should be transparent (the members should be informed about the reasons for the decision), made in a timely manner, and based on reputable information. Members of an organization involved in the decision-making process should clearly understand the problem or situation at hand and should actively seek input from experts or individuals directly involved with the problem or situation using the vision of the organization to explicitly guide decision-making.

Closely related to decision-making is power. **Power** can be thought of as a form of authority (or in some cases, superiority) "over" someone, but it can also be a power "for" achieving a greater purpose. Power should be used to propel an organization to empower individuals, advocate for their staff, and make Vision-oriented decisions.[153]

Two kinds of **conflict** can arise in an organization or unit. Detrimental conflict degrades or disempowers an individual or group and harms morale. Constructive conflict has the intent of finding the best possible resolution to the problem and is displayed as a professional and respectful difference of viewpoints.

Constructive conflict is vital to decision-making as members can challenge one another's ideas and thus find the best solution or option.

The final subdomain within Organizational Behavior is **learning**. Learning involves harnessing new information so that work can more effectively meet the organization's vision. Learning is closely related to change and innovation, as almost every innovation requires some form of learning—learning to use new technologies, learning new work processes, learning to adapt to a new organizational structure, and even learning from previously failed innovations. Healthy learning is a vital component of Organizational Behavior and will also be discussed further in this report as a separate domain (external learning).

Y.4 **Organizational Culture**

Organizational Culture encompasses the values, beliefs, and assumptions members have about their work environment. Like vision, when members of an organization have common values, beliefs, and assumptions, they are better able to understand one another and work collaboratively towards the organization's vision. As mentioned previously in Organizational Behavior, differences in values, beliefs, and assumptions must be discussed openly and constructively so that detrimental conflict can be avoided.

Y.5 **Organizational Structure**

Organizational Structure involves defining the lines of communication and authority throughout an organization. A clear organizational structure is vital for healthy behavior and leadership. It is important that members of an organization know whom to consult for guidance, leadership, and decisions.

Y.6 **Performance Measurements**

Performance Measurements are data collected internally by the organization and used to assess the organization's quality of services or products. There are several recommended processes to ensure that performance measures are used to their full potential. Performance measures should be collected in real-time (or as close as possible to real-time) so that they can be used to quickly identify gaps or problems and efficiently find resolutions; be transparent and understood by all members of the organization and be frequently used to motivate systemic change and decisions. All members must understand the measures so they can recognize why the measure needs to be improved and, ultimately, why a change may need to take place to improve the measure. Performance measures must be prioritized and consistent with the organization's vision and the area identified for change. They should also be changed frequently as the organization changes, with new goals declared for achieving the greater purpose.

Y.7 **Organizational Learning**

Organizational learning adds information and knowledge so that an organization can more effectively reach its intended vision. There are two types of learning systems: internal and external. **Internal learning** involves the application of a systematic process that guides how to apply performance measures and other existing characteristics of the organization so that it can more efficiently work toward its vision. Internal learning can happen informally through unplanned interactions between members of an organization, but also formally through process improvement systems like "Six Sigma" and "Lean" projects. **External learning** occurs when an organization seeks and brings in knowledge and skills that do not currently exist within the organization, based upon a careful examination of organization members' knowledge and skill gaps. External learning can occur in several ways, such as through staff trainings, workshops, and conferences. In large organizations, external learning can happen between large organizational bodies (i.e., one health facility sharing knowledge with another health facility) and informally between organizational units (i.e., a physician in primary care sharing knowledge with a mental health provider). For organizations to have strong external learning systems, they must first understand the members' needs, their current level of knowledge and skills, and the gaps in their knowledge and skills.

Y.8 Organizational Health Assessment

The model is used to determine the degree to which any organization is activating EACH domain using the principles described above (and others). Organizational Health Assessments (OHAs) measure the degree to which an organization functions differently from the preferred principles for each domain and will determine how likely the organization can take on any innovation that is designed to improve accomplishment of the vision. Further, the patterns identified in the analysis of an OHA highlight how well or challenged the organization is with respect to operating its domains throughout its management system or by specific domains and will determine what type of interventions the organization might need to apply that would significantly improve its clinical programs and outcomes. Evaluation of COEs has demonstrated a relationship between organizational health and client care measures.

Z. QUALITY IMPROVEMENT

Centers of Excellence are required to utilize a formalized and documented quality improvement process in accordance with Pennsylvania Department of Human Services Requirements for Centers of Excellence.

Z.1 Learning Networks

Several facilitated Learning Networks events are offered to COEs and other stakeholders to support the implementation of strategies to achieve common COE aims and measures. Learning Network events also assist COEs with developing an internal capacity to continuously learn, adapt, and improve. Through these Learning Networks, COEs have been able to meet, collaborate with, and engage in peer-to-peer learning, as well as share successes and challenges with other COEs. The Learning Networks also give COEs an opportunity to address issues or concerns with the MCOs, learn strategies to engage and retain clients with OUD in treatment, and have an opportunity to learn about QI methodologies and ways to integrate these strategies to improve the services they provide clients.

Z.2 Using Data to Support Quality

In the COEs' ongoing efforts to provide high-quality care to clients in SUD services, it is important for each site to routinely identify aspects of care that need to be improved. To identify these aspects of client care, it is essential to collect and analyze performance measurement data. Specifically, these data points allow the COEs to track the quality of care they are providing in terms of client engagement and retention. Research has shown that performance measurement data is an integral component of an organization's overall quality strategy for improvement.[57,58]

Performance measures can certainly drive high-quality care and are generally developed to establish clear standards of accountability to improve quality of care. The continuous process of collecting and analyzing client care data spearheads the COEs' efforts of accountability and helps to quickly identify gaps in care quality, allowing the organization to focus resources on meaningful change. In turn, the COEs can gauge their performance regarding client care against DHS standards in the monthly COE Checklist. It is this process of ongoing analysis and appraisal that is critical to client-centric organizations like the COEs.

Z.3 Using Electronic Health Record (EHR) Data for Growth

EHR systems provide a systematic framework for health service organizations to maintain information about individuals being served, facilitate day-to-day program operations, and manage and document the delivery of core services.

Whether using a commercial EHR system or a data management system developed specifically for the organization, data that staff across the organization are already collecting and entering into an electronic data system as part of standard operating procedures are a valuable source of data for routine monitoring of core program processes and for informing and supporting QI activities.

The following are benefits of using EHR data to improve client care quality.

Z.3.1 Benefits

5. **Provides a convenient source of program implementation data**: EHRs or other electronic program data management systems typically consist of data regarding an organization's service delivery or program implementation, including information on client enrollment, retention, assessment results, program activities, and services provided, and service completion. These data are typically entered in real-time, allowing organizations to track program activities and assess whether they are on target to meet their performance goals routinely and to identify and address problems quickly.

6. **Aggregates client data across the organization**: Using EHR data to monitor performance is one of the most efficient ways to conduct QI initiatives. With EHR data, organizations can assess performance indicators across an entire client population. EHR systems also allow for organizations to review service delivery performance indicators for subsets of the client population. This allows organizations to easily assess variation in service delivery across different client, staff, or organization subsamples.

7. **Reduces the need for manual chart review or manual tracking**: Manually tracking data for QI is tedious and burdensome for organization leadership and staff. Often, when performance data are collected manually, they are prone to inaccuracies. Additionally, relying on manually tabulated data often minimizes the number of service delivery performance indicators that can be routinely monitored. EHR data are already being entered by staff, and when the reporting features of EHR systems are maximized, performance indicators can be reviewed and monitored routinely with little extra effort.

Z.3.2 Defining Key Performance Indicators

Before an organization can begin to determine the feasibility of using existing EHR to support performance monitoring and QI, it needs to carefully define its key performance indicators.

1. **Performance indicators should be clearly defined**: Service delivery performance indicators typically involve calculating a percentage of clients reaching or receiving some milestone or the average length of time it takes clients to receive key service elements or are retained in certain services. It is important to clearly define what it means for a client to receive the desired service (e.g., the numerator in a given metric) as well as to consider which clients to include in the calculation (e.g., the denominator). Some performance indicators can be defined in several different ways and require different types of data elements for calculation. For example, client retention in services can be calculated as the average number of days served. It can also be calculated as the percent of clients still active in services at some time point (e.g., six months). It is important in both cases to carefully consider what it means to be active in service (e.g., is it the lack of a discharge date, is it having had a contact within the last 30 days). It is also important to define whom to include in the sample. For example, to report the percent of clients still active in service at three months, those who started services two months ago would not be included, because they have not yet had the opportunity to be active for three full months.

2. **Identify the data elements needed to calculate the key performance indicator**: Once performance indicators have been clearly defined, consider what data elements are needed for calculating the indicator. For example, to calculate the percent of all referred clients who received an initial assessment, this would require a data element to indicate that an initial assessment was completed (which could be an assessment date, or a field that indicates whether an assessment was completed, yes or no). In order to calculate the percent of clients active in service at three months, one could use an enrollment date, a discharge date, and/or a date of last client contact.

3. **Key service indicators will vary by organization:** Key service indicators will be specific to their own organization policies and expectations for core service provision, characteristics of the population they serve, and their overarching goals for client outcomes. Below are some examples of performance indicators that can often be measured with basic data elements common to behavioral health EHRs (Table 23).

Table 23. Screening and Assessment

Screening & Assessment
1. Percent of referred clients screened/assessed for services
2. Average length of time from initial referral to screening/assessment
Client Engagement & Retention
3. Percent of clients needing services that engage in services
4. Average length of time from assessment to service engagement
5. Average length of time clients engaged in program services
6. Percent of clients still receiving treatment at specific time points (e.g., three months, six months)
7. Ratio of missed to completed appointments
8. Percent of clients with a successful discharge from services
9. Percent of clients dropping out of services
Service Delivery
10. Average number of completed appointments with clients across the service period
11. Average frequency of completed appointments with client across the service period (e.g., more than weekly, weekly, biweekly, monthly)
12. Average number of days between completed appointment with clients
13. Average number of completed appointments within a specific time period (e.g., first three months)
14. Percent of clients receiving a minimum number of provider contacts per specific time period
15. Percent of clients receiving core program services (e.g., treatment plan development, treatment plan reviews, urine drug screens, formal depression screens)
Referrals
16. Percent of clients with specific types of referrals (e.g., primary care, mental health services)
17. Percent of clients receiving the referred service

Z.3.3 Assessing Alignment of Available EHR Data with Key Indicators

A first step in determining the feasibility of using existing EHR for monitoring performance indicators is to assess the alignment of data available in the EHR with the data elements needed to calculate the performance indicators. Some suggestions and considerations include:

- **Review system documentation:** Users of EHRs in the normal course of day-to-day operations are most familiar with how the data are entered on the 'front-end' or 'user-end' of the system. How and where the data are stored in the underlying data tables, or 'back-end,' might not be readily known. Most commercial EHR vendors can provide a 'data dictionary' or a guide to the system's data structure. Data documentation often provides useful information about the individual data fields and their format and can be important for assessing data quality and for better understanding the data that can be used for performance monitoring. However, the availability and quality of data documentation can vary, and it may require consultation with the EHR developer or vendor to determine specific data availability and usability.

- **Structured vs. unstructured data fields:** Ensure that the data needed to support QI efforts are stored as 'structured' data in the EHR. Data entered into EHRs can be entered into discrete fields with pre-determined options or as open, free text fields. For example, data related to a client's discharge reason that are entered into structured fields, with options such as 'Refused,' 'Completed program,' or 'Client moved,' allows for easier calculations than when client discharge reasons are hand-typed by staff into an unstructured, text field without standardization.

- **Modifying the EHR:** Despite the breadth of data that are often collected in established EHRs, it is not uncommon for EHRs to lack data elements needed for the calculation of important performance indicators or for EHRs to store the data in a format that is not easily used in calculations (e.g., data collected in unstructured, open formats). However, there may be flexibility in modifying existing fields or adding additional fields into the organization's EHR. Consult with the organization's data team or EHR vendor to assess the ability to modify or add data fields that are needed for monitoring key performance measures.

Z.3.4 Assessing EHR Data Quality

EHR systems are a convenient source of data for QI activities. However, organizations need to carefully consider the quality of the data elements being considered for calculating performance measures. High-quality data provides confidence in the findings and limits time spent on cleaning data to achieve accuracy. Data elements should be complete, accurate, and reliable. Below are some factors to consider when assessing the quality of the organization's EHR data.

- **Completeness**: EHR data elements are typically set to be either mandatory or optional during data entry. Mandatory or required fields are those where the user will receive an error message if the field is not completed prior to saving the record or moving to another form or page within the EHR. Making a field required ensures that it will be completed. Fields that are not considered applicable to all clients or service situations or that are deemed less essential to document are often not made required. Data completeness in these fields will likely vary across clients and staff members recording the information. Fields with a large percentage of missing data will not be useful for calculating performance measures without changes in data collection and documentation policies.

- **Accuracy**: EHR data elements being used in the calculation or reporting of performance measures should be carefully reviewed to assure that the data are being captured in these fields consistently and as intended. Some common accuracy issues include:

- o **Format inconsistencies**: Data collected in unstructured data fields are particularly prone to inconsistencies. For example, if race is set up as an unstructured, free text field, it is unlikely that all staff will enter the information in the exact same way every time, resulting in multiple formats and typos (e.g., 'white,' 'Caucasian,' 'White,' 'whit').

- o **Lack of standardization**: Even in structured data fields with explicit response options, it is not uncommon for staff performing the same activity to record it differently in an EHR. For example, if a case manager participates in a phone call with a client while the client is with their treatment provider, one case manager may record that as a 'Phone contact with provider' while another case manager may record it as a 'Phone contact with the client.' It is important that organizations provide standard definitions for documenting important elements of service delivery to enable accurate and consistent data collection across the staff within the organization.

- **Reliability**: Organizations need to verify that data stay consistent and accurate over time to ensure that the analysis results are always measuring what is intended. Data elements should be reviewed on an ongoing basis to ensure that staff are maintaining completeness and consistency in documentation, and there is no drift in data quality. If the organization is monitoring performance measures through canned EHR reports, verify that the EHR produces consistent output for a measure over time. Routinely review outputs with staff to assess whether the output is a good representation of their work. Periodically validate the output by comparing it to a review of the raw EHR data.[154]

Z.3.5 Analyzing EHR Data

The ability of an organization to maximize the data in their EHRs for performance monitoring and QI will vary depending on the capabilities built within the EHR system versus the need to pull the raw data out of the EHR for external data manipulation and calculation.

1. **EHR Reports:** Many EHR systems contain pre-built, 'canned' reports, which are used by leadership and staff to direct services or to report on routine program functions. Review the system's existing reporting capabilities to identify what reports may already exist as well as the flexibility the organization has in developing new, or modified, reports. Having a report built directly into the EHR that provides information aligned with key performance indicators is the most efficient way to use an EHR to support QI efforts. Consultation with the organization's internal data team or EHR vendor may be necessary to modify reports or to develop new reports.

2. **Queries:** EHR systems often include querying functionality. Queries are ways in which users can conduct manual searches of data stored within an EHR. A single query can return aggregate information about your clients or aspects of service delivery very quickly. Queries can be especially useful if you are monitoring just a few performance indicators at a time, and the queries return the needed results without extra manipulation.

3. **External analysis of EHR data:** All data entered into an EHR are stored in data table structures within the EHR and can often be exported into other data formats, such as .csv files which can be opened and manipulated in Excel, SQL, SAS, SPSS or other data management and analysis software programs. If the internal EHR reporting and querying capabilities are lacking, organizations should consider exporting needed data elements from the EHR into one of these other data processing formats. A benefit to processing and analyzing EHR data outside of the system is that it enables greater flexibility in reviewing data quality and data cleaning. A drawback is that the process of manipulating and analyzing data outside of the system often requires having a dedicated data manager or data analyst on staff or the need to contract with an outside data firm to assist with performance monitoring.

Z.4 Potential Challenges

1. **Staffing considerations**: To successfully and efficiently use existing EHR data for performance monitoring, it is advised that organizations have at least one staff person who possesses a detailed knowledge of the EHR and preferably knowledge of data manipulation and analysis. This is especially true if the EHRs internal reporting and querying capabilities are limited. Smaller organizations may need external resources (e.g., assistance from the EHR vendor or external evaluators or consultants) for assistance in assessing the alignment of EHR data to their key performance indicators, assessing the quality of the EHR data, and developing a routine plan and structure for data review and analysis.

   Recommendation: Cross-train multiple staff to be proficient in utilizing EHR data. If there are limitations on staff who can be cross-trained, consider developing a handbook that outlines the step-by-step process of how to extract, manipulate, and analyze the data necessary for quality improvement and any reporting requirements.

2. **Underutilization of the EHR:** Some organizations may not fully utilize all features of their EHR. This could be due to limited knowledge of the software, a limited number of licenses for program staff or a lack of need to enter data into all areas of the EHR.[155] This challenge could impact the availability of data needed for performance monitoring as well as the use of pre-built querying and report functions.

   Recommendation: Contact your EHR supplier to request additional training if there is a lack of awareness of potential uses of the EHR. Integrate the use of the EHR into all aspects of your organization to ensure necessary data is entered and available for later analysis.

3. **Lack of system integration:** If an organization has an EHR that doesn't capture all the information it needs to track for internal or external reporting needs, staff may have developed 'work-around' systems for tracking key data (e.g., spreadsheets or other data systems). Using EHR data for QI can be hampered for organizations tracking data in multiple systems or databases that do not speak to each other or that cannot be easily combined.

   Recommendation: Eliminate work-around systems by integrating the EHR into all policies and procedures. Ensure that the onboarding process for new hires emphasizes the importance of utilizing the EHR and eliminating the use of past workarounds.

4. **Focus on service delivery or processes:** EHRs are most often developed and used for improving the efficiency of day-to-day services provided to clients. Even though QI efforts are often most focused on the processes and delivery of services, a drawback to EHRs is that they are less likely to contain data that can be used for measuring direct client outcomes. If part of the QI activities requires direct client outcomes, it may require additional data collection outside of the EHR, or modifications to the EHR to document client outcomes.

   Recommendation: If it is necessary to collect data outside of the EHR, be sure to structure the data in a format similar to how data is extracted from the EHR in order to combine the data sources. Identify one staff member responsible for the data collection to avoid duplication of efforts and inconsistency in data availability and management.

5. **Extracting data from the EHR:** Most EHRs have a basic platform that is consistent across organizations, which may not include the data and reports needed to capture the organization's performance management. To capture this data, organization-specific personalization may need to occur from the EHR's IT team. This can be expensive and timely, which may delay the capturing of key performance measures.

Recommendation: Request a consultation with your EHR supplier to explore the possibility of personalizing the EHR for your data needs. If you are aware of other organizations that utilize the same EHR platform, see if they are experiencing the same personalization need; In some instances, EHR suppliers will adjust the cost for personalization if it is a need among a number of customers.

Z.5 Managing Changes in Leadership

A change in leadership can be a significant event for a COE. Leadership by nature has a profound impact on the success or failure of the functioning and overall organizational health of the COE. It is important that the COE be as prepared as possible for a change in leadership and how to most effectively move forward when a significant change of the guard arises.

The acceptance of a new leader is crucial as it can potentially be met with noticeable barriers and some degree of adversity from frontline staff. As described in the STF, leadership needs to be agents of change and aid their organization toward the common vision. Below are tips on how to effectively address a change in leadership within the COE.

1. **Obtain feedback from co-leadership and frontline staff**: It is important to find out as much information about the change as possible. Seek feedback from the staff within the COE to understand how the change will affect the team, the workflow, and the ability to offer high-quality care to COE clients. The more leadership understands the effect the change will have on the COE, the easier it will be to respond effectively and efficiently to the change.

2. **Communicate often and effectively:** It is important that change that occurs within the COE be communicated with transparency and candor. As soon as a change is identified or needed, talk with the staff at the COE. Be sure to convey to the staff how this change will affect the team and the work that they do. Make the new leadership aware of the COEs capabilities, weaknesses, and strengths, and talk about successful barriers that they have addressed and successfully overcame.

3. **Deal with barriers and adversity quickly:** It can be anticipated that there will be a degree of ambiguity and/or resistance to the change. How the change is addressed will help to gain the confidence and support of one's team. One should be open to the ideas of staff and communicate those ideas to new leadership but ultimately allow for the strategic innovations needed to make an impactful change.

4. **Be adaptable to the change:** Regardless of the steps that are taken to assure the smooth transition of a team, workflow, or work environment, new leadership will make changes that affect the team. While not all the changes will be met with 100 percent support from the COE team (at least initially), agree to disagree and find out why the changes were made and how staff can best be supported to adapt to the changes. Staff comprehension of all changes will improve the chances of gaining the support and willingness to adapt from COE staff.

Z.6 Data Collection

For information about data collection, please refer to Section L.6.1.

AA. BUILDING COMMUNITY PARTNERSHIPS

As healthcare professionals, we want to ensure that our clients receive the highest level of both physical and behavioral health care available to them. The clinical applications that combat a client's SUD can have a profound impact on the success and sustainability of their recovery. Although an important element of a client's care management, a client's successful treatment journey is not entirely dependent on the level of physical health treatment that is implemented.

Holistic care management is determined by "the extent of linkage and the success of the treatment programs are influenced by the availability of services in the community, how effectively the case/care management is applied, and its integration in the local network of services."[156]

Relevant community resources include housing, food, and transportation and can be different depending on the setting (e.g., rural vs. urban). Figure 15 provides a list of relevant community partners that the COE may wish to consider adding to their partnership network (please see Appendix 6 for a worksheet that can be filled out). Care management and recovery cannot be measured unilaterally by the clinical interventions that are provided to the client. With a fully integrated approach, physical and behavioral healthcare providers work together to develop partnerships within their community that are available to aid in a client's successful recovery.

To aid in the implementation of this integration of services, COEs are encouraged to follow the hub-and-spoke model established first in Vermont.[157] This model is designed to facilitate a client's visit to a COE in a one-stop-shop format where staff provide a range of OUD-relevant services in-house and refer clients out for additional services that tackle a diverse set of needs including job support, housing support, mental health, physical health, and others. As a result, clients are spared from navigating a complex healthcare system and can interface solely with COE staff beyond attending appointments with referral destination providers. An example memorandum of understanding can be found in Appendix 7.

Figure 15. Community Partnership Model
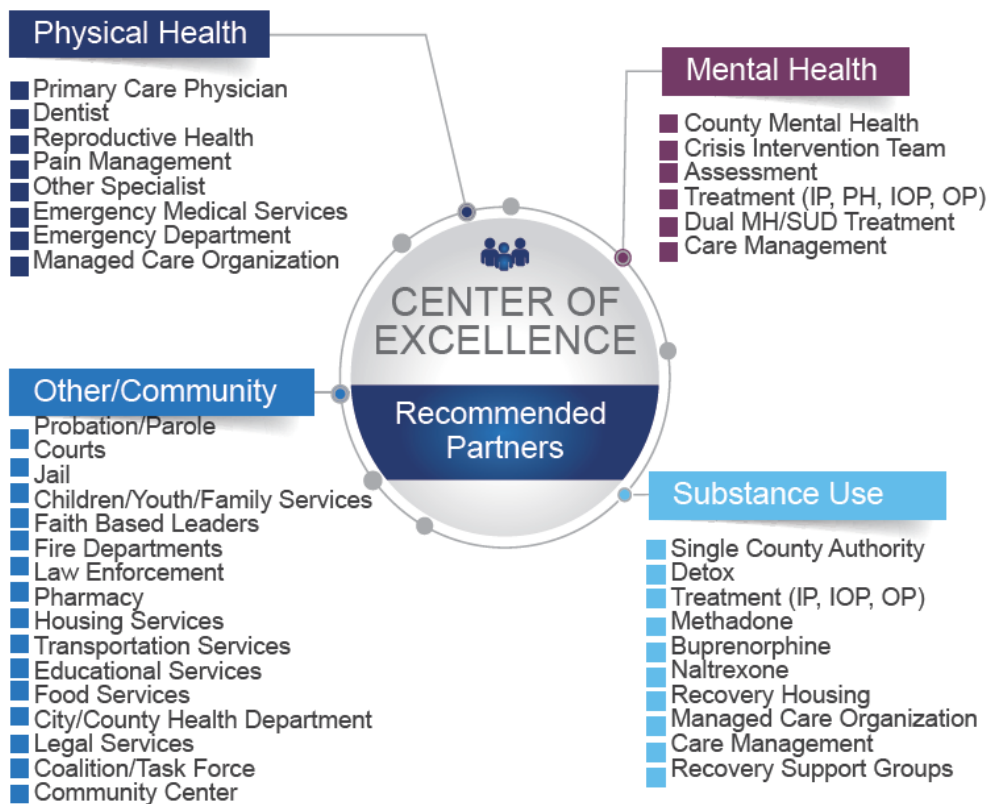
IP: Inpatient; OP: Outpatient; IOP: Intensive Outpatient Program; MH: Mental Health; PH: Partial Hospitalization

Referrals to COE services may be derived from different services depending on physical or behavioral health designation. For example, behavioral health COEs may provide MOUD to clients before their COE status is officially established as an "engaged client." When engaging with COE clients, care management services should seize the opportunity to offer additional support services to these clients during their routine MOUD and/or face-to-face monitoring appointments. Once a client is engaged with the COE beyond just receiving

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MOUD, they might set up appointments independent of MOUD to establish community partnerships that focus on non-treatment issues such as housing, job support, or MH treatment.

Community-based partnerships can be defined as a collaborative body of individuals and organizations working together on a common goal or issue of importance to the community. It consists of a mutually beneficial relationship where all parties play a role with a unified goal composed of a set of shared responsibilities, privileges, and power.[158]

The Health Resources and Services Administration has outlined a multi-stage approach to developing successful and sustainable community partnerships:[159]

1. Stage 1: Assess Your Readiness for Community-Based Partnerships.

   - Assess your and your organization's resources, skill sets, and commitment to forming a community-based partnership.

2. Stage 2: Identify the Community

   - Assess community strengths, assets, and resources.

   - Connect with community stakeholders and conduct key informant interviews.

   - Community Dialogue: Meet with the community stakeholders and possible partners.

   - Establish the partnership group.

3. Stage 3: Define the partnership.

   - Establish group membership and leadership.

   - Develop a partnership vision, goals, and objectives.

   - Create organizational structures and guidelines that support the partnership.

4. Stage 4: Setting Up MOUs.

   - Identify treatment and non-treatment provider(s) within the community.

   - Establish referral agreement/MOUs between the COE and the provider(s) to ensure that clients are accessing the necessary services and that information sharing is occurring between providers.

   - Create data sharing protocol that outlines how data will be shared between agencies.

   - Establish performance metrics to evaluate the efficiency of referral system (e.g., number of referrals made, assessments completed, type of treatment service(s) provided, etc.).

   - Hold regular trainings and monthly meetings to reinforce shared vision and assess quality of referral and data collection process.

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CC.1 **Appendix 1: Brief Assessment of Recovery Capital (BARC-10)**

Similar to more in-depth assessments of recovery capital, the BARC-10 broadly but accurately measures the personal, social, physical, and professional resources in an individual's environment that initiate and sustain recovery and demonstrates a high correlation with longer assessment versions.[48] Although brief, the BARC-10 equally highlights psychometric properties, and, more importantly, accounts for changes over time. In addition, scoring that is shown to increase over time can assist COE staff in determining the specific salient resources attributed to increases in scores. The BARC-10 should be administered to every COE client within 30 days of initial contact at the COE (can be administered during the initial visit with the client) and every six months during a client's engagement with the COE. The BARC-10 instrument is available below. Scores can range from a minimum of 10 to a maximum of 60; the higher the score, the more recovery capital a client is interpreted to have.

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1. There are more important things to me in life than using substances	1	2	3	4	5	6
2. In general, I am happy with my life	1	2	3	4	5	6
3. I have enough energy to complete the tasks I set for myself	1	2	3	4	5	6
4. I am proud of the community I live in and feel a part of it	1	2	3	4	5	6
5. I get lots of support from friends	1	2	3	4	5	6
6. I regard my life as challenging and fulfilling without the need for using drugs or alcohol	1	2	3	4	5	6
7. My living space has helped to drive my recovery journey	1	2	3	4	5	6
8. I take full responsibility for my actions	1	2	3	4	5	6
9. I am happy dealing with a range of professional people	1	2	3	4	5	6
10. I am making good progress on my recovery journey	1	2	3	4	5	6
Add columns		+		+		+
TOTAL						

CC.2 **Appendix 2: Relevant Contact Information**

The table below includes relevant contact information for DHS, MCOs, and PERU:

Pennsylvania Department of Human Services		
General COE Program Questions	Office of Medical Assistance Programs	RA-PWSUDCOE@pa.gov
DocuShare Questions	DocuShare Helpdesk	800-281-5340 (Select Option 2)
Pennsylvania HealthChoices Physical Health MCOs		
Billing and Payment Questions	Aetna Better Health Provider Services Center	1-866-638-1232
	AmeriHealth Caritas Northeast Provider Services Center	1-888-208-7370
	AmeriHealth Caritas PA Provider Services Center	1-800-521-6007
	Gateway Health Plan Provider Services Center	1-800-392-1147
	Geisinger Health Plan Provider Services Center	1-800-876-5357
	Health Partners Plan Provider Services Center	1-888-991-9023
	Keystone First Health Plan Provider Services Center	1-800-521-6007
	United Healthcare Community Plan Provider Services Center	1-800-414-9025
	UPMC For You	1-800-286-4242
Pennsylvania HealthChoices Behavioral Health MCOs		
Billing and Payment Questions	Magellan	Bucks Cty: 877-769-9784 Cambria Cty: 800-424-0485 Delaware Cty: 888-207-2911 Lehigh Cty: 866-238-2311 Montgomery Cty: 877-769-9782 Northampton Cty: 866-238-2312
	Community Behavioral Health	Philadelphia Cty: 888-545-2600

	Community Care Behavioral Health Organization	Adams Cty: 866-738-9849
		Allegheny Cty: 800-553-7499
		Bedford & Somerset Counties: 866-483-2908
		Berks Cty: 866-292-7886
		Blair Cty: 800-553-7499
		Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties: 866-878-6046
		Carbon, Monroe, and Pike Counties: 866-473-5962
		Chester Cty: 866-622-4228
		Erie Cty: 855-224-1777
		Lackawanna, Luzerne, Susquehanna, and Wyoming Counties: 866-668-4696
		Lycoming & Clinton Counties: 800-553-7499
		York Cty: 866-738-9849
	Beacon Health Options/Value Behavioral Health	Armstrong Cty: 877-688-5969
		Beaver Cty: 877-688-5970
		Butler Cty: 877-688-5971
		Crawford, Mercer & Venango Counties: 866-404-4561
		Fayette Cty: 877-688-5972
		Greene Cty: 877-688-5973
		Indiana Cty: 877-688-5969
		Lawrence Cty: 877-688-5975
		Washington Cty: 877-688-5976
		Westmoreland Cty: 877-688-5977

	Community BH Network of PA/PerformCare	Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties: 888-722-8646 Franklin & Fulton Counties: 866-773-7917
University of Pittsburgh School of Pharmacy, Program Evaluation and Research Unit		
Technical Assistance and Learning Networks Questions	Dane Miller, Program Manager	Dpm59@pitt.edu

CC.3 **Appendix 3: Level of Care Options Form**

Level of Care	Organization(s)	Contact for Referrals
0.5 Early Intervention		
1 Outpatient		
1 Opioid Treatment Program (OTP)		
2.1 Intensive Outpatient Services (IOP)		
2.5 Partial Hospitalization Services (PHP)		
3.1 Clinically Managed Low-Intensity Residential Services		
3.3 Clinically Managed Population-Specific High-Intensity Residential Services (Adult)		
3.5 Clinically Managed High-Intensity Residential Services (Adult)		
3.5 Clinically Managed Medium-Intensity Residential Services (Adolescent)		
3.7 Medically Monitored Intensive Inpatient Services (Adult)		
3.7 Medically Monitored High-Intensity Inpatient Services (Adolescent)		
4 Medically Managed Intensive Inpatient Services		

CC.4 Appendix 4: Stages of Clinical Supervision

The following table summarizes the stages of clinical supervision as explained in "Clinical Supervision: An Overview of Functions, Processes, and Methodology.[148]

STAGES OF CLINICAL SUPERVISION

As explained in "Clinical Supervision: An Overview of Functions, Processes, and Methodology" (Durham, 2019)

	Beginning	Intermediate	Advanced
Goal	Increased autonomy	Less dependence on supervisor and start of personal counseling style	Advanced level of autonomy and independence; Mastery of skills and knowledge
Common Characteristics	Anxiety; Self-focused; Concern with "doing it right"; Fear of negative supervisory evaluation; Strong motivation; Eager to learn; Dependent on supervisor; Compliant	Desire for independent clinical decision-making; Less self-focused, more client-focused; Begin to challenge supervisor recommendations;	Clear, grounded understanding of self; Personalized counseling style; High self-aware-ness; Mastered empathizing with the client/ understanding client's perspective; Stable motivation
Potential Challenges	Self-focus leads to increased potential for transference/countertransference; Motivation may be thwarted by challenging cases; Requires significant time of supervisor	Frustration with complexities of counseling pro-cess; risk for over-identification and enmeshment with clients; Motivation impacted by desire for autonomy but still some reliance on supervisor	Resistance to supervision that is too directive and less collaborative;
Supervisor's Role	Model a willingness to be open; Guide supervisee in identifying and resolving potential problems; Provide safe place to discuss challenges	Challenge supervisee to enable development of self-efficacy; Provide corrective feedback to support professional growth; Coach approach – collaborative focus on supervisee self-direction and autonomy; Model problem-solving skills	Collegial, peer-like; Sharing of ideas for mutual growth
Suggested Approaches	Discussion of goals of supervision; Identification of evaluation methods; Establishment of supervisory alliance; Facilitative interventions; Provide structure; Didactic skills training; Observe and suggest approaches	Brainstorming solutions; MI to address ambivalence	Brainstorming; Process comments; Catalytic questions (open-ended questions that provoke thought, self-exploration and problem-solving); Self-disclosure

Durham, T. G. (2019). Clinical Supervision: An Overview of Functions, Processes, and Methodology. NAADAC, the Association for Addiction Professionals

CC.5 Appendix 5: Innovation Model

Leadership

Behavior

Culture

Vision

Performance Measurement

Structure

Internal Learning

External Learning
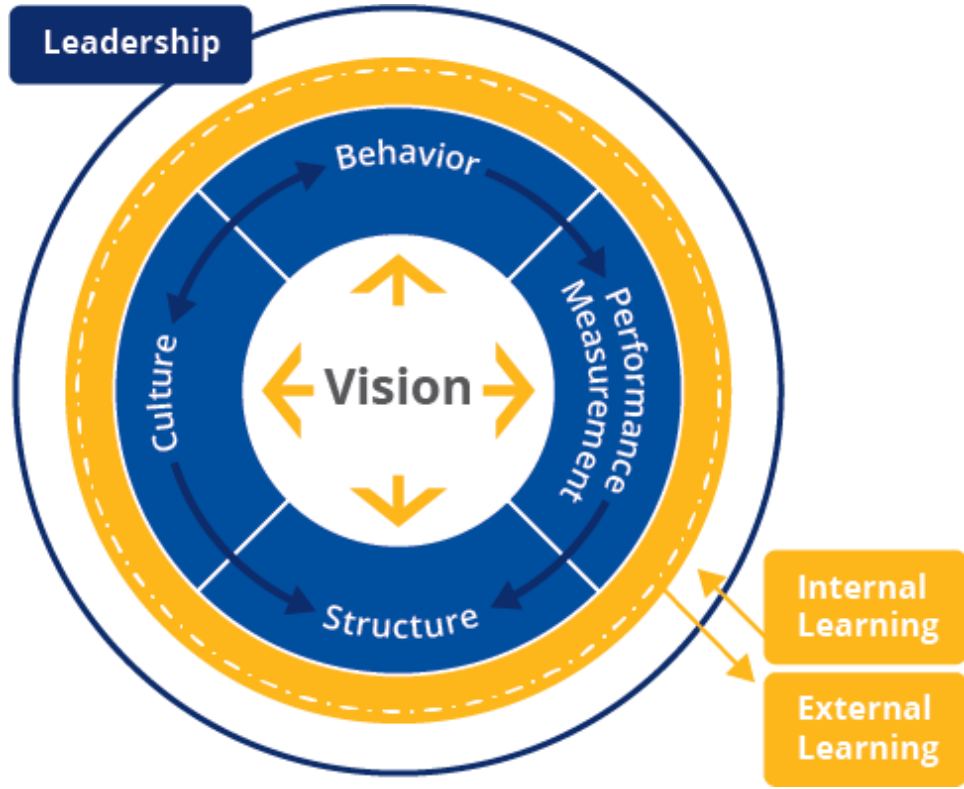
CC.6 Appendix 6: Community Partnership Worksheet

Physical Health					
	Stakeholder	Organization	Email	Phone Number	Notes
Primary Care Physician					
Dentist					
Reproductive Health					
Pain Management					
Other Specialist					
Emergency Medical Services					
Managed Care Organization					
Mental Health					
	Stakeholder	Organization	Email	Phone Number	Notes
County Medical Health					
Crisis Intervention Team					
Assessment					
Treatment (IP, PH, IOP, OP)					
Other Specialist					
Dual MH/SUD Treatment					
Care Management					
Substance Use					
	Stakeholder	Organization	Email	Phone Number	Notes
Single County Authority					
Detox					
Treatment (IP, IOP, OP)					
Methadone					
Buprenorphine					
Naltrexone					
Recovery Housing					
Care Management					
Recovery Support Groups					
Community/Other					
	Stakeholder	Organization	Email	Phone Number	Notes
Probation/Parole					
Courts					
Jail					
Child/Youth Services					
Faith-Based Leaders					
	Stakeholder	Organization	Email	Phone Number	Notes
Fire Department					
Law Enforcement					
Pharmacy					
Housing Services					

Transportation Services					
Educational Services					
Food Services					
Legal Services					
City/County Health Dept.					
Coalition/Task Force					
Community Center					

CC.7 **Appendix 7: Sample Memorandum of Understanding**

MEMORANDUM OF UNDERSTANDING FOR REFERRALS

This memorandum of understanding (MOU) identifies the terms of the referral collaboration between *[COE Provider]* and *[Community Medical Services Provider/Social Services Organization]*.

Purpose

This MOU serves as a mechanism to formalize the relationship between partner agencies with the common goal of optimizing health care delivery and the overall well-being of a shared target population. It is intended to facilitate inter-agency collaboration, communication, coordination of services, and continuity of care.

Description of Agencies

[Name of COE Provider] is a Center of Excellence for Opioid Use Disorder as designated by the Pennsylvania Department of Human Services and designed to engage the community to identify all persons with opioid use disorder (OUD) and make sure every person with OUD achieves optimal health. Ensuring every person with OUD achieves optimal health involves coordination of care across multiple domains, including physical, mental, and behavioral health and social needs including job training, housing, and transportation support, education services, and childcare among others. Centers of Excellence (COE) utilize community-based care management teams to assist with care coordination and recovery support for their clients. The community-based care management teams consist of a diverse group of providers including Licensed Clinical Social Workers, counselors, Certified Recovery Specialists, nurses, peer navigators, care managers, and physicians. These services are provided to individuals with Medicaid who are diagnosed with an OUD.

[Name of Community Medical Services Provider/Social Services Organization]

[Description of Services]

General Provisions

Each agency agrees to:

1. Ensure all reasonable efforts to prioritize and accommodate referrals from one another for services within their respective scopes of practice.
2. Provide any necessary medical information regarding clients to facilitate referral services.
3. Accept phone consultations between referring agencies, as needed, to discuss referral and any follow-up recommendations for the referring agency.
4. Assume responsibility for billing clients and/or third-party payers for any services provided.
5. Periodically assess the effectiveness of referrals and act upon opportunities to improve them.

Confidentiality

Each agency will ensure client confidentiality in accordance with state and federal regulations regarding drug and alcohol patient records. Information obtained by the agency's staff about an individual receiving services may not be disclosed without the individual's documented consent, except as required by law or as may be necessary to provide services to the individual, with appropriate safeguards for confidentiality.

Updates

This MOU can be updated or modified with the agreement of both parties at any time.

Duration

This MOU shall become effective upon signature by a designated official from each agency and is renewable from year to year, unless either agency gives notice of intent to withdraw from the agreement.

_____   _____

[COE Provider]   *[Medical/Social Services Organization]*

_____   _____

[Director's Name]   *[Director's Name]*

_____   _____

Signature   Date   Signature   Date

CC.8 **Appendix 8: Note Formats**

SOAP Format

	Section	Content	Example
S	Subjective	Symptoms and concerns reported by the client. Any efforts made by the client toward objectives/goals. Client reported changes and challenges. Statements by others, such as probation officers or other providers.	"Client reported successfully utilizing deep breathing when feeling overwhelmed."
O	Objective	What the clinician/case manager/peer support observe. Any signs of changes in appearance or social behaviors that are measurable. Any psychological testing results.	"Client appears to be less preoccupied with stressors compared to previous sessions."
A	Assessment	Professional case formulation, conclusions, impressions, and implications for treatment/recovery. Can also include analysis of data from the subjective and objective sections.	"Client's willingness to practice deep breathing strategies at home demonstrates a commitment to treatment and a desire to enact change."
P	Plan	Treatment plans for immediate next steps and the future. Client education, follow-up, "homework assignments," and intended diagnostic studies. Where do COE staff intend to go next?	"Client will continue practicing deep breathing to utilize in times of distress. Client will keep a journal in which they log the physical sensations they experience prior to and during distress with the intention of identifying building stress and being proactive with coping skills."

DAP Format

	Section	Content	Example
D	Data	General content and process of the session. Symptoms and concerns reported by the client. Any efforts made by the client toward objectives/goals. Client reported changes and challenges. Statements by others, such as probation officers or other providers. Was any homework reviewed? What interventions were used by the staff member?	"Client and counselor reviewed client's treatment plan. No new goals were added due to goals not yet being achieved. New objectives created to work toward identified goals."
A	Assessment	Professional's understanding of the client's problem and efforts. Assessment of motivation. What the clinician/case manager/peer support observe. Any signs of changes in appearance or social behaviors that are measurable. Any psychological testing results. How is the client responding to the treatment plan and interventions used? What is the counselor's working hypothesis/prognosis?	"Client appears to lack internal motivation, as demonstrated by client's lack of progress toward goals. Specifically, client consistently did not complete homework assignments, having stated that she found them 'annoying.'"
P	Plan	Treatment plans for immediate next steps and the future. Client education, follow-up, "homework assignments," and intended diagnostic studies. Where do COE staff intend to go next? When is the next scheduled session/service?	"Counselor will utilize Motivational Interviewing to elicit change talk to support efforts toward identified goals."

GIRPP Format

	Section	Content	Example
G	Goals	Identify the goals the client is working on that were addressed.	"Today's service focused on client's goal of achieving three consecutive months free of illicit use."
I	Intervention	What was done during the session/service to work on the identified goal? This is where COE staff would identify EBPs.	"Counselor utilized a CBT approach in which client identified cognitive distortions he is experiencing when he thinks about his ability to meet his goal of three consecutive months free of illicit use. Client identified replacement thoughts for his cognitive distortions."
R	Response	How is the client responding to the treatment plan and interventions used? Does a different intervention need to be utilized?	"Client responded well to the CBT activity. He was able to quickly identify the cognitive distortions and understood how those distortions can impact his goal."
P	Plan	Was any homework assigned? What will the next service or services look like? When will it occur? Can include collaboration with other services/providers.	"Client was assigned homework to journal his cognitive distortions and appropriate replacement thoughts. Additionally, client is to document the situations or emotions that precede the cognitive distortions for review in next session. Client is scheduled to meet with his case manager on x/x/xx and will return for his next session with this writer on x/x/xx."
P	Progress	What is the counselor's working hypothesis/prognosis? Is the client progressing toward goals? Have they achieved any objectives?	"Client continues to make progress toward his goal. With his continued commitment to treatment, this writer has a positive prognosis for client."

Appendix 9: Activity Codes List

The updated care management activity codes and associated definitions are listed below. The COE is not required to utilize all activity codes each month; however, the activity codes are used to show the services that are provided to each client every month. COEs are encouraged to fully document in REDCap's Client Interaction Form all codes that represent services rendered to each client during the reporting month and must execute and document face-to-face monitoring each month to receive the PMPM payment.

Evaluation of Needs: activity conducted in person that evaluates the non-OUD treatment and social determinant needs of clients. The evaluation can be conducted by care management staff and/or medical providers who are equipped to conduct this type of evaluation. The evaluation should, at a minimum, address the following:

- Social determinants of health (e.g., housing, jobs, transportation, etc.).

- Non-OUD treatment needs (e.g., MH, physical health, hep B and C testing, HIV testing, etc.).

- Client goals.

This activity may result in referrals to internal and/or external providers and/or updates to a client's care plan. This activity should be ongoing, occurring every six months to determine client's needs.

Face-to-Face Monitoring: activity that is conducted by the client's CBCM team that involves the client sharing information about key treatment indicators, including treatment attendance, treatment/care plan progress, etc. This monitoring should be conducted face-to-face and should be used to assess the client's progress against his/her care plan. In cases where a client may be incarcerated or in an inpatient treatment program, a phone call may be conducted to discuss progress and must result in an update to the client's care plan.

Care Coordination: activity that "…involves deliberately organizing patient care activities among providers and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that is information is used to provide safe, appropriate, and effective care to the patient."3 Care coordination can also occur when a member of the CBCM team assists a client in scheduling appointments and makes contact with a client's provider to discuss care.

Care Manager Follow-up (Call/Letter/Text Messaging): This activity involves the CBCM team reaching out to the client to follow-up on referrals, or conduct a telephonic follow-up or check-in. This activity takes place with an engaged client and may be used between a client's face-to-face visits.

Urine or Blood Screen: This activity can be conducted internally or externally and involves the collection of urine or blood to monitor the use of licit and/or illicit substances by clients.

Providing Direct Client Transportation: This activity involves the CBCM team directly transporting a client to appointments, agencies/organizations, court appearances, and other activities that help to support an individual's recovery.

Care Manager Re-engagement Contact: This activity is conducted when a client attempts to re-engage a client who has been absent from COE services. According to DHS, a client is considered disengaged when they do not contact the COE for 60 consecutive days. This code should be used when attempting to contact a client who meets DHS's definition of disengagement.

Medication Reconciliation: This activity occurs when the client's clinician "…compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient

and resolves any discrepancies."[4] This is especially important for clients who have physical and behavioral health comorbidities that require medication management.

Chronic Condition Education (e.g., Asthma): This activity occurs when a member of the CBCM team or other healthcare provider educates the client on managing chronic conditions (e.g., asthma). This may occur within the COE or at a client's provider's office.

Diabetes Self-Management Education: This activity can occur within the COE or at a client's provider's office and is defined as the "…process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards."[5]

Health Insurance Benefits Coordination: This activity can occur when a care manager/other provider assists the client to sign up for health insurance benefits.

The next set of codes will be categorized as "Referral," "Monitored Engagement," or "Transition of Care." The categories have been defined below.

Referral: two-way connection of the CBCM team to a recipient agency that will provide services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services.

Monitored Engagement: documented client or client provider contact with a recipient agency that is providing services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services.

Transition of Care: documented client or client provider contact with a recipient agency during a transition of care/services to where monitoring engagement of services between the client and recipient agency is no longer needed (ex: a COE-engaged client that is moving between levels of care of a COE-engaged client that is moving from Medicaid to commercial insurance). The recipient agency may be the COE if the COE is providing the services.

CC.9.1   Referral Category

Referral to Mental Health Services: two-way connection of the CBCM team to an MH agency that will provide services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. MH services are treatment services that are provided by a licensed professional to an individual who has a diagnosed MH disorder.

Referral to Healthcare Services – Primary Care Physician Services: two-way connection of the CBCM team to a healthcare service that will provide primary care services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Primary care physician services are defined as "care that is provided by practitioners specifically trained for and skilled in comprehensive first contact and continuing care for persons … includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illness in a variety of health care settings."[6]

Referral to Healthcare Services – Smoking Cessation Services: two-way connection of the CBCM team to a healthcare service that will provide smoking cessation services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Smoking cessation services are services that are provided to an individual who wishes to quit smoking

tobacco. Smoking cessation services can include one or a combination of the following: tobacco cessation counseling, nicotine replacement medication, and or non-nicotine tobacco cessation medication.

Referral to Healthcare Services – Hepatitis B, Hepatitis C, and HIV Testing: two-way connection of the CBCM team to a healthcare service that can provide hepatitis B, hepatitis C, and/or HIV testing services to the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Hepatitis B, hepatitis C, and/or HIV testing services are provided to clients who may be at risk of contracting hepatitis B, hepatitis C, and HIV. These testing services can be provided by a primary care physician or a community agency with staff that are trained to administer the test and interpret results.

Referral to Healthcare Services – Pain Management Services: two-way connection of the CBCM team to a healthcare service that will provide pain management services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Pain management services are provided by pain specialists who are trained in treating chronic pain. There are multiple modalities for pain management, including medication, which should be closely monitored by the COE and the client's primary care provider.

Referral to Pregnancy Testing/Prenatal Care: two-way connection of the CBCM team to pregnancy testing and/or prenatal care services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Pregnancy testing is provided to women who think they may be pregnant or in accordance with treatment requirements. Prenatal care services are provided to women who are pregnant to ensure the health of mother and baby.

Referral to Health Insurance Benefits Coordination: two-way connection of the CBCM team to a health insurance benefits coordination services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Health insurance benefits coordination is a service that is provided to a client to assist them to obtain benefits, including Medical Assistance or commercial insurance.

Referral to SUD Treatment: two-way connection of the CBCM team to SUD treatment services that will provide SUD treatment for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. SUD treatment services are services that are provided to the client at any LOC by a DDAP-licensed facility or with an approved provider of MAT services. The client should be administered the ASAM LOC Assessment to determine the appropriate LOC.

Referral to Peer Support: two-way connection of the CBCM team to services that will provide peer support for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Peer support services are services that are provided to clients by a CRS and/or other peer support specialist, who has had a similar life experience, to assist an individual in achieving recovery goals.

Referral to Housing: two-way connection of the CBCM team to an agency/organization that will provide housing services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that the information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Housing services are services that are provided

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to a client to aid in securing housing, including long-term housing, recovery housing, or emergency housing.

Referral to SUD LOC Evaluation: two-way connection of the CBCM team to an agency/organization that will conduct a SUD LOC evaluation for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. A SUD LOC evaluation is defined as an ASAM Level of Care Assessment that assesses the appropriate level of care of each client. The LOCA should be done prior to beginning any level of care. The LOCA should be done by a provider who is trained to administer and interpret the assessment.

Referral to Transportation: two-way connection of the CBCM team to an agency/organization that will provide transportation services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Transportation services are services that are provided to the client to aid in securing transportation (e.g., MATP).

Referral to Naloxone Training and Distribution: two-way connection of the CBCM team to an agency/organization that can provide naloxone training and/or distribution services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Naloxone training and distribution is a service that is provided to a client that aims to reduce overdose risk by providing overdose reversal training and/or naloxone to the COE-engaged client.

Referral to Identification/Birth Certificates/Other Identification: two-way connection of the CBCM team to an agency/organization that can provide identification services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. These are services that are provided to a client to assist with obtaining proper identification, which is essential for accessing services, applying for jobs, and securing housing, among others.

Referral to Self-Help Meetings: two-way connection of the CBCM team to self-help meetings for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Self-help meetings are services that help support an individual in their recovery (e.g., Narcotics Anonymous, Alcoholics Anonymous).

Referral to Food Services: two-way connection of the CBCM team to an agency/organization that can provide food services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Food services are services that assist a client in obtaining food, including food pantries and emergency food kitchens (e.g., soup kitchens).

Referral to Advocacy – Adult Probation, Criminal Justice, Police: two-way connection of the CBCM team to an individual and/or agency that can provide advocacy services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Adult probation, criminal justice, and/or police advocacy is defined as an activity that provides rational and knowledgeable information that emphasizes the value of applying care management practices tailored to individual assessments, the identification of resources, the linking of services, the use of local community resources, the advising of any and all legal matters within the criminal justice system.

Referral to Advocacy- Youth Probation, Criminal Justice: two-way connection of the CBCM team to an individual and/or agency that can provide advocacy services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the

client accessed services. The recipient agency may be the COE if the COE is providing the services. Youth probation and criminal justice advocacy is defined as an activity that involves the assurance that the juvenile's rights are protected within the criminal justice system as well as the coordination of care of clinical services within and outside the community to best address the youth's specific behavioral needs.

Referral to Advocacy-Children and Youth Services: two-way connection of the CBCM team to an individual and/or agency that can provide advocacy services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Children and youth services advocacy is defined as an activity designed to coordinate services to address children's health needs, educates parents about resources available to them within their communities, and assists caregivers in navigating the healthcare system.

Referral to Job Training/Vocational Services: two-way connection of the CBCM team to an agency/organization that can provide job training/vocational services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Job training/vocational services are services that are provided to a client that increases employability and skill development to aid in long-term recovery.

Referral to Educational Services: two-way connection of the CBCM team to an agency/organization that can provide educational services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Educational services are services that are provided to a client that assists in obtaining job skills, a GED, college credits, and/or advanced degrees.

Referral to Interpreter Services: two-way connection of the CBCM team to an individual/agency that can provide interpreter services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Interpreter services are services that are provided to a client for whom English may not be their first language. These services are essential to ensuring that clients understand their treatment.

Referral to Voter Registration: two-way connection of the CBCM team to an agency/organization that can provide voter registration services for the COE-engaged client. To be a referral, there must be notification back to the CBCM team that information was received, and the client accessed services. The recipient agency may be the COE if the COE is providing the services. Voter registration services are services that assist a client to obtain voter registration, an important component in long-term recovery.

CC.9.2   Monitored Engagement Category

Monitored Engagement with Mental Health Services: documented client or client provider contact with an MH service agency that is providing services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. MH services are treatment services that are provided by a licensed professional to an individual who has a diagnosed MH disorder.

Monitored Engagement with Healthcare Services – Primary Care Physician Services: documented client or client provider contact with a primary care provider that is providing services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. Primary care physician services are defined as "care that is provided by practitioners specifically trained for and skilled in comprehensive first contact and continuing care for persons … includes health promotion, disease prevention, health maintenance,

counseling, patient education, diagnosis and treatment of acute and chronic illness in a variety of health care settings."[8]

Monitored Engagement with Healthcare Services – Smoking Cessation Services: documented client or client provider contact with a healthcare agency that is providing smoking cessation services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. Smoking cessation services are services that are provided to an individual who wishes to quit smoking tobacco. Smoking cessation services can include one or a combination of the following: tobacco cessation counseling, nicotine replacement medication, and/or non-nicotine tobacco cessation medication.[9]

Monitored Engagement with Healthcare Services – Hepatitis B, Hepatitis C, and HIV Testing: documented client or client provider contact with a healthcare agency that is providing hepatitis B, hepatitis C, and/or HIV testing or care for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. Hepatitis B, hepatitis C, and/or HIV testing services are provided to clients who may be at risk of contracting hepatitis B, hepatitis C, and HIV. These testing services can be provided by a primary care physician or a community agency with staff that are trained to administer the test and interpret results. Follow-up care for a COE-engaged client who has been diagnosed with any of the above conditions should be provided by a provider who is equipped to provide continuous treatment for clients.

Monitored Engagement with Healthcare Services – Pain Management Services: documented client or client provider contact with a healthcare agency that is providing pain management services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. Pain management services are provided by pain specialists who are trained in treating chronic pain. There are multiple modalities for pain management, including medication, which should be closely monitored by the COE and the client's primary care provider.

Monitored Engagement with Pregnancy Testing/Prenatal Care: documented client or client provider contact with a healthcare agency that is providing pregnancy-related services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. Pregnancy testing is provided to women who think they may be pregnant or in accordance with treatment requirements. Prenatal care services are provided to women who are pregnant to ensure the health of mother and baby.

Monitored Engagement with Health Insurance Benefits Coordination: documented client or client provider contact with the agency responsible for assisting the COE-engaged client in obtaining health benefits in accordance with care plan goals, at a minimum of every 30 days or until the client receives appropriate benefits. The provider may be the COE if the COE is providing the services. Health insurance benefits coordination is a service that is provided to a client to assist them to obtain benefits, including Medical Assistance or commercial insurance.

Monitored Engagement with SUD Treatment: documented client or client provider contact with an agency that is providing SUD treatment services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. SUD treatment services are services that are provided to the client at any LOC by a DDAP-licensed facility or with an approved provider of MAT services. The client should be administered the ASAM LOC Assessment to determine the appropriate LOC.

Monitored Engagement with Peer Support: documented client or client provider contact with a peer support person that is providing peer support services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. Peer support services are services that are provided to clients by a CRS and/or other

peer support specialist, who has had a similar life experience, to assist an individual in achieving recovery goals.

Monitored Engagement with Housing: documented client or client provider contact with an agency/organization that is providing housing services for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days or until the client is stably housed. The provider may be the COE if the COE is providing the services. Housing services are services that are provided to a client to aid in securing housing, including long-term housing, recovery housing, or emergency housing.

Monitored Engagement with Transportation: documented client or client provider contact with the agency responsible for assisting the COE-engaged client in obtaining transportation in accordance with care plan goals, at a minimum of every 30 days or until the client receives transportation services. The provider may be the COE if the COE is providing the services. Transportation services are services that are provided to the client to aid in securing transportation (e.g., MATP).

Monitored Engagement with Identification/Birth Certificates/Other Identification: documented client or client provider contact with the agency responsible for assisting the COE-engaged client in obtaining proper identification in accordance with care plan goals, at a minimum of every 30 days or until the client receives necessary identification. The provider may be the COE if the COE is providing the services. These are services that are provided to a client to assist with obtaining proper identification, which is essential for accessing services, applying for jobs, and securing housing, among others.

Monitored Engagement with Self-Help Meetings: documented client or client provider contact with self-help meetings that the COE-engaged client is attending in accordance with care plan goals, at a minimum of every 30 days. The provider may be the COE if the COE is providing the services. Self-help meetings are services that help support an individual in their recovery (e.g., Narcotics Anonymous, Alcoholics Anonymous).

Monitored Engagement with Food Services: documented client or client provider contact with an agency that is assisting COE-engaged clients in obtaining food in accordance with care plan goals, at a minimum of every 30 days or until the client is food secure. The provider may be the COE if the COE is providing the services. Food services are services that assist a client in obtaining food, including food pantries and emergency food kitchens (e.g., soup kitchens).

Monitored Engagement with Advocacy – Adult Probation, Criminal Justice, Police: documented client or client provider contact with an individual that is advocating for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days or until the service is no longer needed. The provider may be the COE if the COE is providing the services. Adult probation, criminal justice, and/or police advocacy is defined as an activity that provides rational and knowledgeable information that emphasizes the value of applying care management practices tailored to individual assessments, the identification of resources, the linking of services, the use of local community resources, the advising of any and all legal matters within the criminal justice system.

Monitored Engagement with Advocacy – Youth Probation, Criminal Justice: documented client or client provider contact with an individual that is advocating for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days or until the service is no longer needed. The provider may be the COE if the COE is providing the services. Youth probation and criminal justice advocacy is defined as an activity that involves the assurance that the juvenile's rights are protected within the criminal justice system as well as the coordination of care of clinical services within and outside the community to best address the youth's specific behavioral needs.

Monitored Engagement with Advocacy-Children and Youth Services: documented client or client provider contact with an individual that is advocating for the COE-engaged client in accordance with care plan goals, at a minimum of every 30 days or until the service is no longer needed. The provider may be the COE if the COE is providing the services. Children and youth services advocacy is defined

as an activity designed to coordinate services to address children's health needs, educates parents about resources available to them within their communities, and assists caregivers in navigating the healthcare system.

Monitored Engagement with Job Training/Vocational Services: documented client or client provider contact with the agency responsible for assisting the COE-engaged client in obtaining job training/vocational services in accordance with care plan goals, at a minimum of every 30 days or until the client receives the training/services desired. The provider may be the COE if the COE is providing the services. Job training/vocational services are services that are provided to a client that increases employability and skill development to aid in long-term recovery.

Monitored Engagement with Educational Services: documented client or client provider contact with the agency responsible for assisting the COE-engaged client in obtaining the necessary/desired education in accordance with care plan goals, at a minimum of every 30 days or until the client receives the training/services desired. The provider may be the COE if the COE is providing the services. Educational services are services that are provided to a client that assists in obtaining job skills, a GED, college credits, and/or advanced degrees.

CC.9.3   Transition of Care Category

Transition of Care for Mental Health Services: documented client or client provider contact with an MH agency during a transition of care/services to where monitoring engagement of services between the client and the MH agency is no longer needed. The recipient agency may be the COE if the COE is providing services. MH services are treatment services that are provided by a licensed professional to an individual who has a diagnosed MH disorder.

Transition of Care for Healthcare Services – Primary Care Physician Services: documented client or client provider contact with a primary care provider during a transition of care/services to where monitoring engagement of services between the client and the primary care provider is no longer needed. The recipient agency may be the COE if the COE is providing services. Primary care physician services are defined as "care that is provided by practitioners specifically trained for and skilled in comprehensive first contact and continuing care for persons … includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illness in a variety of health care settings."[10]

Transition of Care for Healthcare Services – Smoking Cessation Services: documented client or client provider contact with a smoking cessation provider during a transition of care/services to where monitoring engagement of services between the client and the provider is no longer needed. The recipient agency may be the COE if the COE is providing services. Smoking cessation services are services that are provided to an individual who wishes to quit smoking tobacco. Smoking cessation services can include one or a combination of the following: tobacco cessation counseling, nicotine replacement medication, and or non-nicotine tobacco cessation medication.[11]

Transition of Care for Healthcare Services – Hepatitis B, Hepatitis C, and HIV Testing: documented client or client provider contact with a provider during a transition of care/services to where monitoring engagement of services between the client and the provider is no longer needed. The recipient agency may be the COE if the COE is providing services. Hepatitis B, hepatitis C, and/or HIV testing services are provided to clients who may be at risk of contracting hepatitis B, hepatitis C, and/or HIV. These testing services can be provided by a primary care physician or a community agency with staff that are trained to administer the test and interpret results. Follow-up care for a COE-engaged client who has been diagnosed with any of the above conditions should be provided by a provider who is equipped to provide continuous treatment for clients.

Transition of Care for Healthcare Services – Pain Management Services: documented client or client provider contact with a pain management provider during a transition of care/services to where monitoring engagement of services between the client and the pain management provider is no longer

needed. The recipient agency may be the COE if the COE is providing services. Pain management services are provided by pain specialists who are trained in treating chronic pain. There are multiple modalities for pain management, including medication, which should be closely monitored by the COE and the client's primary care provider.

Transition of Care for Pregnancy Testing/Prenatal Care: documented client or client provider contact with a provider during a transition of care/services to where monitoring engagement of services between the client and the provider is no longer needed. The recipient agency may be the COE if the COE is providing services. Pregnancy testing is provided to women who think they may be pregnant or in accordance with treatment requirements. Prenatal care services are provided to women who are pregnant to improve the health of mother and baby.

Transition of Care for SUD Treatment: documented client or client provider contact with a SUD treatment provider during a transition of care/services to where monitoring engagement of services between the client and the SUD treatment provider is no longer needed. The recipient agency may be the COE if the COE is providing services. SUD treatment services are services that are provided to the client at any LOC by a DDAP-licensed facility or with an approved provider of MAT services. The client should be administered the ASAM LOC Assessment to determine the appropriate LOC.

Transition of Care for Peer Support: documented client or client provider contact with a peer support provider during a transition of care/services to where monitoring engagement of services between the client and the peer support provider is no longer needed. The recipient agency may be the COE if the COE is providing services. Peer support services are services that are provided to clients by a CRS and/or other peer support specialist, who has had a similar life experience, to assist an individual in achieving recovery goals.

Transition of Care for Housing: documented client or client provider contact with a housing agency/organization during a transition of care/services to where monitoring engagement of services between the client and the agency is no longer needed. The recipient agency may be the COE if the COE is providing services. Housing services are services that are provided to a client to aid in securing housing services, including long-term housing, recovery housing, or emergency housing.

Transition of Care for Self-Help Meetings: documented client or client provider contact with self-help meetings during a transition of care/services to where monitoring engagement of services between the client and the meeting host is no longer needed. The recipient agency may be the COE if the COE is providing services. Self-help meetings are services that help support an individual in their recovery (e.g., Narcotics Anonymous, Alcoholics Anonymous).

CC.10 Appendix 10: Fentanyl-Related Substances and Non-Prescription Synthetic Opioids

FRSs and NPSOs [1]
Acryl Fentanyl
Acetyl Fentanyl
Benzyl Fentanyl
Butyryl Fentanyl
Carfentanil
Cyclopropyl Fentanyl
Furanyl Fentanyl
Fluorobutyrylfentanyl/Fluorofentanyl
Isobutyryl Fentanyl
3-Methyl Fentanyl
4-Fluorobutyrfentanyl (4-FBF)
4-Methoxy-Butyryl Fentanyl
O-Fluorofentanyl
Methoxyacetyl Fentanyl
A-Methylbutrylfentanyl
MT-45
para-Fluorobutyrfentanyl (FBF)
Sufentanil
U47700
U-48800

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