Department of Health and Mental Hygiene
Behavioral Health Administration
Opioid Treatment Program (OTP) Quality Improvement Workgroup

Minutes for October 25th, 2016

Attendees: K. Rebbert-Franklin, BHA; L. Burns-Heffner, BHA; M. Donohue, BHA; F. Dyson, BHA; L. Fassett, BHA; B. Page, BHA; E. Hall, MA; H. Ashkin; M. Currens; S. Drennan; J. Formicola; C. Halpin; Y. Israel; D. Madden; A. Mlinarchik; J. Severn; K. Stoller; B. Wahl; A.Winepol

On Phone: Geoff Ott, SEC
Guests: Audrey Chase & Kristen Forseth, BHA

1. Welcome and Approval of Draft Minutes from October 18th meeting.

   - Minor changes were requested and made re standardizing the word Beacon.
   - Regarding grid- add improvements to PDMP technology under PDMP implementation considerations
   - Add funding to areas as pertinent as implementation considerations

2. Finish work on Overall Quality Standards, complete suggested criteria and methods for monitoring for remaining areas.

   Discharge-

   - A question was raised regarding origin of "time frame of 30 days of less" where it came from, COMAR? Detox? Old smart? Believe it is in reference to a statement re completing an administrative discharge within 30 days of the start of withdrawal process. Not in Beacon, may be in conditions of award. Decision made to strike reference to timeframe of 30 days or less.
   - A question was raised as to whether we need to reference current COMAR language or statute in these standards? Standards are meant to augment regulations, therefore, no need to reference them throughout.
   - In general programs indicated dislike of administrative discharge, with mandatory withdrawal. Most prefer to transfer to a more appropriate setting; most stated that administrative withdrawals are very infrequent.
   - Comment agreeing and stating that cutting people off can be life and death. It is very important to look for an alternative.
   - A question was raised clarifying rules re % reduction in dose per day allowed, and indicating it is physically dangerous with high relapse rates if not done properly.
   - Another clarification was made regarding mandatory discharge for missing 3 days of doses. COMAR states "may" discharge, not must. Program has permission to

discharge after 3 days, can be implemented as policy, may not be the best policy, and should be based on wider clinical consideration.

- Payment is not the most important issue for HD, not likely to discharge before 30 days.
- Suggest going by ASAM criteria, as not using a slot efficiently could also lead to death for someone on waiting list.
- A gold standard would be the use of an administrative protocol for withdrawal to include **fair warning, reversible nature**, etc.
- Add “based on established process and protocol which is reviewed by a medical supervisor” to statement. **Elements of a desirable discharge protocol include review by clinical team, warnings, transfers, re-admission considerations.**
- All discharge **decisions should be made by treatment team**, there is a fine balance re fee payments, and need to pay counselors as well.
- Some situations are such that person can’t return the next day, but can facilitate next day transfers-guest dosing is a 30 day or less.
- Can we say “offer” instead of “shall transfer” for last statement.
- Front desk staff must be trained to defer decision to clinical staff.
- Some programs do a good job of letting people know their rights, important to have patient orientation to go over all information. Discharge information should be included in enrollment package for new patients, reviewed around a week after, not when patient is ill. Not effective during induction stage.
- Suggest **Orientation group** within 7 days of first dose, with handbook, rights and responsibilities, discharge rules. Make sure the patient understands the language, terminology, clarify 1-1 or in group (will get sample protocol for this).
- Suggest we add statement in engagement section to include orientation that explains program once patient is “stable”.
- Retention has improved based on establishment of protocol re orientation – Program willing to share protocol with group-aim is to increase engagement.
- Statement made that it means a lot that this standard area and criteria (discharge) has been included as it was peer driven.
- Suggest add to desirable protocol list above “When a patient is transferring from one program to another, clinicians from the two programs **conduct a warm handoff in order to discuss the patient’s recent clinical status and issues of** concern.” Add, “whenever possible”.
- What about diversion issue? Does that need to be part of this? Diversion was addressed in first set of criteria but would also come under admin discharge issue.
- There is not a universal right or wrong, **all situations are handled case by case**, and circumstance should be reviewed individually, hard to make any generalized statements.
- There is a reason for word “may”. Each setting has different considerations.
- **For protocol language** – would also suggest adding testing for pregnancy, overdose education, prescription of narcan or kit.
- **Suggest having peer with MAR experience give support during discharge as part of elements of a good protocol.**
- Also **Connect with recovery supports** along with referrals.

3. Discussion on Guidance Documents and Next Steps.

   Through this process, BHA has attempted to address concerns expressed by community. BHA appreciates everyone's input and involvement; this was a fully complimentary process. This has been quite a process; we have accomplished something significant, and are on a path to making programs more responsive, and communities more understanding. We appreciate everyone's willingness to cooperate in these sessions.

   - Do we envision TA sessions?
   - We need to formulate a plan as to how this is disseminated with others not in the room. Guidance documents, examples from programs in the room are key. Maybe webinars, trainings, not sure what best mechanism are.
   - Suggest workshops, peer to peer trainings, using people who were in the room during the discussions. Who better to learn from than those who were part of the process?
   - Offer was made to organize a panel of persons with lived experience for legislative hearings, bills to negate. Peers make a huge difference, will be part of the 2017 legislative workgroup, programs really need that support.
   - Need voices from all concerned, variety drives good decision making.
   - From the community perspective there is unfinished business re needs assessment, we are trying to understand methodology used.
   - The total report will show the need vs service and services provided by zip code. This information will go to LAA/BHA to recruit providers to areas of un-met need.
   - What is review process for report? Review is internal to DHMH.
   - As to legislative process, procedures and regulations within DHMH are the way to go. Legislative approach became community vs providers, not the best process. More hopeful for change out of process that occurred in this room.
   - There are legal constraints on all of us, let's see where programs are and see if we can fix them. Lots of good work being done individually, where true progress lies.
   - What about sub-committee on training? Peers want to do that kind of work
   - Central Baltimore Partnership is putting a program together to help establish structure for conversation using the model from Central Baltimore. Creating model for way it can be done community by community throughout Baltimore.
   - Ask to have this model used again if necessary if other future community concerns occur?
   - Discussion of SWAT team to deal with issues? BHSB intrigued with idea.
   - Are there any other groups like this? Would like to make sure peer voice is represented in other groups like this.
   - Thanks expressed from a community representative who has a brother with this condition, now able as community member to enlighten other community members. Thank you all.

4. Themes from a set of Public Comments received.

   BHA acknowledgement of receipt of one set of public comments which will be posted on the BHA website on the OTPQI Workgroup page http://bha.dhmh.maryland.gov/Pages/otp-quality-improvement-work-group-public-comments.aspx

   - Themes expressed in comments contained several concerns about co-occurring substance use disorder and mental health conditions. BHA noted that these types of concerns were addressed through our recommended overall standards.
   - Concerns were also expressed related to side effects of methadone. These concerns will be shared with the BHA Medical Director.
   - Further concerns were expressed regarding quality of care. BHA indicated these types of concerns were also addressed through the standards workgroup.
   - Concerns were also shared regarding perception of problematic programs or specific patient issues. BHA indicated in these situations, persons involved should follow the established complaint process. Express concerns to the provider first, then to the BHA SOTA for investigation.

   Comments will be posted on-line

   - Update on BPC training on required 4 hours of MAT training, to include medication, engagement, continuum of treatment, discharge considerations, etc. stigma, use of buprenorphine, naloxone, long acting naltrexone, etc.
   - Training proposal was presented well, the Board listened intently. Board asked about financial impact. MATOD agreed to bring up for discussion, funding to offset as a barrier?
   - Suggest cost friendly training using OETAS or DANYA Institute. Also PCSS are already providing some free training.
   - 7 vacancies coming up on board, looking for volunteers, would like information sent out widely.
   - Standards documents will be reviewed by DHMH for acceptance, final product forwarded to legislature December 31.
   - Do not distribute draft standards document.

5. Adjourn