Opioid Treatment Program (OTP) Workgroup

Thursday, October 24, 2019

9:30 a.m. to 12 p.m.

Behavioral Health Administration (BHA)

Dix Building Basement Conference Room, 55 Wade Avenue, Catonsville, MD 21228

MINUTES

Attendees:

Andre Pelegrini, Senator Adelaide Eckardt, Andy Owen, Marianne Gibson, Barbara Wahl, Beth Schmidt, Corey Carpenter, Dan Martin, Eleanor Dayhoff, Howard Ashkin, Iva Jean Smith, Kathy Rebbert-Franklin, Laurence Polsky, Paul Parker, Delegate Robbyn Lewis, Stacey Diehl, Steve Whitefield, Susan Steinberg, Yngvild Olsen, Barbara Allen, Sydney Rossetti, Kim Jones, Lisa Burgess, Stephanie Slowly, Tom White, Tanya Hurst, Deirdre Davis, Stacey Jefferson, Barbara Brocato, Vickie Walters, Denise Wheatley-Rowe, Bolaji Olgboja, and Nancy Rosen-Cohen (by phone).

Welcome and Introductions: Lisa A. Burgess, M.D., BHA (Acting) Deputy Secretary

- Dr. Burgess welcomed all attendees and gave a brief overview of the purpose and goals of the group. All attendees introduced themselves.

OTP Workgroup Overview, Agenda, and Goals Presentation: Steve Whitefield, M.D., BHA Medical Director

- Dr. Whitefield reviewed the letter the Chair and Vice-Chair of the House Health and Government Operations (HGO) committee sent to MDH requesting that an OTP workgroup be convened, based on community complaints about certain OTPs in Baltimore regarding their regulatory compliance. The letter requested that the OTP workgroup examine the quality of care of Baltimore OTPs, make recommendations regarding any necessary legislation to increase the accountability of OTPs, and had recommendations for workgroup membership. A report and briefing on the findings of the workgroup was requested prior to the 2020 legislative session.
- The HGO letter also requested that the workgroup examine eight additional issues, which were summarized: (1) The role of State, local, and national entities in the oversight of OTPs; (2) The complaint process; (3) Liability under State or federal law; (4) Patient outcomes at OTPs; (5) Effectiveness and legality of limiting OTP capacity; (6) Whether to rely on national accreditation as the standard for licensure or a state process; (7) How to improve OTP relationships with their surrounding communities; and (8) Standards for

the revocation of licensure and the process for corrective action.

- MDH/BHA goals for the workgroup were reviewed. One goal is to apply the workgroup findings statewide since the issues from the HGO letter to be examined are not specific to Baltimore. Another goal is to focus on OTP best practices as a foundation of quality care since they improve patient outcomes and are associated with regulatory compliance. Dr. Yngvild Olsen, BHA Substance Use Disorder (SUD) Medical Consultant and Medical Director for IBR/Reach Health Services is on the agenda today for presenting a Maryland OTP Best Practices document, from the statewide OTP Medical Directors' group. This augments but does not replace national best practice guidelines such as SAMHSA's 2015 guidelines and SAMHSA's Treatment Improvement Protocol (TIP) Number 63.
- Questions and Discussion:
    - None

BHA Compliance, Accreditation, and Licensing Overview Presentation: Stacey Diehl, BHA Director of the Office of Behavioral Health Licensing

- Handout: a flowchart was provided to the workgroup that shows each step in sequential order that an OTP must go through for licensing.
- Licensing requirements set forth in COMAR 10.63 for all behavioral health programs, including OTPs, were reviewed. Most behavioral health programs must meet the licensure requirements of COMAR 10.63, including OTPs. Exempt from COMAR 10.63 are: 1) Individual health professionals in a solo or group practice licensed under their Health Occupations Article and operating within the scope of their license; 2) peer support programs (AA/NA); 3) DUI education; 4) certain assessment referral services; and 5) BHA approved pilot projects.3. Before an OTP can begin operations, they must complete the following action items: 1) become accredited from an approved accreditation agency; 2) obtain use and occupancy certificate and fire inspection certificate from their local government; 3) enter into an Agreement to Cooperate with their jurisdictional authority; 4) acquire a license from BHA; and 5) obtain approval from the DEA/SAMHSA/OCSA. If they wish to be a Medicaid provider, the OTP will also need to enroll in Medicaid. OTPs are the most regulated programs of the substance use treatment providers, as they must comply with both federal and state regulations, and have oversight by local, state and federal agencies.
- If an incomplete application for licensure is submitted to BHA, the application is returned as per the regulations.
- Questions and Discussion:
    - In response to a question it was clarified that OTPs were required to be accredited by a national accrediting body before it was required by the State. It is not a new requirement for OTPs, but it is new for most other services.
    - An attendee asked the presenter to clarify why health professionals are exempt from COMAR 10.63. BHA licenses programs, not individuals – physicians are licensed by the Maryland Board of Physicians.
    - The BHA flow chart of the licensure process was reviewed, which is an accreditation-based licensure.
- Zoning was discussed. BHA defers to the local jurisdiction. With the application, the provider must submit use of occupancy approval from the appropriate local agency. Zoning is a local determination, not a state level determination. Every jurisdiction has a

zoning authority. Additionally, once OTPs get a license from BHA, they have to get approval from the DEA and the MDH Office of Controlled Substances (OCSA).

BHA Compliance Overview Presentation: Susan Steinberg BHA Program Manager of Managed Care and Quality Improvement standing in for Frank J. Dyson, MHS, BHA Director of Quality Assurance/State Opioid Treatment Authority

- Ms. Steinberg first covered a brief description of BHA's Division of Quality Assurance. This Division is responsible for statewide compliance reviews and coordinates OTP oversight. Every OTP is audited at least once a year by BHA, and OTPs that frequently receive complaints are audited more often. It is important to note that OTPs are also audited by other entities throughout the year.
    - BHA will establish a plan of correction if necessary based on the findings of their audit. If necessary BHA will take disciplinary action against a provider.
- The specific federal guidelines were reviewed by the group regarding take-home medications; a patient is able to take home medications rather than come in everyday for their medications after an individualized review by the OTP medical director/physician with input from the clinical team and in accordance with federal regulations. The State Opioid Authority (SOTA) can make universal exceptions, for example extreme weather conditions might warrant approval for take-home medications for all patients of the OTPs in an affected area.
- Questions and Discussion:
    - None.

OTP Quality Improvement Recommendations (2016) Presentation: Kathleen Rebbert-Franklin, LCSW-C, BHA Director of Service Access and Practice Innovation

- Background: The 2016 workgroup focused on identifying best practices for OTPs statewide. In order to better understand the geographic gaps in service and better inform the group's recommendations, a needs assessment was completed prior to the 2016 formulation of recommendations. A report was created detailing the 2016 group's recommendations, which were sent out to all OTPs in Maryland so that they might understand and implement the recommendations.
- The group focused especially on improving quality of care (to enhance clinician competency), as well as clarifying the role of the LAAs/CSAs/LBHAs to better give them a level of control and insight into their jurisdiction.
    - The 2016 Goals were to create an integrated State and local process for approval of new programs and to improve the quality of care in OTPs. The recommendations fell into two categories.
        - Community relations section included: (1) specific policies/procedures, (2) clean and orderly facilities, (3) specific space, staff, and hours of operation, (4) maintain and enforce pre- and post- treatment patient flow management policy, (5) maintain and enforce safety and security of program participants, (6) maintain

efforts to control diversion of medications, and (7) engage in ongoing discussions to collaboratively address issues.
        - Quality of Care section included: (1)Establish a supervisor to trainee ratio for professional counselors and therapists, (2) consult the PDMP at specific times, (3) offer naloxone to all patients, (4) identify medical/clinical training needs and implement, (5) provide hours of service that meet the needs of the population, (6) provide responsive medical coverage, (7) share information with somatic providers, (8) employ a multi-disciplinary approach to treat patients with chronic pain, (9) manage co-occurring psychiatric disorders, (10) provide concurrent treatment for other substance use disorders, (11) Establish protocols to prevent or manage administrative tapers, (12) establish a patient outcome tracking system, (13) ensure OTPs provide orientation for new patients, (14) individualize care to maximize outcomes.
            - The group discussed the importance of emphasizing interventions to ensure that patients are managed in a therapeutic manner rather than tapering medication and discharging them from treatment, which has been associated with a high risk of relapse.
- Questions and Discussion:
    - The group discussed what information would be in the Prescription Drug Monitoring Program (PDMP) if a patient is receiving medications for addiction treatment. Prescriptions for medications such as buprenorphine for opioid use disorder (OUD) that a patient receives from a prescriber in a non-OTP office based setting will be in the PDMP because pharmacies are the source of information to the PDMP. An attendee stressed that even though he is a physician, he is often not aware if a patient is taking methadone for an OUD or receiving buprenorphine in an OTP because OTPs are not currently permitted by federal law to submit that information to the PDMP and patients sometimes do not disclose that information to their healthcare practitioners. Why don't patients divulge this information? It was further discussed that this can be because of stigma. Patients receiving medications for addiction treatment still face a large amount of stigma, even from the medical community, especially around methadone.
        - An attendee mentioned 42CFR Part 2, the federal confidentiality regulation that prohibits the uploading of OTP information into PDMPs.
    - An attendee brought up their concern about suicidal ideation and getting people into treatment, especially when they might need hospitalization. If a person is hospitalized, the hospital may focus on the suicidal ideation but not the SUD. Or the suicidal ideation could be underestimated if a SUD is present, and stigma can be a factor. Outcomes for someone with suicidal ideation in need of more extensive treatment includes voluntary admission to a hospital, a crisis bed, or it can be an emergency petition for involuntary hospitalization.

- An attendee noted that most OTPs really go out of their way when one of their patients is hospitalized to communicate with the hospital to encourage not tapering the patient off of the medication they are receiving from the OTP. Most OTPs work to ensure a warm-handoff.

Best Practices for Maryland Opioid Treatment Programs Presentation: Yngvild Olsen, M.D., M.P.H., BHA SUD Medical Consultant

- Dr. Olsen described how starting in 2017 the OTP Medical Directors worked to further define and implement clinical/medical quality of care recommendations to build off of the work done by the 2016 workgroup. They established the "Best Practices" report, which identifies best practices for OTPs to ensure that Maryland has a set of standards agreed upon by medical directors of OTPs to achieve the best outcomes for patients.
- OTPs are regularly visited by the DEA and national accrediting bodies for unannounced site visits to ensure OTPs are meeting regulations. For Medicaid providers, there are additional regulations that must be adhered to as well.
- The three FDA approved medications to treat opioid addiction were reviewed (methadone, buprenorphine, injectable naltrexone). It was noted that they will not appear in the PDMP if dispensed through an OTP. The mechanism of action of the three medications also was reviewed, including that methadone is a full opioid-agonist, and buprenorphine is a partial opioid agonist, which means that people develop physical dependence to these medications and will go through withdrawal if the medication is abruptly discontinued or the dose significantly reduced— but Dr. Olsen stressed that physical dependence is not the same as addiction.
- The OTP Medical Directors have created a comprehensive report with 60 best practices identified for OTPs to strive to adhere to. To make review of the recommendations manageable for the group, Dr. Olsen categorized the recommendations based on 6 topic areas.
    - The first group of recommendations pertain largely to treatment of Opioid Use Disorder (OUD) and work to build off of SAMHSA's recommendations, such as offering all three types of FDA approved medications as no one medication will work for every patient. The majority of recommendations fall into this topic area.
    - The second group of recommendations pertain to the approach to other substances/SUD, including benzodiazepines, alcohol, and cocaine.
    - The third group of recommendations start to look into the future to identify emerging trends both in Maryland and nationwide and a recommendation on how OTP medical directors can respond to that.
    - The fourth group of recommendations look at what types of interventions should be used to improve retention and care continuity. Because SUDs, including OUD, are chronic conditions, SAMHSA and other national organizations recommend taking a chronic disease management approach. This is supported by studies that show significant reductions in relapse risk only after five years or longer of remission and recovery. The OTP best practices report makes recommendations in alignment with a chronic disease model, and stress that OTP medical directors should therefore identify and address the changing needs of their patients.
    - The fifth group of recommendations focuses on the role of drug testing. OTP

Medical Directors establish drug test panels, and the recommendations ensure that they are using the most evidence-based processes to do this. The recommendations in this group focus on providing clinically effective responses to patients who are showing signs of their disease. For example, when someone is still using substances and has positive drug tests, it is not a clinically effective response to discharge them from care.

- The sixth group of recommendations focus on training and implementation strategies. Science changes and so OTPs need to have best practices that keep up with that. Several of the recommendations focus on how to measure progress of patients and when to assess them.
- Questions and Discussions:
  - Diversion care plans were discussed more in-depth. Federal regulations found in CFR42 (SAMHSA regulations) and CFR21 (DEA regulations) require OTPs to have diversion care plans. Because they are dispensing controlled medications, OTPs need to have a plan for how they order medications, who can sign for the medication, how they are inventoried, how they are dispensed, how dispensing is documented and controlled, etc. And the DEA has very specific requirements surrounding what those dispensing units must look like. For example, the administration of medication to the patient needs to be done in a certain way to ensure that the person is not misusing the medication or saving it to give to somebody else. If someone is getting take-home medications, there should be routine call backs to make sure they are handling it appropriately.
  - Some discussion took place around how to treat the trauma that most of the patients have gone through. Some studies suggest that 80-90% of patients with SUD have experienced some kind of trauma, and adverse childhood experiences also increase the risk for addiction. It was discussed that continuing the conversations around recovery and connecting people with resources could help to address trauma. This includes, for example, giving first responders naloxone and increasing access to effective medications/treatment. Also, it was discussed that Peer Recovery Specialists are very valuable and often help people not just in their recovery from a SUD, but in recovery from their trauma.
    - An attendee discussed that there is a pilot program in Massachusetts that is working to create Peers to provide support for families who have lost members to OUD/SUD.

Presentation of Two Journal Articles that Studied Crime Rates Around OTPs in Baltimore City: Steve Whitefield, M.D., BHA Medical Director

- Dr. Whitefield gave an overview of two articles that had been distributed prior to the meeting for review.

1. A 2016 Johns Hopkins study: *Not in My Backyard: A Comparative Analysis of Crime Around Publicly Funded Drug Treatment Centers, Liquor Stores, Convenience Stores, and Corner Stores in One Mid-Atlantic City.* J Stud Alcohol Drugs, 77, 17-24, 2016.

2. A 2012 University of Maryland (UM) study: *Use of a 'microecological technique' to study crime incidents around methadone maintenance treatment centers.* Addiction 107, 1623-1638, 2012.

- Both studies were done in Baltimore and both found that there was reduced crime in the areas around drug treatment centers and OTPs, relative to other business types that were studied.
- The 2012 UM study also briefly discussed that methadone maintenance treatment decreases crime among treated patients. Studies show that OUD treatment that includes medications reduces crime. This has been shown for methadone, with less data for buprenorphine, as per a National Academies 2019 report (National Academies of Sciences, Engineering, and Medicine 2019. Medications for Opioid Use Disorder Save Lives. Washington, DC: The National Academies Press).
- The 2019 National Academies report indicated that medications for opioid use disorder, particularly methadone and buprenorphine, also improve social functioning, reduce overdose deaths, and reduce rates of HIV and hepatitis C infection. These positive outcomes and reductions in crime further improve with the addition of counseling to these medications.
- Even with the evidence for reduced crime resulting from the medication and counseling OTPs provide to patients, questions will arise about whether OTPs, and other drug treatment centers, could still be magnets for crime in the areas around them. These two Baltimore studies looked at this and they found there was less crime.
- The 2016 Hopkins study compared violent crime in Baltimore in the areas around 53 publicly funded outpatient drug treatment centers, which included OTPs, to 53 each of the three types of other businesses studied: liquor stores, major chain convenience stores, and corner stores. The surrounding areas went out to 1,400 feet. Each group of 53 were matched by a similar neighborhood disadvantage score, calculated in relation to poverty level indicators. The violent crimes included were homicides, manslaughter, rapes, aggravated assaults and robberies. The study results found that the mean count of violent crime was significantly higher around liquor and corner stores compared to the count around drug treatment centers. There was no statistically significant difference in the violent crime count between convenience stores and drug treatment centers. The study analysis excluded data for on-site robberies although the authors mention that these counts were higher for liquor, corner, and convenience stores, as compared to drug treatment centers.
- The 2012 UM study examined crime in the areas around 13 OTPs in Baltimore to three types of control locations: general medical hospitals, convenience stores, and points in residential areas. It included eight types of crimes ranging from homicide to theft from a vehicle. The study found that OTPs and hospitals in Baltimore were not associated geographically with increased crime, in contrast to convenience stores.
- Questions and Discussion:
    - An attendee raised the issue that the two studies did not account for calls for service and concerns surrounding the quality of life in the neighborhoods in which drug treatment centers are located. The attendee mentioned concerns from the surrounding community about social disruptions related to drug treatment centers

including OTPs. Loitering was discussed, as was an OTP's responsibility for addressing this with their patients, and the limitations in how it can be addressed. Attendees brought up ideas on possible ways to address loitering such as drug treatment centers having cafeterias for their patients, providing transportation to and from the facility, daytime activities and services, and providing an adequate seating area inside. An attendee related that it is vital to ensure that treatment centers are good neighbors to help create an ecosystem of support for individuals in recovery.

- An attendee noted that Baltimore has a law against loitering. An attendee related that many OTPs employ security who will move people along if they are loitering, which can be helpful since drug dealers can wait around outside of programs to prey upon patients. An attendee pointed out that the loitering law is not enforced at all treatment sites.
    - An attendee related that zoning restrictions could potentially impede OTPs from expanding to provide seating areas or a cafeteria for patients.
- An attendee suggested that a possible future study could be done to assess the effectiveness of the loitering law in Baltimore City that allows OTPs to control loitering around their locations. Possible questions the study could focus on would be if the boundary should be expanded to more than 200 feet around the facilities.

Closing Remarks:

- Dr. Whitefield thanked everyone for coming and reminded the group that the next meeting will be November 15th, at 9:30am in the same location. BHA will send out the OTP Best Practices document and attendees were asked to send back comments prior to the next meeting. Meeting adjourned.
- **Next Meeting:** Friday, November 15, 2019, from 9:30 a.m. to 12 p.m. at the Behavioral Health Administration, Dix Building Basement Conference Room, 55 Wade Avenue, Catonsville, MD 21228.