Pennsylvania Department of Human Services

Centers of Excellence Fidelity Guidelines

August 2024

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DEPARTMENT OF HUMAN SERVICES

University of Pittsburgh School of Pharmacy

PERxU

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Acronym Guide

ACRONYM	DEFINITION
AHC	Accountable Health Communities
ASAM	American Society of Addiction Medicine
ASAM LOCA	American Society of Addiction Medicine Level of Care Assessment
BARC-10	Brief Assessment of Recovery Capital (10-question version)
BH	Behavioral Health
CBCM	Community-Based Care Management Team
CMHC	Community Mental Health Centers
COE	Centers of Excellence for Opioid Use Disorder
CMS-HRSN	Centers for Medicare & Medicaid Services Health Related Social Needs
CFRS	Certified Family Recovery Specialist
CRNP	Nurse Practitioner
CRS	Certified Recovery Specialist
C-SSRS	Columbia-Suicide Severity Rating Scale
DDAP	Department of Drug and Alcohol Programs
DHS	Department of Human Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
DWC	Discharge Without Contact
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
FQHC	Federally Qualified Health Center
GAD-7	Generalized Anxiety Disorder 7-item
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRSN	Health-Related Social Needs
IV	Intravenous
LOC	Level of Care
LOS	Length of Stay
MA	Medical Assistance
MAT	Medication Assisted Treatment
MAWD	Medical Assistance Benefits for Workers with Disabilities
MCO	Managed Care Organization
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MOUD	Medications for Opioid Use Disorder
NACHC	National Association of Community Health Centers
OBOT	Office-Based Opioid Treatment
OMAP	PA Office of Medicaid Programs
OMHSAS	PA Office of Mental Health and Substance Abuse Services
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PA	Pennsylvania
PA	Physician Assistant
PCP	Primary Care Provider
PERU	University of Pittsburgh Program Evaluation and Research Unit
PHQ-9	Nine-Item Patient Health Questionnaire
PRAPARE	Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences
PTSD	Post-Traumatic Stress Disorder
RN	Registered Nurse
ROI	Release of Information
SCA	Single County Authority
SDOH	Social Determinants of Health

SUD	Substance Use Disorder
UDS	Urine Drug Screen
VBP	Value Based Payment
WHO	Warm Handoff

Introduction to the Fidelity Guidelines

August 2024

Standard guidelines ensure that all Pennsylvania Centers of Excellence (COEs) provide consistent, evidence-based care to individuals seeking treatment for opioid use disorder. Following established guidelines helps ensure that individuals receive the most effective and up-to-date treatments, increasing the likelihood of successful recovery. Standard guidelines facilitate better coordination among healthcare providers within the COE, this coordinated approach ensures that individuals receive comprehensive and integrated care, addressing both their medical and psychosocial needs. Guidelines help streamline workflows and procedures within the Center of Excellence, leading to more efficient and effective care delivery. Consistent procedures promote staff efficiency and reduce variability in care. Establishing standard guidelines promotes client safety, care coordination, regulatory compliance, and data-driven improvement efforts, ultimately leading to better outcomes for individuals and strengthening the overall response to the opioid crisis.

The Fidelity Guidelines outline enhanced care management services offered by COEs under the state plan and therefore the scope of this document is only care management, it does not apply to other services that an organization that houses a COE may offer alongside enhanced care management, such as MOUD prescribing, substance use counseling, or mental health treatment. The implementation of the Fidelity Guidelines does not override MA Bulletin 01-20-08, 08-20-11, 11-20-02, 19-20-01, 21-20-01 and 31-20-08 or pages 6.i. and 6.j of Attachment 3.1A/3.1B to the Pennsylvania Medicaid State Plan, which continue to serve as guidance documents for COEs alongside the fidelity guidelines. Providers should consider an approach to the implementation of the Fidelity Guidelines that shows commitment to high-quality enhanced care management and supports the delivery of evidence-based practices that facilitate each community member's ability to achieve optimal health, well-being, recovery, and choice.

Begin by thoroughly reviewing and understanding the standard guidelines applicable to your COE. PERU can assist in the provision of comprehensive training to all staff members on the standard guidelines and how they should be implemented in daily practice. It is best to ensure that everyone understands their roles and responsibilities in adhering to the guidelines. Compare your COE's current policies and procedures with the standard guidelines and identify areas where adjustments or improvements are needed to align with the guidelines.[1] Please reach out to the Managed Care Organizations (MCOs) with which your COE contracts and your PERU point of contact for guidance and training.

Core Guiding Principles of the COE[2]

1. The COE will assertively engage individuals with a history of emergency department (ED) treatment episodes for opioid use; individuals with a history of inpatient or residential substance use treatment; individuals with a high risk for overdose; individuals with opioid use in addition to polysubstance use; and individuals with current intravenous drug use.
2. The COE will place primary focus on high-risk priority populations such as pregnant women, individuals recently released from incarceration, individuals with intravenous substance use, individuals with acute or chronic homelessness or housing instability, individuals with a history of opioid overdose, and Veterans.
3. The COE will induct individuals on medication for opioid use disorder (MOUD) expeditiously.
4. The COE will function as a hub and spoke program for diverse community resources and treatment options.
5. The COE will consist of care coordination that is assertive and community-based to eliminate gaps in care.
6. The COE will integrate interventions for mental health and substance use, and behavioral and physical health.

[1] See Appendix I for COE Visual Depiction
[2] See Appendix II for Rationale of the Guiding Principles

Fidelity Guidelines

COE Inclusion	
COE	The ideal client to include in the COE should: • Be 18 years and older, • Currently be enrolled or eligible for Medicaid Coverage, • Meet the criteria for an opioid use disorder (OUD) and not in sustained remission based on criteria in the current version of *the Diagnostic and Statistical Manual of Mental Disorders (DSM)* • Not currently enrolled or have been enrolled in a substance use treatment program, including but not limited to MOUD treatment, OBOT, OTP or other outpatient providers, for less than 30 days. **Exception(s)**: ○ The client has been enrolled in a MOUD program beyond 30 days but shows reasonable harm, including a recent increase in substance use (verified by >2 urine drug screens [UDS]), recent overdose or other opioid-related medical event or a treatment episode in an inpatient or residential level of care in the past 30 days (psychiatric or SUD treatment); ○ The client experiences a change or continuation of significant health-related social needs (HRSN)/social determinants of health (SDOH) needs which could impact recovery (the specific HRSN/SDOH needs to be identified in the client's chart, including what has changed that could risk the client's ability to avoid opioids); ○ The client is a transfer from another COE and continues to submit positive UDS and/or have significant HRSN/SDOH needs. *It is recommended that all clinical and HRSN/SDOH needs be documented in the client chart to indicate the necessity for enrollment into COE services. **The 30-day enrollment criteria apply to each COE individually; the clock does not start until the client enters services at your location. ***The exceptions to the inclusion criteria only apply when new COE clients are enrolled in the COE's enhanced care management services after 30+ days in SUD treatment at a facility. For guidance on discharging/transitioning enrolled clients, refer to the Discharge/Transition section.
MCO	The COE program was specifically designed for Medicaid[3] beneficiaries, if MCOs or primary contractors (PCs) would like to expand coverage and payment to non-Medicaid clients they may be permitted to do so. An additional indicator may be placed in REDCap to identify the clients not covered by Medicaid. It is recommended that MCOs verify that the COE is using the outlined inclusion criteria and a SDOH screening tool to accurately determine medical and non-medical care management needs through the submission of service descriptions. Service description submission from the COEs may be recommended by the MCOs as services may be enhanced or modified through continued quality improvement. MCOs can use claims data to assess the length of stay (LOS) of clients in a MOUD program prior to enrolling in the COE as well as claims for assessing increased risk of clients who were enrolled after 30 days in a MOUD program. Claims that show increased risk include those that indicate the client was likely to experience harm because of their opioid use disorder, such as recent inpatient or residential treatment, ED encounter or other crisis level of care provided to clients within the past 60 days before the first G-code bill is submitted. The 60-day timeframe is the denominator of analyses; MCOs are not required to collect real-time data, considering the claims lag. Thus, these instructions are for creating a cohort for analyses. BH-MCOs can monitor the LOS of clients in OTPs to limit access to those who are likely stable in standard OTP services (the same for those in an OBOT). UDS data can also be used, available to BH-MCOs and PH-MCOs, to assess clinical changes in clients leading to COE enrollment. One positive UDS should not be used, as nearly all clients in a MOUD program will have a positive UDS for illicit substances in the year

[3] This also includes clients who are covered under Medicaid for Workers with Disabilities (MAWD).

	(consider 2 to 3 consecutive positive UDS tests for enrollment or a combination of a positive UDS screen and at least one crisis service in the past 60 days). The 60-day timeframe is for the cohort analyses. Because of the claims data lag, real-time tracking of UDS patterns is not possible. BH-MCOs can see the UDS results through chart reviews while PH-MCOs can utilize claims data. MCOs will encourage the COEs to retain clients in medication management if they no longer meet case management criteria. Through chart review and/or review of COE's policies and procedures, MCOs can confirm the documentation of items related to Inclusion outlined in the Fidelity Guidelines Documentation Guidance.
Identification	
COE	Each COE will be expected to develop a documented outreach process[4] (i.e., referral arrangements with an active MOU, a formal written referral agreement, a systematic process for checking for eligible clients within specified organizations or a systematic case finding outreach process) that involves actively recruiting clients from the treatment and non-treatment communities, not just from their internal programs and referral processes (the origin or pathway needs to be documented in REDCap). Each COE will develop a process for warm handoffs (WHO) from emergency departments, crisis services (EMS, police, crisis response teams), hospitals (psychiatric & medical), residential programs, and incarceration (jails & prisons). The WHO process includes a plan for accepting new clients within 24 hours of the WHO interception. COEs will ensure that the referral sources for enrollment are documented in the client's chart as well as in REDCap. This guidance does not take the place of the DDAP funded WHO program and COEs should work in conjunction with existing WHO programs in their area when establishing warm handoff processes. Each COE has a written strategy for identifying as well as reducing disparities (e.g., racial, ethnic, cultural, language, gender) in client identification or enrollment processes[5]. Staff involved in client identification have received training in evidence-based client engagement strategies (i.e., use of Motivational Interviewing Principles) and the identification process. COE staff have up to one year to complete required training[6]. COEs should select staff training that is best for their model and staff makeup. They may reference relevant DDAP trainings as necessary. COEs should keep documentation of completed trainings in organizational training logs. *It is recommended that the COE keeps a record of outreach attempted to local organizations (e.g., SCAs, hospitals, correctional facilities, and other SUD programs) for MOUs and WHOs.

[4] See Appendix III for Sample Outreach Process
[5] See Appendix IV for Sample Written Strategy for Reducing Disparities
[6] See Appendix V for full list of staff competencies

MCO	MCOs will verify that the COE has a demonstrated outreach process that involves one or all the three processes listed (i.e., referral arrangements with an active MOU/referral agreement; systematic process for checking for eligible clients within specified organizations/ communities, and/or a systematic case finding outreach process) through the submission of service descriptions. MCOs will assist COEs in the connections to local organizations or other providers to assist in the MOU and WHO process. MCOs can review COE REDCap[7] data quarterly through PERU provided reports to track referral sources for clients enrolled with the COE and can work with the COE to identify gaps in referral/identification sources. MCOs can confirm through COE's service description that the COE has a process developed for reducing disparities, MCOs can verify that the process is used appropriately through a comparison of client claims, demographic data, and regional demographic data. MCOs can confirm through submission of training logs that the COE staff involved in client identification have been adequately trained on the identification process and evidence-based client engagement strategies. MCOs can determine when and how the information is acquired. Through chart review and/or review of COE's policies and procedures, MCOs can confirm the documentation of items related to Identification outlined in the Fidelity Guidelines Documentation Guidance.
Client Enrollment	
COE	Enrolling clients in the COE requires a formal, interactive process that cannot be automated, (i.e., assigning clients to the COE) and must include the following requirements: • All clients who are eligible for the COE ***must be*** provided with a brief description of the program (verbal or in writing) • All clients ***must sign*** a formal consent to enrollment in the COE before they can be enrolled, this consent is an acknowledgement and acceptance to receive COE services[8]. • COE consent forms should include language that indicates the COE as the client's choice of provider for COE services For WHO encounters, enrollment in the COE may be delayed until the person can understand the purpose of COE program and provides consent for COE activities (it is recommended that COEs delay enrollment until the person's readiness for treatment can be determined). COE programs are encouraged to offer rapid access to MOUD before or during the enrollment process but must not delay access to MOUD while completing the COE enrollment process; in other words, initiate buprenorphine or methadone rapidly while completing the enrollment process (a person may receive MOUD but decline the COE program). It is recommended that COE clients who consent to receive MOUD are inducted on MOUD within 24 hours of initial contact, as outlined in the MA Bulletin. • Pathways to prescribers can include but is not limited to: prescribers on the COE team that offer on-site inductions; telehealth if the COE prescriber is not on-site at the time of enrollment; telehealth prescribing by a bridge clinic; or same day referral and access to a verified COE partner prescriber. • COEs were required to outline their process for rapid MOUD induction to enroll as a COE provider. These processes should be updated in the COE service description as changes are made. Rapid access to MOUD is encouraged as a parallel process to the COE and not after these steps are completed. COE clients are not required to be on MOUD to receive COE services, MOUD is client choice. COE staff should encourage the use of MOUD as an evidence-based best practice.

[7] PERU provided REDCap report focusing on referral sources
[8] See Appendix VI for COE consent form example

After acquiring consent for COE services, the following additional steps for enrollment should be completed:

- A meeting with a COE team member, preferably face-to-face, but may occur by telehealth; this will likely be the same person acquiring the consent and providing the overview of the COE program (if during WHO, it may require more than one meeting);
    - Selection of face-to-face meeting vs. telehealth meeting should be based on client need and preference.
    - Telehealth meetings should follow organizational and PA Office of Medicaid Programs (OMAP) and Office of Mental Health and Substance Abuse Services (OMHSAS) policies.
    - Face-to-face meetings can occur in the office or in the community via mobile engagement
- Client receipt of contact information for their COE team should they need to contact them for support prior to the next scheduled appointment;
- Determine that the person resides in or is going to reside in the service catchment area and can receive care management services;
- COE-specific enrollment paperwork to include the completion of ROIs for providers in the area to allow for coordination of care and ROIs to release de-identified data to MCOs, DHS, and PERU. COEs should document in the client's chart the outreach to other COEs, MOUD, and care management providers in the area to avoid client duplication[9];
- A rapid assessment of needs following the fidelity guidelines below (can be brief to cover basic requirements including review of immediate HRSN/SDOH needs, referrals to address these immediate needs, suicide risk screening, and provision of MOUD education – more detailed data collection can be collected over days or weeks);
- If any screening tool (C-SSRS, GAD-7, etc.) was completed by staff outside the COE (an outside agency, an SUD treatment department of the facility, etc.) on the same day as COE enrollment, COE staff should obtain and review those results with the client and determine if an assessment is needed. COE staff should document in the client's chart that these screening results were reviewed and updated as needed. If clinically appropriate, the screening should be repeated at COE enrollment. A rapid care management plan which should focus on helping the person stay engaged in COE services and substance use, mental health, and/or medical treatment services– a more detailed plan can evolve over time[10].
    - A rapid care management plan is intended to reduce the risk of disengagement during the initial 30 days of COE enrollment.
    - It is recommended that COE staff focus on the highest indicated needs (e.g., transportation; housing; harm reduction).
    - It is recommended that the rapid care plan and strategies for preventing disengagement be documented in the client's intake note in their electronic record.[11]

Once these requirements have been completed, the enrollment date must be entered into REDCap – this date will begin tracking retention by PERU.

The following items must occur on the client's COE enrollment date:

1. Confirmation of COE eligibility (using inclusion criteria)
2. Completion of intake assessment(s) / screening(s) (which takes less than 120 minutes and is completed in whole)
3. Development of rapid care management plan
4. Completion of COE-specific enrollment paperwork
5. Introduction to case manager (preferably face-to-face and not telephonic or via referral)

If additional information is required, that can be assessed during a subsequent meeting, but enrollment is considered to have occurred at the completion of all the above activities during one session on one calendar day. The above must be documented in the client chart.

[9] See Appendix VII for Best Practices for Avoiding Duplication
[10] See Appendix VIII for sample rapid care plan template
[11] See Appendix IX for sample strategies for preventing disengagement.

	Every COE ensures that staff involved in the above enrollment activities have received training in conducting the activities and in evidence-based patient engagement strategies. COE staff have up to one year to complete required training. COEs should select staff training that is best for their model and staff makeup. They may reference relevant DDAP trainings as necessary. COEs should keep documentation of completed trainings in organizational training logs.
MCO	MCO can confirm through chart review that the enrollment activities have been conducted in the first visit for each client. MCO can confirm through chart review that there is an enrollment date for each client that corresponds to their rapid care management plan development. MCO can confirm through submission of training logs that the COE staff have received training on enrollment process and evidence-based engagement process. Through chart review and/or review of COE's policies and procedures, MCOs can confirm the documentation of items related to Enrollment outlined in the Fidelity Guidelines Documentation Guidance.
Client Initial Assessment	
COE	COEs should document the challenges with completing the outlined paperwork items when they are unable to meet them within the specified timeframes. If a COE prefers to complete additional items at enrollment, they may do so if the intake assessment does not exceed 120 minutes as specified above. An individualized approach should be reflected in the notes. Any COE staff person involved in client assessment must be trained in the assessment process and in evidence-based client engagement strategies. COE staff have up to one year to complete required training. COEs should select staff training that is best for their model and staff makeup. They may reference relevant DDAP trainings as necessary. COEs should keep documentation of completed trainings in organizational training logs. **Rapid Assessment of Needs[12] (to be completed for COE enrollment as specified in the enrollment section of the fidelity guidelines):** All COEs will need to provide an HRSN/SDOH assessment for immediate health-related social needs/social determinants of health needs using a validated tool.[13] Immediate needs should be assessed during enrollment, with full HRSN/SDOH assessment completed within 7 days of COE enrollment. All COEs will need to identify HRSN/SDOH needs in the client's chart and REDCap. In REDCap this can be indicated in the interactions under "Need Identified". *PA Navigate will be available in 2024 as a hub that can be utilized by COEs to place referrals and assess closed loops of service. A rapid care management plan[14] is developed (same calendar day) to decrease risk of overdose & substance using behaviors and to address immediate needs that could create barriers to consistent attendance within the first month after COE enrollment. An extended care management plan around HRSN/SDOH gaps can be implemented by the second month and updated through monthly monitoring. If substance use behaviors appear to be constant with no reduction, maintain focus on harm reduction (if appropriate to programming with which the client is involved) and reducing substance use with a focus on pressing HRSN/SDOH needs, until substance use behaviors decrease.

[12] The PERU developed and piloted High-Risk Screening can be used to rapidly assess risk and inform the rapid care plan. It is in Appendix X.
[13] Further explanation of the PRAPARE and The Accountable Health Communities Health-Related Social Needs Screening Tool (CMS-HRSN) can be found in appendices XI & XII. These resources are recommendations not requirements.
[14] See Appendix VIII for sample rapid care plan template.

	Suicide risk screening is applied by a COE staff member using the Columbia Suicide Severity Rating Scale (CSSS-RS) or other validated screening/assessment tool.[15] • A full comprehensive suicide assessment should be completed by licensed clinical staff if indicated in the screening that it is needed. • Suicide screenings should occur annually unless otherwise indicated by institutional protocols. • Screening score and follow-up screening timeframe should be documented in the client's electronic record. Medical team or trained COE staff member is available on the first day of COE enrollment to provide an overview of MOUD options to clients. The medical team or trained COE staff member does not need to be on the campus; however, all clients should have access to the medical team or trained COE staff member (e.g., telehealth) to review the MOUD options and the client's preference about MOUD on the first day of the COE enrollment. This review includes the client's concerns around stigma and MOUD. • All clinical questions regarding medication should be documented and discussed with licensed medical provider during the client's first visit with the medical team. **Within 72 hours of COE enrollment:** ASAM Level of Care assessment is applied by a trained person[16] to each client within 72 hours of their enrollment, unless an ASAM LOCA was completed within 6 months prior. It is recommended that the ASAM LOCA is reviewed and updated (if needed) by the COE during enrollment. An ASAM level of care assessment will assist the COE staff in determining the level of care the client should be referred to for substance use treatment. • If the ASAM was completed prior to COE enrollment, the date of completion should be documented in the client's electronic record. • If the ASAM was completed at an outside agency, it is recommended that an ROI be signed by the client to obtain a copy of the most recent ASAM LOCA. **Within 7 days of COE enrollment:** All COEs will need to provide an HRSN/SDOH assessment for health-related social needs/social determinants of health needs using a validated tool.[17] Clients can be assessed using a rapid HRSN/SDOH assessment at least monthly for the first two months, with the full HRSN/SDOH screening repeated and every six months thereafter while they are enrolled in the program. Care plans should be updated every six months or sooner if there is a new need identified. **Within 30 days of COE enrollment:** All clients should receive the Brief Assessment of Recovery Capital (BARC-10) in the first 30 days. BARC-10 scores must be utilized by COE staff to assist clients in building recovery capital.[18] **Optional Additional Screenings to Include within Assessment/Screening Process:** MOUD placement guide is applied by the COE medical team to each client within 48 hours of their enrollment[19].

[15] See Appendix XIII for C-SSRS suicide screening tool.
[16] See Appendix XIV for ASAM Requirements for COEs
[17] Further explanation of the PRAPARE and The Accountable Health Communities Health-Related Social Needs Screening Tool (CMS-HRSN) can be found in appendices XI & XII. These resources are recommendations not requirements.
[18] See Appendix XV for BARC-10 information.
[19] The PERU developed MOUD Guide is an instrument that assesses what type of MOUD the client should receive, more information is available in Appendix XVI.

	A client risk screening process is applied that at minimum includes placing the client into categories for more intensive to less intensive care management interventions based upon their risk for overdose. Consider using PERU's Risk Screening Instrument[20].
MCO	MCO ensures that the assessment process (including timeframes) and instruments as well as the application of evidence-based client engagement processes are applied as described. Assessment timeframes may be monitored through chart review, while application of evidence-based client engagement processes may be monitored through the submission of training logs. MCO provides feedback to COEs based on PERU provided REDCap data reports around engagement and retention within the first 90-days. Identification of factors that appear to be leading to disengagement including slow uptake of MOUD, slow uptake of care coordination, limited or no monitoring of substance use behaviors, racial disparity, or transportation/distance to the COE may be found through client chart reviews. MCOs will receive and review PERU provided REDCap reports that focus on disparities quarterly. Through chart review and/or review of COE's policies and procedures, MCOs can confirm the documentation of items related to Initial Assessment outlined in the Fidelity Guidelines Documentation Guidance.
Care Management	
COE	COE care management services may include activities such as supporting clients with reducing substance use, assisting clients in accessing or re-engaging with services, enhancing recovery capital (e.g., social support), removing deficits in HRSN/SDOH, working with family members to support the client, enrollment and/or recertification of Medicaid[21], or assessing clients' needs for the aforementioned services (e.g., a ASAM LOCA, locator form[22], or risk of disengagement). COEs are encouraged to offer a variety of visit frequencies and venues based on clients' needs, goals and preferences. An individualized approach should be reflected in care management notes and data. At least one COE care management visit each month should be 15 minutes or longer. Mobile engagement is encouraged based on client need and preference. It is recommended to follow your COE's organizational policies; but consider incorporating strategies to engage with clients in the community which could help prevent client disengagement. Clients who prefer office-based care management visits are not required to complete them in the community. However, mobile engagement is an important component of the COE program as the intention of COE is to engage individuals who do not respond to the traditional SUD system and therefore may require more proactive engagement to remain engaged in services. COEs should have a documented mobile engagement policy that indicates how they will provide this service based on need and preference of the client. Telehealth should follow organizational and PA Office of Medicaid Programs (OMAP) and Office of Mental Health and Substance Abuse Services (OMHSAS) policies. The extended care management plan (initially developed by the end of month two) should be updated every six months, or sooner if there is a new need identified. Care plans should contain the client's phase of recovery (listed below), as designated by the COE based on assessment and clinical expertise. When a new need is identified, the care plan should be updated to reflect that need if it is something the client will be working on in the long-term. Care management support for short term needs can be reflected in the EHR note but may not necessitate a care plan update if the need is addressed in one care management visit. Extended care management plans should include the client's treatment and non-treatment needs as identified on the full

[20] PERU is currently piloting and evaluating a high-risk assessment, this can be found in the Appendix X.
[21] COEs are encouraged to become Compass Community Partners which allows staff to check client's enrollment status and recertification period.
[22] See Appendix XVII for the locator form example.

HRSN/SDOH screening and goals, objectives, and/or action items to address those needs. Extended care management plans can also include client strengths and recovery specific needs and goals. Extended care management plans should contain documentation (such as signature) that the client agrees with the goals and

participated in the development of the plan. The client, the care manager, and other individuals on the CBCM team[23] (or as specified by the COE organization) should sign the initial and all subsequent care plans.[24]

Continuous Assessment is suggested based on the clients' stage of readiness and timeframe in the COE. Consider three phases for the COE, in terms of screening, with the first phase focusing on the first month, the second phase focusing on the next three months, and the third phase occurring in the fifth month, approximately (timeframes are flexible based on individuals' recovery needs).

Care management services can be provided through a stepped care approach, based on the clients' stability (i.e., clinical status) and needs. Care management services can be grouped into three phases over a period of 12 months (more time can be added), based on clinical status, including (all phases are considered guides, not mandatory timeframes):

- Engagement and stabilization of substance using behaviors (approximately the first 30 days),
- Integration of global health care issues and skills training to manage urges (months two to four), and
- Expansion of recovery capital and transition to self-management of OUD/SUD behaviors (months 5 to 12 or beyond).

Engagement & stabilization:
In the first month, the primary focus is retaining the clients in COE services and connecting to services and providers to assist in HRSN/SDOH barriers. Encourage clients to integrate family members in the program during the engagement phase and provide family members with education on the client's service options and needs (e.g., benefits of MOUD, need for long-term care). The COE can obtain ROIs for family members and/or natural supports at the time the client is agreeable to involving these individuals in their care. Any emergent medical or mental health needs[25] can also be addressed in this phase through coordination of care, such as referral for pre/post-natal care or psychiatric consultations (e.g., hospitalization for suicidal behaviors).

- Depending on the makeup of the care management team and provider type, some physical or mental health needs can be addressed on-site without referral.
- Focusing on active substance use and harm reduction behaviors during the first 30 days is critical, as COEs are intended to enroll the clients who are at the highest risk of disengagement.
- All clients should receive the Brief Assessment of Recovery Capital (BARC-10) in the first 30 days. BARC-10 scores must be utilized by COE staff to assist clients in building recovery capital. The BARC-10 should be repeated every 6 months.

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

[23] See Appendix XVIII for information ideal community-based care management team components.
[24] See Appendix XIX for best practices for care planning.
[25] See Appendix XX for Clinical Collaborations with COE Service Providers.

	If the client is receiving behavioral health or substance use treatment within your facility, it is recommended that care team meetings be conducted to ensure that all members of the client's community-based care team stay informed. Integrate family members in the clients' care management plans, as family members can help re-engage clients during this phase. Help family members see the value of MOUD as well as how to provide support. The integration of family into client's care management plans is client's choice; however, COE staff should encourage involvement. **Expansion of recovery capital, skills training, and transition to self-management:** During the third phase, focus on expanding social supports for clients, through educating family members on helping clients manage urges, family therapy to reduce stigma, and/or coaching on how to support recovery (e.g., Community Reinforcement Approach). Focus also on addressing critical healthcare needs, such as screening & treatment for HCV/HIV (if not already done in phase 2), sexually transmitted diseases, smoking cessation & medications for those who smoke cigarettes, and unmet HRSN/SDOH/recovery capital needs (e.g., education, employment, expanding social networks). The third phase is also used to identify a PCP/FQHC or OTP where clients can receive MOUD and healthcare services beyond the COE. The BARC-10 should be assessed at 6-month intervals to demonstrate recovery capital. Successful discharge includes enrolling clients in a PCP/FQHC/OTP where they can receive ongoing MOUD and health care services.
MCO	MCOs can use claims, REDCap, and pharmacy data to identify when clients are disengaging from the COE and what types and frequency of care management services are being offered. Look for discrepancies in intensity of care management services (e.g., everyone receives one contact per month) and disengagement rates. REDCap quarterly summary reports will provide comparison aggregate interaction data which can help to identify patterns of disengagement. MCOs can also provide resources/support on using a combination of stepped care for counseling/care coordination, family training, harm reduction for those who are using other substances (without a decrease in use over time), and dosing patterns to address relapse risks (e.g., increasing dosing when still using opioids or other substances). MCOs are encouraged to develop a file sharing protocol with COEs related to the enrollment and recertification of Medicaid. This will help to ensure that clients remain covered for COE and other Medicaid services. Consider VBP models that encourage rapid access to MOUD and intensive services within the first and second phases of the COE Program Offering resources/support on how to use simple monitoring tools to assess risk of substance use, suicide (how to use the Columbia scale) and symptoms of behavioral health disorders (e.g., anxiety, depression, or PTSD) Help COEs to lower burden of paperwork to complete screens or delay some assessments if clients remain difficult to engage. Help COEs to develop low-barrier protocols to provide buprenorphine or methadone even if clients struggle to engage in other SUD services or continue to use illicit substances (look for policies that remove clients from treatment for ongoing substance use). BH-MCOs should help COEs to coordinate services with SUD inpatient/residential programs and monitor the risk of disengagement due to disruptions in coordination of care between the COE and inpatient/residential providers, such as elimination of MOUD during the inpatient/residential stay or a transfer to a non-COE program upon completion of the inpatient/residential stay without coordination with the COE. MCOs can confirm, through chart review, that the COE is using a care plan that includes the client's treatment and non-treatment needs as identified on the full HRSN/SDOH screening and goals, objectives, and/or action items to address those needs and that the care plans contain documentation (such as signature)

	that the client agrees with the goals and participated in the development of the plan. The MCO may confirm that the care plan was signed by the client and the COE team member who developed it and that the care plan is updated as indicated. Through chart review and/or review of COE's policies and procedures, MCOs can confirm the documentation of items related to Care Management outlined in the Fidelity Guidelines Documentation Guidance.
Enhanced Care Management Discharge/Transition	
COE	Discharge from enhanced care management at the COE can occur for a variety of reasons, there are no specification of the lengths of time a client can receive COE services; however, if a client has completed their care management plan and/or has no new goals or significant HRSN/SDOH needs that they wish to work on the clients can be transitioned out of enhanced care management services to allow capacity for other high-risk clients. At the point of COE transition, the client should be able to navigate community-based resources independently. Clients should not be immediately discharged upon stabilization[26], clients may need less intensive support while continuing to work on goals that are set in the client's care management plan or until care management plan goals can be managed outside the COE by the client. COE staff should continue to document which care management plan goals are being worked on during each visit. Enhanced care management discharge/transition should occur if one or more of the following criteria are met: 1. Client had no contact with the program for > 60 days, and there is a record of three or more attempts to contact by the COE that includes friends or family members as well as other providers who have worked with the client in the past (e.g., residential treatment providers, community mental health centers (CMHCs), or PCPs). The date of this discharge ascertainment is as close to the 61-day window with contact attempts as possible. COE indicates the discharge date and a qualifier that this is a Discharge Without Contact (DWC). 2. Client is incarcerated and cannot be contacted for at least two months, in which case the estimated release date from jail or prison is provided or estimated, based on the sentence. COE indicates the discharge date and a qualifier that this is a "Client Incarcerated". COE will indicate in the discharge plan in the EHR the name and location where the client is incarcerated, if available. If the client can be reached, even if Medicaid cannot be billed, and will likely be released within the next two to three months, COEs should keep the client as active and indicate incarcerated status. 3. Client has completed planned COE care management services; the COE indicates the transition date and that is a successful "transition from COE services" and codes it as "Client Completed Planned COE Services". 4. Client requires more intensive care coordination, is moving, or chooses to receive services from another provider; the COE indicates the discharge date and codes it in REDCap as "Client Transferred to other COE". If the client transfers to a provider that is not a COE, the care management can be provided by their current COE. 5. Client has died. The COE indicates the discharge date (which is the date the death is known) and code the discharge reason as "Client Deceased". 6. Client has contact with the COE but declines to continue receiving COE services, code the discharge reason "Client Voluntary Discharge". COE staff should offer client rapid re-enrollment should the client wish to reengage with COE services.

[26] Stabilization indicates consistent medication adherence (MOUD), absence of opioid use, and positive supports are in place.

	COE will list in the discharge plan in the client's chart the names and locations of PCP, OTP, CMHC, peer services/recovery support and/or other treatment provider(s) who will provide ongoing care and medication to the client after they leave the COE. In addition to the providers noted above, the discharge plan should also include but is not limited to: • Last available BARC-10 score, • Current recommendations for continued care, • Referrals placed, • Documentation that client received information on how to return to the COE if needed, • Documentation that client received Naloxone/harm reduction supplies, and • Signature of the client indicating that the plan was completed in collaboration with the client, if the client was present at the time the transition/discharge is indicated. COEs should refer to the Fidelity Guidelines documentation guide for guidance on documenting their COE's discharge policy. **Note One:** Clients who no longer meet eligibility for Medical Assistance (MA) can sometimes receive funding for continued care via the relevant SCA. Thus, the COEs are strongly encouraged to understand how to access the SCAs sources of funding for clients who are not eligible for MA or other third-party payment. **Note Two:** Clients who continue to submit positive drug screens for any substance ***should not*** be discharged from the COE, unless the client requests discharge. This would fall under "Client Voluntary Discharge". **Note Three:** BARC-10 scores at discharge can show an increase or decrease in recovery capital, which could assist COE staff in the development of aftercare plans and recommendations for the client. Clients who have completed their planned COE services, or who no longer wish to be enrolled in care management/peer support services, may remain in medication management ***and/or*** primary care with the COE. This information should be placed in the client's chart.
MCO	MCOs can track the COE's client population using claims data, with gaps in claims of 61 days used to define a client as disengaged from the COE; the client population size from claims data can be compared to the REDCap report of active clients for agencies to maintain consistency in reporting discharges. The 61-day gap in claims is the timeframe for defining an individual as having disengaged from the COE, not the suggested timeframe for monitoring retention. Because of the claims lag, MCOs will not be able to assess discharge/retention in real time but can run cohort analyses within the past 12 months (e.g., six-month retention rates for all individuals who have been enrolled between the past 9 and 12 months). MCOs can also track clients who may disengage from a COE and return after 60 days to the same COE (most will return to the same COE) or initiate services with another COE (track clients that tend to cycle in and out of COE episodes as well as COEs that seem to be related to poor retention; cycling clients tend to use crisis services between COE episodes). It is suggested that MCOs consider the completion of the client's care plan goals combined with no ongoing HRSN/SDOH needs (as determined by a validated tool) as a point to suggest discharge/transition. It is not appropriate for an MCO to use standard timeframes for COE services that apply to all clients universally. Track the outcomes of clients who have been discharged successfully from the COE, when possible, to confirm the patient is still receiving MOUD and other services from a PCP, recovery support service provider or other type of service provider (e.g., CMHC, peer services, OTP). Most clients will require MOUD for several years.

	Through chart review and/or review of COE's policies and procedures, MCOs can confirm the documentation of items related to Discharge/Transition outlined in the Fidelity Guidelines Documentation Guidance.

Fidelity Guidelines Documentation Guidance

Policies and Procedures		
Guideline Location	Chart/REDCap	Details
Inclusion	Policies & Procedures	Written procedure on how COE staff check with other COE providers in the area to ensure that there is no duplication of services, including a process for obtaining ROIs for care coordination purposes.
Inclusion/Identification	Policies & Procedures	Have a documented outreach process with active MOUs, referral agreements, a systematic process for checking for eligible clients within specified organizations, or a systematic case finding outreach process for treatment and non-treatment organizations.
Identification	Policies & Procedures	Have a documented warm hand-off process from emergency departments, crisis services, jail/prison, hospitals, substance use treatment, and mental health treatment. If the COE is having difficulty with warm hand-off partners it is recommended that the COE keeps a record of outreach attempted to local organizations (e.g., SCAs, hospitals, correctional facilities, and other SUD programs) for MOUs and WHOs.
Identification/ Enrollment/Initial Assessment	Policies & Procedures	Training plans for all staff involved in identification, enrollment, and client assessment that include engagement best practices like motivational interviewing (MI), updated regularly to indicate that training was completed
Inclusion	Policies & Procedures	COE service description, with updates as applicable
Enrollment	Policies & Procedures	Program description which is meant to be client facing that explains the care management services offered, and the potential benefits of enrollment.
Identification	Policies & Procedures	A written strategy for identifying and reducing disparities (e.g., racial, ethnic, cultural, language, gender) in client enrollment processes
Enrollment	Policies & Procedures	Consent form for COE services that includes the COE as the client's choice of provider for COE services
Care Management	Policies & Procedures	Mobile engagement policy
Care Management	Policies & Procedures	Telehealth policy (if applicable)
Discharge/Transition	Policies & Procedures	Discharge/transition policy that includes: • The reasons why a client will be discharged from program that includes transfers, , incarceration, completion of services, and discharge without contact and an explanation of the reasons • The outreach efforts that must be taken prior to discharging a client for disengagement • The required resources and referrals that must be made available to a client prior to discharge and how it must be documented in the discharge note
Client Chart Documentation		
Client Profile Information: DAY ONE		
Guideline Location	Chart/REDCap	Details
Inclusion	Client chart/ REDCap	Documentation of client's age (year of birth)

Inclusion	Client chart/ DHS crosswalk	Documentation of client's MA number or documentation that the client uninsured, but MA eligible and the COE is helping the client enroll in MA- should be documented in client chart and in the quarterly COE crosswalk provided to DHS
Enrollment	Client chart/ DHS crosswalk	Documentation of client's Client ID - should be documented in client chart and in the quarterly COE crosswalk provided to DHS
Enrollment	Client chart/ REDCap	Documentation of enrollment date
Identification	Client chart/ REDCap	Documentation of client's referral source
Inclusion	Client chart	Documentation of client's OUD Dx, not in sustained remission *based on DSM-V criteria*
Inclusion	Client chart	Applicable exception to inclusion criteria (if applicable)
Client Intake Assessments/Screenings: DAY ONE		
Guideline Location	Chart/REDCap	Details
Enrollment	Client chart/ REDCap	Rapid HRSN/SDOH assessment for immediate health-related social needs/social determinants of health needs
Enrollment	Client chart/ REDCap	Suicide risk screening using a validated tool
Client Intake Note: DAY ONE		
Guideline Location	Chart/REDCap	Details
Enrollment	Client chart/ REDCap	Documentation of client's consent to receive COE services (Signed form should be in client's chart)
Enrollment	Client Chart	Documentation of client receipt of contact information for their COE team should they need to contact them for support prior to the next scheduled appointment
Enrollment	Client chart	Documentation of client receipt of an overview of the COE program
Inclusion/Enrollment	Client chart	Documentation of a discussion verifying client is not enrolled in another program that may be duplicative
Enrollment	Client chart	Documentation that the client resides in or is going to reside in the service catchment area and can receive care management services
Enrollment	Client chart	Documentation of ROIs that were signed for providers in the area and that the client acknowledges involvement with these providers that allows for coordination of care. COE should document in the client's chart the outreach to other COE, MOUD, Care Management providers in the area to avoid client duplication.
Enrollment	Client chart	Documentation that ROI was signed to release de-identified data to MCOs, DHS, and PERU
Enrollment	Client chart/ REDCap	Documentation that MOUD education was provided
Enrollment	Client chart	Documentation of the client's MOUD acceptance or refusal
Enrollment	Client chart/ REDCap	Documentation that the client met with a member of the COE CBCM team; include the team members position (Care manager; CRS etc.)
Enrollment	Client chart/ REDCap	Documentation if COE CBCM meeting occurred in-person or virtually
Enrollment	Client chart/ REDCap	Rapid care management plan that identifies immediate needs to reduce risk of overdose and reduce barriers to COE attendance
Enrollment/Initial Assessment	Client chart/ REDCap	Rapid HRSN/SDOH needs identified in the client's chart and REDCap ("need indicated")
Enrollment	Client chart/ REDCap	Documentation of referral(s) placed for any immediate needs

Enrollment	Client chart/ REDCap	Documentation that a suicide screening was completed with the client, the screening score, and the recommended follow up and referrals placed, if necessary
Initial Assessment	Client chart	Documentation that all clinical questions regarding MOUD were discussed with licensed medical provider during clients first visit with medical team (if the first visit with the medical team occurred on day one. Otherwise, document that clinical questions regarding MOUD were addressed on the date of the first visit with the medical team)
Initial Assessment	Client chart	Documentation of the challenges completing the outlined paperwork items when unable to meet them in the specified timeframes
Client Intake Assessments: Within 72 Hours of Client Intake Appointment		
Guideline Location	Chart/REDCap	Details
Initial Assessment	Client chart/ REDCap	ASAM LOCA or verification that client completed one in the last 6 months
Client Note Corresponding with 72 Hour Assessment/Screenings		
Guideline Location	Chart/REDCap	Details
Initial Assessment	Client chart/ REDCap	Documentation that the ASAM was completed, or results were received from organization that completed it within the last 6 months (with appropriate ROI)
Initial Assessment	Client chart/ REDCap	Documentation of the ASAM LOC recommended based on the assessment
Initial Assessment	Client chart	Documentation of who completed the ASAM LOCA (internal/external, position, CBCM team/other staff from organization)
Initial Assessment	Client chart	Documentation of the challenges completing the outlined paperwork items when unable to meet them in the specified timeframes
Client Intake Assessments/Screenings within 7 Days of Client Intake Appointment		
Guideline Location	Chart/REDCap	Details
Initial Assessment		Full HRSN/SDOH Screening using a validated tool
Client Note Corresponding with 7 Day Assessment/Screenings		
Guideline Location	Chart/REDCap	Details
Initial Assessment	Client chart/ REDCap	Documentation that a full HRSN/SDOH screening was completed
Initial Assessment	Client chart	Documentation of who on the CBCM team completed the HRSN/SDOH screening with the client
Initial Assessment	Client chart/ REDCap	HRSN/SDOH needs identified in the client's chart and REDCap ("need indicated")
Initial Assessment	Client chart/ REDCap	Referrals that were placed based on the HRSN/SDOH screening results identified in client's chart and in REDCap ("referral for service")
Initial Assessment	Client chart	Documentation of the challenges completing the outlined paperwork items when unable to meet them in the specified timeframes
Client Intake/Assessment/Screenings within 30 Days of Client Intake Appointment		
Guideline Location	Chart/REDCap	Details
Initial Assessment	Client chart/ REDCap	BARC-10
Client Note Corresponding with 30 Day Assessments/Screenings		
Guideline Location	Chart/REDCap	Details
Initial Assessment	Client chart/ REDCap	Documentation that the BARC-10 was completed with client and the domain scores
Initial Assessment	Client chart	Documentation of who on the CBCM team completed the BARC-10 with the client

Subsequent Care Management Notes Should Include:		
Guideline Location	Chart/REDCap	Details
Initial Assessment	Client chart/ REDCap	Documentation of repeated rapid HRSN/SDOH assessment during the first 2 months
Initial Assessment	Client chart/ REDCap	Documentation of repeated full HRSN/SDOH assessment every 6 months
Initial Assessment	Client chart/ REDCap	Documentation of care plan updates every 6 months or sooner if there is a new need identified
Care Management	Client chart/ REDCap	Documentation of the development of an expanded care management plan (completed by the end of first 2 months)
Care Management	Client chart	Documentation within the expanded care management plan (such as signature) that the client agrees with the goals and participated in the development of the plan. The client, the care manager, and other individuals on the CBCM team (or as specified by the COE organization) should sign the initial and all subsequent care plans.
Care Management	Client chart	Documentation of client's phase of recovery, with care plan goals aligned to the appropriate phase
Care Management	Client chart/ REDCap	Documentation of continuous assessment based on the client' stage of readiness and timeframe in the COE, including BARC-10 assessment every 6 months
All Client Care Management Notes Should Include:		
Guideline Location	Chart/REDCap	Details
Care Management	Client chart	Documentation of the activity that was conducted to bill the G-9012 code
Care Management	Client chart	Length of time of visit
Care Management	Client chart/ REDCap	How the visit was completed, virtual or in-person
Care Management	Client chart/ REDCap	Where it was completed, in office (and which satellite office) or in the community
Care Management	Client chart/ REDCap	Who completed the care management visit
Care Management	Client chart/ REDCap	Needs that were addressed or referrals placed
Care Management	Client chart/REDCap	The care management plan goal addressed during the visit and the referrals the client received (if client received referrals at a previous visit, best practice is to document follow up to ensure services were received. When services are confirmed as received, they should be documented in REDCap as "service performed".)
Care Management	Client chart	Next planned activities for CBCM team **AND** the client
Discharge/Transition Note Should Include the Following, if applicable:		
Guideline Location	Chart/REDCap	Details
Discharge/Transition	Client chart/ REDCap	Reason for discharge
Discharge/Transition	Client chart	Documentation of 3 or more attempts to contact the client prior to discharge, if being discharged for inactivity
Discharge/Transition	Client chart	Names and locations of providers (PCP, OTP, CMHC, other treatment providers) who will provide ongoing care
Discharge/Transition	Client chart/ REDCap	Last available barc-10 score
Discharge/Transition	Client chart	Recommendations for continued care
Discharge/Transition	Client chart/ REDCap	Referrals that were placed

Discharge/Transition	Client chart	Documentation that the client received information on how to return to COE (N/A if client disengaged prior to this
Discharge/Transition	Client chart/ REDCap	Documentation that the client received harm reduction supplies/Naloxone
Discharge/Transition	Client chart	Documentation if the client will remain engaged in medication management or primary care at the organization after discharge from the COE

Appendix I: COE Visual Depiction

The primary goal of the COE is to provide comprehensive care and support to clients with specific needs, particularly related to Medications for Opioid Use Disorder (MOUD) and Social Determinants of Health (HRSN/SDOH). Overall, the image illustrates a structured and systematic approach taken by the COE to cater to the complex needs of clients, ensuring they receive comprehensive care through a network of specialized providers and social support services.

Here's a breakdown of the steps in the workflow:

Client Referrals:
The COE receives client referrals from medical providers, community-based organizations, the justice system, and first responders. These referrals likely involve clients with complex medical and social needs.

Rapid Assessment
Within 24 hours of receiving the client referral, the COE conducts a rapid assessment of the client's condition and requirements. This quick evaluation is crucial to identify immediate needs and prioritize services accordingly.

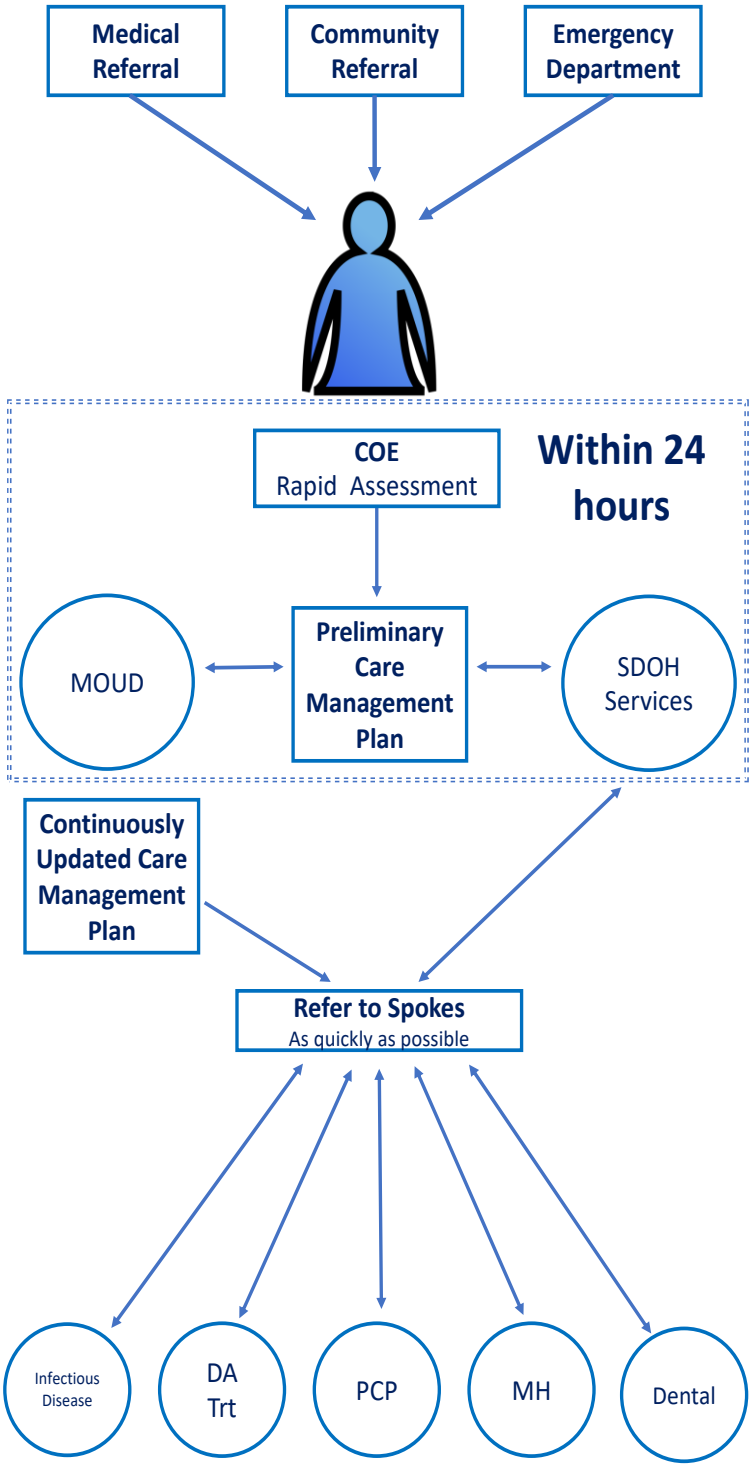
MOUD Induction
MOUD refers to Medications for Opioid Use Disorder such as Buprenorphine, Naltrexone, and Methadone. The COE assesses the client's eligibility for MOUD and, if suitable, initiates the induction process.

Preliminary Care Plan
The COE develops a preliminary care plan for the client based on the assessment results. This plan outlines the initial course of action and services needed to address the client's medical and social needs effectively.

HRSN/SDOH Services
The COE begins providing Health Related Social Needs/Social Determinants of Health (HRSN/SDOH) services to the client. HRSN/SDOH refers to the social and environmental factors that impact a person's health and well-being, such as housing, education, income, access to food, and transportation. The COE aims to address these factors to improve overall health outcomes.

Referrals to Spoke Providers
As HRSN/SDOH needs are identified, the COE places referrals to specialized providers known as "spoke providers." These providers can include Primary Care Physicians (PCPs), Drug & Alcohol (D&A) treatment centers, mental health specialists, pain management services, dental services, and infectious disease providers.

Monthly Reassessment and Referrals
On a monthly basis, the COE reassesses the client's HRSN/SDOH needs to ensure they are receiving appropriate and ongoing support. If new or changing needs are identified, the referral process to spoke providers is repeated to address those requirements.



Appendix II: COE Guiding Principles

	COE Guiding Principles	
Short title	**Core Principle**	**Rationale**
Engaging high risk individuals with an OUD	Engaging individuals with an OUD who are at high risk of an overdose, due in part to being difficult to engage in existing MOUD or other SUD services, is the overarching goal of the COE. These individuals are struggling to either engage or remain in MOUD or other SUD services, encountering crisis settings (e.g., ED, hospitals, or recent discharge from incarceration), experiencing none-fatal overdoses, and using multiple substances in addition to opioids.	The rationale behind enrolling these "hard-to-engage clients" is to ensure that those with the most complex and high-risk situations receive specialized care and support. By addressing their unique needs and challenges, the COE aims to improve health outcomes, reduce emergency department visits, prevent overdoses, and ultimately enhance the overall well-being and quality of life for these individuals.
Prioritizing high risk populations, e.g., pregnant women, incarcerated individuals, & veterans	Prioritizing high risk populations for the COE on individuals who are not benefiting from existing SUD services, including the following subpopulations: individuals who use intravenous (IV) opioids (with or without other substances), pregnant women, individuals recently discharged from incarceration, recurrent ED visits for overdose events. and military veterans. Conversely, the COE is not to be used to replicate other case management services available to those who are already enrolled in MOUD or other SUD services.	The rationale of placing a primary focus on these high-risk priority populations is so that the COE can allocate resources, expertise, and tailored interventions where they are most needed. This targeted approach aims to bridge gaps in care, reduce health disparities, and improve the overall health outcomes of these vulnerable groups. Additionally, by addressing the specific challenges faced by these populations, the COE can work towards fostering a more inclusive and compassionate healthcare system that meets the diverse needs of its clients.
Providing rapid access to MOUD	Providing rapid access to MOUD is a core feature of the COE Program, regardless of where the COE program is housed. Individuals who are eligible for the COE are provided with access to all three FDA approved medications, with an emphasis on same-day induction of agonist medications. COEs are required to bypass traditional, cumbersome enrollment protocols to expedite access to MOUD.	The rationale behind expeditiously inducting clients on medication for opioid use disorder within the COE program is centered on providing timely, evidence-based, and effective treatment that can significantly improve clients' chances of recovery, reduce the risk of complications, and promote overall well-being. Rapid induction onto MOUD can serve as a harm reduction strategy by decreasing the risk of overdose and the potential for engaging in risky behaviors associated with seeking and using illicit opioids.

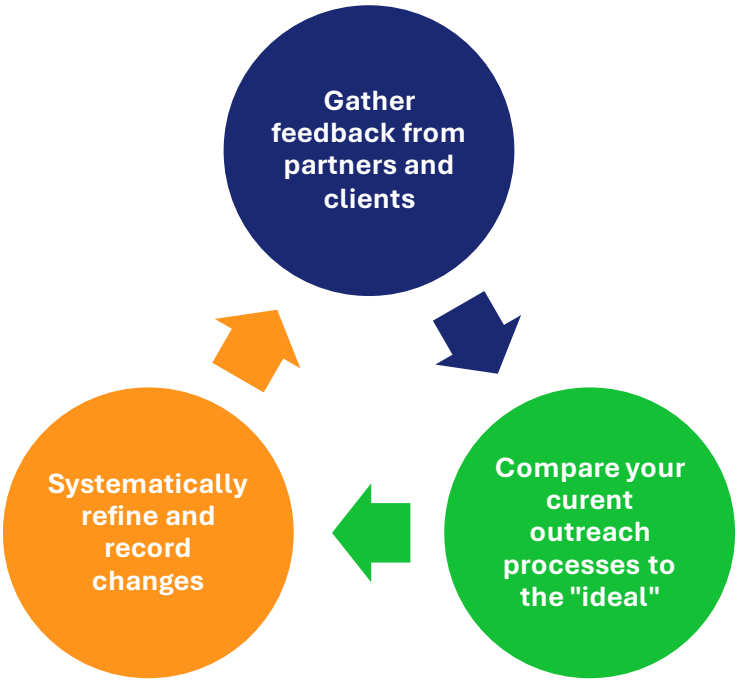
COE Guiding Principles *cont.*		
Short title	**Core Principle**	**Rationale**
The COE will function as a hub and spoke Operating COEs as hubs within a hub & spoke model program	Operating COEs as independent hubs within a hub and spoke framework serves as the core structure of the program, due mostly to expediting access to care management services and MOUD, separate from traditional SUD enrollment procedures. COEs are required to be independent, though integrated with the larger agency or organization that houses the care management team. COEs can refer individuals to all other services offered by the larger agency housing the program; however, individuals meeting the COE criteria are expected to be enrolled rapidly in the COE, prior to or in parallel to other traditional SUD services. Conversely, individuals cannot be automatically enrolled in the COE through traditional SUD services, as most of these individuals would not be eligible for the program or would need to be enrolled voluntarily to the COE program.	The rationale behind the hub and spoke model is that it allows the COE to act as a central point of coordination, providing specialized care and allocating resources efficiently. By collaborating with various spoke providers, the COE can ensure that clients receive comprehensive and tailored treatment, ultimately improving the overall effectiveness and impact of the program.
Providing assertive, community-based care management services	Providing assertive, community-based services is the primary intervention of COE care management teams. COE care managers are deployed in the community to both engage individuals needing COE services or re-engaging individuals who are struggling to remain engaged. Conversely, COEs are not to replicate office-based services already available to individuals through existing case management or counseling services. The majority of care management contacts need to occur physically in the community, including crisis settings (e.g., EDs) or through virtual contacts.	The rationale behind using an assertive and community-based care coordination model within the COE program is to ensure that clients with opioid use disorders receive comprehensive, personalized, and continuous care. This approach helps bridge gaps in care, improves treatment engagement and retention, and fosters a supportive environment that enhances the likelihood of successful recovery and overall well-being.
Integrating physical and behavioral health services	Integrating both physical and behavioral health services is the other core feature of a COE program. Individuals entering the COE program will have access to both physical and behavioral health services, regardless of how the COE is funded. COEs are required to develop active referral protocols to meet this requirement.	The rationale behind integrating behavioral and physical health within the COE program is to provide comprehensive and patient-centered care that addresses the interconnected nature of mental, emotional, and physical well-being. This approach leads to better treatment outcomes, improved client satisfaction, and a more effective healthcare system overall.

Appendix III: Sample Outreach Plan

Effective outreach is essential for engaging new clients and ensuring appropriate referral sources to address client's needs (SAMHSA, 2022). This proactive approach not only helps to build trust and foster strong community relationships but also boosts the impact of programs by reaching and supporting those who are most in need (SAMHSA, 2022). This document provides actionable recommendations for Centers of Excellence (COE) to enhance their outreach efforts.

1. **Establish Partnerships**
    a. **Identify potential partners**: Focus on organizations that engage with high-risk populations for OUD, including hospitals, primary care providers, mental health clinics, courts, probation, parole, and social determinants of health providers (e.g., food banks, harm reduction services, and housing providers) (SAMHSA, 2016).
    b. **Develop MOUs and referral agreements**: Create Memorandums of Understanding (MOUs) and formal written referral agreements with partner organizations. The agreements should detail the referral process, roles, responsibilities, and how information will be shared while complying with confidentiality laws (SAMHSA, 2022).
    c. **Engage regularly:** Conduct regular meetings with partner organizations, including potential case conferences, to ensure they understand the referral process, the services offered by the COE, and how to coordinate comprehensive care. These sessions also help identify clients appropriate for a COE referral and engage potential clients effectively (CDC, 2011).
2. **Outreach**
    a. **Community outreach teams**: Deploy outreach teams to engage directly with the community in high-risk areas, including conducting educational sessions, participating in community events, and offering on-site preliminary assessments (CDC, 2011).
    b. **Social media**: Create awareness and provide information about OUD treatment options and COE services through social media and digital platforms targeting both treatment and non-treatment communities (SAMHSA, 2022).
    c. **Educational workshops and seminars:** Organize educational workshops and seminars in collaboration with local libraries, schools, community organizations, and places of worship (Reif et al., 2020).
    d. **Partner with employers:** Work with local employers to provide information and resources about OUD to their employees (SAMHSA, 2016).
3. **Referral process**
    a. **Referral process**: Develop a system for receiving referrals from both internal and external sources. Monitor the utilization of this system and document the referral source for all clients to streamline the referral process effectively (CMS, 2016).
    b. **Timely response protocol**: Implement a structured protocol to ensure timely responses to referrals, including initial contact with potential clients. This protocol prioritizes prompt engagement and support for incoming referrals (CMS, 2016).
    c. **Follow up**: Ensure referral sources are promptly updated about missed appointments, cancellations, or instances where individuals are referred to other specialists for more appropriate care. This transparent communication strengthens collaboration and maintains continuity in patient management (CMS, 2016).
4. **Nurture Partnerships**
    a. **Engage Proactively:** Invite staff from partner organizations to actively participate in the planning of events (SAMHSA, 2016). Encourage their involvement by assigning hands-on roles during event activities.
    b. Highlight Partnerships: Showcase the invaluable contributions of your partners by describing your partnership in marketing materials and event promotions. This recognizes their efforts and strengthens your collective impact (SAMHSA, 2016).
5. **Continuous Improvement**
    a. **Feedback loops**: Establish feedback loops with clients, partner organizations, and within the COE to gather insights on the outreach and referral process (Golden et al., 2021).

b. **Adapt**: Continuously adapt outreach strategies based on feedback and data analysis. Identify successful approaches that can be scaled and new opportunities for partnership or outreach (Golden et al., 2021).



Appendix IV: Sample Written Strategies for Reducing Disparities

Background

A written strategy for reducing disparities is essential for delivering culturally responsive services. By outlining clear objectives and methods based on demographic research and organizational self-assessment, the plan serves as a blueprint for action (SAMSHA, 2014). It ensures consistent implementation, facilitates progress tracking, and enhances service delivery by evolving to meet the community's diverse needs (SAMSHA, 2014). This strategic document strengthens organizational accountability and commitment to cultural humility (SAMSHA, 2014).

Essential Components of a Written Strategy (SAMHSA, 2014)

Introduction

- Purpose: Define the aim of the strategy, highlighting the importance of equitable access and the commitment to reducing disparities in the identification and enrollment processes.
- Scope: Outline the areas of service or sectors the strategy will cover, specifying the types of disparities (racial, ethnic, cultural, language, gender, etc.) it aims to address.

Background and Rationale

- Context: Provide an overview of the current situation within your service area regarding disparities.
- Detail methods for collecting and analyzing data to identify existing disparities, including using local data sources.

Goals and Objectives

- Goals: State the goals of the strategy, such as reducing racial and ethnic health disparities within your service area and achieving health equity within the organization.
- Objectives: List specific objectives, including measurable targets for identifying and reducing disparities.
    - Break down the strategy into actionable steps with assigned responsibilities.
    - Provide a timeline for the implementation of each action item.
    - Outline the resources (financial, human, technological) required.

Monitoring, Evaluation, and Reporting

- Establish monitoring and evaluation mechanisms to track the effectiveness and health impact of implemented programs. By systematically assessing outcomes and collecting data, organizations can identify successful interventions, address shortcomings, and continuously improve strategies to advance health equity for all individuals.
- Include in your written strategy:
    - **Data:** Define indicators for measuring progress toward reducing disparities. Detail ongoing data collection and analysis plans to monitor implementation and outcomes.
    - **Reporting:** Describe how progress will be reported to stakeholders and the broader community.
    - **Feedback:** Establish mechanisms for receiving and incorporating feedback from clients and stakeholders.
    - **Review:** Outline procedures for regularly reviewing the strategy’s effectiveness and making necessary adjustments.

Appendix V: COE Staff Core Competencies

COE Care Managers

Core competencies of care management are the essential skills and capabilities that COE care managers need to effectively coordinate and provide care to clients with complex needs. These competencies enable care managers to deliver high-quality patient-centered care and achieve positive recovery outcomes.

Here are some key core competencies of care management:

Competency	**Rationale**
Assessment and Care Planning	Care managers must have the ability to conduct comprehensive assessments of clients medical, behavioral, and social needs. Based on these assessments, they develop individualized care plans that address the specific goals and requirements of each person.
Patient Advocacy	Care managers act as advocates for their clients, ensuring that their preferences, values, and concerns are heard and considered in the care planning process. They empower clients to actively participate in their care decisions and treatment options.
Care Coordination	Effective care management involves coordinating care across multiple healthcare and community providers and settings. Care managers facilitate communication and collaboration among healthcare professionals to ensure seamless transitions and continuity of care.
Health Education and Support	Care managers provide education and support to clients and their families, helping them understand their care plans, HRSN/SDOH needs, and access to community-based organizations and healthcare providers. They also assist clients in developing self-management skills to improve health outcomes.
Communication Skills	Excellent communication skills are essential for care managers to interact effectively with clients, families, and other providers. They must be able to convey information clearly and empathetically, ensuring all parties are informed and involved in the care process.
Problem-Solving and Critical Thinking	Care managers must be adept at problem-solving and critical thinking. They encounter complex situations that require quick and effective decision-making to address challenges and barriers to care.
Cultural Competency	Understanding and respecting cultural diversity is crucial in care management. Being culturally competent helps care managers provide patient-centered care that aligns with the cultural beliefs and values of clients they serve.
Care Transitions	Care managers facilitate smooth transitions between different levels of care, such as hospital to home or primary care to specialty care. This includes coordinating discharge plans, arranging follow-up appointments, and ensuring medication reconciliation.
Data Management and Documentation	Care managers need to maintain accurate and organized client records that comply with all Medicaid, state and federal, regulated documentation. Efficient data management and documentation help track patient progress, evaluate outcomes, and ensure continuity of care.
Ethical and Legal Awareness	Care managers must adhere to ethical standards and legal guidelines in healthcare. They maintain confidentiality, respect patient autonomy, and navigate complex ethical dilemmas that may arise in care management.
Quality Improvement	Continuous quality improvement is essential in care management. Care managers engage in ongoing evaluation of care processes, identify areas for improvement, and implement strategies to enhance the quality of care.

Certified Recovery Specialist

Certified Recovery Specialists (CRS) are individuals who have received specialized training and certification to provide support and assistance to clients in recovery from substance use disorder. Their peer-based approach fosters a sense of connection and understanding that can be a powerful factor in achieving successful, sustained recovery. These professionals play a vital role in helping clients achieve and maintain their recovery goals.

The core competencies of Certified Recovery Specialists typically include:

Competency	**Rationale**
Recovery Support and Coaching	CRS possess the ability to provide non-clinical support and coaching to clients in recovery. They offer encouragement, motivation, and guidance to help clients stay focused on their recovery journey.
Peer Support	CRS are individuals with lived experience in recovery themselves. They draw upon their personal experiences to offer empathetic and non-judgmental peer support, creating a connection with clients based on mutual understanding.
Advocacy	Certified Recovery Specialists act as advocates for clients in recovery, helping them navigate the healthcare system, access appropriate treatment and support services, and address any barriers or challenges they may encounter
Relapse Prevention	CRS are skilled in helping clients develop effective relapse prevention strategies. They work with clients to identify triggers and develop coping mechanisms to prevent relapse and maintain long-term recovery.
Communication Skills	Effective communication is crucial for CRS to build trust and establish a strong therapeutic alliance with clients. They must be skilled in active listening and clear communication to understand clients' needs and concerns fully.
Boundaries and Ethics	Certified Recovery Specialists are trained in maintaining professional boundaries and adhering to ethical standards in their interactions with clients. They respect confidentiality and ensure that their support remains non-clinical and focused on peer-based assistance.
Cultural Competency	CRS demonstrate cultural competency to provide support that is sensitive to the diverse needs and backgrounds of the clients they serve. They respect and honor the cultural beliefs and values of their clients.
Crisis Intervention	CRS are trained in crisis intervention techniques and are prepared to assist clients during times of acute distress or emergency situations. They can provide immediate support and link clients to appropriate resources if needed.
Goal Setting and Planning	CRS work with clients to establish recovery goals and develop personalized recovery plans. They collaborate with clients to identify strengths and resources to achieve these goals effectively.
Self-Care	CRS understand the importance of self-care to maintain their own well-being while providing support to others. They practice self-awareness and engage in self-care strategies to prevent burnout and promote resilience.

CRS Supervisors

Certified Recovery Specialist (CRS) supervisors are individuals who oversee and guide CRS professionals in their work, ensuring that they provide effective and quality support to clients in recovery from opioid use disorders. CRS supervisors have additional responsibilities that require specialized competencies to effectively lead and mentor CRS professionals.

Some core competencies of CRS supervisors include:

Competency	**Rationale**
Leadership	CRS supervisors must demonstrate strong leadership skills to effectively guide and mentor their team of CRS professionals. They provide direction, set clear expectations, and support their team in achieving their goals.
Clinical and Peer Support Knowledge	Supervisors of CRS professionals should have a thorough understanding of both clinical approaches and peer-based support strategies in the context of substance use disorder recovery. This allows them to provide valuable guidance and insight to CRS professionals as they support clients in recovery.
Supervision Techniques	CRS supervisors are skilled in providing supervision tailored to the needs of CRS professionals. They utilize different supervision techniques, such as reflective practice, case discussions, and feedback sessions, to support professional growth and development.
Program Management	Supervisors are responsible for overseeing the implementation of the CRS program. They coordinate program activities, track progress, and ensure that the program adheres to established guidelines and best practices.
Quality Assurance	CRS supervisors monitor the quality of services provided by CRS professionals. They conduct audits, evaluate performance, and provide constructive feedback to enhance the effectiveness of the CRS program.
Ethics and Boundaries	CRS supervisors' model ethical behavior and promote adherence to professional boundaries for both CRS professionals and the clients they serve. They ensure that ethical standards are upheld and guide CRS professionals in managing challenging situations appropriately.
Cultural Competency and Diversity	Supervisors understand the importance of cultural competency in providing support to clients in recovery from diverse backgrounds. They promote cultural awareness among CRS professionals and ensure that services are delivered in a culturally sensitive manner.
Professional Development	CRS supervisors support the professional growth of CRS professionals. They identify training and educational opportunities, encourage ongoing learning, and provide resources to enhance the skills and knowledge of their team.
Team Building and Collaboration	Effective CRS supervisors foster a positive team culture and encourage collaboration among CRS professionals. They promote open communication and create a supportive environment for professional growth.
Crisis Management	CRS supervisors are prepared to handle crisis situations that may arise in the course of providing support to clients in recovery. They have crisis management skills and know how to guide CRS professionals in managing such situations effectively.

Appendix VI: COE Consent Form Example to Receive COE Services

SAMPLE CONSENT FORM

<INSERT COE Name, Address, and Logo (if applicable)>

Agreement to Receive Centers of Excellence Care Management and Certified Recovery Specialist Services

As a patient interested in medication for opioid use disorder (MOUD), you may benefit from the care management program our Centers of Excellence (COE) offers to Medicaid enrollees. The services available through our COE care management program includes:

- Helping you manage concerns relating to social determinants of health (e.g., housing, transportation, food security, childcare etc.) as well as physical and behavioral health conditions.
- Making sure you can get in touch with your provider or care team 24-hours-a-day, 7-days-a-week, including by telephone, email, and telehealth.
- Seeing that you each time you come to the health center you see a regular provider or care team, whenever possible.
- Working with you to develop and continuously update a care management plan for how to best care for your health and social determinants of health needs.
- Helping you work with and coordinate care across different providers and settings, including specialists or other providers, hospitals, and emergency departments.

Your Rights

As part of the COE care management services, you will receive a copy of your care plan each time there is an update. You have the right to stop COE care management services at any time (effective the end of a calendar month). Please contact the COE at (xxx) xxx-xxxx to withdrawal your consent and discharge from the COE. A discharge plan will be completed with you at that time.

You agree and consent to the following by signing this agreement:

You consent to XXX COE providing care management and certified recovery specialist support services to you.

- You agree to allow XXX COE to bill Medicaid for these services during any month that we provide at least 20 minutes of care management and/or certified recovery support services to you.
- You agree to meet with a care manager or certified recovery specialist a minimum of one time per month to discuss and update a care plan which includes the identification of social determinant of health needs and physical/behavior health needs.
- You are aware that only one provider or hospital can provide and bill for COE care management services for you during a calendar month. Please let us know if you receive these services from any other provider during any month.
- You agree that the COE can share deidentified data to behavioral health managed care organizations, physical health organizations, the Department of Human Services, and University of Pittsburgh's Program Evaluation and Research Unit.

Patient Name:

Signature:

Date:

Appendix VII: Best Practices for Avoiding COE Service Duplication

Duplication of services occurs when multiple providers deliver the same service to a client, leading to inefficiencies and potential billing conflicts. This is problematic because it can result in fragmented care, client confusion, and wasted resources. Ensuring that services are not duplicated helps maintain streamlined, coordinated care, prevents unnecessary expenditures, and aligns with regulatory billing requirements. This resource was developed to support COEs in minimizing client duplication.

Sample Process for minimizing duplication at enrollment

1. Assess client eligibility for the COE program.
    a. Educate the client about the program and its benefits.
    b. Allow clients to opt-out if they don't want the enhanced care management the COE offers, even if the client appears to need support.
    c. Clarify to the client that COE program is separate from treatment.
2. Determine if the client is already enrolled in a COE.
    a. Ask the client if they work with a care manager (CM) or Certified Recovery Specialist (CRS) at another COE in your area.
        i. Review service titles to avoid confusion due to different program terminology.
        ii. Some common titles of COE staff include care coordinator, care manager, case coordinator, CRS, and mentor.
    b. If the client receives MOUD or is connected to other providers check to see if those locations are COEs.
    c. Check the PDMP to see what providers have worked with the client recently and determine if these locations are COEs.
3. If another COE is involved with the client:
    a. Do not automatically enroll if the client is already in another COE program.
    b. Explain to the client that they must choose a single COE provider.
    c. Respect the client's choice to stay with their current COE or switch to your COE.
    d. Obtain a Release of Information (ROI) if the client is agreeable.
        i. Work with the other COE location and determine, with the client, which services each will provide.
4. Understand that future duplication may arise. Talk with clients regularly to see if they have started any new services. If a client begins treatment with or changes their MOUD provider, be aware of the possibility of duplication and address as necessary.

Client Duplication FAQs

Q. Can COEs have contracts with both BH and PH MCOs for their COE clients?

A. According to *COE Transition to Managed Care FAQs* [1] that is allowed; ***however***, Pennsylvania Department of Human Services (DHS) encourages Centers of Excellence (COE) to select one during the application stage.

MCOs and DHS both encourage COEs to use a client choice form at intake. A client choice form is used to identify other local providers that clients may be enrolled with including other COEs, drug & alcohol counseling providers, Single County Authorities (SCAs), and/or care management services.

COEs should obtain a release of information (ROI) for all COEs in their area for care managers to confirm the client's enrollment and status.

MCOs encourage COEs to have signed consents for both physical health (PH) and behavioral health (BH) MCOs to provide effective and efficient coordination of care.

A COE may **not** bill both a PH and BH MCO for care management services rendered to the same member during the same month.

Helpful Tips

- Become familiar with the local Centers of Excellence (COEs) in your region.
- Establish Memorandums of Understanding (MOUs) with relevant providers in your area to facilitate collaboration.
- Create a comprehensive Informed Consent process to ensure client understanding and consent for services.
- Conduct a thorough review of all healthcare providers (both PH and BH) involved in an individual's care and request a signed Release of Information (ROI) to facilitate effective communication and collaboration.
- PERU can assist in the development of client choice forms, or to identify COEs in your region.

Q. How can COEs ensure that they are not billing for both BH and PH for the same client?

A. COE leadership should work with their fiscal/billing department to ensure that claims are not submitted for both PH and BH.

Helpful Tips

- PERU can send the original application and service description to COE leadership to verify which type of specialty provider they applied to be (physical health/behavioral health).
- If your COE has billed both types of managed care in the past; make the determination internally and confirm with the MCO that you will no longer bill for the G-9012 code.

Q. How can COEs ensure that they are not billing for clients who are enrolled in services at another COE?

A. COEs should obtain ROIs and outreach to the neighboring COEs to verify which organization will be continuing client enrollment. Clients will be able to choose which COE they would like to continue enrollment with based on their individual recovery needs, and the services and structure offered.

Limited and brief overlap of care (no longer than 2 consecutive months) is expected when clients are transferring COEs, finding a COE that meets their recovery needs, and/or if the client is leaving/entering residential substance use treatment.

If the COE refers out to a partner for MOUD prescribing, both parties are highly encouraged to have ROIs signed by the client for effective coordination of care and minimization of care management/certified recovery specialist (CRS) service duplication.

COEs should develop and maintain positive working relationships with the SCAs in their region. There are multiple SCAs in the Commonwealth that also function as COEs. Coordination and collaboration of care management and American Society of Addiction Medicine Level of Care Assessment (ASAM LOCA) are essential to ensure multiple providers are not submitting G-9012 claims for the same member.

Helpful Tips

- It is recommended that COEs develop a "Consent to Treatment" for each COE client, as this may help to identify which services are offered at your COE to assist clients in deciding which COE best meets their recovery needs.
- PERU can assist in the development of a "Consent to Treatment" form.
- PERU can also send your original application and service description to COE leadership to identify which services to include in your "Consent to Treatment" form.

Q. What other services may be duplicative of the G-9012 billing code?

A. The following are services considered to be duplicative of COE care management services rendered using the G9012 procedure code:

- Drug and Alcohol (D&A) Level of Care Assessment

- Alcohol and/or other drug abuse (sic) service, not otherwise specified (D&A other requires service description approved by the Office of Mental Health and Substance Abuse Services (OMHSAS))
- Alcohol and/or drug services: case management (D&A Intensive Case Management)
- Alcohol and/or drug services case management (D&A Resource Coordinator) CRS services being provided by another outside agency

Helpful Tip

Client choice and consent to treatment forms could help mitigate this risk by ensuring that the client is aware of the services they are being provided at your COE.

Q. What parameters have been developed for COEs to follow when engaging/enrolling clients that are currently in residential substance use treatment, or inpatient hospital stays for physical health concerns?

A. Coordinate with the MCO to which you will be submitting COE care management claims prior to proceeding, as guidance on how to proceed may differ.

Integrating COE services while the client is in residential and/or inpatient can be beneficial in keeping these clients consistently engaged as they transition back into the community.

Helpful Tip

ROIs and MOUs with residential and hospital-based providers will be essential for this collaborative care and warm hand-off.

Appendix VIII: Sample Rapid Care Plan Template

A rapid care management plan which should focus on helping the person stay engaged in COE services and substance use, mental health, and/or medical treatment services– a more detailed plan can evolve over time. A rapid care management plan is intended to reduce the risk of disengagement during the initial 30 days of COE enrollment.

Immediate need #1 (e.g. housing, harm reduction, or transportation)

Resources provided onsite:

Referral(s) placed:

Immediate need #2 (e.g. housing, harm reduction, or transportation)

Resources provided onsite:

Referral(s) placed:

Immediate need #3 (e.g. housing, harm reduction, or transportation)

Resources provided onsite:

Referral(s) placed:

Immediate need #4 (e.g. housing, harm reduction, or transportation)

Resources provided onsite:

Referral(s) placed:

Strategies for preventing disengagement:

See Fidelity Guideline Appendix IX for additional information about strategies for preventing disengagement.

The rapid care management plan can be documented in the intake note in the client's electronic health record as stated in the Enrollment section of the fidelity guidelines.

Appendix IX: Sample Strategies for Preventing Disengagement

COEs should complete rapid care management plans for each client at COE enrollment, which are intended to reduce the risk of disengagement during the initial 30 days of COE enrollment. These plans are important to increase client engagement with the COE and ensure they can return to care to move forward with their recovery journey. Rapid care management plans should include referrals and resources provided to address the highest indicated HRSN/SDOH needs. These needs should be determined through the rapid assessment of needs, which COEs administer at enrollment. COEs should include strategies for preventing disengagement in the rapid care management plan.

Examples of strategies for preventing disengagement include:

- Communicating clearly with the client on how the enhanced care management offered by the COE will support them in their recovery journey. Consider developing an elevator speech about how care management can be tailored throughout their time in the COE program so they understand how their needs will continue to be addressed by the CBCM team.
- Communicating the scope of the COE program to the client on day one, including an explanation of the suggested frequency of visits with the CBCM team and the COE's outreach strategy should the client not be able to be reached for future visits.
- Completing a client locator form to ensure the COE has multiple ways to contact the client if one method is unsuccessful. Consider recording multiple avenues of contact such as phone, e-mail, text, or in-person outreach.
- Ensuring the client has contact information for their CBCM team should a need arise prior to their next scheduled visit. Consider a direct phone number as opposed to a general number for the COE organization and let the client know the hours that the CBCM team will be responsive at this number.
- Ensuring the client's immediate needs are addressed on day one, so they understand how the COE can help them and have a desire to return for future visits.
    - This includes immediate needs determined by the COE and the needs with which the client requests support on day one.
    - If immediate needs cannot be addressed on day one (ex: long housing wait lists), consider educating the client on how the CBCM team can start the process of addressing their needs during the first visit and how they will continue to follow up on these needs during care management visits.
    - Confirm the client has transportation to return for future visits.
- Building rapport with the client on day one so they feel they have a personal connection with their CBCM team. Participants with more robust social networks have greater treatment engagement (Schweitzer, et al., 2024). So, until a social network can be built in the community, the CBCM team can provide social support to the client.
    - Consider offering support from a certified recovery specialist on day one to connect to ensure social support from an individual with lived experience.
    - Members of the CBCM team should provide a welcoming, non-stigmatizing, individualized care management environment that offers multiple recovery pathways.
- Rapidly connecting clients with MOUD (if the client chooses to receive MOUD). Rapid induction improves engagement (Roy, et al., 2020) and client's ability to work on their treatment plans (Timko, et al., 2023). CBCM teams should ensure that clients are connected with one of the pathways to prescribers cited within the fidelity guidelines during their first care management visit.
- Individualizing the suggested timeframe for clients' second appointment. Clients at higher risk for disengagement may need to be seen within a shorter period after their initial visit. Consider using PERU's risk screening tool to assess risk.
- Communicate the next appointment date to the client.
    - If the COE offers walk-in appointments or "drop in" periods for clients to see the CBCM team, let them know how they can access the CBCM team without an appointment.
    - If the COE provides appointment reminders, let the client know when they will receive these.
    - Explain the importance of returning to see the CBCM team and that rescheduling missed appointments is welcomed.

Appendix X: High Risk Screening

Assessing the risk of overdose at intake to substance use treatment is of paramount importance for several reasons:

1. Safety of the Individual: The primary concern in any substance use treatment program is the safety and well-being of the individual seeking help. Assessing the risk of overdose allows treatment providers to identify individuals who may be at immediate risk and implement appropriate interventions to prevent overdose.

2. Tailored Treatment Planning: Understanding the risk of overdose helps treatment providers tailor the treatment plan to meet the individual's specific needs. For example, individuals at high risk of overdose may require closer monitoring, more intensive interventions, or specialized services such as medication-assisted treatment (MAT) to address opioid use disorder.

3. Prevention of Fatalities: Overdose is a leading cause of death among individuals with substance use disorders. By assessing the risk of overdose at intake, treatment providers can intervene early to prevent potentially fatal outcomes. This may involve providing education on overdose prevention, distributing naloxone (an opioid overdose reversal medication), or referring individuals to services that can help reduce their risk, such as supervised consumption sites.

4. Identification of Co-occurring Disorders: Substance use disorders often co-occur with other mental health conditions, such as depression, anxiety, or post-traumatic stress disorder (PTSD). These co-occurring disorders can increase the risk of overdose due to factors such as self-medication or impaired judgment. Assessing the risk of overdose at intake allows treatment providers to screen for and address any co-occurring disorders that may contribute to overdose risk.

5. Continuum of Care: Assessing overdose risk at intake is not a one-time event but rather an ongoing process throughout the course of treatment. By continually reassessing overdose risk, treatment providers can adapt the treatment plan as needed to ensure the individual receives the appropriate level of care and support.

In summary, assessing the risk of overdose at intake to substance use treatment is essential for ensuring the safety of individuals seeking help, tailoring treatment plans to meet their specific needs, preventing fatalities, identifying co-occurring disorders, and providing a continuum of care to support long-term recovery.

PERU has developed a screening tool that can be used at intake, this assessment follows through several domains that include:

a. Overdose History,
b. Social Determinant of Health Needs,
c. Substance Use History,
d. Mental Health,
e. Veteran Status, and
f. Pregnancy.

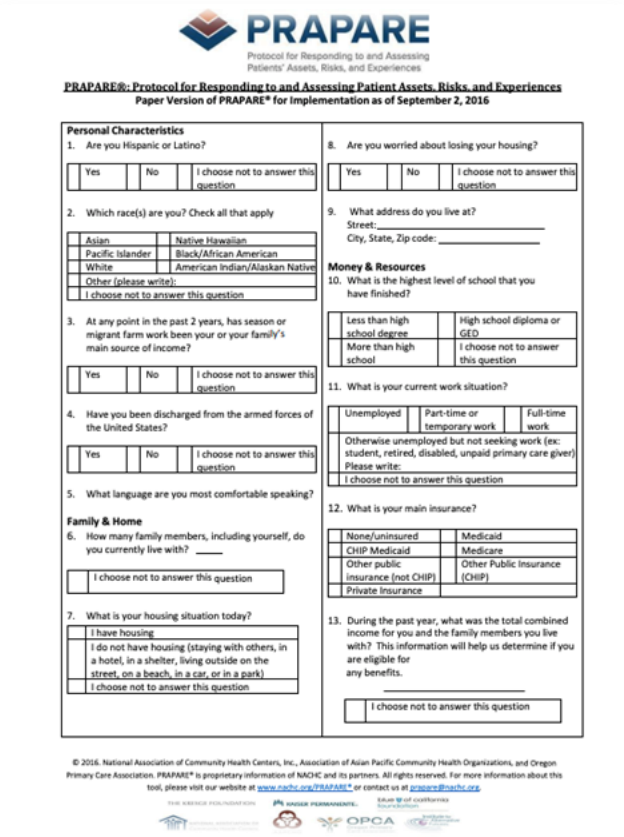
Appendix XI: Social Determinant of Health Assessment: PRAPARE

The PRAPARE (Protocol for Responding to and Assessing Individuals' Assets, Risks, and Experiences) tool is a widely used standardized assessment tool designed to collect essential data on health-related social needs/social determinants of health (HRSN/SDOH) from individuals in healthcare settings. It helps healthcare providers and organizations gain a better understanding of their individuals' social needs, enabling them to provide more comprehensive and patient-centered care. The PRAPARE tool was developed by the National Association of Community Health Centers (NACHC), in collaboration with other partners, to address health disparities and improve health equity.

The PRAPARE tool consists of a series of questions that cover key areas related to HRSN/SDOH, including:

1. **Demographic Information**: This includes questions about the patient's age, race, ethnicity, and primary language spoken.

2. **Socioeconomic Status**: Questions related to the patient's employment status, income, housing situation, and access to transportation are included to understand their financial stability and potential barriers to healthcare access.



PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?
   Yes | No | I choose not to answer this question
2. Which race(s) are you? Check all that apply
   Asian | Native Hawaiian
   Pacific Islander | Black/African American
   White | American Indian/Alaskan Native
   Other (please write):
   I choose not to answer this question
3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?
   Yes | No | I choose not to answer this question
4. Have you been discharged from the armed forces of the United States?
   Yes | No | I choose not to answer this question
5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? ____
   I choose not to answer this question
7. What is your housing situation today?
   I have housing
   I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
   I choose not to answer this question
8. Are you worried about losing your housing?
   Yes | No | I choose not to answer this question
9. What address do you live at?
   Street:_____
   City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?
    Less than high school degree | High school diploma or GED
    More than high school | I choose not to answer this question
11. What is your current work situation?
    Unemployed | Part-time or temporary work | Full-time work
    Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)
    Please write:
    I choose not to answer this question
12. What is your main insurance?
    None/uninsured | Medicaid
    CHIP Medicaid | Medicare
    Other public insurance (not CHIP) | Other Public Insurance (CHIP)
    Private Insurance
13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.
    _____
    I choose not to answer this question

3. **Health Insurance**: The tool collects information about the patient's health insurance coverage, including Medicaid, Medicare, private insurance, or lack of insurance.

4. **Social Support**: Individuals are asked about their social support networks, such as family, friends, and community resources that can contribute to their well-being.

5. **Education**: The tool assesses the patient's educational background and potential impact on health literacy and understanding of healthcare information.

6. **Family and Household Composition**: Individuals are asked about the composition of their households, including the number of family members and dependents.

7. **Housing**: The tool inquires about the patient's housing stability, such as homelessness, unsafe or unstable housing, or concerns about housing affordability.

8. **Food Insecurity**: The tool includes questions about the patient's access to sufficient and nutritious food.

9. **Employment**: Questions related to employment status, job security, and workplace safety are included.

10. **Stress and Mental Health**: The tool assesses the patient's emotional well-being, stress levels, and any history of mental health concerns.

By gathering this information, healthcare providers can identify individuals who may be at higher risk due to social factors and provide targeted interventions to address their specific needs. The data collected using the PRAPARE tool can inform care plans, resource allocation, and community partnerships to improve health outcomes and promote health equity among individuals from diverse backgrounds. Moreover, aggregating data across patient populations can help identify patterns and trends related to social determinants of health, guiding broader public health initiatives and advocacy efforts.

Appendix XII: Social Determinant of Health Assessment: The Accountable Health Communities Health-Related Social Needs Screening Tool (CMS-HRSN)

The Accountable Health Communities Health-Related Social Needs Screening Tool (CMS-HRSN) is a standardized assessment tool used by healthcare providers and organizations participating in the Centers for Medicare & Medicaid Services' (CMS) Accountable Health Communities (AHC) Model. The AHC Model is a community-based initiative aimed at addressing health-related social needs (HRSNs) to improve health outcomes.

The CMS-HRSN tool is designed to identify and assess the various health-related social needs that individuals may be experiencing. These social needs are often referred to as health-related social needs/social determinants of health (HRSN/SDOH) and can significantly impact an individual's overall health and well-being. The tool aims to identify these needs and connect individuals with appropriate community resources and services that can help address them.

The CMS-HRSN tool typically covers the following domains of health-related social needs:

1. **Housing Instability**: This includes assessing the patient's housing situation, such as homelessness, inadequate or unsafe housing, or concerns about housing affordability.

2. **Food Insecurity**: The tool includes questions to determine if the patient has consistent access to sufficient and nutritious food.

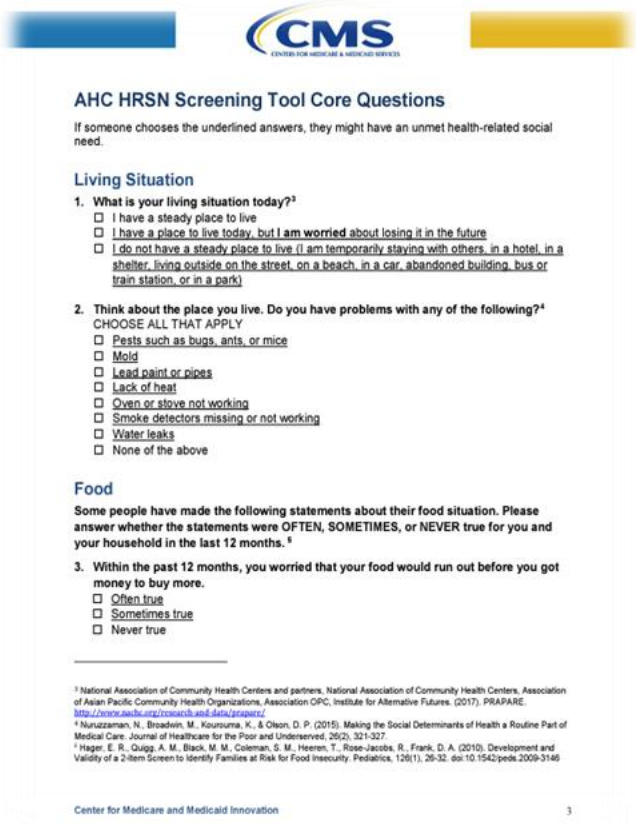
3. **Utility Needs**: This domain assesses whether the patient faces challenges in accessing or affording utilities like electricity, heating, or cooling.

4. **Interpersonal Violence**: The tool addresses potential exposure to interpersonal violence or unsafe environments.

5. **Transportation:** Individuals are asked about their access to reliable transportation to reach medical appointments and other essential services.

6. **Legal Needs**: This domain identifies any legal concerns or barriers that may impact the patient's health or well-being.

7. **Education**: The tool includes questions about the patient's educational background, which can impact their understanding of health information and self-care.



AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. What is your living situation today?[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but I **am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following?[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

[3] National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/
[4] Nunuzzaman, N., Broadwin, M., Kounsuma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.
[5] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

Center for Medicare and Medicaid Innovation 3

8. **Employment**: This domain assesses employment status and any employment-related issues, such as job security or workplace safety.

9. **Social Isolation**: The tool identifies any social isolation or lack of social support experienced by the patient.

Healthcare providers can use the information gathered from the screening to tailor care plans and interventions that address the specific social needs of their individuals. Additionally, the data collected using the CMS-HRSN tool is used to track patient outcomes, evaluate the impact of interventions, and inform community partnerships to address social determinants of health more effectively.

Appendix XIII: Columbia Suicide Severity Rating Scale (C-SSRS)

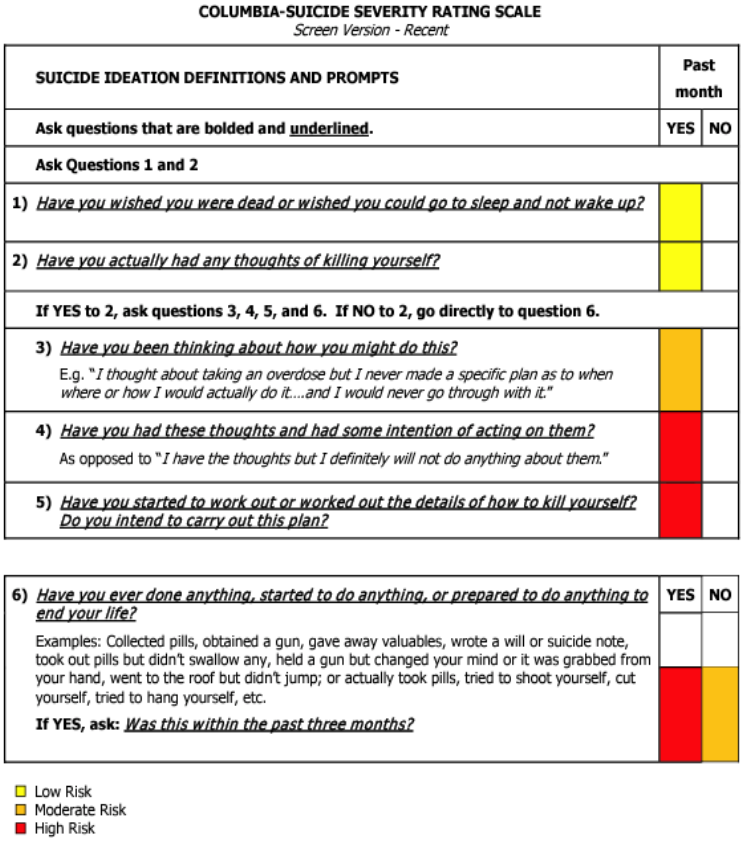
The Columbia-Suicide Severity Rating Scale (C-SSRS) is a widely used and evidence-based tool for assessing suicidal ideation and behavior. It was developed by researchers at Columbia University to provide a standardized and comprehensive method for evaluating suicide risk across different populations and settings. It consists of a series of structured questions that focus on various aspects of suicidal ideation and behavior. The tool is typically administered through an interview format, but there are also self-report versions available for individuals to complete on their own. The C-SSRS assesses suicidal ideation along a continuum, ranging from mild thoughts of suicide to more severe and concrete plans or attempts.

It consists of the following components:

1. **Suicidal Ideation Severity Scale**: This section evaluates the frequency, intensity, and duration of suicidal thoughts over the past month. It assesses the presence of passive suicidal thoughts (e.g., "wish to be dead") and active suicidal thoughts (e.g., "wish to kill oneself") and categorizes them based on severity.

2. **Suicidal Behavior Scale**: This component assesses suicidal behaviors, including preparatory acts, interrupted attempts, and completed attempts. It helps determine the level of risk and whether the individual has taken any steps towards carrying out a suicide plan.

3. **Reasons for Living Scale:** In contrast to assessing suicidal ideation and behavior, this section identifies protective factors and reasons for living. It explores factors that may serve as a buffer against suicide risk, such as family support, coping skills, and future goals.



COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** *Was this within the past three months?*	**YES**	**NO**

Low Risk
Moderate Risk
High Risk

The C-SSRS provides a systematic way to evaluate suicide risk, enabling clinicians to identify individuals at risk for suicide, initiate appropriate interventions, and monitor changes in risk over time. It helps differentiate between various levels of suicidal ideation and behavior, allowing for a more targeted and individualized approach to treatment and support.

Due to its reliability and validity, the C-SSRS is widely used in clinical settings, research studies, and suicide prevention efforts. It helps to improve the identification of at-risk individuals and facilitate early intervention, ultimately contributing to reducing suicide rates and providing support to those in need.

Appendix XIV: ASAM Requirements for COEs

Centers of Excellence designated by the Department of Human Services, will not be required to be licensed by the Department of Drug and Alcohol Programs in order to complete the LOCA. The LOCA must be completed by an individual who meets the qualifications and minimum experience and training requirements identified in Part 5.08 of DDAP's Case Management & Clinical Services Manual or who is a licensed individual trained in administering LOCAs. The minimum experience and training requirements for the applicable classifications are as follows:

- **D&A Case Management Specialist Trainee:** A Bachelor's Degree in Chemical Dependency, Sociology, Social Welfare, Psychology, Nursing or a related field; OR a Bachelor's Degree which includes or is supplemented by successful completion of 18 college credits in sociology, social welfare, psychology, criminal justice or other related social sciences; OR an equivalent combination of experience and training.

- **D&A Treatment Specialist Trainee:** One year of experience as a Social Worker; OR a bachelor's degree that includes 18 college credits in the behavioral sciences; OR certification by the PA Chemical Abuse Certification Board as a "Certified Addictions Counselor"; OR a master's degree with major course work in addictions science, psychology or social work; OR an equivalent combination of experience and training which includes 18 college credits in the behavioral sciences.

A CRS may not complete LOCAs. A CRS may complete a screening, as defined in Part 5.01 of DDAP's Case Management & Clinical Services Manual, but a trained Case Manager or Counselor must complete the assessment. If a CRS has the required training and meets the minimum education and training as a Case Manager or Counselor, they should be acting in the role of a Case Manager rather than the role a CRS.

- **Additional ASAM resources include:** ASAM National Practice Guideline for the Treatment of Opioid Use Disorder – 2020 Focused Update

- ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: Pocket Guide

BARC-10						
ID/Name			Date:			
	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 if 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						
*Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card						

Appendix XV: Brief Assessment of Recovery Capital (BARC-10)

The Brief Assessment of Recovery Capital (BARC-10) is a self-report tool used to assess an individual's recovery capital, which refers to the internal and external resources that support an individual's ability to initiate and sustain recovery from substance use disorders. The BARC-10 is a relatively brief and easy-to-administer questionnaire that can be used by healthcare providers, counselors, researchers, and others working in the field of substance use and recovery.

The BARC-10 consists of ten items, and respondents rate each item on a 5-point scale, indicating the extent to which they agree or disagree with each statement. The items cover various domains related to recovery capital, including personal, social, and environmental factors that can influence an individual's recovery journey.

Some of the domains assessed by the BARC-10 include:

1. Abstinence-Specific Recovery Support: This domain assesses the extent to which individuals feel supported in their efforts to maintain abstinence from substance use.

2. General Social Support: The BARC-10 evaluates the level of social support individuals receive from friends, family, and other social networks.

3. Goal and Success Orientation: This domain explores the individual's ability to set recovery-related goals and their confidence in achieving those goals.

4. Peer Support: The tool assesses the extent to which individuals have supportive relationships with peers who are also in recovery.

5. Spirituality: This domain evaluates the role of spirituality or a sense of purpose in an individual's recovery journey.

6. Family Support: The BARC-10 examines the level of support received from family members and the family's understanding of recovery.

7. Global Drug or Alcohol Use: This item assesses the extent of an individual's substance use.

The BARC-10 provides a quantitative measure of an individual's recovery capital and can be useful in treatment planning, assessing progress in recovery, and identifying areas where additional support may be needed. It helps treatment providers tailor interventions and support services to address the specific needs and strengths of each individual, ultimately enhancing their chances of achieving sustained recovery.

Appendix XVI: Medication for Opioid Use Disorder (MOUD) Guide

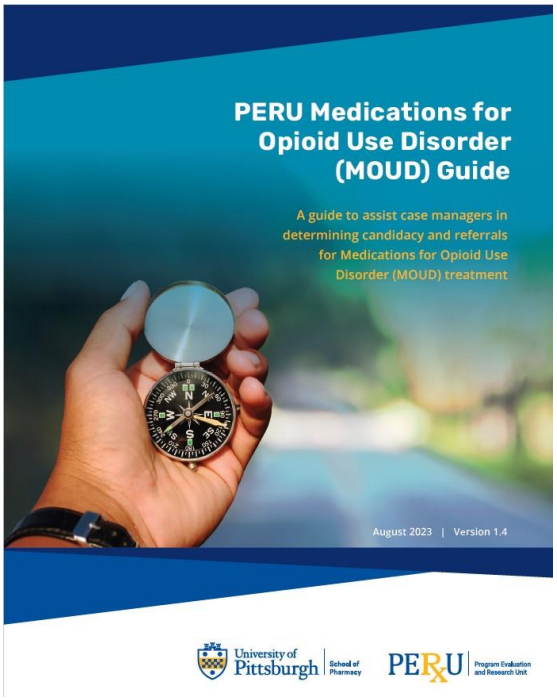
Purpose: to increase client retention by increasing the number of clients who have medications for opioid use disorder (MOUD) matched to their clinical needs.

The aim of incorporating the MOUD Guide within the COE initial assessment process is to tailor specific MOUD and dosages to each client's clinical needs whether the COE offers that MOUD on-site or not. The three types of MOUD included in the guide are methadone, buprenorphine, and naltrexone. If one of these medications is not provided on-site, COEs are expected to refer clients through a warm handoff to a nearby provider that does offer it. There is significant evidence that when clients do receive the most appropriate MOUD, retention with the medication is improved. (Greiner et al, 2021; Wakeman et al, 2020)

The PERU Medications for Opioid Use Disorder Treatment Guide is a tool to help case managers determine potential substance use disorder (SUD) treatment options for a client, including determining outpatient MOUD treatment candidacy, identifying the most appropriate MOUD treatment for the patient, and selecting the MOUD treatment provider/facility best suited to meet the patient's unique needs. It was developed for adults (≥18 years old) who meet the criteria for American Society of Addiction Medicine (ASAM) levels 1, 2.1, and 2.5 outpatient treatment, Users of this guide should note that it is not meant for adolescents (<18 years old) or those who require a higher level of care.

Steps within MOUD Guide implementation include:

1. Assess the need for immediate intervention
2. Administer the *What I Want from Treatment Questionnaire* to assess preferences
3. Review the sections of the LOC to complete the *PERU MOUD Guide*
4. Complete the *PERU MOUD Guide: Section I* with the individual to determine if MOUD is recommended
5. Complete the *PERU MOUD Guide: Section II* with the individual to determine the MOUD medication
6. Complete the *PERU MOUD Guide: Section III* to determine the MOUD provider/facility
7. Develop and review the service plan
8. Refer individual to MOUD provider via facilitated warm handoff



PERU has implementation plans and training available to assist COEs in incorporating the MOUD Guide into current enrollment processes. Technical Assistance providers can support COEs who are interested in using the MOUD guide through linking them with additional resources and training.

Appendix XVII: COE Client Locator Form

Client Locator Form

Purpose

The purpose of this form is to assist the provider in the collection of information to reach out for general appointment reminders, connections to internal and external services, and/or to assist in reengagement of care.

General Contact Information

Name (First, Middle Initial, Last):	
Nickname or Preferred Name:	
Date of Birth:	
SSN:	
Preferred Phone #:	
☐Home ☐Work ☐Cell ☐ Other:	
Secondary Phone #:	
☐Home ☐Work ☐Cell ☐ Other:	
Emergency Contact Name:	**Phone #:**
Relationship:	

Home Environment

Primary Address:		
City:	**State:**	**Zip:**
☐House ☐Apartment ☐Recover Residence ☐Hotel ☐Other:		
Does anyone else live with you: ☐ Yes ☐ No		
Name:	**Relationship:**	**Phone #:**
Name:	**Relationship:**	**Phone #:**
Name:	**Relationship:**	**Phone #:**
Name:	**Relationship:**	**Phone #:**
How often do you stay at the identified residence? ☐ Every night ☐ 3-5 times a week ☐ 1-3 times a week ☐ Less than 4 times a month		
How long have you been at this address? ☐ 0-6 months ☐ 7-12 months ☐ 1-3 years ☐ Longer than 3 years		

If less than 12 months, please list previous addresses:

Address:		
City:	**State:**	**Zip:**

Address:		
City:	**State:**	**Zip:**

If experiencing homelessness, unstable housing, or concerns over losing housing, please identify other places you would stay overnight:
Would you like immediate assistance in securing housing: ☐Yes ☐No ☐Unsure at this time

Personal Contacts
Please identify at least 4 reliable individuals who could help locate you, that do not reside at the same address

Name:
Relationship:
Address:
Phone #:
Release of Information Signed: ☐Yes ☐No

Name:
Relationship:
Address:
Phone #:
Release of Information Signed: ☐Yes ☐No

Name:

Relationship:
Address:
Phone #:
Release of Information Signed: ☐Yes ☐ No

Name:
Relationship:
Address:
Phone #:
Release of Information Signed: ☐ Yes ☐ No

Community Supports

Is there a case worker, counselor, physician, community clinic, or other contact that you see regularly?

☐ Case worker ☐ Counselor ☐ Physician ☐ Community Clinic
☐ Other:

Name:
Address:
Phone #:
Release of Information Signed: ☐ Yes ☐ No

☐ Case worker ☐ Counselor ☐ Physician ☐ Community Clinic
☐ Other:

Name:
Address:
Phone #:
Release of Information Signed: ☐ Yes ☐ No

Are you currently on probation, parole, or have active court cases?

☐ Probation ☐ Parole ☐ Active Court Cases
☐ Next probation/parole/court date:

Probation/Parole County:
Probation/Parole Officer Name:
Probation/Parole Officer Phone #:
Release of Information Signed: ☐ Yes ☐ No

Are there any places you go regularly to hang out or meet up with friends?

Name:
Address:
Phone #:
Times you may be there:

Prior to enrolling in treatment, where would you most often use? If you do not know the address, please identify the city/town/neighborhood and restaurants/businesses nearby
If you were to return to use, would these be the same places you would go? ☐ Yes ☐ No ☐ Unsure
Other places you may go if you return to use:

Appendix XVIII: Ideal Community-Based Care Management Team Components

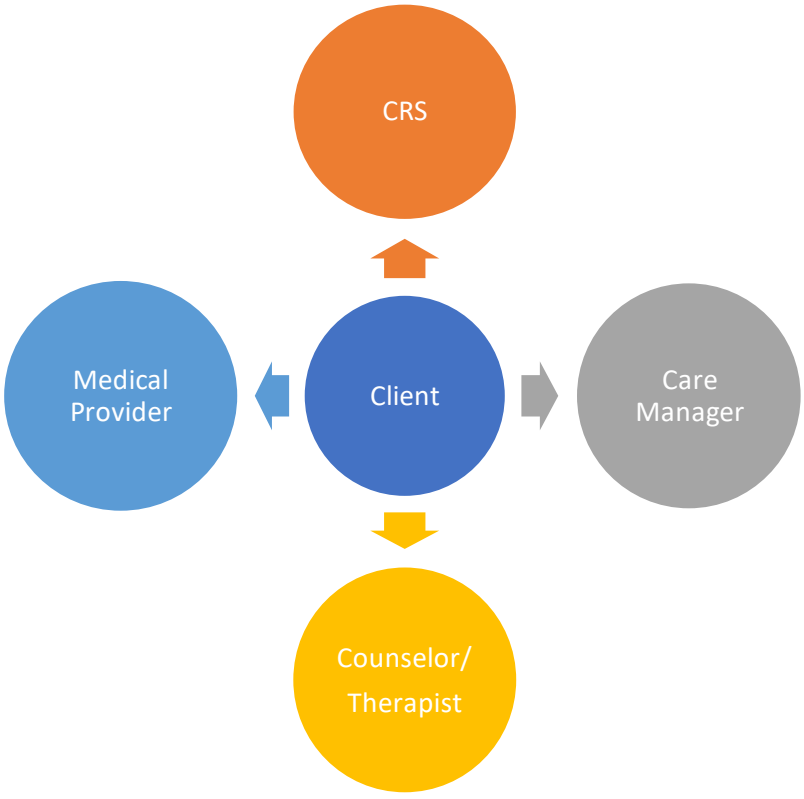
The COE program was designed to provide low-barrier care to individuals with an opioid use disorder in Pennsylvania. Due to the wide variation in population density, available resources, and geographic landscape, there was a need for programs that could adapt to the communities they were in.

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. The CBCM team should be adaptive, inclusive, culturally competent, and pragmatically client-focused.

According to the MA Bulletin, originally released July 1, 2020, "COEs use a blend of licensed and unlicensed, clinical and non-clinical staff to coordinate the care needs of an individual to ensure that their treatment and non-treatment needs are met". The MA Bulletin also states "Employing a community-based care management team, which must include a Certified Recovery Specialist credentialed by the Pennsylvania Certification Board, and may include peer navigators, nurses, social workers, and other provider types. The COE must employ sufficient staff to effectively manage their predicted caseloads."

That leads us to the main question, "What is the IDEAL Community-Based Care Management Model?"

Because of the varied COE models across Pennsylvania, it is expected that COEs will naturally have different staffing structures to best meet the needs of the population they serve. However, the ideal COE model allows all clients access to a variety of licensed and unlicensed providers based on their individual recovery needs. Ideally, a COE's care management team would not be made up of only one type of staff member. Not every client will need or want to work one-on-one with each member of the COE's CBCM team, but every client should have access to medical providers, care management staff, Certified Recovery Specialists (CRS), and counselors if their recovery needs and preferences align with the responsibilities of these staff. Refer to the table, *Typical Roles and Responsibilities of COE Community-based Care Management Team Members* for more information about role specification for CBCM team members.



Composition of COE CBCM teams may vary between providers based on their model and the number of clients served. Each COE should have a staffing model that is adequate to provide the covered COE services. Any member of the CBCM team may deliver covered COE services, but the members of the team should possess the qualifications necessary for the tasks they are being asked to perform. COEs may refer to the DDAP Case Management and Clinical Services Manual for a better understanding of staff qualifications, but this manual is to serve as a resource, not a COE requirement.

The "COE" should be defined as the department responsible for the COE enhanced care management services, rather than referring to the larger organization that houses the COE. This COE department includes members of the CBCM team who provide the covered

services. Additionally, depending on the service description, it may also include other licensed or unlicensed providers who regularly collaborate with the CBCM team to coordinate client needs but who do not provide covered services such as MOUD prescribers, counselors/therapists, or other personnel outlined in the COE's service description. The number of staff and staff titles who provide covered services were outlined in each COE's service description at the time a provider enrolled as a COE. COE staff can perform covered COE services in addition to other services offered by their organization if their staffing structure is adequate to provide those covered services. COEs should ensure their service description accurately depicts their COE's CBCM team through documentation of staff changes as they occur. COEs should ensure that they are not duplicating services within their organization.

In addition to ensuring clients have access to a variety of staff to adequately meet their recovery needs, COE's community-based care management teams should engage in regular interprofessional collaboration and not use a model where team members are singlehandedly addressing all a client's concerns. Interprofessional collaboration is "a type of interprofessional work involving various health and social care professionals who come together regularly to solve problems, provide services and enhance health outcomes." (Committee on Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes, Board on Global Health, & Institute of Medicine, 2015).

An important note about interprofessional collaboration relates to the requirement of each COE to employ a CRS. COEs who do not have a CRS employed by their organization may contract their CRS services. However, COEs with CRS contracts in place are expected to develop regular feedback loops between their onsite community-based care management team and the CRSs at the contract agency. This means that contracts and/or MOUs for CRS services should include regular meetings between contracted the CRSs and the other members of the COE's community-based care management team (care managers, counselors, and/or medical providers) so that the COE's onsite staff are aware of peer support needs met by the contracted agency and can address any care management, mental health, or medical needs that the client may have discussed with the contracted CRS that are better met by other members of the community-based care management team. Since they are considered a member of the CBCM team, payment for contacted CRS services should be considered part of the covered services for which a COE receives reimbursement.
For more information about interprofessional collaboration at COEs, review the recording of the COE learning network, Team Based Decision Making for COE Effectiveness.

Typical Roles and Responsibilities of COE Community-based Care Management Team Members

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."

MOUD Provider/Medical Team Member
• **Physician**
• **Nurse Practitioner (CRNP)**
• **Physician Assistant (PA)**
• **Registered Nurse (RN)**
	• Provides SUD treatment services, including, but not limited to, MOUD such as buprenorphine
	• Depending on COE setting, the medical team member may:
	  • Facilitate access to infectious disease screenings (HIV, hepatitis, etc.)
	  • Provide wound care recommendations
	  • Assess need for mental health/behavioral health services
	  • Provide feedback and/or referrals regarding other medical needs
	  • Providing MOUD Education
		• 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.

Appendix XIX: Best Practices for Care Planning

Developing care plans is a core activity of COE care management services. There are key considerations for the care planning process and standard components of care plans that are important to include. A care plan can lead to reduction in lengths of stay, improved quality of care and client satisfaction, better allocation of resources and coordination of services, and improved communication systems among the various disciplines (Tahan, 2002).

Care Planning Considerations

Care planning addresses the full range of an individual's needs: health, personal, social, economic, educational, and mental health while considering an individual's unique circumstances (e.g. ethnic and cultural background, housing situation, welfare benefits, access to care and stage of change) (Ross, et al., 2011; Mancini, 2012).

- Care planning includes several key elements:
    - Identification and discussion of needs and problems caused by or related to opioid use disorder (OUD) This should include the review of all formal assessments completed (Center for Substance Abuse Treatment, 2006)
    - Decision making about what treatment and non-treatment services the client needs or wants (Coulter, et al., 2015)
    - Location of where services will be provided (Center for Substance Abuse Treatment, 2006)
    - Identification of who will monitor the individual's progress (Center for Substance Abuse Treatment, 2006)
    - Outlining how services will be coordinated (Center for Substance Abuse Treatment, 2006)
- Clients should be involved in care planning (Coulter, et al., 2015)
    - Shared decision making considers both the expertise of the individual and the team members.
    - There should be a shared understanding of the individual's needs, goals and outcomes.
    - The individual's values and concerns should shape the way their OUD is managed.

Key Elements of the Care Plan Document

A care plan is a client-centered document designed to facilitate communication among members of the care team with the client (AHRQ, nd).

- Multiple purposes of a care plan
    - Identifies goals in all relevant life domains, using the strengths, needs and wants articulated during the assessment process (SAMHSA, 2015)
    - Includes jointly agreed upon goals and actions for managing the client's health problems (Coulter, et al., 2015)
    - Identifies the opportunities for collaboration with internal and external services, family, and friends (Case Management Society of America, 2016)
    - Enables the care manager to make referrals, coordinate the services, and monitor the individual's progress (Ross, et al., 2011)
- Key elements of a care plan (Pennsylvania Department of Human Services, 2021)
    - Should be individualized to each unique client.
    - The client should lead the discussion and identification of problems or needs to be addressed (e.g. shared decision making).
    - Include identified strengths connected to the client's goals
- Components that should exist in each care plan
    - **Goal:** the intended outcome that is determined thought assessment and care planning (SAMHSA, nd). The care plan should have client identified measurable goals (Case Management Society of America, 2016)

    - **Objective:** a step to be achieved in progress toward the identified goal. Each goal should have measurable objectives with time frames to achieve them. (SAMHSA, 2015)
    - **Interventions:** actions or steps that will be taken by the CBCM team to assist the client in achieving objectives toward overall goal completion (Tahan, 2002).
- Care planning best practices to consider:
    - Incorporation of the client's strengths and areas of prior success helps inform the care management interventions (Center for Substance Abuse Treatment, 2006)
    - Consideration of the individual's readiness to change when determining appropriate treatment and/or support interventions (Case Management Society of America, 2016)
    - All team members have input into the care plan, ongoing access to it, and update it as needed (AHRQ, nd)
    - Inclusion of the individual's family and or other supports to maximize the potential for achieving goals (Case Management Society of America, 2016)

Example Care Plan Goal, Objectives & Interventions

Goal: Within the next 3 months, improve my ability to manage cravings and reduce opioid use through personalized coping strategies as evidenced by daily self-report.

Objective 1: Develop a relapse prevention plan with clear strategies and steps to take when facing high-risk situations or triggers (within 1 month)

Intervention: CRS will provide a relapse prevention plan template and coach client on completing it.

Objective 2: Find a method that works for me to track cravings and coping strategies (within 2 weeks)

Intervention: Care manager will provide and review options of tracking cravings and coping strategies. CRS will review pros and cons of methods.

Objective 3: Track cravings and coping strategies 5 out of 7 days per week for the next 2 months

Intervention: Care manager and/or CRS will check-in with the client weekly to remind them to track. CRS will discuss coping strategies with client and identify which are most effective.

Making Goals Measurable (SAMHSA, nd)

	Attribute	**Content**
S	Specific	What exactly is to be accomplished?
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 review the goal of how it would be determined if the goal were met?
A	Attainable	It's realistic for the client to achieve the goal. It is 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	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."

Appendix XX: Principles for Developing Clinical Collaborations with COE Partners

Principles for Developing Clinical Collaborations with COE Service Providers

PERU

June 20, 2023

For each type of service, determine the desired and likely frequency the average COE enrolled individual will need to access the service. The following are issues for consideration in determining the number of individuals who will need to be effectively connected with services such as mental health, primary care, MOUD, dental care, gynecologic/obstetrical care, pediatric care:

a. What are the projected average numbers of individuals who will need these services at the frequencies recommended by the US Preventative Services Task Force (i.e., yearly, semi-annually, monthly, weekly, daily)?
b. From this projected average number[27] and contact frequency determine the range in number of available service providers needed to meet the anticipate individuals' needs.
c. Determine if issues such as type of third-party payer accepted, accessibility, and receptivity to COE client population would require an even larger pool of potential service providers.

Approach potential service providers ensuring that they are in areas convenient to the enrollees, will accept their third-party payment, and are willing to take the enrollee on as a client. In approaching these providers develop clear expectations for how frequently they will be asked to take on a client and what they can expect regarding how the client's access will be managed and monitored by the COE. Ensure that written materials are provided that explain the COE program in a clear concise manner.

For some service providers such as MOUD, mental health, primary care, and obstetrical care service providers it is recommended that a collaborative referral agreement be executed between the COE and the service providers that permits, with appropriately applied enrollee consent, the sharing of basic information such as service access dates. These agreements provide vital information to the COE care management service functionalities that permit it to ensure that the enrollees are consistently accessing the services they may require.

The COE should consistently survey their enrollees to determine the reasons why they are not accessing services to which they have been referred and from this ascertain whether it should expand its list of collaborating service providers. The REDCap data reports will also assist in identifying gaps in service access for COE enrollees.

[27] Considerations such as to what proportion of individuals already have a suitable service provider should also be taken into account in determining the number of service providers to which a referral agreement is needed.

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