**Department of Health and Mental Hygiene**

**Behavioral Health Administration**

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

**Minutes for August 30thth, 2016**

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

On Phone: J. Formicola; Y. Isreal

1. Welcome and Approval of Draft Minutes from July 26th meeting. Two minor corrections were sent in, one correction pending to be submitted.
2. Discussion was held on timeline for legislative report and internal due dates. Final draft report is due to Dr. Bazron by November 15th, to be submitted to OAG by December 1. This changes deadline for our work to be completed by Oct 25th meeting. BHA posed question as to how to use Nov & December meetings which were scheduled post 11/15? Suggestion from the group was made to drop the last two meetings, and instead add a meeting in September, and one in October in order to have sufficient time to prepare remaining work. No one indicated objection to this plan. BHA noted that we don’t have the luxury to wordsmith the next set of standards, will be keeping the discussion moving and ask to have additional comments sent in between meetings as well.
3. BHA Review of Overall Work plan items and associated documents

*Geo-mapping* – This phase is complete, will be looking at how to incorporate Buprenorphine data. A question was raised and answered regarding the methodology used for the report. The report followed the format of the Baltimore City Heroin task force report. Information won’t be available on a community by community level, just jurisdictional. A comment was made that the Baltimore City report used zip codes and it was felt that wasn’t informative enough, but it’s important to get to at least get to zip code level. A concern was expressed re not being able to provide feedback on the geo-mapping report process, and should comments go to Jeff?

*Letter to LAA/BHA* –This letter will be sent 9/19 and explains the Goals and Objectives of Work Plan, as it relates to consulting the LAA for location recommendations prior to submitting application to OHCQ/BHA. To include revised role of LAA.

*Revised Role of the LAA/BHA –* Contains additional areas the LAA will be responsible for related to OTPs, as discussed and determined by OTPQIWG

*Letter to OTPs*-This letter is to inform OTPs of request to meet with the LAA prior to siting a program in a jurisdiction in order to review geo-mapping/needs assessment information. It was noted that a workgroup member provided feedback for BHA consideration regarding the letter via email. A comment was made regarding making sure the Work plan language was clear that OTPs are not expected to perform the referenced needs assessment.

*Criteria for Managing Patient Volume-* A comment was made re not recalling coming to conclusion about what the definition of “high volume” was, or what was meant by that? Request was made to come back to that at some point.

*Enhance Clinician Competence-* Concerns were expressed regarding the urgency and lack of responsiveness from the Board of Professional Counselors regarding the need for this training, and the provision that counselors must participate in this training as part of their renewal process. Questions were raised on when the training would occur, and how long was the timeline given the Board has asked for two more presentations on the course content. Concern was expressed re need to address this issue separately due to the urgency for the need for this training and if the Board understood how they (*their requests*) were blocking the progress on this process. A side comment was made about a letter sent to the Board by MATOD which was cc’d to BHA.

1. Begin work on Overall Quality Standards – Some background context was provided by BHA re the task, how the grid was organized and developed. The grid was divided into Program Related, and Patient Related Categories. The following represents comments made regarding suggested Standards/Criteria in the following categories

**Program Related**-

*Staffing Considerations*-

* Concerned about current 50-1 ratio in light of Board of Professional Counselor’s responsiveness, counselor availability, etc.
* Recommend the ratio be removed. Not in control of variables. Or open up who can provide the service; expand pool of individuals who can provide service. Why caseload limits in OTP if not in mental health?
* Suggest we look at these from a long term perspective. Not sure what data there is related to this (caseload ratios).
* Some mental health programs do have ratios in new COMAR regulations which vary program by program. For example, PRP for adults have a ratio for rehab specialists. CMS limits the size of groups.
* Peers are underutilized. Every clinic should have peer capacity with MAR as lived experience.
* We need to keep requirements, not make them easier to pass.
* Peers can run support groups, no other place for people to go. Some places care, some don’t.
* Current regulations have a ratio. Talking about peers is way to change conversation. Suggestions to be made re use of peers in addition to current ratio of staff.
* Clinical supervision is important. Would like to see a ratio of supervision to trainees. There is currently a ratio related to supervisory caseload.
* Two keys, good supervision and increased use of peers.

Note- Conversation jumped to Patient Care-Meaningful Coverage. See section at end of Overdose Prevention

*Outcome measures*-

* Doesn’t COMAR or TJC, CARF include the need for outcome measurements? MFRs were always there, but no consequences for not meeting them. Providers stated use of various internal outcome measures.
* OMS will provide in treatment measures eventually. Suggested scale of measures.
* Most providers indicated using own measures.
* Would we want to standardize measures used? Would be challenging with different data collection systems. We will have ways through OMS to collect. Do we want to set a goal, vs first taking a look at retention across all programs?
* 90 day retention in treatment is key, 180 days, and one year marks are important as well. Maybe use one standard that would have ongoing work. Have to build a scale, start with a measure like retention. % of retention at time marks. But not just important to retain, have to get good care while there.
* Beacon would have to follow across programs to get accurate LOS, patients change programs but stay in care.
* A point was made to not inadvertently penalize providers of buprenorphine who intentionally move patients to primary providers prior to one year. Those patients are part of overall census now, and should not be held to that as a standard.
* Concern about patients that may want to reduce dose, or taper off, and would potentially be kept longer than they want to.
* Don’t be afraid of measures, use urinalysis as measure, and be aware that retention in treatment does not always correlate with negative urinalysis.
* Are there other metrics to consider like in state stat? Criminality, etc.?
* Drug stat used retention, urinalysis and utilization.
* Use counseling sessions and adherence to them, engagement as measure.
* Don’t penalize patients with take homes for not coming in, there needs to be a score card or matrix with multiple variables.
* Is there any discussion with Beacon about pulling out this kind of data? Part of long term plans, we have a long way to go. OMS doesn’t ask about these types of results now, or for the next two years. Can we pull utilization data from Beacon now?
* Clarification that we are looking at “in treatment” data, not based on discharges.
* If want to look at retention, we can get that from claims data.
* Some people are terrified to come off methadone, it’s important to provide extra support during that time.

*Coordination of care (use of PDMP/Crisp)-*

* Should we require use of PDMP? There is some funding for upgrades to PDMP in the Governor’s budget. Even if data not exactly up to date now, still very useful to have the conversation.
* TJC will require use of PDMP as of July1, 2017 prior to initial dose, and change in take homes, and whenever there is a significant change. Also suggest using it for 90 & 180 day treatment plan reviews.
* Suggest at least for 90 day review, or at point of treatment plan. CDC guidelines recommend annually.

*OD prevention-co-prescribe naloxone*.

* A second step would be to provide the kit. (Several commented currently doing this). Beacon will pay for kits. The gold standard is to give it to all patients with MA.
* Suggest we mandate giving them medication, document why not if not giving the medication. Role of the LAA is to help develop partnerships with pharmacy, etc.
* Concerned too much too soon, we may set programs up if they can’t comply.
* Maybe we decide this is a high priority issue?
* Prescription is absolute, then down road default to medication. More realistic.

*Training-*

* Description is needed of what *internal stigma reduction* refers to. Clinicians inside the OTP need to not use offensive language (clean/dirty, detox vs taper, etc.)
* Procedures around take home can restrict important life events. Some OTPs use punitive based policies and punishment. Take homes, medication, everything is dangled in front of patient, can’t complain. Some places are all about cash. Its life or death for patients, have to look at it from that perspective. These types of comments all relate to proper supervision issue, need to train employees on this issue.

**Patient Care-**

*Meaningful Coverage*

* There is a need for adequate medical coverage. Recommend FT coverage, doesn’t have to be a physician, could be nurse practitioner. Coverage needs to be meaningful, not just by a Medical Director, but someone who has more contact with patients on a regular basis.
* Suggestion made for BHA (Barry) to draft a letter to SAMHSA related to allowing other types of staff to provide medical coverage.
* Medical Directors meeting with counselors would be very valuable. Should be part of their role.
* There might be more clinically based responses (to Standards Grid) if providers knew that the fiscal resources would follow. Most providers are concerned that they can’t do any of the things being suggested without sufficient resources.
* Recommend we tread a line for good practice/quality of care but only if there is sufficient resources to fund.
* Also, we need to look at things that we could include without resources.
* The clinical supervisor academy that the state held several years ago was very useful. Lower cost way to provide good supervision training.

1. Assign Tasks for Next Meeting
2. Next Meeting: September 13, 2016 @11:00 Hat Room of Tuerk Building, Spring Grove Campus
3. Remaining Meeting Dates:

September 27th, 2016 @ 1:00 Dix Building

October 18th, 2016 @ 2:30 Dix Building

October 25th, 2016 @ 1:00 Dix Building