**Department of Health and Mental Hygiene**

**Behavioral Health Administration**

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

**Minutes for September 13, 2016**

Attendees: K.Rebbert-Franklin, BHA; C. Trenton, BHA; L. Burns-Heffner, BHA; B. Page, BHA; M. Donohue, BHA; F. Dyson, BHA; E. Hall MA; G. Ott, SEC; H. Ashkin; A. Breidensteine; M. Currens; S. Drennan; C. Halpin; D. Hodge; Y. Israel; D. Madden; A. Mlinarchik; Y. Olsen; J. Severn; K. Stoller;; B. Wahl; V. Walters; A. Winepol

On Phone: R. Faulkner, BHA; M. Viggiani; J. Formicola; V. Waters

1. Welcome and Approval of Draft Minutes from August 30th meeting- One suggestion made for an additional comment to be added. Will be provided by email.
2. A note was made of new meeting schedule and location on next 3 meetings.
3. BHA re-stated the Workgroup’s task of developing suggestions for Overall Quality Standards. Recommendations for standards will be prepared by Workgroup and presented to DHMH for consideration.
4. Comments began from the start of grid in order to review BHA additions of suggestions for criteria made during the last meeting.

-*staffing considerations*: additional comments

*Ratios, etc.*

* Consider BHA providing guidance to field around the existing patient/counselor ratio requirements (trainees, CSC staff, alignment of complicated patients with more experienced counselors, etc.) maybe part of best practice document? –*BHA request*-Please send questions to be clarified to Barry, not for regulations, but for a guidance document.
* New requirements or timeline for the board of professional counselors to approve applications is not part of this workgroup work. BHA will hold internal conservation with our sister agency. BHA has no authority on these or zoning issues. Please do not send BHA suggestions for the Board at this time. Tracey DeShields is the DHMH contact as the Board President. The Board is overseen by the Secretary, but do have a different level of autonomy than other agencies. Are board meetings open?
* Is there a nursing ratio for patients? Bring up in medical coverage section.

*Creation of Multidisciplinary team*

* Important, but hard to define. Best practice, but hard to monitor or mandate. Accreditation standards don’t specifically address this; they gave feedback to programs they are reviewing in that area though. Nothing in CARF other than documentation of team meetings with staff credentials, but no standards. Current DHMH regulations make it clear that there is a requirement for a multidisciplinary treatment plan. Leave specifics for future guidance?

-*Patient outcomes*-additional comments

* Make sure that Beacon can track patients across programs when transferred successfully, track both buprenorphine and methadone medicines similarly.
* Adherence to treatment better proxy than just retention. How would we know what was expected? Minimally, track attendance, provide incentives, and make sure lack of attendance is addressed. Don’t equate getting medication with being retained in treatment. Look at unplanned or AMA discharges.
* Beacon can track and provide information re reasons for discharge.
* Evaluation measures may have to be program driven based on type of EHR.
* BHA requested for programs to forward policies re current outcome measures if possible, to be included in best practice docs. Would like programs to have a standard approach to tracking care. Dr. Brunner’s program mentioned as gold standard.
* Add 3 year and five year to retention markers?
* Other markers might include #of take homes

-*Coordination of care, use of outside information*-additional comments:

* Use of PDMP prior to prescribing and at 3 month intervals already to be mandated by law, what about adding prior to increasing take-homes? Yes, can cause problems if get them too soon, Yes, important piece of information.
* Suggestion to mandate and correlate timewise with other legal changes (July, 2018). This gives PDMP and programs time to get ready, plan and train staff.
* Would be a challenge to check monthly.
* Providers should check if they see changes in clients.
* Suggest creating a baseline for when we check, to be used as a tool like urinalysis

-*ODP* additional comments:

None

-*Training* additional comments:

* Question about supervisor academy availability? Training may be available, but culture of program may not be receptive to one individual. What about OETAS? Still trainings, but fewer due to other resources for training available in field.
* Suggestion for training to be provided to a whole program? What about EBP center from UM? Need whole culture change, would anything available there?
* BHA suggested training needs and methods could be developed by a sub-workgroup of BHA, OWFD, & OTP group, to flush out more definitive plan for this.
* Could Beacon offer training via webinar? (we would have to provide training info to Beacon) This type of topic is not conducive to webinar training, not appropriate vehicle. Need a more intensive training plan unique to each agency to make particular changes. Every OTP has to identify own needs and gaps.
* A provider offered to forward information on specific training that was provided previously that may be helpful.
* Want to make sure we attack stigma, should have universal language, etc.

-*Hours of operation*:

* Sometimes 8-5 does meet patient needs. TJC questioned traditional 8-5, but SAMHSA contact indicated 8-5 may be ok if that is what meets participant needs, but consider other hours as needed by patients and meeting needs of community.
* Consider external issues such as community considerations with flow of other business in area, patient satisfaction. Will vary based on where located.
* From the community perspective, the only consideration is that available hours are sufficient to handle patient flow and needs.
* Suggestion to add satisfaction regarding hours of service as part of patient satisfaction survey.
* Caveat that programs can’t meet every patient’s needs, have to make judgement based on overall utilization, help outliers find other programs that met their needs in the area.
* It’s good for programs to have diversity in hours in order to dovetail with other programs that may meet patients’ needs better. Congestion would indicate problematic hours.
* It’s more important to measure how a program assesses need for hours, and to document being thoughtful re this.

*Patient Care related*:

-Medical coverage

* Provider indicated a gut reaction to using the words “rapid responsiveness” to patient needs. Would suggest using the word “timely” instead.
* There are multiple layers of medical coverage, what do we actually mean here?
* What about ratios for nursing, or for Medical Directors? How thin can these people be spread?
* The focus should be on outcomes; do people get attended to as needed? Ultimately the amount/timeliness of care given should be the criteria, not hard/fast ratios.
* It’s about good clinical care for patients; somehow qualify so it is clear that coverage is available.
* Can we use “Medical Provider” instead of Medical Director? It’s difficult to talk numbers, more about coverage.
* Suggestion made that if a patient wants an increase, address request within 24 hours?
* This suggestion prompted discussion regarding clinical issues that might prohibit responding to a request within 24 hours, such as need for review of records, & if during week.
* There should be daily coverage for medical decisions (on-site or available remotely?) Should be available at all times, except maybe weekends? Can still have phone coverage on weekends as needed.
* Need to define Medical Provider, as inclusive of other medical professionals
* It’s about responsiveness and timeliness. How would you monitor that? Charts may not indicate actual time service was provided.
* Suggest provider being able to produce a document that describes the program’s medical coverage.
* What about including satisfaction with medical coverage in patient survey? Concern expressed that results may not be based on timeliness, but on medical decisions made. May be kind of a loaded question.
* Medical staff needs to follow through with what is said to patient, and need to be able to guarantee that if it is promised, will be consistently delivered.
* Communicating expectations is key, and then documenting that it has happened.
* So what is the reasonable expectation?
* Communication re medical decisions should be part of training and best practice.
* Maybe not a specific checkbox, but part of overall review of program, like CARF. Reviewer gets an overall sense of how clinical care works.
* Responsiveness depends on program process. Specific to dosage adjustment- urgency and response will vary by patient. It is about addressing the need, and closing the communication issue. Don’t think we should regulate this, use common sense, general guidelines.
* From a monitoring perspective, can a program demonstrate that they have coverage that allows for timeliness and responsiveness? We don’t want to mandate or regulate clinical practice.
* Perhaps track and compare with other programs? Look at outliers?
* Maryland is focused on patient centered care, most likely we are ahead of the curve for other states
* If we go with suggestion to add to a patient satisfaction survey, use care as to how we ask the question.

-Coordinates care

* There are several layers to this process- 1) Need to know what % of patients have an identified Primary Care doctor, and what % with co-occurring disorders have a mental health provider
* Suggest requiring this information prior to approving take homes, must have things in place such as Primary Care doctor, bank account, etc.
* Question rose about procedures for monitoring of take home medication; answers provided included descriptions of monitoring procedures, more restrictive than any other medication. Link to applicable state and federal regulations that cover these processes will be provided.
* Reviewers should look for the presence of Release of Information, or if there was a refusal to sign appropriate releases.
* What about action of coordinating care? Do we want to include anything more measurable about that issue?
* Would need to determine if there were other providers, if so, is there consent, then is there sharing of information? In what timeframe? Does provider document a number of attempts per year?
* Evidence of exchange of information as a measure?
* Is there any way to know if someone is going to two different programs? Programs employ a base level of consent process, to check for other programs. Not foolproof.
* Beacon can check for payment to more than one provider, but not for self-pay patients. The PDMP isn’t structured to do this, programs send a fax to other programs in their area, and do best they can do to ensure this isn’t happening..
* Having a Health Home allows for more sharing of information, it’s part of the nature and role of these programs to have care coordination.
* So how do we measure? If psychiatric or other medical issues are on treatment plan, they must be addressed. Following through with items on the treatment plan can be used as a measure, easily tangible.

1. Assign Tasks for Next Meeting:

Please send questions regarding patient/counselor ratios to be clarified to Barry, not for further regulations, but for use in developing a guidance document.

BHA requested for programs to forward policies re current outcome measures if possible, to be included in best practice Guidance Documents

1. Next Meeting: September 27th, 2016 @ 1:00 Dix Building

**Remaining Meeting Dates:**

October 18th, 2016 @**2:30** pm Dix Building

October 25th, 2016 @ 1:00 pm Dix Building