**Department of Health and Mental Hygiene**

**Behavioral Health Administration**

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

**Minutes for October 18th, 2016**

Attendees: K. Rebbert-Franklin, BHA; C. Trenton, BHA; L. Burns-Heffner, BHA; K. Bright, BHA; M. Donohue, BHA; L. Fassett for R. Faulkner, BHA; E. Hall, MA; H. Ashkin; A. Breidenstine for R. Smith; M. Currens; C. Halpin; Y. Israel; D. Madden; Y. Olsen; J. Severn; K. Stoller; B. Wahl; V. Walters; A.Winepol

On Phone: B. Page, BHA; J. Formicola

1. Welcome and Approval of Draft Minutes from September 27th meeting. Minutes approved as provided. However, concern was expressed about making co-prescribing and distribution of naloxone kits mandatory (as stated in grid).

* Request made to change “Overdose Prevention” to “Overdose Response” in Practice standards.
* Concerns expressed were that some patients are not interested, unable to fill prescription consistently across state. Also, it is an additional onerous requirement without additional funding, and not required of other non-MAT programs. Similar recollections were expressed, re prescribing as best practice but provision of kit is an issue.
* Would like grid criteria revised to state that “programs must offer a prescription for naloxone to all patients” with the method of measurement as “documentation of offer of prescription”, leaving that criteria as mandatory, but to move the second part to the Guidance Documents section, stating that “programs should facilitate distribution of kits”.
* Concerns expressed were about lack of systemic ways to provide kits; therefore, it shouldn’t be mandated, but the word “should” would be kept rather than a suggestion of a change to “may”, and encouraged as best practice.

A 2nd concern was raised under the method of monitoring for the Training Standard regarding the language of “punitive based policies re take homes”.

* Clinically, there are appropriate reasons to reduce take homes, such as when someone is showing signs of destabilization. It may also be a safety issue, and one of motivating behavior, not necessarily stigmatizing.
* An explanation was requested from member who had initiated comment, and expressed experiencing this type of behavior from staff.
* The concern for training staff against using punitive based policies may be more for people who aren’t in the room, as not all take home reductions are punitive; those who do this give the rest a bad name.
* Requests were made to consider strength based recovery oriented language for the method of monitoring, use of satisfaction surveys, etc.
* Discussion was held about the need for cultural competence, meaning the culture of the program and how patients are treated. Concern expressed about people not in room not getting it if we just use positive language, will defer details to training committee.
* When talking about training, it’s important to have a peer to co-present with clinician.
* BHA will craft a sentence re how to measure.
* A request was made to receive minutes and revised documents prior to next meeting.

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

*Care is provided based on outcome and individual response, monitoring criteria-*

* Ways of monitoring could include discussions in team rounds, chart reviews.
* Program should be able to produce guidelines or policy & procedures as to how they make these decisions, what criteria to use, range of services to offer, how they are determined, and are they prescribed vs selected by patients.
* Suggest using Beacon data to see average range of types of episodes, can see outliers.
* Beacon data doesn’t address quality or variety of services. Gets to dose, not the content for service sessions. Match Beacon data to schema of what is provided, gets to dose (data) and content (schema of offerings, oversite, supervision).
* Schema is a set of criteria that drives treatment assignment, with ability to make changes if necessary, an algorithm that suggests treatment interventions. This drills down further from ASAM, principles, protocols. Having some guidance for clinical staff that provides consistency is important.
* Are there benchmarks for too little, too much?
* Beacon data can be amount of service offered per person and program.
* Statement made that hospital programs are not being unbundled, worried about fairness across the board, sample size, etc. regarding use of Beacon data. Comment that some are re-bundling, not clear if ruling applies to HRCSC programs. Suggest to take conversation off line and review with MA.
* If using Beacon, can match frequency of visits and services provided.
* Does Beacon have urinalysis results as part of data collection for OMS tool? Not part of 49 questions, but can collect in other areas.
* Urinalysis result alone don’t tell a complete story, need more information to interpret correctly.

*Provide combination treatment-*

* Very similar to discussion just had. What we just talked about with schema would address this. Gets to quality of care.
* Method is the schema, and the analysis of Beacon data. Can apply to either end, too much, or too little.
* Concern expressed about how this will be presented to legislature.
* Suggested Standards will be reviewed by AG office prior to submission to legislature.

*Engagement-*

* Do both these items go together? Both are about engagement, all part of same person.
* Incentives-does this imply paying clients? Can be evidence based to do so.
* Really talking about quality of care, incentives are not allowed at start of treatment, once in it is ok.
* There are a variety of types of incentives, not only fiscal. Use word “incentivize”.
* Goes to use of EBP “incentivize” individuals. Whole body of research about “incentivizing” to assist in engagement to treatment.
* Suggest change language of criteria to “Use of EBP to incentivize engagement and adherence”.
* How to monitor? Suggest “Policy and procedure identifying EB practices that incent engagement and adherence”.

*Management of concurrent misuse-*

* Request made to adding “or referral” after treatment in the criteria. This led to a discussion regarding should programs be required to address all concurrent issues, or is it letting them off the hook by saying “or referral” or management.
* Discussion was held about non-medicine interventions being the same regardless of substance. All counseling and group sessions are applicable to all substance use disorders.
* Should we add tobacco and gambling to criteria as well?
* Suggestion to use word “offer” instead of provide? Use words “refer and manage”?
* This criteria reflects the shift to being more than just an OTP, services are applicable to all SUD, not always definitive. Either the program manages it or provides by referral.
* Personal experience with concurrent drug use was shared, use was addressed together. Focus groups indicate that patients want all services to be provided together.
* This criteria is getting to the need to provide treatment for all substances, the measurement is way to know what is intended.
* Method for measurement could be treatment plan notes, etc.
* Measurement will address flexibility of being able to make referrals for additional services needed.
* What are we going to measure? Can we use Beacon data to determine if program is addressing other diagnoses? Suggest measurement to read “Policy is in place to instruct staff to assess for other drugs of misuse; include in treatment plan and address in treatment sessions”.
* If you tell someone to stop using everything all at same time it is overwhelming and doesn’t work well.

1. Assign Tasks for Final Meeting:

Review of minutes and grid prior to meeting.

1. Next Meeting: October 25th, 2016 at 1:00 pm, Dix Ground Floor Conference Room