Opioid Treatment Program (OTP) Workgroup

Friday, November 15, 2019

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

Maryland Department of Health, Behavioral Health Administration (BHA)

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

Minutes

Attendees: Senator Adelaide Eckardt, Adrienne Breidenstine, Andrew Boyer, Andy Owen, Ann Ciekot, Barbara Allen, Barbara Wahl, Beth Schmidt, Senator Cory McCray, Eleanor Dayhoff, Enrique Olivares, Frank Chika, Frank Dyson, Howard Ashkin, Iva Jean Smith, Jennifer Martin, Kathleen Rebbert-Franklin, Kimberly Qualls, Lisa Burgess, Stephanie Slowly, Steve Schuh, Steven Whitefield, Sydney Rossetti, Tom White, and Yngvild Olsen.
By phone: Al Redmer, Nancy Rosen-Cohen, Tracey Bushee, and Rose Burnhill (on behalf of Rebecca Garcia).

Introductions and Approval of the Minutes: Steven Whitefield, M.D., BHA Medical Director

- Dr. Whitefield welcomed everyone and all attendees then introduced themselves. The minutes from the October 24, 2019 workgroup meeting were approved by the group.

Synopsis of the First Workgroup: Steven Whitefield, M.D., BHA Medical Director

- Dr. Whitefield provided a presentation to the group reviewing the October 24, 2019 workgroup meeting. This presentation highlighted the goals of the workgroup as identified by the General Assembly and briefly summarized the information discussed in the October 24, 2019 meeting.

Medication Assisted Treatment and Counseling: Steve Schuh, Executive Director, Opioid Operational Command Center (OOCC)

- In light of studies showing the efficacy of combining medication assisted treatment (MAT) with counseling and other psychosocial supports for patients with Opioid Use Disorder (OUD), Steve Schuh, the Executive Director of the Opioid Operational Command Center(OOCC), posed some discussion questions to the group regarding how and if the OOCC should get involved with promoting this practice across the state. The discussion questions centered around how the state can better support patients seeking to

undergo counseling and other psychosocial supports linked with their MAT and how the OOCC could and should get involved.

- It was noted that though pairing MAT with counseling may be the right approach for some patients, no one single approach is the best fit for all patients. While some patients may seek counseling, other patients may not want counseling and may still have the same outcomes without pairing their MAT with counseling. Additionally, those patients who do want to pair their MAT with psychosocial support feel ready to do this on an individualized basis — there is not one single time that would work best for all patients to be encouraged to start counseling. Was discussed that with the treatment of any disease, treatment needs to be patient-centered. Also was discussed that while pairing MAT with counseling is an effective practice for some patients, the state should not seek to encourage this practice through legislation.
- Was also discussed that there are ever-evolving standards of care and best practices in health care, so to promote one specific approach may limit the state's ability to respond to future findings and changes in the science.
- Also mentioned was that MAT alone is saving lives and the state should be careful to not make it seem like they are saying that MAT alone cannot produce positive outcomes when it has not been linked with psychosocial support.
- The group briefly discussed the varied intensities of counseling offered across the state for patients with OUD. It was mentioned that though Maryland has made strides in increasing access to MAT and psychosocial support within the past few years, patients still may not be able to find a counselor that fits their needs or is a good match for them.
- It was discussed by the group that an effective approach for the OOCC might be to encourage the increased availability of educational resources regarding OUD for patients on MAT. Ideas discussed by the group included increasing understanding of the course of the disease and teaching different methods for how to cope with it.
- It was discussed that because OUD is a long term disease, patients should also be educated on the behavior changes that often accompany MAT and how they happen at an individualized pace. It was discussed that it is vital to meet patients where they are in the stages of change and to help them to identify what their individualized needs are in a variety of areas. As the individualized needs are identified, it is also vital to work with patients to figure out what they are willing to engage in and at what point, with the goal of moving patients along in the stages of change so that someday they may actually be able to embrace or feel ready to embrace the stages of change. This is similar to the approach with other chronic diseases, like diabetes, heart disease, etc.

Best Practices and Recommendations for the Medical Management of Patients Served in Maryland's Opioid Treatment Programs: Yngvild Olsen, M.D., MPH, BHA Substance Use Disorder Medical Consultant

- Since the 2016 OTP Workgroup led by BHA, the Medical Directors of the OTPs in Maryland have continued to meet in a separate workgroup to identify specific recommendations and best practices. The workgroup has produced a report complete with 58 recommendations for best practices for OTPs. For the purposes of summarizing these recommendations for her presentation, Dr. Olsen grouped the recommendations into six sections.
- <u>1st section:</u> recommendations that address the treatment of OUD. The 18 recommendations that fall into this section range from addressing the inclusion of all three FDA approved medications, to setting paraments for determining optimal medication doses, to using the Prescription Drug Monitoring Program (PDMP). Dr. Olsen highlighted four specific recommendations from this section to share with the group:
    1. OTPs should provide at least one formulation of each of the three FDA-approved medications approved by the FDA for the treatment of OUD. This is because not one single medication will work for every single individual. OTPs are the only outpatient setting where people can have access to all three because of the way that it is regulated;
    2. Doses should be individually titrated and adjusted as needed to allow the patient to fulfill normal daily activities without withdrawal symptoms and with no daytime drowsiness;
    3. Dose effectiveness should be determined clinically; thus single serum levels are not indicated, and
    4. Prior to initiative methadone or buprenorphine, OTP practitioners should query the PDMP, document their findings, but not use the information to withhold potentially life-saving opioid agonist therapy.
- <u>2nd section:</u> recommendations that address the treatment of other SUDs. The 25 recommendations that fall into this section review treatment for other disorders such as PTSD, anxiety, and insomnia, discuss risks related to legal and illegal substance use, emphasize care coordination and appropriate screening, and highlight evidence based treatments and alternative therapies. Dr. Olsen highlighted four specific recommendations from this section for the group:
    1. OTP medical staff should coordinate care with any benzodiazepine prescriber with whom they share patients;
    2. Medical and clinical staff should screen for and address alcohol use and treat alcohol use disorder in their patients, including discussing breathalyzer and other monitoring and medication management techniques for patient safety;
    3. Medical and clinical staff should employ proven behavioral interventions, including contingency management, cognitive behavioral therapy, and

motivational interviewing, to treat patients with stimulant use disorder, and

iv. OTP medical practitioners should offer FDA-approved pharmacotherapies to patients identified as having an active tobacco use disorder and tailor treatment choice to patient preference.

- 3rd section: recommendations that address recognizing and staying abreast of emerging trends. The specific recommendation in this category are as follows:
    i. Through attending conferences, talking with patients and colleagues, and remaining up-to-date on addiction related research, OTP Medical Directors should stay apprised of emerging and new substances used by patients.
- 4th section: recommendations that address interventions to improve retention and care continuity. The 7 recommendations in this category range from addressing appropriate medical coverage in OTPs, to addressing involuntary discharge of patients, to discussing the provision of take-home medication and the alignment with federal regulations. Additionally, Dr. Olsen stressed that in the age of fentanyl, OTPs need to be really careful to not end treatment too early. Dr. Olsen highlighted three specific recommendations from this section for the group:
    i. OTP Medical Directors should implement clinical policies for involuntary discharge from an OTP that minimize harm to patients, avoids where possible financially based discharges, includes a menu of options, and reflects a non-punitive, trauma-informed approach;
    ii. OTP Medical Directors should implement programming in OTPs, such as behavioral health homes, that serve to effectively coordinate and assist in the treatment and management of common medical and psychiatric conditions, including depression, chronic pain, hepatitis C, and HIV, and
    iii. OTP Medical Directors should develop and ensure implementation of clinic policies that facilitate close care coordination and clinical information sharing, including summaries of treatment response and recommendations, trauma-related considerations, and notable patient behaviors, between OTP clinical and medical staff for patients transferring from one OTP to another.
- 5th section: recommendations that address the role of drug testing at OTPs. The recommendations in this section address the OTP Medical Director's role in setting drug test panels and emphasize the clinically appropriate use of drug tests. Dr. Olsen highlighted two specific recommendations from this section for the group:
    i. Avoid making significant clinical changes on the basis of one unexpected drug test result; instead consider such test results in the broader context of a patient's clinical situation, stability, and progress in treatment, and

ii. OTP clinical and medical staff should use unexpected drug or breathalyzer test results to inform clinical care of patients in non-punitive ways, which includes discussing results with patients prior to making any major clinical changes to either medications or behavioral interventions.

- <u>6th section:</u> recommendations that address training and implementation of best practices. The three recommendations that fall into this section emphasize the need for outcomes measures for OTPs, as well as maintaining the best practice document. Examples of outcomes measures that could initially be used by OTPs include the retention rate of patients in treatment, and the percentage of patients in OTPs remaining illicit opioid free for at least three months. The three recommendations in this section are as follows:
    i. BHA, with support from the OTP Medical Directors Workgroup, should explore training and dissemination of the best practice recommendations;
    ii. The OTP Med Directors Workgroup should reconvene and update the Best Practices document at regular intervals to ensure that recommendations align with the most current relevant scientific evidence and medical standards of care, and
    iii. OTPs should assess their quality of care by measuring retention in care coupled with percentage of patients remaining free of illicit opioids for at least three months.
- Questions and Discussion:
    - A question was asked about whether OTPs are looking at providing resources such as a functional living skills assessment to be able to look at how behaviors have been modified or how patients have adjusted their behaviors based on the treatment they are receiving. Dr. Olsen confirmed that the Medical Directors are looking at the integration of other services at OTPs and that they are interested in assessing how a patient might change their behaviors while undergoing treatment. Was also discussed that for a lot of patients, successfully entering into recovering requires a paradigm shift for them and that it would be interesting to be able to assess this.
    - A question was asked about whether or not OTPs set limits on how many patients they serve based on the ratio of patients to the Medical Director. Dr. Olsen and others said that ratios are assessed when OTPs are acquiring their licensure, but are not applied programmatically by OTPs to the medical coverage or the Medical Director. A rigid ratio could be especially difficult, using patients to counselors as an example, because patients are not at the same severity at the same time and their needs are different, so the amount of clinical effort from a counseling perspective will change over time. While the Medical Directors are responsible for medical and clinical activities at the OTP, they are not the only individuals providing direct medical care, such as other physicians or nurse practitioners. Dr.

Olsen mentioned that the Health Home service in OTPs is a valuable service because the model that Maryland Medicaid adopted is based on a Registered Nurse (RN) model, so the RNs working in OTPs have a clinical lense that they can use to help supplement and support nurse practitioners, PAs, and the Medical Directors at OTPs.
    - An attendee that had served as part of a past workgroup that was comprised of community providers and consumers informed the group that one of the clinical conversations that the group had focused on was the importance of shifting the conversation away from a patient to Medical Director ratio, and towards the medical responsiveness of the medical team in attending to the patient's needs. It was discussed that it was important to view the Medical Director as part of the boots on the ground effort, not as the only boots.
    - An attendee indicated that some work is currently being done to look at the qualifications of Medical Directors, and noted that unless Maryland changes their requirements, there will soon be a shortage of Medical Directors.

Break

OTP Community Relations: Frank Dyson, MHS, BHA Director of Quality Assurance/State Opioid Treatment Authority

- Frank Dyson, Director of BHA's Office of Quality Assurance/State Opioid Treatment Authority, provided a presentation that detailed the role of BHA in regulating and licensing OTPs. Frank detailed BHA's role in conducting an initial site visit when an application is first submitted for licensure to BHA. Frank also detailed the process that BHA undertakes to review staff credentials to ensure that all staff are appropriately licensed and credentialed. BHA then provides technical support to help improve the quality of care and conducts Clinical Compliance Reviews to verify quality of care. BHA also monitors OTPs for diversion control, monitors medication call-back logs, and reviews dosing procedures. To coordinate with the other entities that regulate OTPs, BHA works in cooperation with the DEA, SAMHSA, and MDH's Office for Controlled Substances Administration. BHA also works in cooperation with accrediting organizations and the ASO to report program quality concerns and to report billing concerns so that when records are reviewed and an irregularity is recognized, the ASO can conduct an additional site visit.
- Frank also detailed the complaint process: anyone can file a complaint to BHA, and BHA reviews all complaints from internal sources (from within an OTP — a staff complaint or a patient complaint) or from external sources (a concerned citizen or any member of the community). BHA then conducts an investigation. When a complaint is received by BHA

about community concerns, they work with the Local Addiction Authority/Local Behavioral Health Authorities (LAA/LBHAs) to ensure that the LAA/LBHAs are able to address concerns in their communities. BHA supports local jurisdictions on community issues and attends community meetings as requested by the LAA/LBHA.

- Discussion and Questions:
    - A member of the workgroup referenced an OTP in western Maryland that requires patients to come to the provider site within two hours of a call back for take-home medication or else be disqualified from the program, even if employed, and asked if this was permissible. Frank informed the group that if the provider identified this practice in their patient handbook and it is a requirement they are clearly communicating to their patients, it isn't a practice that he would think of as illegal, and that it is a matter of provider choice. He did indicate he would try to work with the OTP to see if the call back could be done in a manner that would not risk someone losing their job.
        - Dr. Olsen mentioned that federal regulations say that Medical Directors need to consider all of the aspects of the treatment and weigh that against the risks of no longer treating a certain patient
    - An attendee asked about BHA's role in addressing complaints regarding loitering by OTP patients. Frank explained that BHA has an agreement with the LAAs/LBHAs that they conduct these complaint investigations, but will help mediate as needed. When BHA conducts the initial site visit, they work with the provider to identify methods for controlling activity around their building. Frank explained that most providers manage controlling this activity very well, but there are limits in their ability to control activity that is happening further away from their building.
    - Another question posed during this discussion was whether or not BHA regulates safety plans at OTPs or the ratio of patients to staff members, especially pertaining to their medical director. It was further asked if there was a suggested best practice for composition of staff for those larger OTPs that serve up to and exceeding 1,000 patients. Upon consideration of these questions, the group began to discuss the various measures adopted by several OTPs to ensure both external and internal safety and security, and BHA's role in this. Frank explained that BHA does not have the authority to regulate a specific staff-to-patient ratio or external security measures. The group discussed that several OTPs hire off-duty police officers to serve as security guards at their facilities, while others hire greeters to welcome patients in and to help move foot traffic along outside. It was mentioned that though the greeters have, at times, similar job functions as security guards, the interactions they have with the community and the impact they have on the community is fundamentally different from a security guard.

    - The group then discussed the potential impacts of requiring all OTPs in Maryland to have dedicated external security personnel on staff. Though OTPs must comply with both state and federal regulations, external security is not addressed in any of the regulations; existing regulations that address the security measures that must be taken by OTPs primarily target the safe storage of medications. It was discussed that regulations surrounding this aspect could be potentially onerous to many of the OTPs across the state, particularly those OTPs where loitering is not an issue.
    - Additionally, an attendee suggested that trying to regulate and legislate the relationship between an OTP and their community through a non-individualized approach could be potentially detrimental because all regulations would impact a divergent community.
    - Also noted was the need to be mindful of the American Disabilities Act.

Next Steps: Lisa Burgess, M.D., BHA Acting Deputy Secretary

- Dr. Burgess asked that if any of the attendees had any issues or concerns that were not addressed in either of the two workgroup meetings to contact BHA.
- BHA will now draft a report detailing the recommendations and findings of the group. The draft will be provided to all workgroup members for review and comments. Once all feedback has been received, BHA will finalize the report and provide it to the Health and Government Operations (HGO) committee in early December.
- Dr. Burgess ended by thanking everyone for their time.