**Department of Health and Mental Hygiene**

**Behavioral Health Administration**

**Opioid Treatment Program (OTP) Quality Improvement Workgroup**

**Minutes for July 26thth, 2016**

Attendees: K.Rebbert-Franklin, BHA; C. Trenton, BHA; L. Burns-Heffner, BHA; B. Page, BHA; BHA; M. Donohue, BHA; F. Dyson, BHA; Elaine Hall MA; J. Adams; M. Aghevli; H. Ashkin; M. Currens; J. Formicola; D. Madden; A. Mlinarchik; Y. Olsen; J. Severn; R. Smith; K. Stoller; M. Viggiani; V. Walters; C. Watson; A. Winepol

On Phone: J. Sperlein; J. Pyles, DHMH

1. Welcome and Approval of Draft Minutes from June 28th meeting. One correction was sent and provided to the group prior to the meeting. Correction was reviewed and accepted, no other comments or edits were made, and minutes stand as corrected.
2. Continued review of Draft Criteria for **New and Existing Program Criteria related to Management of Large Volume of Patients** document

BHA added a paragraph regarding a statement in TIP 43 re balancing the need for individual consequences and the overall good of the OTP. Kathy suggested this be added to the material provided in the Guidance Documents. The group agreed with suggestion.

*Diversion control*-

* Requests made to change the language in the grid from “…including progressive discipline, intervention and fair hearing” to “as guided by senior clinical and medical review” and to change the word “consequences” to “intervention”.
* A question arose as to the rationale for why we would want to soften the language?
* Responses included, if speaking to something internal, would want to ensure there is gathering of individual information and review, may be just an appearance or info may have come second or third hand. Words like discipline, consequences aren’t in line with a disease model. Responses should be therapeutic but discharge is definitely a possibility.
* Discussion on definition of diversion, expanding to include inappropriate use of medication such as taking half dose, inappropriate handling, storage of meds, etc.
* General consensus that the statement would keep everything through consequences, then add “as guided by senior clinical and medical review” as long as there is an expectation of something happening.
* BHA requested examples of policy & procedures to address this issue. (Will obtain P&Ps previously provided to Larry Stevens at BHA.) Suggestion that BHA make a diversion control generic P&P to add to guidance documents, positive in its approach.
* Suggestion was made to add in another section related to diversion control with the concept of inappropriate use of medications. Decision was made to discuss in quality of care part of standards, including other types of inappropriate behavior related to medication.

*Problem resolution*-

* Language used is consistent with Federal Standards and accreditation expectations, addition of the LAA is key.
* Mediation is new concept-identified as best practice by the mayors report. It’s complicated though, is it binding, what are parameters?

**Some background context was given by BHA**-

BHA has received community complaints regarding 10 of 77 total OTPs in State. All 10 are in the City. There were two in another jurisdiction in the past, but not recently. Given this context, what kind of special activities could we have for the LAA in the jurisdiction with programs having the vast majority of complaints? This warrants further discussion with the Baltimore City LAA, specific to their problems. Actions may not apply to all the other jurisdictions, so we need to be careful how we phrase this so it doesn’t adversely impact areas without problems.

* It may be useful to have a statewide swat team to be used as consultants, team made of state reps, LAA & a consumer?
* How are criteria to be enforced? We have BHA/LAA team for each as some are generic; some are very specific to location. Partnerships with community, public safety must happen. Exa. given by Ryan for quarterly meetings with community reps & LAA
* Funding is a consideration for mediation. Must be part of the conversation, don’t know how much it would cost, basically, a third party could be helpful, may not be necessary.
* One program pays 10k per month for security as a result of request made during problem resolution. Who would pay for mediation? Another program paying that much as well.
* Comments and discussion about unbundling process not covering overhead like lights, cameras, security, etc. Huge line items in budget would not be paid for by MA if not being paid just one weekly rate. Request made for clarification re how is rate developed and how often? 2% increase in July. Last increase prior to that was 1/10. OTPs have weighed in; still have opportunity for community members to weigh in. All businesses in certain neighborhoods are expected to light premises, but they have a different way to recoup costs. Report of perception of some headway on additional funding before MA proposes another rate.

BHA asked for review and suggestions for input into guidance documents to be provided via email off line.

**Regarding method of enforcement of criteria:**

* BHA requested consensus that the method of enforcement would be provided by BHA/LAA. There was full consensus and no further discussion on this point.

Collective sigh of release that we are halfway done.

*Patient Flow Management-Post treatment*

One member requested revisiting this section, suggesting we add in a standard for the absence of significant loitering-post treatment, more than just having a policy and procedure. This led to a lengthy discussion on the wording for this standard. Concepts expressed included:

* BHA clarified that grid is for new and existing programs, the guidance document is items to put together to help them implement what they are to do.
* Suggest “free of significant loitering in general vicinity of program”. Can’t specify exact numbers, but there needs to be a statement that indicates a mechanism for monitoring this. Can’t put all the expectation on the program, it’s a public safety issue as well. Disagreement on that is just the program’s issue but agreement on OTP being responsible for the facility.
* Discussion regarding expectation of “Facility is free of individuals waiting outside of building for services upon observation” in Patient Flow Management-Before Service section as to whether that meant before program opened, or after. Suggestion and agreement to add “in line from time program opens” to statement.
* Getting a group together around the vicinity is key, not just pushing patients out of clinic boundaries. Need to link this issue to next part of the project. Quality of care with what they are receiving inside will tie with why they are staying. BHA/LAA needs to really deal with quality inside, not just checks off boxes. If there isn’t a way for people to connect inside, they will make connections outside. Quality part is how you intervene with specific issues.
* Reports by accrediting committees and BHA can be useful.
* What happens if an improvement plan is not put in place? May not be able to state consequences, but a clear standard should be put in place. Important issue for stigma, etc.
* Mark Parino’s statement re loitering was read. Security staff identified patients and told program staff.
* OTP programs need to have stuff for their patients. Not just be a gas n go program.
* There needs to be some onus on programs to make an active effort to push people away from the program. From community perspective, need to show that you are doing all you can to help the problem. Extending therapeutic aspect to expectations goes a long way. Biggest request that public safety folks have is to tell people to go home, so they can separate “wheat from chaff” (who is supposed to be somewhere, and who is there to do bad things).
* The OTPs can’t solve the problem by themselves. Creative things happening inside OTP can help get message across. Patient specific vs population focus.
* Need to look at specific site issues as well, like is there a bus stop at program site, etc.
* Many people don’t have a home to go to; program is refuge, social support. Alternatives are less warming, need outside partners.
* Need to be very careful with our expectations for public sites like grocery stores. Worry that this is a code for we just don’t want you here.
* Guys hang out at VA and smoke, and that is ok.
* Understand that people see the program as safe place, challenge is when stepping out door is not safe, and there is a need to protect the patient from the environment, when staying is putting self at risk.
* Concern that use of word significant is not objective. It will be different at each place. BHA likes the term problematic instead. Would rather error on side of program self-regulation. Not just the presence of people, but the behavior. Perception of a problem will remain gray.
* Agreed that it’s the behavior, not always the volume.
* There was a request to use both words “significant” and “problematic”. Not just complaint driven, it’s individualized.
* Discussion on whether we need both words, disagreement that “problematic” includes significant. A problem can be identified by internal or external sources.
* Patients and programs need to take responsibility together.
* Take homes tend to be a big issue.
* Responsibility lies within individual program to manage, then spheres moving out of public safety and LAA /BHA. When reaches outer spheres, then may need mediation. Change order to LAA prior to public safety. If interventions move patients further out then the community comes in place.
* Volume makes a difference even when individual behavior is not a problem. Volume is a problem.
* Final show of hands regarding just using “problem” as it supersedes “significant”. All but two members agreed.

**BHA Reviewed what we will be discussing in the next meeting**:

-Geo-mapping project

-Letter to LAA re Overall Work Plan and revised Role of LAA as it relates to meeting with OTPs re placement

-Letter to OTPs re above

* Concern expressed by a LAA that we can’t tell people where they can or can’t site based on ADA, just make suggestions.
* Suggestion that there are provisions in both the ADA and Section 504 of the Rehabilitation Act that would allow for restrictions on treatment facility siting (that would otherwise be deemed facially discriminatory) if they are in the interest of the affected class.
1. Assign Tasks for Next Meeting

BHA requested policy and procedures on patient flow management and interventions.

1. Next Meeting: August 30, 2016 @ 1:00 Dix Building

Remaining Meeting Dates (all @ 1:00pm):

September 27th, 2016

October 25th, 2016

November 22nd, 2016

December 20th. 2016